FIFTH REPORT OF THE COURT MONITOR
ON PROGRESS TOWARD COMPLIANCE
WITH THE AGREEMENT:
U.S. v. STATE OF DELAWARE

U.S. District Court for the District of Delaware, Civil Action No: 11-591-LPS

May 19, 2014

I. Introduction

This is the fifth report of the Court Monitor (Monitor) on the implementation of the above-referenced Settlement Agreement (Agreement) between the United States, through the U.S. Department of Justice (DOJ), and the State of Delaware (the State). This report covers the six-month period July 15, 2013 through January 15, 2014; it also reflects the State's overall progress in fulfilling its requirements under the Agreement during the past 2 ½ years.

The Agreement lays out specific corrective actions with respect to public programs serving Delawareans with Serious and Persistent Mental Illnesses (SPMI). As has been noted in past reports, the State is not only working to meet the targets delineated in the Agreement, but is attempting to do so in ways that will result in sustainable improvements in its service systems. This is not a simple task. At the outset of implementation, Delaware's public systems relevant to the Agreement reflected a patchwork of disconnected requirements, funding opportunities and expedient reforms within and across bureaucratic divisions. The resultant policies were often incoherent, poorly coordinated, or directed towards conflicting priorities. The State's fulfillment of its requirements under the Americans with Disabilities Act (ADA)—around which much of the Agreement is framed—was not an organizing value. This was essentially the state of affairs in Delaware (as it remains in many states nationwide) when the Agreement took effect in 2011.

In its 2 ½ years of implementing the Agreement, the State has made an admirably strong effort to remedy these inefficiencies and to realign its strategies. This has required it to focus not only on the quantitative requirements of the Agreement, but also to look at the structures and systems—many of them embodying longstanding, ingrained practices—that underlie the provision and management of services. While it is making good progress in this complicated endeavor, these system refinements are ongoing; as is discussed in this report, the State's fulfillment of some requirements of the Agreement remain hampered by practices that are not well aligned. Nevertheless, from the

Governor's office on down, there is a commitment to serve people with SPMI, as well as other disabilities, in ways that promote their full participation in community life. This is the principle underlying the Agreement and the ADA.

As last time, this report begins with a discussion of the State's progress with respect to some essential improvements in the structure of services and services management. Several of these cut across departments, divisions and relationships with private providers. These reforms challenge—and, sometimes, are challenged by—persistent bureaucratic silos.

The report then presents findings with respect to the Agreement's measurable targets. As is discussed below, the State is in Substantial Compliance with the Agreement, having met or exceeded its requirements, with only two exceptions, where it is in Partial Compliance: the Discharge Planning provisions relating to Crisis Stabilization Services, and the requirements for Risk Reduction. The State is taking appropriate steps to achieve Substantial Compliance with respect to these requirements and, appears to be well-positioned to meet additional new requirements that go into effect in July, 2014.

The July targets include a challenging new benchmark with regard to reducing psychiatric inpatient bed-use. As things are currently configured, oversight of psychiatric bed-use straddles two divisions within DHSS. As a result, achieving the necessary reductions has been an unusually vexing issue for the State. Nevertheless, as is discussed in the following section, the State is now taking some immediate-term measures and it has developed longer-term plans to address this important requirement.

In summary, Delaware continues to make impressive progress in implementing the Agreement. With a sustained focus on both the Agreement's Implementation Timeline (Section III) and the structural factors discussed below, there is good reason to expect that it will successfully meet its obligations within the five-year period that the parties projected. Much of the success in implementing the Agreement can be attributed to the uniquely collegial relationship between the State, DOJ, and the Monitor, whereby issues that need attention are identified early on and the parties collaborate around strategies for tackling them. This relationship is exemplified in the inpatient bed-use reduction plan which is discussed herein.

II. Progress on Structural Improvements

The State's achievement of Substantial Compliance with virtually all of its targets has required flexibility, a willingness to critically evaluate longstanding practices, and openness to trying new approaches. For example, the Agreement reflects the challenging goal of reducing the State's reliance on hospital care and moving towards a much more preventive, voluntary, and recovery-oriented model. Meaningful accomplishment of this goal is not simply a matter of creating the new community programs that are delineated

in the Agreement. It also requires a careful understanding of the pathways that lead people to adverse outcomes such as mental health crises, hospital admissions, and involvement of the police or courts. Such analyses allow the State to test new administrative or service approaches that may—or may not—ultimately prove to work as expected. All of these elements have made it necessary for the State to develop new capabilities to capture timely data (often across bureaucratic divisions) and to evaluate the impact of services and the context within which they are provided.

A. Use of Data

Delaware continues to move forward in an overhaul of its information systems, with the broad goals of unifying data, allowing proper and timely data access across (and within) divisions, and promoting better and more efficient outcomes in its public programs. This important endeavor entails a concerted effort over several years. At the same time, the Agreement is envisioned to be carried out within a five-year window, with evaluations of progress about every six months. Notwithstanding the State's longer-range efforts, the Agreement presents an immediate need for data that has required the State to devise some interim measures. A large share of the data presented in this report is generated by these means.

As Delaware's larger refinement of its information technology systems goes into effect, some of the interim measures may come to be replaced and better integrated with larger, and in some ways more sophisticated, data sets. Even if that is the case, the interim approaches are already changing how staff at DHSS utilize data to inform their work. Whereas staff had been accustomed to relying upon outdated information that was compiled manually and on an impromptu basis, they are now increasingly incorporating into routine practice data systems that consolidate information across and within bureaucratic divisions, and trending charts with various measures of programs' performance over time. Many of these are presented in this report. This reflects an important, positive change in the culture of services management that is not particularly explicit in the Agreement, but that nonetheless positions the State to provide effective, efficient services in accordance with its ADA obligations, through the implementation period and beyond.

Data improvements (or at least those relevant to the Agreement) have been most dramatic within DHSS's Division of Substance Abuse and Mental Health (DSAMH). At the outset of implementation, DSAMH relied heavily on an array of inefficient and incomplete data sources, including paper or faxed reports, idiosyncratic spreadsheets constructed by individual staff members, extraction of information buried in clinical records, and a good deal of manual counting and sorting. While still very much a work in progress, today DSAMH's data systems are a far cry from what they were 2 ½ years ago. The Division has created a unified data scorecard that includes measures relevant to each

of the major provisions of the Agreement. These measures are updated monthly and trended over time, thereby facilitating the State's (and the Monitor's) oversight of compliance and the identification of successes or problems in services. Some data sets, such as the number of individuals served through Assertive Community Treatment (ACT), can readily provide an overall picture of where the State stands, or they easily can be drilled down to the status of a particular agency or clinical team. This is an impressive accomplishment.

The Division's evolving data capacities are also being applied to evaluate the impact of new initiatives. For example, data relating to the mental health screening that is required under recent legislation allow DSAMH to assess outcomes such as whether an individual who was screened was ultimately admitted to a hospital, who had conducted the screening, and other key factors. Such information is allowing Delaware to evaluate how the State's new law is working and to take appropriate steps to improve outcomes and align them with its broader system reforms.

For a variety of reasons, the Division of Medicaid and Medical Assistance (DMMA) has found the collection and analysis of data relevant to the Agreement to be more difficult. At this juncture, DMMA is far less advanced in this regard, but it is recently making some progress. DSAMH has direct responsibility for services relevant to the majority of individuals with SPMI in the state, but DMMA manages care to a significant population of individuals who are diagnosed with serious mental illnesses, including some who meet the Agreement's criteria for SPMI (i.e., serious and *persistent* mental illness). They are served through Medicaid programs that are administered by private Managed Care Organizations (MCO) operating under contract with the State.

In contrast to DSAMH, most individuals served through MCOs have primarily physical healthcare needs; those with serious mental illnesses represent only a small portion of the covered population and those with SPMI are an even smaller subpopulation. DMMA's data systems were not designed to easily capture the sort of information that is critical to the Agreement and that is more routine within DSAMH. In fact, even the basic task of identifying the MCO population of individuals diagnosed with serious mental illness, and then extracting the sub-population of this group that meets the criteria for SPMI (i.e., the persistence and intensity of disability and associated adverse outcomes specified in Section II.B) has been challenging for DMMA and remains so.

Moreover, although the State contracts with MCOs to provide active care management during the course of an individual's psychiatric hospitalization—that is, the MCO's monitor an individual's inpatient care from admission through discharge—DMMA maintains that it is unable to get accurate "real-time" information about hospital utilization. Instead, it asserts that accurate bed-day data are only available many months after hospital discharge, when Medicaid claims have been reconciled. In evaluating the State's status with regard to reductions in hospital use, this causes obvious problems.

Furthermore, such long delays in access to what are ostensibly straightforward data (i.e., the number of days spent in psychiatric hospitals) present significant problems in evaluating the impact of measures intended to reduce hospital use.

On one level or another, the data issues discussed above have been impediments to monitoring compliance with the Agreement that have been referenced in each of the prior Monitor reports.

Recently, there have been some promising collaborative efforts by DMMA and DSAMH, and between these Divisions and the Monitor, to devise some immediate and longer-range remedies. These are presented in the section of the report relating to Crisis Stabilization Services. As things now stand, DSAMH's data are reasonably reliable and timely; DMMA's data are less so. The data sets from DMMA that were incorporated in the Monitor's past reports were considered by all parties to be accurate, per se, but highly unreliable with respect to the requirements of the Agreement. Largely, this is because diagnostic information that would trigger an individual's inclusion in the Targeted Priority Population List (TPPL)—and the monitoring of such factors as inpatient psychiatric bed-day use—was based on what appeared on Medicaid billings. These ranged from diagnoses rendered by emergency room physicians who are not psychiatrists to diagnoses by psychiatrists in IMDs that were potentially incentivized by the scarcity of beds for substance abuse treatment or misperceptions about MCOs' decision-making relating to payment for inpatient services. Accordingly, these data are problematic for purposes of evaluating compliance, in that they may include substantial numbers of individuals whose mental health issues are misdiagnosed or overstated.

While the number of individuals included in the TPPL, in itself, is not a factor that generates a rating with respect to the State's implementation of the Agreement, the TPPL is important because it provides an overall picture of the population covered by the Agreement and this group's experiences with adverse outcomes such as emergency room use, homelessness and police encounters. Furthermore, as is discussed later (in the section relating to Crisis Stabilization Services), the use of psychiatric inpatient beds by individuals on the TPPL is an important compliance measure that is tracked and rated. For these reasons, it is essential that the State has accurate data about people with SPMI who are served through its public systems.

Most of the measures of compliance presented in this report concern DSAMH-managed programs, such as Assertive Community Treatment (ACT), supported housing, and intensive case management. These are not affected by issues with DMMA's data that affect implementation monitoring and, at least for now, do not materially affect the State's standing with regard to compliance with the Agreement. However, in preparing this report, an initial analysis of the State's data strongly suggested that some measures of compliance could be significantly distorted if adjustments were not made in how individuals with SPMI were identified within the MCO group. For example, when

applying the same data protocols for TPPL inclusion to DMMA as are used with respect to DSAMH (these are the same protocols that have been used since implementation monitoring began), the DMMA data for this fiscal year showed over a 59% *increase* in bed-days within acute psychiatric hospitals for individuals managed by MCOs relative to the "base year" of 2011. Most of these reflect first, and only, admissions. That increase did occur—at significant expense to the State—but clinical incidence rates and other considerations would suggest that such an increase in the number of Delawareans with SPMI and their use of hospital care would be far, far lower. Much more likely is that the diagnostic data from the private psychiatric hospitals that are available to DMMA through Medicaid claims, represent greatly overstated numbers of people with SPMI.

As the Monitor's discussions of available inpatient bed-use data with DMMA and DSAMH moved forward in recent months, it became clear that in order to extract the most accurate information about individuals prioritized in the Agreement whose care is managed by an MCO, an alternative strategy would need to be developed. Accordingly, the Monitor is working closely with these Divisions to establish a methodology to determine which MCO-managed individuals with diagnoses of serious mental illnesses should be included on the TPPL based upon their admissions to a private psychiatric hospital (in the Agreement's federal parlance, these facilities are known as "Institutions for Mental Disease," or "IMDs"). As of this report, the Monitor and the State have established at least an interim methodology, which is reflected in several sections that follow. This protocol includes all MCO-managed hospital admissions for individuals diagnosed with schizophrenia, as well as individuals diagnosed with certain serious mental illnesses who have had at least one prior psychiatric hospital admission within a two-year period. The diagnoses that appear to be most prone to misapplication by Medicaid providers are not included in these interim numbers. Figures for DSAMH-managed services are not affected since their data are usable as-is for monitoring purposes.

The Monitor plans to work with the State in the coming months to assure that the process of DMMA data extraction is further refined by the time some of the critically important targets (e.g., hospital bed-days) are evaluated in July, 2014. The data presented in this report reflect the best current estimates as to where the State stands with respect to compliance. Because of changes in methodology, figures that have appeared in prior Monitor reports relating to the base year (2011) have been revised accordingly. The numbers reported here may be further revised in the next report.

To present the status of compliance as accurately as possible in light of these issues, as applicable in this report, measures that *are* reliant on DMMA's data are not only presented as a single "State" figure, but also break-out DSAMH and DMMA components.

