

1 **SIXTH REPORT OF THE COURT MONITOR**
2 **ON PROGRESS TOWARD COMPLIANCE**
3 **WITH THE AGREEMENT:**
4 **U.S. v. STATE OF DELAWARE**

5 U.S. District Court for the District of Delaware, Civil Action No: 11-591-LPS
6 December 29, 2014
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9 **I. Introduction**

10 This is the sixth report of the Court Monitor (Monitor) on the implementation of the above-
11 referenced Settlement Agreement (Agreement) between the United States, through the U.S.
12 Department of Justice (DOJ), and the State of Delaware (the State). This report presents
13 compliance data and ratings covering the six-month period January 16, 2014 through July 15,
14 2014, and it also includes more recent findings with respect to certain aspects of the State's
15 implementation efforts.

16 At this juncture, the Agreement has been in effect for well over three years. The State
17 continues to make admirable progress in achieving most of the benchmarks delineated in the
18 Agreement, and also systemic reforms that will help ensure that these reforms are sustainable
19 and well aligned with broader practices affecting individuals with Serious and Persistent
20 Mental Illnesses (SPMI). As has been noted in prior Monitor reports, Delaware has had
21 special challenges in assuring that all individuals in the population targeted by the Agreement
22 benefit from the full array of services and supports required in its provisions. To a large
23 degree, this is because the State has a bifurcated system, whereby a significant population
24 with SPMI receives specialty mental health services under management by the Division of
25 Substance Abuse and Mental Health (DSAMH) and another significant population with
26 SPMI receives services through Managed Care Organizations (MCOs) that operate as agents
27 of the Division of Medicaid and Medical Assistance (DMMA). Both DSAMH and DMMA
28 are divisions of the Department of Health and Social Services (DHSS). Theoretically, at
29 least, those individuals with SPMI who are at high risk of adverse outcomes and who require
30 intensive mental health services are referred from DMMA to DSAMH for specialty care.

31 Although the system managed through DSAMH is still evolving, individuals' needs are
32 routinely assessed and Assertive Community Treatment (ACT), supportive housing, and
33 other services critical to achieving the Agreement's goal of community integration are
34 largely in place and subject to ongoing efforts to improve performance and quality. As is
35 discussed later in this report, however, the State still has not demonstrated a similar
36 understanding of the needs of the significant SPMI population whose care is managed
37 through DMMA, nor does it have an effective means of ensuring that these needs are being

38 addressed in keeping with the requirements of the Agreement. In many important respects,
39 during the past 3 ½ years, the State’s approach to managing services to the relevant DMMA
40 population has not palpably changed, and things have remained pretty much as they were
41 prior to the Agreement.

42 As with any complex public system serving high-need individuals who often have multiple
43 clinical, social and legal challenges, the State routinely confronts problems in service
44 provision and unanticipated adverse outcomes for some individuals. An important difference
45 between the State’s two service structures is that, under the leadership of the DSAMH
46 Director Huckshorn (who recently resigned from her position), DSAMH has in place systems
47 and data sets to track the quality of care provided, service outcomes, and risk factors. These
48 are functions required by the Agreement (e.g., Section V), but have been essentially absent in
49 any comprehensive form for individuals served through DMMA for whom the Agreement
50 also applies. As a consequence, although the State is largely in compliance with the
51 Agreement with respect to services and outcomes provided through DSAMH,
52 notwithstanding some recent efforts to improve the referral process for specialty mental
53 health services, it is very difficult to ascertain its status with respect to those whose services
54 are managed through DMMA.

55 What is clear is that individuals who are at high risk and who, ostensibly, are in need of
56 specialized services have remained under DMMA’s management. Based upon a small
57 random sample that was not even constructed to identify people who may require specialty
58 mental healthcare through DSAMH,¹ the following scenarios emerged with respect to
59 individuals served through MCOs who were being involuntarily re-hospitalized in a private
60 psychiatric hospital (an “Institution for Mental Disease,” or “IMD”):