Recommendations:

1. It is strongly recommended that the State redouble its efforts to make immediate improvements in its data capacities, particularly with respect to individuals with SPMI whose care is managed via DMMA. It is essential that the State has timely and accurate information about the numbers of individuals with SPMI who are served through its public programs. The Monitor will continue to closely work with the State in this regard.

2. It is strongly recommended that DHSS ensure that DMMA appropriately prioritizes compliance with the Agreement and associated monitoring requirements.

B. Targeted Priority Population List:

Section II.B of the Settlement Agreement defines the populations of people with SPMI who are prioritized for the required service expansions. These include individuals who have been psychiatrically hospitalized, who have been treated in an emergency room or had criminal justice contact for issues attendant to SPMI, or who have been homeless. It is not uncommon that a single individual has experienced several of these adverse outcomes and, therefore, is represented in more than one of the statistics presented below. Because of the status of the State's data systems and the need to gather information across Divisions and Departments, creating the Targeted Priority Population List (TPPL) was initially quite challenging. The State is continuing to greatly refine its capacities to provide information about Delawareans with SPMI who are served by its public systems.

Based on currently available data, and applying the revised methodology with regard to DMMA, the TPPL now includes a total of 11,131 individuals. By way of comparison, the Monitor's last report (in September, 2013) indicated that there were 8,254 on this list.

The table below presents a breakdown of the characteristics of individuals on the TPPL, including the proportion whose care is managed by DSAMH and the proportion managed by DMMA. DMMA data are not included in the statistics related to the adverse outcomes of criminal justice contact or homelessness. Emergency room treatment for issues relating to serious mental illness is based upon Medicaid claims data and includes both populations. Again, an individual may be represented in more than one category of adverse outcomes.

Overall Composition of the TPPL

- Services managed by DSAMH (approx.)..... 58.8%
- Services managed by DMMA (approx.) 40.1%

Adverse Outcomes Experienced by Individuals on the TPPL

- Treatment at DPC[1] (DSAMH-managed) 10.9%
- Treatment in an IMD..... 33.4%
  - DSAMH-managed 15.7%
  - DMMA-managed..... 17.7%
- Criminal justice contact (DSAMH) 16.2%
- Homeless (DSAMH)..... 18.2%
- ER use for mental health (DSAMH+DMMA)..... 50.0%

The TPPL identifies Delawareans with SPMI who may be at high risk for adverse events and who are prioritized for specialized services and supports. In itself, inclusion on the TPPL need not indicate that an individual is in need of the full complement of intensive services offered by the programs developed in accordance with the Agreement; it simply suggests that there may be an elevated risk for one or more specialized mental health services.

C. Delaware Psychiatric Center:

Over the past decades, state-operated psychiatric facilities nationwide have undergone significant changes, shifting from massive self-contained facilities that warehoused people for years on end to much smaller hospitals that provide active specialty treatment directed towards successful community living. Prior to the development of this Agreement, Delaware Psychiatric Center (DPC) had already embarked on reducing its number of beds, although a sizable population of individuals remained on its long-term care units because of the absence of appropriate community alternatives. The expansions in housing and community services that have taken place in accordance with the Agreement have allowed a substantial number of these individuals—some of whom were hospitalized for decades—to return to their communities and to realize the opportunities that are afforded them under the ADA. Their discharge to community settings accelerated a shift in the function of DPC that was already underway, from mainly providing long-term care to more acute stabilization and recovery-oriented services.

[1] Forensic patients at the Mitchell building are not included in these numbers, since the criminal courts, rather than the State's human service programs, have control over them.

Evaluation of Individuals Discharged Following Long Hospitalizations:

The Monitor's last report included data demonstrating the positive outcomes for individuals who were discharged from DPC following extended continuous hospitalizations, defined as 60-days or longer. As a brief update, in calendar year 2013, 102 such individuals were discharged to community settings, generally with ACT and other high-intensity services discussed later in this report. The re-admission rates for these individuals, following 30- and 180-days in the community are presented in the table below. For comparison are the most recently published national readmission rates and those for the state of Delaware.

	30-DAY READMISSION RATE	180-DAY READMISSION RATE
Post-Discharge DPC Population of 102 Individuals:		
Readmission Rates*	5.9%	13.7%
Comparison Rates:		
U.S. Rates (SAMHSA, 2012)**	9.1%	20.1%
Delaware Rates (2013)	9.6%	23.1%

*The above numbers are based upon all clients discharged from DPC within FY13 following stays of 60+ days

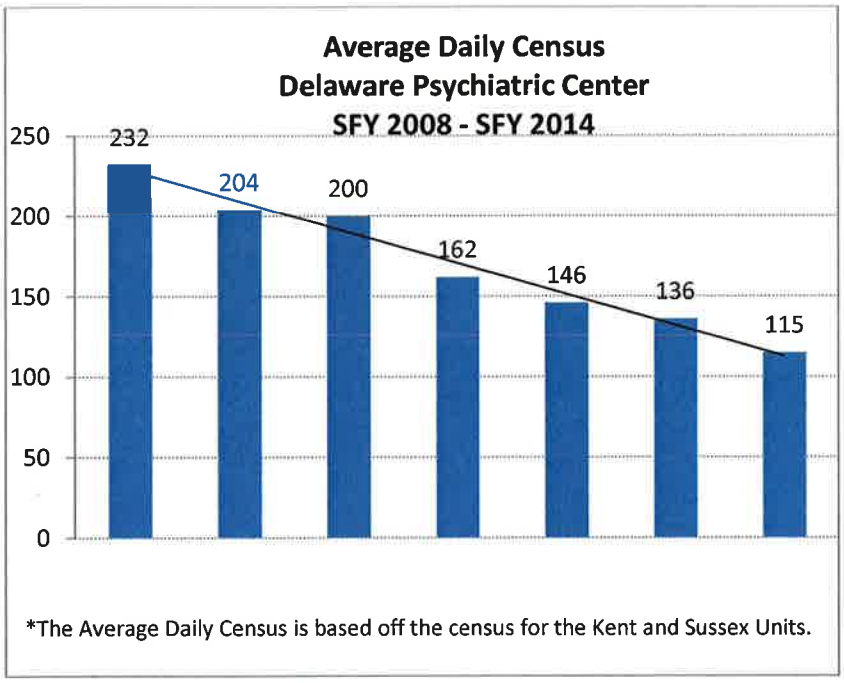
** U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, National Outcomes Measures, 2012.

As is reflected in their histories of protracted inpatient psychiatric treatment, members of this population have significant levels of disability, often complicated by physical health issues, addictions, and dependencies bred by long-term institutionalization. Nevertheless, their readmission rates one-month and six-months following discharge from DPC remain significantly better than the comparison populations with serious mental illness. These data are a blunt—but very positive—measure of the impact of Delaware's investment in alternative community based mental health programs. The low readmission rates for individuals discharged from long-term care during this period are consistent with those reported in the Monitor's September, 2013 report, for the prior year.

Facility Downsizing& Repurposing:

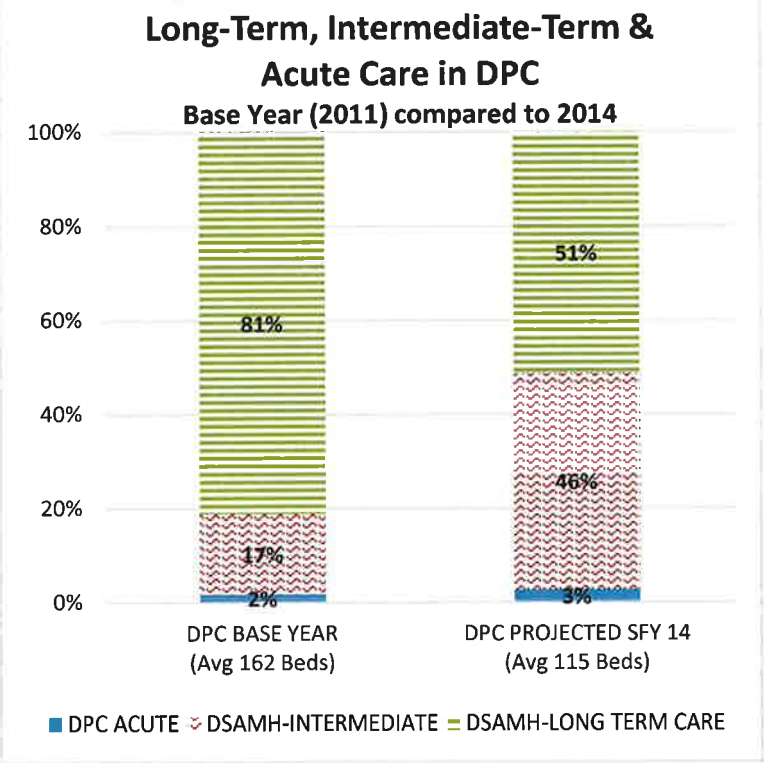
The successful discharge of individuals from DPC following long-term care has resulted in significant reductions in bed-days at the hospital (see discussion below relating to

Section III.D.3) and to a reconfiguration of the facility towards more intermediate-term and acute care. These discharges have also enabled significant reductions in the hospital's average daily census. As is reflected in the table that follows, DPC's current average daily census of 115 is about 50% lower than it was in the State's 2008 fiscal year, and 30% lower than in 2011, the "base year" prior to the Agreement that is used as a comparison point for implementation monitoring.



DPC can be regarded as providing three levels of non-forensic care: Long-Term Care (defined as 180 days+), specialized Intermediate-Term Care (defined as 15-179 days), and Acute Care (defined in the Agreement as 14 days or fewer). The following table shows how the proportions of DPC's inpatient population are shifting from predominantly Long-Term Care and towards Intermediate-Term Care and Acute Care.

The Long-Term Care population at DPC includes individuals with SPMI with ongoing needs for intensive mental health services, often accompanied by physical health issues. While this group is defined here as individuals who have had 180 days of continuous hospitalization or longer, some have been in the hospital much longer, even for decades. The Intermediate-Term population includes individuals with SPMI with intensive mental health needs, most of whom were transferred from Acute Care from one of the IMDs because significant psychiatric issues could not be resolved within 14 days. DPC's Acute-Care population includes new admissions, mostly of people who either are uninsured or who have been carved-out of Medicaid Managed Care for DSAMH's intensive community programs; in either instance, DSAMH assumes the responsibility for the cost and management of inpatient psychiatric care.

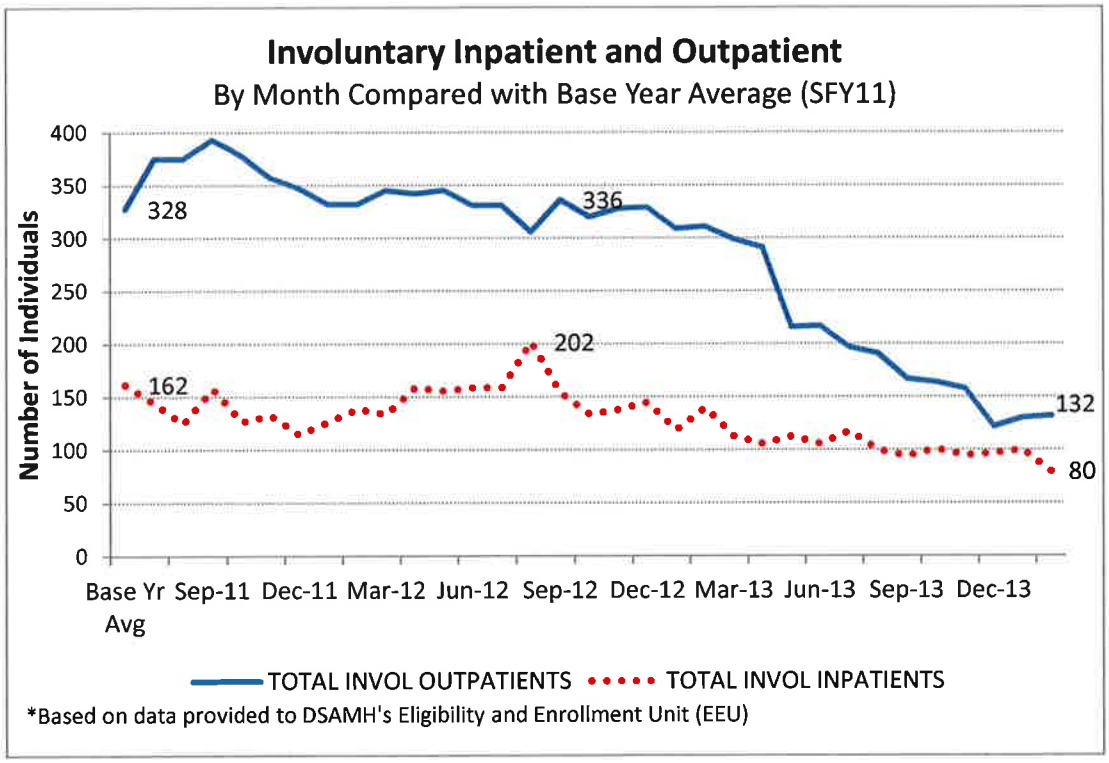


To assist DSAMH in its ongoing efforts to improve the quality of care at DPC and to assist DPC in its transition towards a more acute-care orientation, the Monitor has facilitated expert technical assistance relating to nursing services and the hospital's Utilization Review program. This technical assistance will be continuing during the remainder of the year and, likely, beyond.

D. Reliance on Court-Ordered Treatment

Prior reports by the Monitor have referenced Delaware's long history of over-reliance on court-ordered treatment and the disjuncture between this tradition and the reforms that DSAMH is pursuing. Properly used, judicial involvement in mental healthcare is a last-resort, emergency measure; its overuse signals problems in services earlier on. Furthermore, unwarranted involuntary treatment—including court-ordered treatment to reduce providers' perceived liability, assure payment, facilitate transports by police, or as

a substitute for good consumer engagement—is not the "least-restrictive" approach consistent individuals' rights under the ADA and other laws.



The State continues to make significant progress in extracting the court system from routine care for individuals with SPMI and in moving towards a much more voluntary approach to services. The chart above quantifies the State's dramatic progress in reducing its reliance on court-ordered treatment for both inpatient and outpatient services. It presents the number of individuals who were under active civil commitment orders each month by type of order, as well as the monthly average for the base year prior to implementation of the Agreement (i.e., July, 2010 to July, 2011).

The State has achieved about a 60% reduction in its use of outpatient commitments, dropping from an average of 328 active orders in the base year to just 132 in February, 2014. This reduction is particularly significant since the number of people being served in outpatient programs has increased during this period, including (as discussed above) a sizable population of individuals with high levels of disability who had been served on DPC's long-term care units.

In terms of inpatient treatment, there has been about a 50% reduction in reliance upon involuntary treatment orders, with 162 as the average in the base year and only 80 inpatient orders in February, 2014.

The impressive progress that the State is making reflects an array of measures to change

practices and a service culture that saw involvement of the courts and police in mental health services as unremarkable and routine. Some corrective measures taken by the State have been major, such as the recent change in law requiring an evaluation by a qualified screener (discussed immediately below) before a person is placed under an involuntary hold. Other measures, such as expanding alternatives to police transports, are less obvious but have important implications for everyday practice. Building upon its success, the State is continuing its refinement in services to avert crises and to provide alternatives to hospital care, and it is moving forward in examining ways to modernize its mental health laws. These efforts can play an important role in furthering its transformation of services systems towards least-restrictive care, voluntary engagement, and a recovery orientation.

E. Mental Health Screeners

In July, 2012, Governor Markell signed into law a bill requiring that an assessment be conducted by a certified mental health screener prior to an individual being detained on a 24-hour hold, which is the first step in the State's civil commitment process. Among other things, the screener is qualified to certify that the individual indeed appears to have a serious mental illness (as defined by law) and the screener must also certify that voluntary treatment options were considered and appropriately offered. Following the development of processes for screeners' certification and training by DHSS, mental health screenings were implemented statewide on July 1, 2013.

Based upon reviews by the Monitor and a consultant, the mental health screening process appears to be off to a good start. A random sample of recent admissions to IMDs, including individuals whose care is managed by DSAMH or DMMA, found that 100% of the hospital charts examined had the required screening forms. Reflecting its new data capacities, DSAMH is now in the position where it can evaluate the impact of mental health screenings and their quality. For example, for people who were detained on 24-hour holds, DSAMH is able to produce reports identifying the specific screener, the facility in which the individual was screened (e.g., a particular hospital emergency room), where the individual was hospitalized, and whether a screener's recommendation for involuntary hospitalization actually resulted in that outcome. With regard to the latter, DSAMH has already identified a surprisingly large number of instances whereby (after offering an opportunity for voluntary services) screeners have authorized police transfers and 24-hour holds; within a matter of hours, following transport to the hospital, the individual then agrees to a voluntary admission. In the past, it was frequently reported to the Monitor that, notwithstanding legal protections guaranteeing that individuals would be afforded "least restrictive" measures, involuntary holds were a convenience to emergency room personnel because the police (at great expense to Delaware's taxpayers, the Monitor has learned) provide ready transportation to a psychiatric facility. Whether

the numerous instances of quick conversions of 24-hour holds to voluntary care reflect the overall newness of the mental health screening process, inadequate screening approaches, a lingering dependence upon convenient police transports, or individuals changing their minds about accepting voluntary services are all unknowns. What is important—and laudable—is that DSAMH is in a position to monitor how mental health screenings are working, to develop some performance scorecards that can provide screeners with feedback, and to make necessary refinements as things move forward.

F. Management of Clinical Services

The table below presents, in a somewhat simplified form, how responsibility for management of public services to people with SPMI is assigned. Each of the Monitor's four prior reports has cited how the State's bifurcated approach to serving people with SPMI—some within DSAMH, and others within DMMA—creates fundamental problems in managing services, ensuring good outcomes, using public resources efficiently, and complying with some of the key requirements of the Agreement. Despite repeated recommendations by the Monitor for the State to restructure things in ways that clarify and consolidate accountability, develop consistent service standards, and establish a unified information system to provide appropriate oversight, to this day the management structure affecting citizens with SPMI remains largely unchanged. As is discussed later in this report (in the section concerning Crisis Stabilization Services), Delaware is taking measures to alter its Medicaid State Plan and restructure its contracts with MCOs that may ultimately address many of these concerns.

DMMA	DSAMH
• Community-based services for individuals in Medicaid Managed Care • Acute Inpatient Care at an IMD for individuals in Medicaid Managed Care	• Community-based services for individuals carved out of Medicaid Managed Care for much more extensive specialized DSAMH services • Inpatient Care at an IMD or DPC for individuals who are carved out of Medicaid Managed Care • Inpatient Care and Community-based services for individuals who are otherwise uninsured • Inpatient Care at DPC for individuals in Medicaid Managed Care who are transferred from IMDs for intermediate- or long-term care.

Currently, people with SPMI who are served through an MCO under contract with DMMA have access to a much more limited menu of services and supports than do people who are "carved-out" for DSAMH services. The more limited array of services available through MCOs may appropriately meet the needs of some individuals with SPMI, but the State lacks a clear mechanism to evaluate individual cases to determine whether this is, indeed, the case. If people with SPMI were consistently referred to DSAMH—at least for review, if not for direct services—there would then be a vehicle to ensure that they are given an opportunity to access the broader range of services and supports (many of them described below) that are not generally available through Medicaid's managed care programs.

Based upon the State's data, as well as the Monitor's recent review of documentation by the mental health screeners, there appears to be a sizable population of individuals with SPMI and very serious levels of disability whose care is being managed by DMMA. Unless these individuals are referred to DSAMH for carve-out, they do not get such services as ACT, Supported Housing, Supported Employment, Respite, Transitional Housing, or Intensive or Targeted Care Management. As is discussed throughout this report, entry into the DSAMH system not only vastly expands the array of services available, but also access to a system that is increasingly attuned to identifying the needs of individuals with SPMI, measuring clinical outcomes, and ensuring quality.

To encourage greater numbers of referrals of DMMA-managed individuals with SPMI, several months ago DSAMH streamlined the process through which these individuals can be assessed for carve-out. Unfortunately, this has not prompted any evident surge in new referrals, in part, because it is unclear what entities within DMMA's domain have responsibility for identifying candidates for carve-out or making an actual referral. Furthermore, oversight of this important function—to the extent that it exists—is embedded within the individual MCOs' practices and is not appropriately aligned with an overall State standard.

As is discussed below, in the section on Crisis Stabilization Services, there are some measures that are being planned to improve service coordination within DMMA and between DMMA and DSAMH. Some of these measures will not be initiated until the year 2015. At the present time, though, information about the number of individuals under DMMA's management who have SPMI, what their needs are, and how well these needs are being addressed remains unclear.

III. Ratings of Compliance with the Agreement

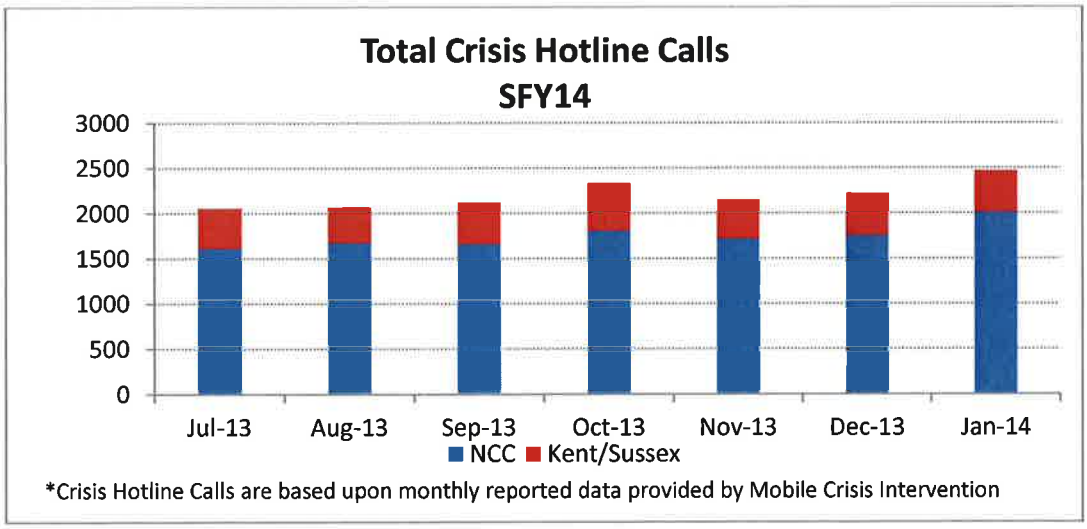
The issues discussed above have implications that cut across the programs required in the provisions of the Agreement that are discussed in this section. For instance, information systems that produce timely and meaningful data are important not only for demonstrating compliance with the Agreement's numerical targets, but also for monitoring the impact, access and quality of services being provided and identifying unmet needs. Furthermore, the unnecessary use of coercion through the courts, reliance on police, or in provider interactions with individuals being served is inconsistent with fulfilling both the State's legal requirements and its goal of recovery-oriented mental health services.

For the period covered by this report, the State is in Substantial Compliance with each of the targets that are required under the Agreement, except for Crisis Stabilization (Sections II.C.2.d.iii and iv) and Risk Reduction (Section V.B); the State is in Partial Compliance with these two provisions.

A. Crisis Hotline

Substantial Compliance.

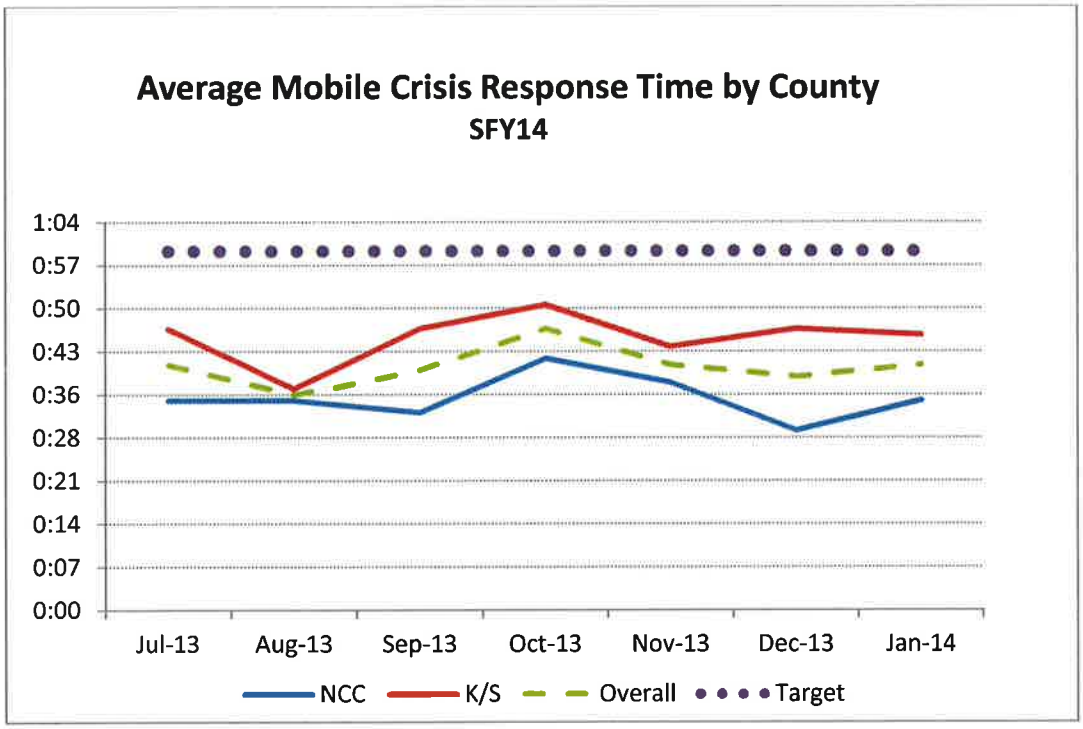
Section III.A of the Agreement requires the State to establish a crisis hotline, allowing individuals 24-hour access to assistance and referral information. Delaware remains in substantial compliance with this provision in that it operates a fully functional hotline. The table below presents its tracking of calls during this fiscal year. As would be expected, the majority of calls are being received from New Castle County (NCC), where most of the state's population is situated.



B. Mobile Crisis Services

Substantial Compliance.