- 61 • Mr. A is a young man with a long history of substance abuse, a co-occurring mood
62 disorder (possibly schizoaffective disorder), and history of suicide attempts, for
63 instance, attempting to hang himself while in jail. He was hospitalized after slicing
64 his neck with a knife.
- 65 • Ms. B is a middle-age woman who has been homeless for about 9 years, has a history
66 of bipolar disorder and co-occurring substance use and psychiatric hospitalizations.
67 She was re-hospitalized after she stopped eating, discontinued her medication in an
68 attempt to trigger a diabetic coma, and threatened to shoot herself.
- 69 • Ms. C is a young woman who was homeless and living in a hotel. She is reported to
70 have a long history of violence and is diagnosed with Bipolar Disorder and co-
71 occurring substance use. Ms. C has had multiple admissions to psychiatric hospitals
72 and was complaining of depression at the time of this hospital admission. At some

¹ The sample comprised individuals—both with care managed through DSAMH and DMMA—who were admitted to an IMD in southern Delaware under 24-hour psychiatric detentions in January, 2014.

73 point after her discharge from this hospitalization, she was referred to DSAMH for
74 services.² But by the time the referral was made (evidently several weeks later), she
75 could not be located. Had discharge planning occurred in compliance with Section
76 II.C.2.d.iii of the Agreement, there would have been a seamless transition to
77 community services (including housing), and it is unlikely that this outcome would
78 have occurred.

79 As is characterized in these examples (which, again, were *not* sampled by the Monitor with
80 the intent of identifying individuals appropriate for DSAMH’s services), people known to
81 have SPMI and who are clearly not doing well in the community have not been successfully
82 referred for specialty mental health services through DSAMH.³ Furthermore, there is no
83 evidence to suggest that DMMA has in place a working system to appropriately identify such
84 ostensibly high-risk individuals and to assure that the State is meeting its obligations to them
85 under the Agreement and the ADA.

86 As is described later in this report, the State has only recently launched an initiative whereby
87 DMMA has begun to systematically refer at least some of the individuals with the most
88 obvious need for specialized services (as evidenced by multiple admissions to psychiatric
89 hospitals) to DSAMH for services⁴. Up until now, not only has there been no such concerted
90 effort, but even the entity responsible for making such referrals—an MCO, DMMA, or an
91 IMD—has remained vague. For the State to meet its obligations under the Agreement, it will
92 need to aggressively move forward on initiatives such as this to ensure that individuals are
93 appropriately referred for specialized services and that those whose care remains managed
94 through DMMA are also afforded access to needed services.

95 In summary, while the State continues to evidence admirable progress in serving one
96 subgroup of individuals with SPMI, there remain significant “unknowns” with respect to
97 other individuals covered by the Agreement. To what extent addressing the unmet needs of
98 the DMMA population may affect the capacities of DSAMH’s programs (e.g., with the

² Such referrals were apparently not made with respect to the other individuals described here.

³ In the summer of 2014, the Monitor notified the leadership of DHSS and DMMA that he was finding what looked to be a pattern of high-risk individuals who are covered by the Agreement and who were not being referred for DSAMH’s specialty services (including ACT and housing).

⁴ This initiative includes a backlog of referrals accumulated over the 3 ½ years the Agreement has been in effect, whereby transition plans for DSAMH services were not made as part of hospital discharge planning. The time lag between these individuals’ hospitalizations and DMMA’s recent referrals has been problematic in that many individuals’ whereabouts are now unknown. As of November, 2014, the State’s data show that of 116 highest-risk individuals referred by DMMA for DSAMH services, 21.6% had incorrect or no contact information and a phone message could not be left for an additional 18.1%. In two months of implementing this initiative, referrals were completed or actively in progress for only 6 individuals. (TCM Outreach Status Breakdown data, Priority Groups 1a and 1b, November 13, 2014)

99 prospect of large numbers of new referrals for ACT or supported housing services) remains
100 an open question. Likewise, although the State is currently negotiating contracts with the
101 MCOs that should better align with the requirements of the Agreement, it has not yet
102 clarified how it intends to operationalize these contracts, to meet its obligations to Medicaid-
103 covered individuals with SPMI who are not referred for specialty services or whose referrals
104 are pending,⁵ or to monitor the quality or services provided. DSAMH has established what
105 appear to be sustainable and solid programs to provide these specialty services under the
106 leadership of Dr. Huckshorn, who is a nationally known expert in public mental health, and
107 continuity of such leadership is of obvious importance to the Agreement. As of this writing,
108 the State has not yet named a permanent replacement for the Division Director. Resolution
109 of these and other factors discussed in the body of this report are essential to the State’s
110 ability to demonstrate continuing progress and ultimate fulfillment of the Agreement’s
111 requirements.