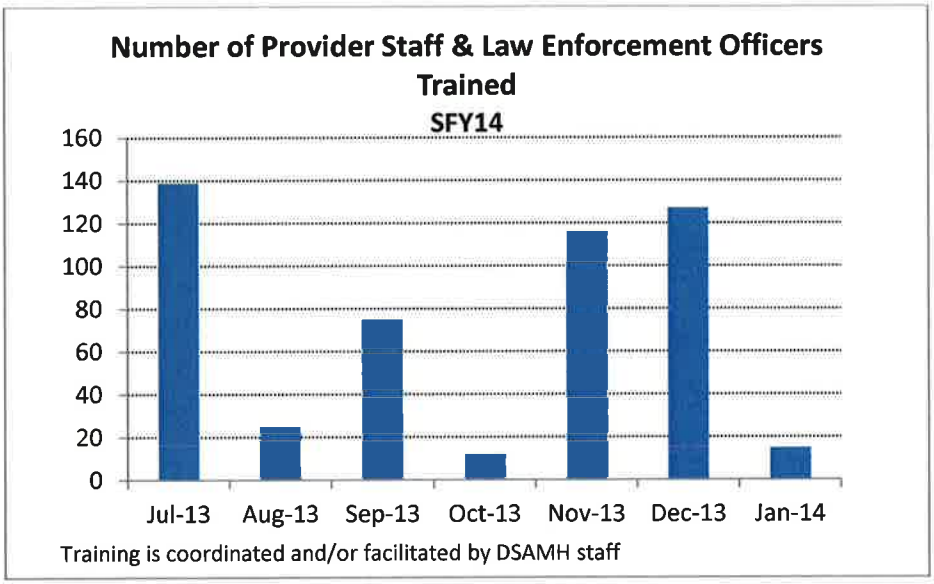
Mobile Crisis programs are a critical element of the State's emergency response system for people with SPMI in that they allow an opportunity for on-site evaluation and, ideally, de-escalation of a crisis, as well as the referral of the individual to the most appropriate service needed. As is required in Section III.B.1, the State has created mobile crisis programs throughout Delaware. Furthermore, it is continuing to meet the important target of a one-hour response time for mobile crisis calls. The chart below presents the State's monthly monitoring of this provision for the teams stationed in New Castle County and Kent/Sussex Counties. It demonstrates that the statewide program is well



within its response-time requirements, even in the downstate counties of Kent and Sussex (K/S), which are more rural and where travel tends to be more challenging. Response times are recorded from the time a call is completed until the point at which a face-to-face contact occurs. In reporting to the State, the mobile crisis programs provide information when specific calls result in longer response times, for example, in situations when callers request that the mobile crisis responder come at a particular time of day; these are not included in the chart above.

Section III.B.2 requires the State to train state and local law enforcement personnel about the availability, purpose, and procedure for accessing mobile crisis teams (Section III.C.2 has a similar requirement with regard to Crisis Walk-In Centers. Because these programs and related training are interwoven, they have been consolidated for monitoring

purposes). The State remains in substantial compliance with these provisions. The table below presents trainings that have occurred this fiscal year.

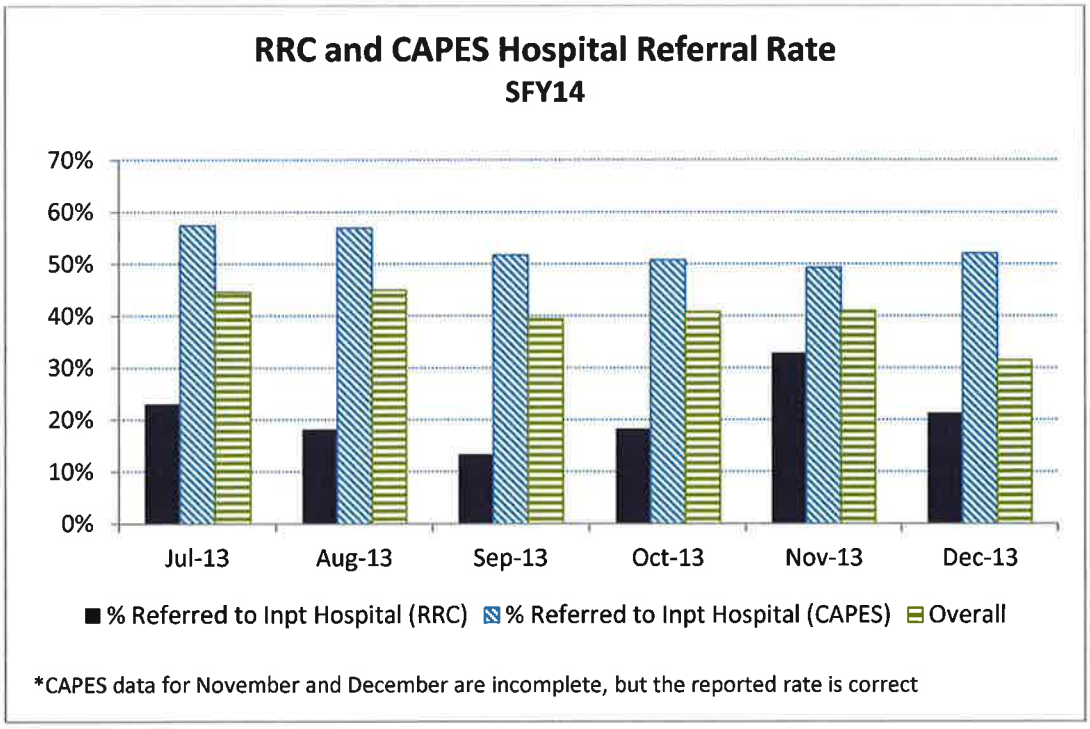


C. Crisis Walk-in Centers

Substantial Compliance.

Crisis Walk-In Centers are an important element of the Agreement in that they provide alternatives to hospital emergency rooms. They allow the evaluation of individuals who are experiencing psychiatric crises in settings that are attuned to their clinical needs, as opposed to physical health emergencies. Section III.C of the Agreement requires the State to develop a Crisis Walk-In Center to serve downstate residents, where no such service had existed. The Recovery Response Center (RCC), located in Ellendale, was developed in fulfillment of this provision.

As is indicated in the following chart, between the State's single hospital-based service in New Castle County (CAPES) and RRC, about 60% of individuals seen are able to be diverted from hospital care. Whereas CAPES is hospital-based and operates more along the lines of a traditional psychiatric crisis center, RRC's program is structured more around the "National Living Room" model where, in addition to a multidisciplinary clinical team, peer support is a central factor and the physical environment is much more reflective of a comforting home than it is of a hospital. The figures presented in the chart for this fiscal year are consistent with—and even an improvement upon—those reported in the last Monitor's report. RRC consistently diverts a much greater percentages of individuals from hospital care than CAPES.



Recognizing the success of the RRC program, and in concert with the state policy to do a formal RFP every five years, the State is pursuing measures to develop a similar program in New Castle County (this action was among the recommendations in the last Monitor's report). A request for funds to support such a program has been made to the legislature and is already in the Governor's approved budget.

D. Crisis Stabilization Services

1. Reduction in Inpatient Bed Days:

Trending Towards at Least Partial Compliance.

Section III.D.3 of the Agreement requires that by July 1, 2014 the State will need to reduce the number of inpatient bed days by 30% of its baseline, which is defined as the inpatient bed use in the year prior to implementation of the Agreement (the State's Fiscal Year 2011). This is an important provision of the Agreement in that it reflects the combined effects of such factors as the State's new programs that are oriented towards recovery and early intervention; the shift in its public system's practices and culture towards voluntary, least-restrictive services; the impact of recently enacted legislative reforms; and improved management capacities through better use of data. Furthermore, the Supreme Court's decision in *Olmstead* specifically referenced unwarranted institutionalization as a form of discrimination that is illegal under the ADA.

In addition to reforms in programs and practices, fulfillment of this requirement will also reflect the State's success in restructuring its current convoluted division of

responsibilities for services to members of the TPPL. In the absence of clear, unified mechanisms for evaluation, oversight, planning and accountability, it is difficult for the State to control bed use in the private psychiatric hospitals. Likewise, it is difficult for the State to demonstrate that actual bed use (notwithstanding the reduction targets within the Agreement) is justified by the identified needs of the individuals affected.

To date, the State's success in regard to this provision has been uneven, but it is increasingly moving towards compliance with the July, 2014 target. As is discussed later, the State has recently developed a plan for reducing inpatient bed days for individuals whose care it manages. It includes strategies such as 23-hour observation beds, better access to detox for individuals with substance abuse problems, and more integrated Utilization Review. Most components of the plan are not yet in effect, though.

At this time, bed days for individuals managed by DSAMH have been significantly reduced for the long-term care population at DPC, largely because of new supportive housing and intensive community services such as ACT, Intensive Care Management (ICM), and the Community Reintegration Project (CRISP). In addition, the State has achieved some more modest reductions in acute inpatient bed use among people managed by DSAMH who are served at DPC or one of the IMDs. This accomplishment is attributable to at-risk individuals' access to these high-end community programs, but also to service approaches that are increasingly well-integrated with other resources DSAMH has developed pursuant to the Agreement. Finally, the State's dramatic and continuing improvements in its use of information systems for the management and oversight are enabling the DSAMH to monitor quality and to adjust service approaches in ways that had not been available in the past.

DSAMH has expanded its Utilization Review (UR) program for the inpatient populations it manages and has sought technical assistance through an expert engaged by the Monitor. The expert has been working with DSAMH around a number of refinements in its UR system, including improved supervision of the UR nurses and more standardized protocols for determining the need for inpatient psychiatric care. In reviewing records in the IMDs, the expert found several factors that substantiated the urgency in improving UR functions—and these apply to *both* the Utilization Review Processes provided by DSAMH and UR provided for DMMA-managed individuals through the MCOs (discussed below). Her concerns regarding the local private hospital (IMD) chart reviews included such factors as:

- Admissions for preventable reasons or matters for which community alternatives exist (an example cited is that of an individual ran out of medications while the physician was on vacation);
- Vague treatment focus with poorly specified objectives and discharge criteria;
- Treatment that does not flow from the clinical assessments; and

- Assessments and plans that do not appropriately address recidivism.

Again, these fundamental problems in documentation within the IMDs not only have implications for monitoring the effectiveness of hospital treatment that is being provided to individuals with SPMI through use of State funds (DSAMH or Medicaid), but they also challenge efforts to evaluate whether hospitalization is necessary or whether a less-restrictive mode of intervention is more appropriate. This is a critically important determination, in terms of compliance with the ADA and other laws, and also in ensuring that public resources are not needlessly spent on expensive hospital services.

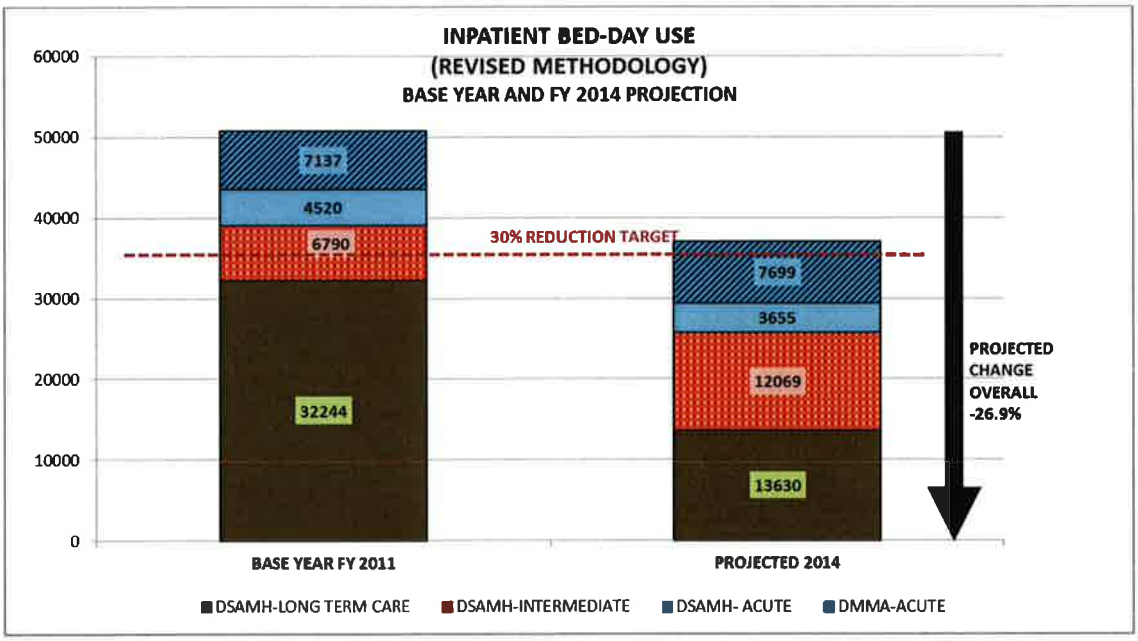
DMMA has responsibility for a sizable population of individuals who have been diagnosed with serious mental illness. In theory, at least, individuals with SPMI who require the higher intensity or scope of services provided by DSAMH are carved-out of DMMA's Medicaid managed care programs and enrolled with DSAMH for their mental healthcare (MCOs continue to manage physical healthcare for these individuals). However, *how* within DMMA's system the State ensures that such individuals are identified and appropriately referred, *who* has responsibility for carrying out these essential functions, and *how* this overall process is monitored remains surprisingly vague, even 2 ½ years into implementation of the Agreement.

Furthermore, for those individuals with SPMI who, for whatever reason, are not referred for carve-out, it remains unclear how such functions as crisis intervention, hospital discharge planning or assessment of housing needs are occurring in accordance with the requirements of the Agreement and where within DMMA's system oversight responsibility rests. Data presented in the next section give a glimpse of the differences between DSAMH- and DMMA-managed individuals with respect to discharge planning in the IMDs.

These issues, which are pivotal with regard to fulfilling the requirements with regard to bed-use reductions, are long standing. They have been referenced in prior reports by the Monitor and, as noted earlier, are now beginning to be addressed. Because the important target to reduce hospital bed use is impending, it is very important that the State demonstrate a focused effort to improve the timeliness and reliability of DMMA's data with respect to the requirements of the Agreement and that it be able to present a reliable consolidated State figure with regard to its level of compliance.

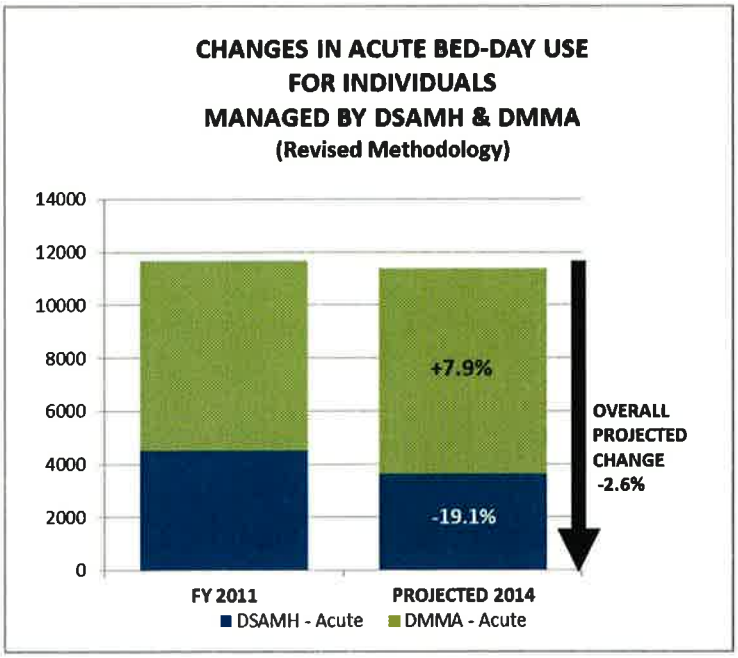
The table below presents projections as to bed-day use for this fiscal year, applying the revised methodology—as it now stands—for DMMA-managed care. As was noted earlier, the Monitor's continuing discussions with the State around DMMA's data may result in additional revisions (either up or down) by the time the July target date is reached. As such, these are tentative projections. They assume that current patterns of bed use will continue through July, 2014. However, efforts now under way to further reduce bed use—particularly among individuals with SPMI who are covered through Medicaid Managed Care—may ultimately result in better outcomes than are shown. At

this juncture, the State's overall reduction in bed-days is projected to be 26.9%, largely as a result of discharges from long-term care at DPC. Between long- and intermediate-term care, DPC realized about a 34% reduction in bed days compared with 2011. Since the



overall population of DPC is reducing, particularly with respect to long-term care, the State will find it difficult to achieve the further bed-day reductions that are required in the Agreement if it remains heavily reliant on practices in that facility.

Sections III.D.3-4 specifically reference reduction in acute care bed use. The chart below presents projected change in the State's use of inpatient psychiatric beds for acute care, defined in the Agreement as 14 days or fewer.



As was described earlier, DMMA has oversight responsibility for acute inpatient care—14 days or fewer—within IMDs for individuals whose behavioral health is covered through Medicaid Managed Care. DSAMH manages acute care in IMDs or DPC for individuals who have been carved-out from these programs based upon a need for the more intensive services that it offers through its system, as well as for individuals who are uninsured. Individuals whose behavior health is covered by Medicaid managed care generally are not admitted to DPC unless they require intermediate- or long-term care services.

The above chart compares acute inpatient bed-days in the base year (as managed by DSAMH and DMMA) with what is projected for this year, based on current patterns of hospital use. The projections indicate that, while DSAMH-managed acute care has been reduced by about 19%, acute care under DMMA has *increased* by almost 8%. The latter figure, which reflects the tentatively revised methodology for identifying individuals with SPMI whose behavioral healthcare is managed through DMMA, is dramatically lower than what would have resulted had the criteria used in prior Monitor reports been applied.

Generally, in accordance with the longstanding "IMD Exclusion" in federal law, Medicaid programs do not pay for care in an IMD. However, Delaware is one of a small number of states where IMD services are reimbursed, through an arrangement with the federal Centers for Medicare and Medicaid regarding its Medicaid managed care program. This is essentially the reason that management of care in these facilities is bifurcated in the State, with DSAMH having responsibility for state funded care (as is the case in most other states with regard to IMD care) and DMMA having the unusual responsibility for managing IMD care because it is reimbursed through Medicaid for those who are not carved out of its managed care programs.

As was referenced earlier and in previous reports, this bifurcated arrangement presents significant problems in terms of the State's oversight and management of inpatient psychiatric bed use. Furthermore, to the extent that the State's ability to capture federal reimbursement incentivizes IMD care (e.g., by relieving the State of the cost burden for hospitalizations), it reduces pressure on the system to carefully evaluate the need for admission and to develop appropriate alternatives. The clinical populations managed by DSAMH and DMMA that are represented in the above chart are not all that different, particularly given the new methodology that is being used. The differences in outcomes are much more likely reflective of DSAMH's stronger focus on diversion and utilization review and the reality that the State is financially at risk for hospital services for the population it manages. In contrast, this risk is mitigated by federal Medicaid reimbursements with the DMMA-managed population.

In any event, if further refinements in the methodology for extracting DMMA data do not significantly change things, the State will likely achieve—or come close to achieving—compliance with the Agreement's important bed-reduction target in July, 2014. Whether

or not this turns out to be the case, it is important that the State demonstrates its best efforts to identify individuals who are covered by the Agreement and to ensure that hospitalizations—voluntary or involuntary—occur only when clinically justified and when less restrictive alternatives are not appropriate.

DSAMH has launched on-site Utilization Reviews to evaluate whether or not hospital care is appropriate for individuals whose mental healthcare it manages. In most instances, but certainly not all, individuals being admitted for hospital care under DSAMH management are already being served by a community provider, and there has been a determination that hospitalization is, indeed, appropriate. In addition, when the admission is on an involuntary basis, the State's evolving program of mental health screening (discussed earlier) makes a similar determination.

When individuals managed through DMMA are admitted for psychiatric inpatient care on an involuntary basis, mental health screeners are involved, as well. These individuals may also be evaluated through Mobile Crisis or one of the Crisis Walk-In Centers if they happen to appear there for services. However, individuals with SPMI whose mental healthcare is managed through DMMA currently do not have access to the same array of early interventions or alternatives to hospitalization that DSAMH provides (Crisis Respite is one example). Moreover, the State maintains that its current contracts with MCOs do not enable it to require that these contractors provide early mental health intervention and diversion, whereby they would offer alternatives to hospitalization for consideration by hospital emergency physicians. Similarly, MCOs' current level of involvement in managing inpatient care within IMDs through their UR programs appears to be significantly more limited than is the case with respect to DSAMH-managed care. Possibly for these reasons, hospital days continue to rise for the DMMA-managed population.

To address these issues, the Monitor requested that the State develop a specific blueprint for bed-use reduction for all people with SPMI whose care it manages. Through a collaboration between DSAMH and DMMA, the State has recently crafted some specific measures aimed at ensuring that inpatient care occurs only when appropriate for people with SPMI. These include:

- A State Plan to Reduce Inpatient Bed Use, with such elements as:
    - the creation of 23-hour observation beds and crisis respite beds for MCO-covered individuals to provide better opportunities to evaluate the need for hospital care and make alternative referrals accordingly;
    - refinements in DMMA's contracts with the MCOs to better integrate the requirements of the Agreement (these were included in the recent Request for Proposals issued by DMMA);
    - expanded access to detox and substance abuse services;

- the creation of Quality Improvement scorecards with data relating to services in each IMD;
- pending modifications in the State's Medicaid Plan, through which DSAMH will have expanded responsibilities for coordinating a broad array of new services, including case management, through its "PROMISE" program;
- the potential for DSAMH to expand its Utilization Reviews within IMDs to include DMMA-managed individuals, and
- the collection of data relating to the impact and quality of newly required mental health screening prior to the issuance of involuntary holds and hospital admissions.

- A streamlined process for referring individuals with SPMI who are in DMMA's Medicaid managed care program for carved-out mental healthcare through DSAMH (albeit with the limitations discussed earlier).

Not all of the these initiatives will have an immediate impact on inpatient bed use—the new MCO contracts, for example, will not go into effect until 2015—but they are certainly positive steps.

Recommendations:

1. As these measures go into effect, it is critical that the State has unified data systems in place (i.e., with the capacity to integrate timely information about bed use from DSAMH and DMMA) to allow for meaningful UR, ongoing program monitoring and refinement, and to demonstrate these measures' impact on bed use. This information is important in itself, and, in light of the challenges of meeting this requirement, can also help demonstrate that the State is making its best efforts to achieve compliance.
2. It is strongly recommended that the State immediately implement measures to ensure that all individuals putatively having SPMI and meeting the criteria for inclusion in the TPPL be evaluated for carve-out and access to the more intensive services and supports that are available through DSAMH.

2. Discharge Planning:

Partial Compliance.

Sections II.C2.d.iii & iv of the Agreement require the involvement of a community provider within 24 hours of the admission of an individual with SPMI for acute care in an IMD or DPC. Based upon the Monitor's reviews, this appears to be generally occurring within DPC. Either a community provider or, if no provider already has been assigned, a

Targeted Care Manager (TCM) meets with the individual and the treatment team, beginning shortly after admission. In discussions with DSAMH, the practical goal was to assure that these encounters take place within one business day.

To facilitate monitoring of this provision, DSAMH has developed a form to be completed by community providers to record discharge planning and coordination activities for DPC inpatients. The plan is to expand the use of this form to IMDs, both for individuals whose care is managed by DSAMH and ultimately for those managed through DMMA, as well. These measures will significantly improve data available to DSAMH for monitoring the involvement of community providers and their role in effecting appropriate discharge plans.

When a DSAMH-managed individual is admitted to an IMD, the Division's Enrollment and Eligibility Unit (EEU) notifies the assigned community provider directly and also identifies the provider to the IMD in order to facilitate care coordination and discharge planning. No clear parallel system exists for DMMA-managed care.

In part to evaluate compliance with the Agreement's discharge planning requirements, a consultant engaged by the Monitor reviewed a sample of charts in each of the three IMDs relating to recently discharged individuals. The sample included both individuals whose care is managed through DMMA and those managed through DSAMH. She reported great inconsistencies in the engagement of community providers. She found poorest compliance with the requirement for involvement by a community provider in two of the IMDs, and in all settings, for individuals whose care is managed via DMMA. Monitoring compliance with this provision was difficult because of inconsistent or conflicting documentation within the IMD records, an issue that is further troubling because input from a community provider should be so central to treatment and discharge planning for individuals with SPMI. The table below summarizes her findings:

COMMUNITY PROVIDER INVOLVEMENT IN IMDs

(DPC not included)

	DSAMH-Managed	DMMA-Managed	Overall Rates
Community Provider contact w/in 24 hrs.	50%	12%	29%
Additional Community Provider contact during remainder of hospital stay	43%	0%	19%

Recommendations:

Engagement of a community provider in discharge planning for hospitalized individuals is critically important to ensure that an appropriate array of services is in

place upon return to the community and that there is continuity in services and service approaches. While there is a need for improvement both for individuals whose care is managed by DSAMH and for those managed via DMMA, compliance with this provision of the Agreement is particularly troubling for DMMA-managed individuals, who account for the bulk of inpatient days within IMDs. Accordingly, it is strongly recommended that the State:

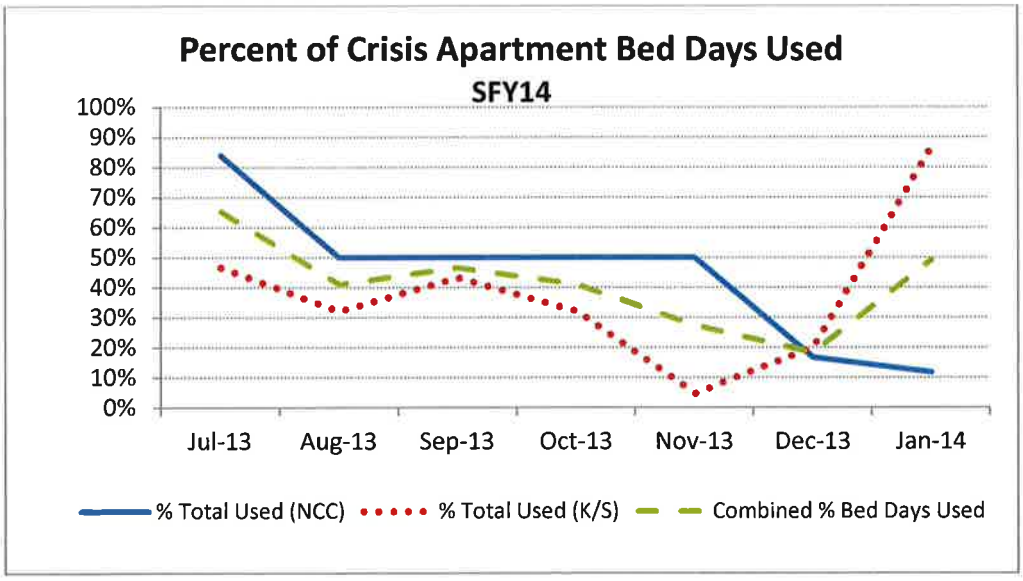
1. Quickly move to establish a consistent system-wide process for documenting the involvement by community providers within the IMDs and DPC, for both DSAMH and DMMA-managed individuals;
2. Include monitoring of compliance with this requirement on the State's monthly dashboard; and
3. Continue to avail itself of the technical assistance that the Monitor has facilitated with regard to this, and other quality monitoring requirements with respect to the targeted population within the IMDs and DPC.