112
113 **II. Progress on Structural Improvements**

114
115 **A. Targeted Priority Population List:**

116 The Agreement’s Targeted Priority Population List (TPPL) is defined in Section II.B as
117 individuals with SPMI who have been psychiatrically hospitalized, treated in an emergency
118 room or had criminal justice contact for issues attendant to mental illness, or who have been
119 homeless. A single individual may fall into more than one of these categories.

120 As of the end of the 2014 fiscal year, the State’s TPPL included 12,125 individuals, an
121 increase of 994 from data available at the time of the Monitor’s May report. About half of
122 the new members of this group were added as a consequence of admissions to IMDs. The
123 histories of individuals on the TPPL are summarized as follows:

- 124 • Treatment at DPC 9.1%
- 125 • Treatment in an IMD 59.3%
- 126 • Criminal justice contact 18.0%
- 127 • Homeless 11.1%
- 128 • Emergency Room use for mental health 33.6%

129 In comparison to the May, 2014 data, the proportion of individuals on the TPPL who were
130 admitted to IMDs has increased significantly—from 33.4% to 59.3%—highlighting the

⁵ Based upon the DSAMH’s capacity to process these new referrals, working through the initial group of about 460 high-risk individuals may take six months or longer to complete.

131 importance of the State’s plans to reduce inpatient bed use in these settings (discussed below
132 in regard to Crisis Stabilization Services).

133 In itself, inclusion on the TPPL need not indicate that an individual is in need of the full
134 complement of intensive services offered by the programs developed in accordance with the
135 Agreement; it simply suggests that there may be an elevated risk and a need for one or more
136 specialized mental health services.

137

138 **B. Delaware Psychiatric Center:**

139 *Evaluation of Individuals Discharged Following Long Hospitalizations:*

140 The Monitor’s prior reports presented data relating to the positive outcomes for individuals
141 who were discharged from Delaware Psychiatric Center (DPC) following extended
142 continuous hospitalizations, defined as 60-days or longer. As is evidenced by their
143 protracted hospitalizations—in some instances, decades-long—such individuals tend to

| Figure-1: Readmission Rates for Individuals Discharged from DPC Following Long-Term Care (FY 2014) | | |
|---|--|---|
| | 30-DAY READMISSION RATE | 180-DAY READMISSION RATE |
| Post-Discharge DPC Population of 102 Individuals: | | |
| Readmission Rates* | 8.8% | 15.7% |
| Comparison Rates: | | |
| U.S. Rates (SAMHSA, 2013)** | 8.6% | 20.3% |
| DPC Rates (2013)** | 16.0% | 32.0% |
| * Based upon all clients discharged within FY14 from DPC following lengths of stay of 60+ days | | |
| ** U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, National Outcomes Measures, 2013. | | |

144

145 present special service challenges. Thus, how they fare is an important indicator of the
146 effectiveness of community alternatives to inpatient care. Figure-1 presents an update on this

147 population for Fiscal Year 2014⁶ with respect to 102 such individuals. The vast majority of
148 them receive ACT or other intensive mental health services within the community.

149 The year's readmission rates for 30 and 180 days following discharge (8.8% and 15.7%,
150 respectively) represent increases over those reported in the Monitor's May report (5.9% and
151 13.7%, respectively). In part, this is an artifact of the small size of the group; in a population
152 of 102 individuals, one readmission represents a change of about 1%. That factor, as well as
153 the clinical complexity of the group, suggests DSAMH's community programs are doing
154 well in that the sample's readmission rates approximate the 30-day national average of 8.6%,
155 and that they are significantly below the 180-day State and national comparisons of 32.0%
156 and 20.3%, respectively.

157 The much higher percentages of readmissions reflected in DPC's overall recidivism rates—
158 16.0% within 30 days and 32.0% within 180 days—represent individuals who had been
159 hospitalized for much shorter durations. While some of these individuals were served by
160 ACT teams, as is described later in this report (e.g. Figures 18 and 19), hospital admissions
161 among clients of ACT occur relatively infrequently. The State is currently in the process of
162 analyzing the factors underlying readmissions to DPC, including the fact that they are much
163 higher than the national norms, with the goal of making adjustments in hospital and
164 community providers' practices accordingly.