E. Crisis Apartments

Substantial Compliance.

Section III.E.2 of the Agreement requires the State to develop a total of 4 crisis apartment beds to provide temporary respite to individuals whose needs are not at a level requiring hospital care. The typical length of stay in these crisis beds is designed to be about three to seven days. The State has surpassed this requirement. It not only developed two crisis apartments—one in the northern part of the state and the other in the southern part—each with 2 beds, but it also made available an additional 4 respite beds, bringing the total to 8. In addition, DSAMH has established 10 "Resource Beds" in the community that can be flexibly used, including for crisis respite. Unlike the Crisis Apartments, these are not staffed by peers overnight.

The table below presents trend data relating to the occupancy of the four crisis apartment beds. Because the program is still fairly new, it is not yet being used to capacity. To make better use of this resource, the Mobile Crisis Team has begun circulating updates about vacancies in Crisis Apartments three times per day (once per shift) among team responders and to DSAMH's Enrollment Eligibility Unit. Furthermore, use of the crisis beds is being monitored by DSAMH as a part of its monthly compliance scorecard.

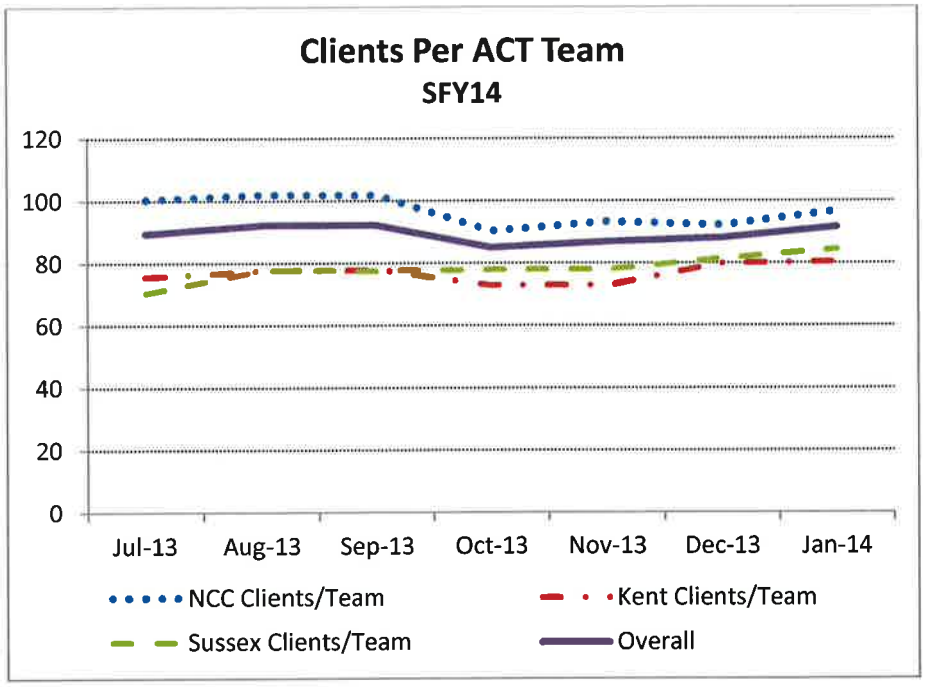


In both the northern and southern sites, the landlords of the crisis apartments have expressed concerns about leasing units that will be used by unidentified tenants (i.e., individuals not known to them who come to be in crisis). As a result, in March, 2014, DSAMH moved these crisis programs to free-standing houses, each with four beds. One is located in New Castle County and the other is near the border between Kent and Sussex Counties.

F. Assertive Community Treatment

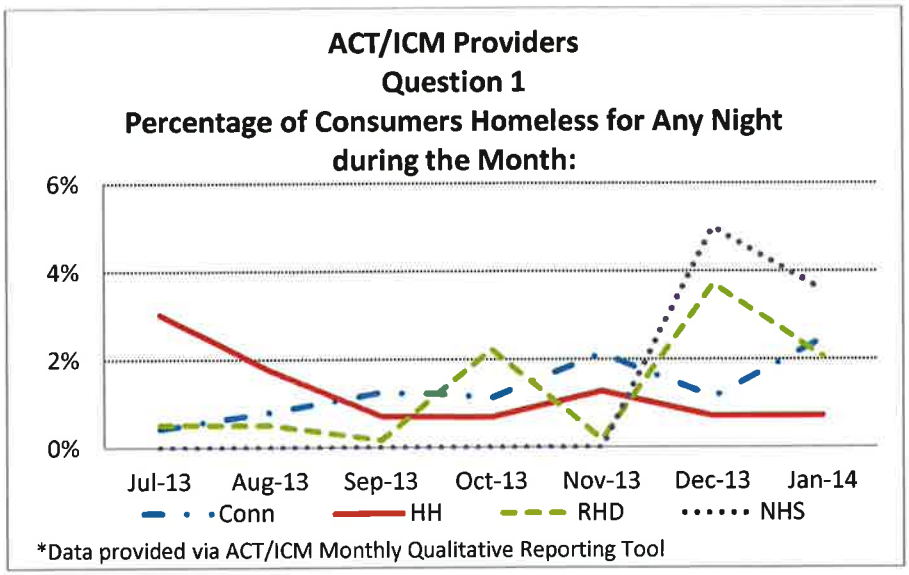
Substantial Compliance.

ACT is a critically important service for people with SPMI who have intensive service needs in the community. It is a well-established, evidence-based practice whereby individuals received flexible, mobile services to promote their recovery and to help them navigate the demands of community life. Section III.F.2 requires that the State have 9 ACT teams operational by September 1, 2013. The State has established 11 ACT teams and is essentially already in compliance with requirements that go into effect in September 2014 and 2015 (Sections III.F.2-3). The teams—7 in New Castle County and 4 in the southern counties—are in various states of development and enrollment. The table below summarizes the average numbers of clients active in teams within each county. Full ACT teams can accommodate between 100 and 120 individuals. ACT teams in the southern rural counties can accommodate somewhat fewer.

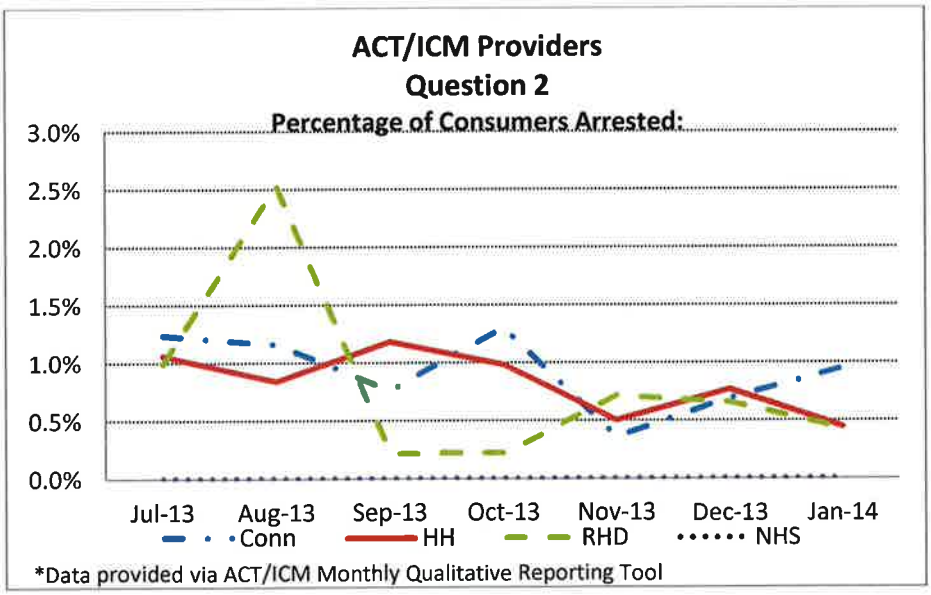


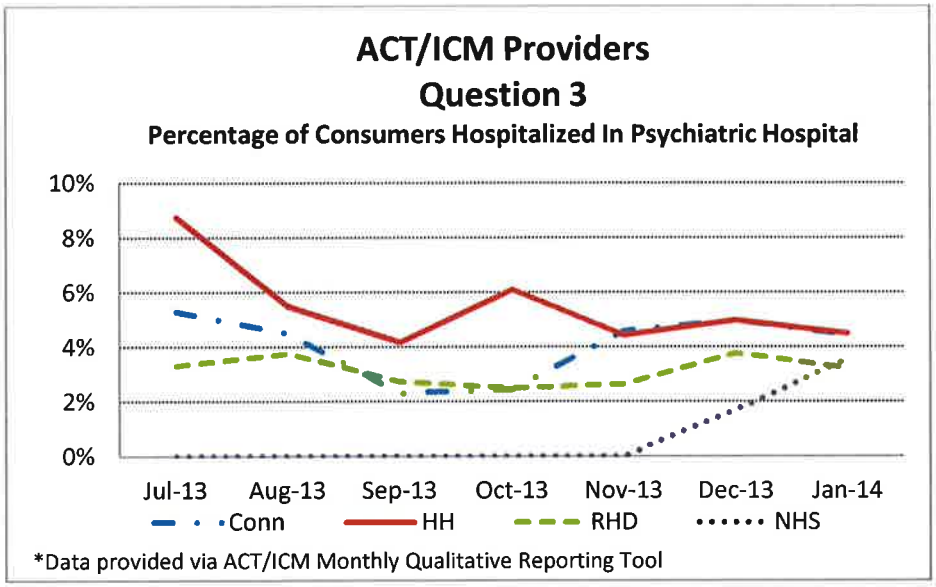
DSAMH has an active program of surveying each ACT team for program fidelity (as is required in Section II.D.2.a) and providing needed consultation. The survey process includes written appraisals of each team's adherence to the program model and, as indicated, corrective action plans. In addition to fidelity surveys, DSAMH monitors various quality measures relating to its ACT and Intensive Care Management programs, examples of which are presented in the charts below.

The first chart (which reflects responses to Question 1 on DSAMH's Quality survey instrument) presents the number of ACT members who were homeless for any night during the month reported. Overwhelmingly, the reported instances of homelessness do not represent individuals who are receiving ongoing services; instead, they reflect the housing status of new members who are being enrolled in services. For instance, the NHS team, which showed a 5% homeless rate in December, is actually a new ACT team that was just recently launched. Nevertheless, access to this information allows DSAMH to monitor this adverse outcome and, as applicable, to take appropriate corrective actions.

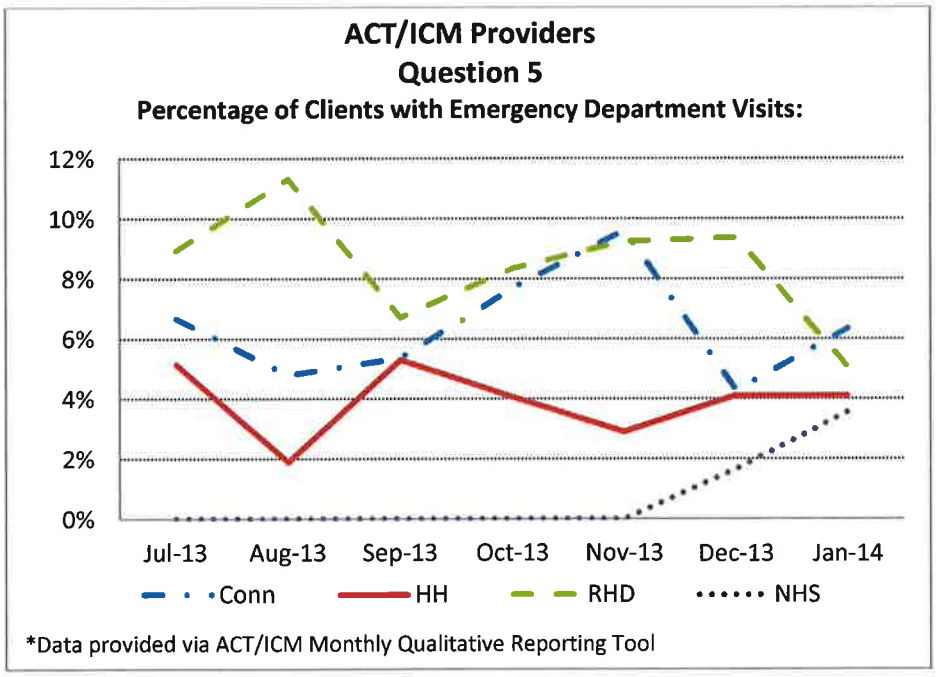


The following trending charts present additional quality measures being monitored by DSAMH The first shows the percentages of ACT clients who were arrested each month—rather low figures given the level of disability of these individuals and the frequency of co-occurring substance use problems. The next presents the number of individuals hospitalized for psychiatric inpatient care. Again, with respect to this measure, some of the hospitalizations reflect individuals being enrolled in the ACT program and their hospital status at the point of enrollment.

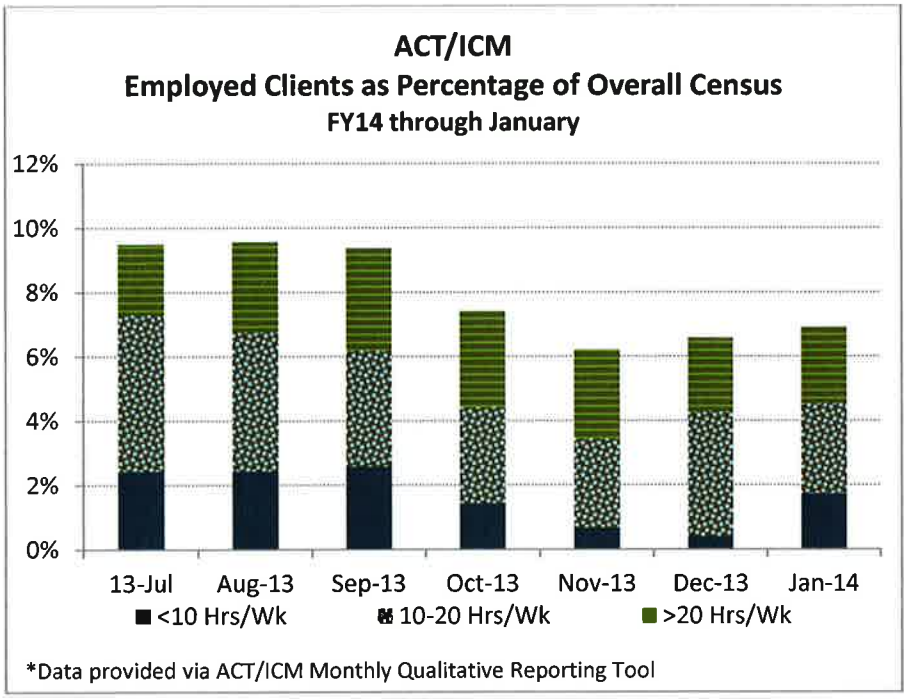




The table below presents the percentages of ACT clients who used a hospital emergency room during each month. These encounters could reflect either physical health issues, or behavioral issues.



Finally, the table below presents the percentage of ACT clients who are employed each month, in terms of the number of hours per week that were worked.

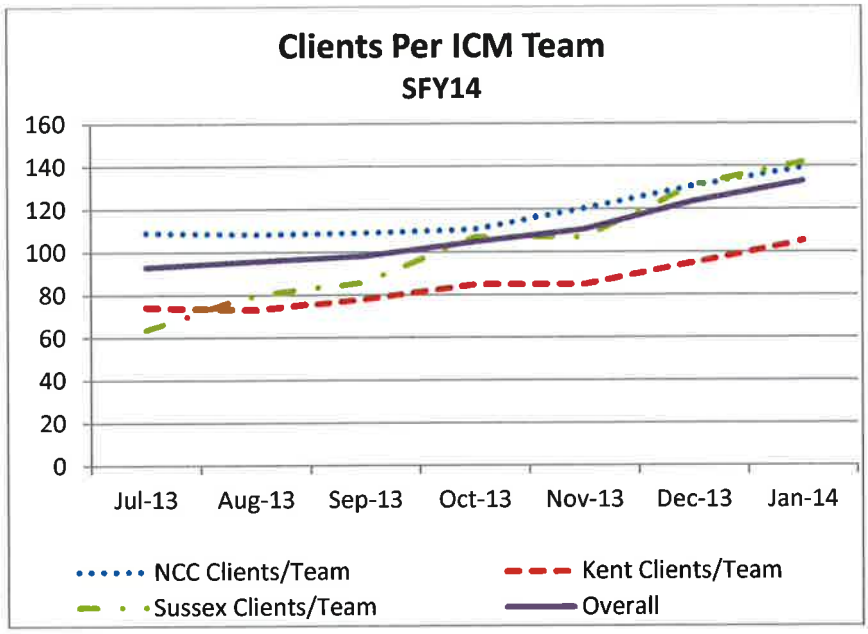


As has been discussed throughout this report, DSAMH is making significant progress in its capacities to capture timely data and to do trend analyses of key indicators of quality. The tables above evidence this commendable progress and reflect the State's success in meeting its obligations around Quality Assurance and Performance Improvement (Section V of the Agreement).

G. Intensive Care Management

Substantial Compliance.

Section III.G.2 of the Agreement requires the State to have a total of 4 Intensive Care Management (ICM) teams operational by January 1, 2013. The State is surpassing this requirement in that it has a total of 5 ICM teams. The Agreement requires that each staff member on a team have responsibility for no greater than 20 clients and that the supervision of staff be no less intense than a one-to-ten ration. ICM teams vary in their levels of staffing and in the numbers of individuals served. Based upon a staffing review of some of the teams, it appears that the State is appropriately meeting the requirements for staffing ratios. The table below presents the number of clients per ICM team and an overall trend towards these numbers increasing as new clients are added to each team.



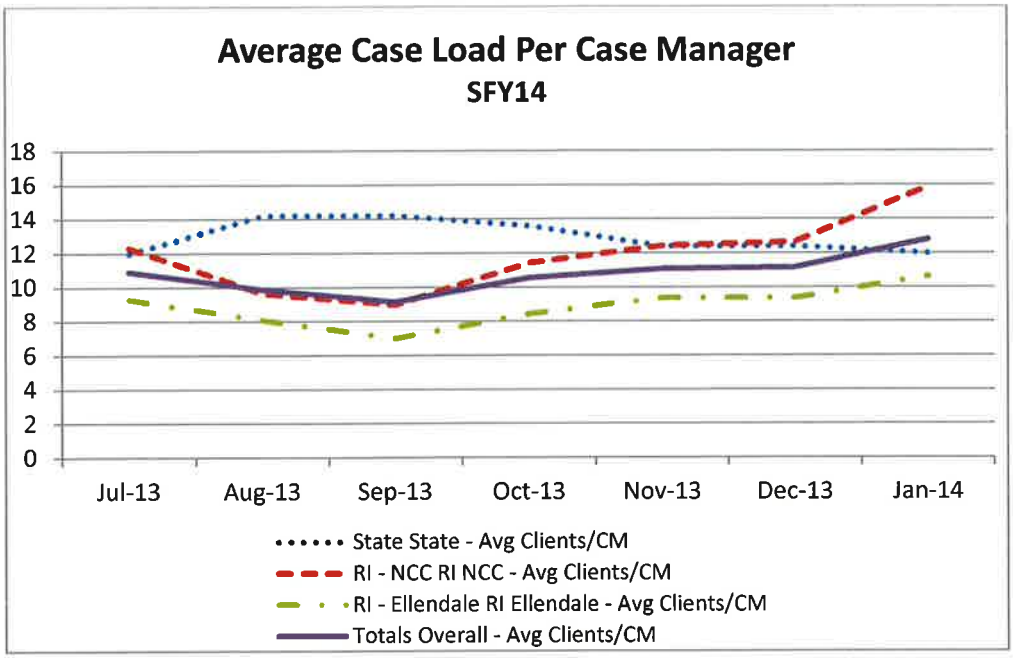
It is also worth noting that, given the level of need demonstrated by clients assigned to ICM, the State is now reconfiguring its teams to allow for more intensive levels of staffing. It plans to enhance staffing levels on four of the ICM teams to that of ACT teams; it will maintain one ICM team at its current staffing levels because it appears that an increase in staff intensity is not clinically warranted. The numbers of individuals served are not expected to be affected by these changes. These changes result in enhancements in staffing levels over and above what is required in the Agreement for ICM and, as such, do not change the State's Substantial Compliance with this provision.

H. Case Management

Substantial Compliance.

Section III.H.2 required the State to have a total of 18 Targeted Care Managers (TCM) available to assist individuals in identifying and accessing needed community services and supports. The State continues to surpass the requirements of this provision, having a total of 25 TCMs available statewide. The Agreement requires that each care manager serve no greater than 35 individuals at a time. The chart below demonstrates that the State is well within this guideline.

Both within hospital and in the community, TCMs play a critical role in linking individuals who have SPMI to needed services. For many such individuals, they are the "front door" the State's mental health service system. Depending upon the specific needs of the individual, TCM may be a brief service, or one that extends in time.



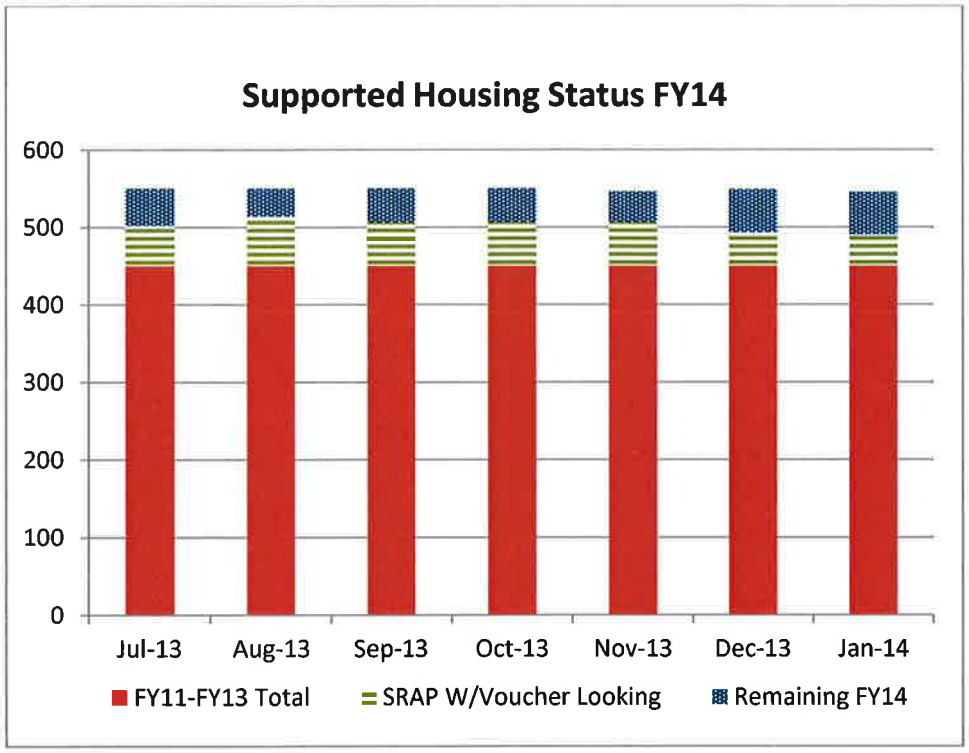
I. Supported Housing

Substantial Compliance.

Housing is a critical need for many individuals with SPMI. The Agreement seeks not only to address this need, but to do so by creating housing for individuals that reflects the vision of the ADA that people with disabilities—including SPMI—can live like ordinary citizens. Accordingly, the Agreement includes requirements that the State develop new housing that is integrated in the community (as opposed to congregate housing or clustered developments that are limited to people with disabilities) and that they develop individualized supports to allow people to live successfully as neighbors and tenants.

Section III.I.4 of the Agreement will require the State to fund a total of 550 supported housing vouchers or subsidies by July 1, 2014. The State is already in compliance with this provision in that it has funded at this level. As would be expected, there has been some movement and vacancies among individuals who had secured supported housing vouchers in past years— for instance, some have had difficulty finding an apartment to their liking, and some had problems adjusting to this housing (generally due to co-occurring medical needs). Furthermore, due to changes in how some of the HUD vouchers that had been utilized in past years were administrated (by parties other than the State), there has been a need to replace some of the housing slots that were counted in past years. As a result, there has been some "back-filling" of housing slots that were created and, prior to this fiscal yearend, counted with respect to past evaluations of

compliance. The following chart demonstrates how DSAMH is tracking the utilization of Supported Housing vouchers, including individuals with vouchers who are in the process of seeking housing and the number of additional vouchers available. As has been noted in prior reports, DSAMH has been diligent in monitoring both the quality of housing and compliance with respect to the requirements for integration that are delineated in the Agreement.