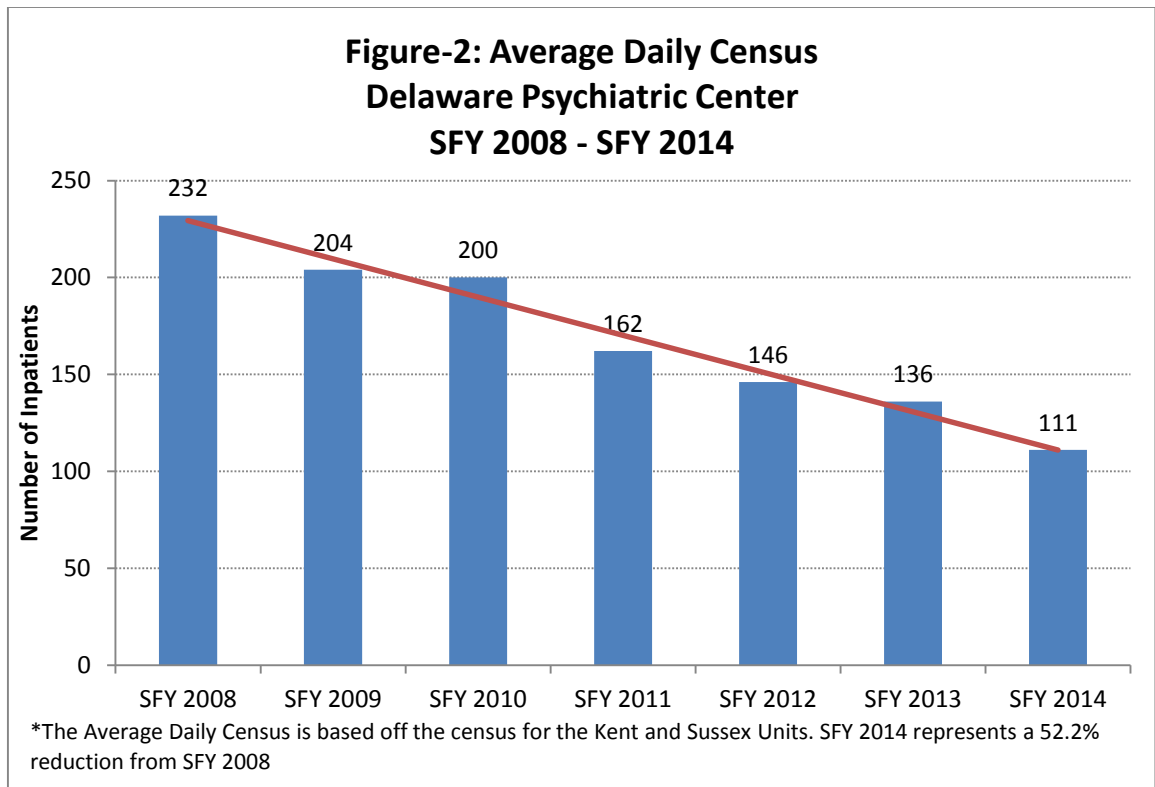
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166 ***Facility Downsizing & Repurposing:***

167 Past monitoring reports have presented data showing the State's success in reducing the
168 census of DPC, particularly on its long-term care units. Figure-2 updates these data for the
169 State's full 2014 fiscal year, showing a modest, but continuing downward trend relative to
170 figures reported in May, 2014. These discharges have significantly furthered the State's
171 efforts to reduce bed-use days (see discussion relating to III.D.3) and, although a need for
172 long-term services will likely remain for a small group of individuals, to reorient the
173 hospital's services more towards acute care. DPC's current average daily census remains
174 about half of what it was in 2008, and is about a third smaller than it was in the Agreement's
175 "base year" of 2011.

176 This is obviously a positive achievement for the State, and even more so because of the
177 ongoing improvements in care provided in this once troubled facility that have occurred
178 during the period the Agreement has been in effect.

⁶ Delaware's fiscal year is from July 1 to June 30.