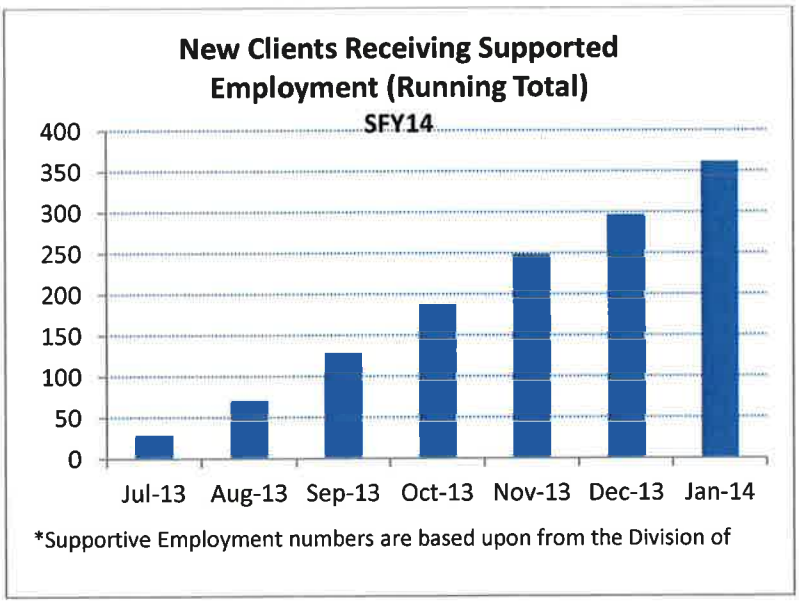
Making arrangements for permanent supported housing can take several months—securing an apartment of an individual's choice, getting furnishings, putting benefits in order, and so on. To enable individuals to leave hospital settings while these arrangements are being made, DSAMH has established 17 transitional beds. In addition, the Division has created 10 Resource Beds in the community that can be flexibly used for housing transition purposes or for respite, according to the immediate need.

In summary, the State is creating integrated supported housing opportunities for individuals with SPMI who, in the past, would remain institutionalized or whose options would be largely limited to congregate settings. The supported housing efforts the State has made pursuant to the Agreement represent a distinct change in culture and practice, in accordance with the ADA. This was an early focus in its implementation efforts that was commendable early on, and that remains so to this day.

J. Supported Employment

Substantial Compliance.

Section III.J.2 of the Agreement requires the state to provide supported employment services to a total of 400 individuals. As has been noted in earlier reports, there are several levels of employment services provided through the State's Division of Vocational Rehabilitation (DVR). For purposes of evaluating compliance with this provision, only individuals who have at least progressed to the point of having an active vocational plan are being counted. The Monitor's last report found a total of 569 individuals who met these criteria, thus surpassing the Agreement's requirements in



effect. Given the current rates, DSAMH estimates that approximately 600 individuals on the TPPL will receive supported employment services this fiscal year, thereby again exceeding the requirements of the Agreement.

It has been noted in previous reports that there is an unusually positive working relationship between DVR, which is situated within the State's Department of Labor, and DSAMH, which is a division of DHSS. Accordingly, a large percentage of the individuals receiving services through DVR have SPMI. This very much benefits the State's fulfillment of the requirements of the Agreement. Nationwide, unemployment among individuals with SPMI is shamefully high. As is the case with where one lives (e.g., in integrated supported housing, as opposed to a specialized facility), whether an adult with disabilities such as SPMI is in the mainstream workforce is an important "bottom line" indication of the impact of the ADA. The State is making admirable progress in this regard.

K. Rehabilitation Services

Substantial Compliance.

Section III.K.2 of the Agreement requires the State to provide rehabilitation services to a total of 600 individuals. As was discussed in the last report, rehabilitation services comprise an array of activities, such as education, substance abuse treatment, and recreational activities. Some of these components are not well defined in the State's data systems. Furthermore, without sufficient intensity the meaning of the service is questionable. Applying the criteria used in the last report, figures are as follows:

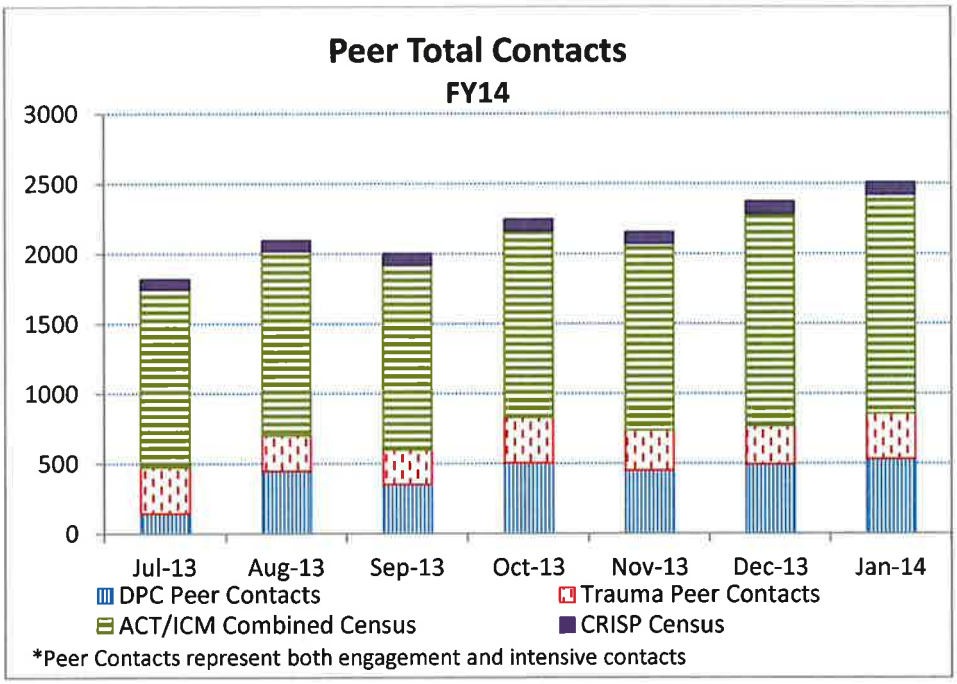
- Psychosocial Rehabilitative Services, Psychosocial Group Services, or Family Psychosocial Education was provided at least twice per month for at least 6 months ..... 259 individuals
- Some level of substance abuse service for a co-occurring disorder was provided during the year..... 978individuals
- Total Unduplicated Count..... 1,222 individuals

The State is surpassing its requirements with respect to Rehabilitation Services and has already met the July, 2014 target of 1,100.

L. Family and Peer Supports

Substantial Compliance.

Family and peer supports are incredibly important means of enhancing individual's natural social connections. Peer supports in particular allow individuals to connect with people who have "lived experience" with mental illness and the various systems that provide services to them; they are a crucial element in promoting recovery. Section III.L of the Agreement required the State to provide Family and Peer Supports to a total of 500 individuals by July of 2013, and will require services to an additional 250 individuals by July 1, 2014. The State's data system makes it difficult to extract an unduplicated count of peers and families being served, but the numbers of contacts—2,500 in January, 2014 alone—strongly suggest that it is meeting, if not exceeding this requirement. Past reports have recognized the State's successful promotion of very robust peer programs at DPC and in the community. The chart below demonstrates the degree to which peer supports have become a routine and important part of the various elements of DSAMH's system.



M. Quality Assurance and Performance Improvement

Substantial Compliance.

Section V of the Agreement requires the State to develop systems to ensure the quality of services offered and to improve service outcomes. Aided by its improving data capacities, DSAMH is increasingly enhancing its Quality Assurance (QA) and Performance Improvement (PI) efforts. In addition, the Monitor has arranged for ongoing technical assistance with respect to these important functions. Evidence of measures taken by DSAMH in this regard appears throughout this report.

In addition, DSAMH has contracted with the University of Pennsylvania to provide quality of service research with regard to service outcomes for individuals on the TPPL and for the CRISP program (a program providing flexible, intensive services and supports primarily to former long-term inpatients of DPC). UPenn's research with regard to the TPPL is comprehensive, allowing longitudinal evaluations of cohorts of individuals appearing on the list. In plain language, this means that the researchers are examining outcomes for individuals who were placed on the TPPL during the initial year of implementation, and that they will be able to track how these individuals fare in the following year, the year following that, etc., with regard to such factors as hospitalizations and emergency room use. The researchers will be able to conduct similar assessments for people placed on the TPPL in year 2 of implementation, and so on. This study is ongoing. It should be able to provide invaluable information about service outcomes for individuals with SPMI and how these outcomes change as the various new

programs that have been launched mature. This is important not only for Delawareans, but for other states that are pursuing reforms in their systems in fulfilment of the ADA.

The CRISP research includes periodic clinical and functional assessments of individuals in the program, as well as interviews with clients and staff about their perceptions of the program and its impact. The UPenn research relating to the TPPL includes individuals whose care is managed by DSAMH and by DMMA. The research relating to CRISP, which is a program administered by DSAMH, includes only individuals whose care is managed by that entity.

UPenn's longitudinal studies are in relatively early phases. As significant findings come to be generated, they will be incorporated in DSAMH's QA and PI processes and, no doubt will be included in monitoring reports.

At this juncture, the State is in Substantial Compliance with the provisions of the Agreement relating to Quality Assurance and Performance Improvement. This rating does not mean that the relevant systems are all in place, and properly and fully functioning, but it does reflect the finding that DSAMH is taking appropriate steps to develop comprehensive and meaningful programs to fulfill these requirements. Meeting the Agreement's requirements for QA and PI requires a long-term, ongoing endeavor which will likely extend through the term of its implementation.

Although QA and PI efforts are far less clear with respect to individuals managed via DMMA, overall the State is where it should be with respect to the requirements of Section V and, for this reason, is in Substantial Compliance. Maintaining this rating, of course, will require a continuing effort and more focused consideration of individuals whose behavioral health care is coordinated through Medicaid managed care.

N. Risk Management

Partial Compliance.

Section V.B of the Agreement requires the State to have risk management systems in place that address adverse outcomes for individuals in DPC, IMDs or community programs. There are currently multiple systems at multiple levels within DHSS, DSAMH, DPC, the IMDs, and community programs that are intended to capture information about adverse events, including abuse, neglect, injury and death, and to ensure appropriate corrective action. The multitude and idiosyncratic nature of these processes significantly dissipates the overall impact of any system-wide risk-reduction efforts. What entity reports an adverse event affecting an individual covered by the Agreement, to whom the report is made, and with what consequences may depend largely upon where the incident happened to occur. For instance, an event in a State-operated setting (such as DPC or a group home) may trigger a "PM-46" report that ultimately

lands in the Division of Long Term Care. The same event happening in an IMD or in a community program may be subject to reporting and, as indicated, investigation by DSAMH. Similarly, DHSS has a Mortality Review Committee that examines deaths and, as indicated, their root causes, but only within programs operated by the State. In summary, there is no single system-wide repository for reports of adverse events and there is no single system-wide authority that conducts investigations, for oversees corrective actions, and implements risk reduction measures.

As a concrete example, there was an adverse event in DPC that involved an individual on the TPPL choking on food that was a not a part of the individual's prescribed diet. Just by happenstance, the Monitor learned of a very similar event that occurred with another individual who was living in a community setting. These events were reported according to the required protocols, investigated, and corrective action plans were developed. Yet, the reporting, investigations, and corrective measures taken occurred in isolated bureaucratic streams. There is no mechanism for capturing information about the frequency of choking episodes within the overall service system—both those that result in injury and those that are "near-misses" as a result of timely staff intervention. Likewise, there is no mechanism whereby DHSS might use these data as a basis for taking some system-wide preventive measures, such as issuing an alert about appropriate procedures to prevent choking. Without question, there are similar instances relating to other adverse events that are not being captured.

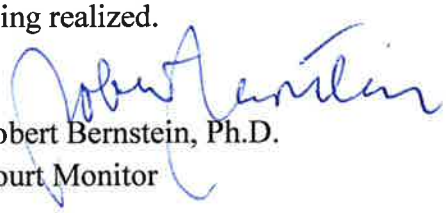
The State's various parallel, disconnected systems of incident reporting and risk reduction are very difficult to understand, either individually or collectively. Properly configured, risk-reduction measures should be straightforward, transparent, and accountable. The systems that are currently in place appear to be largely an accumulation of measures that have been taken over the years, either in response to an adverse event or to comply with some specific certification or regulatory requirements. What is sorely lacking is an overall blueprint for risk reduction.

Recommendation:

It is strongly recommended that DHSS establish a unified, system-wide process for reporting adverse events, conducting investigations and root cause analyses, ensuring corrective actions, and broadly implementing preventive measures. Embedded in the various processes now in place may well be some model practices or promising approaches; an initial first step might be to map out current systems and to explore the feasibility of making them universal. Critical to any reconfiguration is that there be data systems in place that provide timely and usable information.

IV. Summary

This report documents that the State continues to make impressive progress towards fulfilling the multiple requirements of the Agreement. This progress is being demonstrated not only in meeting the quantitative targets contained in the Agreement, but also in moving Delaware's public systems increasingly in the direction of supporting the recovery of people with SPMI and their inclusion in their communities—factors that are less easily reduced to numbers. The collaborative relationship between the State, DOJ, and the Monitor, no doubt, has created an environment that promotes the success that is being realized.



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