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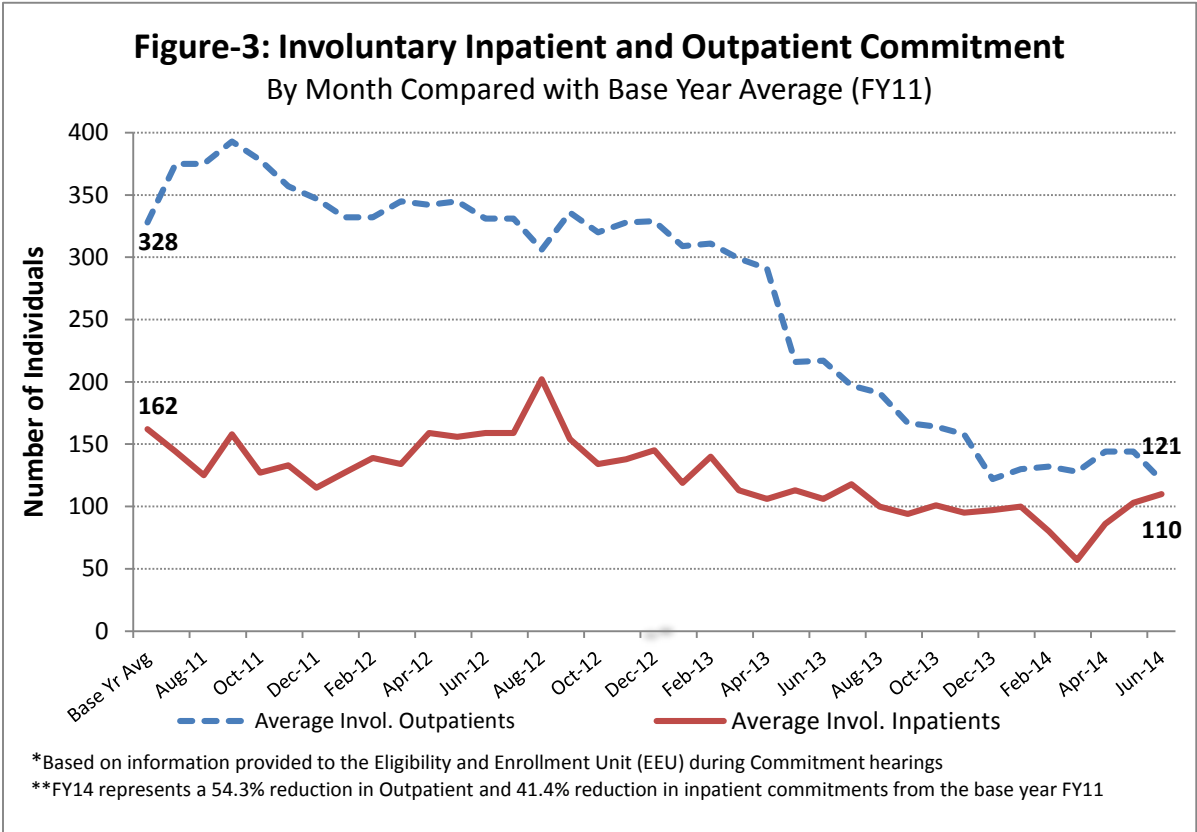
C. Reliance on Court-Ordered Treatment

Court-ordered treatment is sometimes required to address the needs of individuals who are imminently at risk of harming themselves or others as a result of mental illness. However, situations demanding courts’ intervention do not exist in isolation. Programs that provide early intervention, peer supports, effective individualized crisis plans, and other services can significantly reduce the number of scenarios culminating in involuntary treatment. Furthermore, Delaware’s reliance upon involuntary psychiatric detention has reflected other factors, for instance, being used as a means of facilitating ready transport from an emergency room or overcoming wait lists for substance abuse treatment. Both of these scenarios had been widely reported to the Monitor; they are clearly inappropriate uses of the State’s civil commitment law.

Over the past few years, the State has taken a number of measures to reduce its over-reliance on involuntary treatment and to move towards the recovery-oriented model of services promoted by the Agreement. It has made major refinements in its laws governing civil commitment, including a requirement that psychiatric detentions—the first step towards involuntary hospitalization—be pre-approved by certified mental health screeners who are versed in the alternatives to hospital care that are available through the States’ mental health service system, as well as the legal requirements for least restrictive interventions, including those underpinning the Agreement.

200 The State has been tracking civil commitments, both for inpatient care in psychiatric
 201 hospitals and court-ordered outpatient treatment. Figure-3 presents its impressive success in
 202 reducing the number of such court-orders. Monthly tracking data for hospital care show a
 203 reduction by 41.4% and for outpatient treatment by 54.3%—both relative to the base year
 204 (2011) immediately preceding the Agreement.

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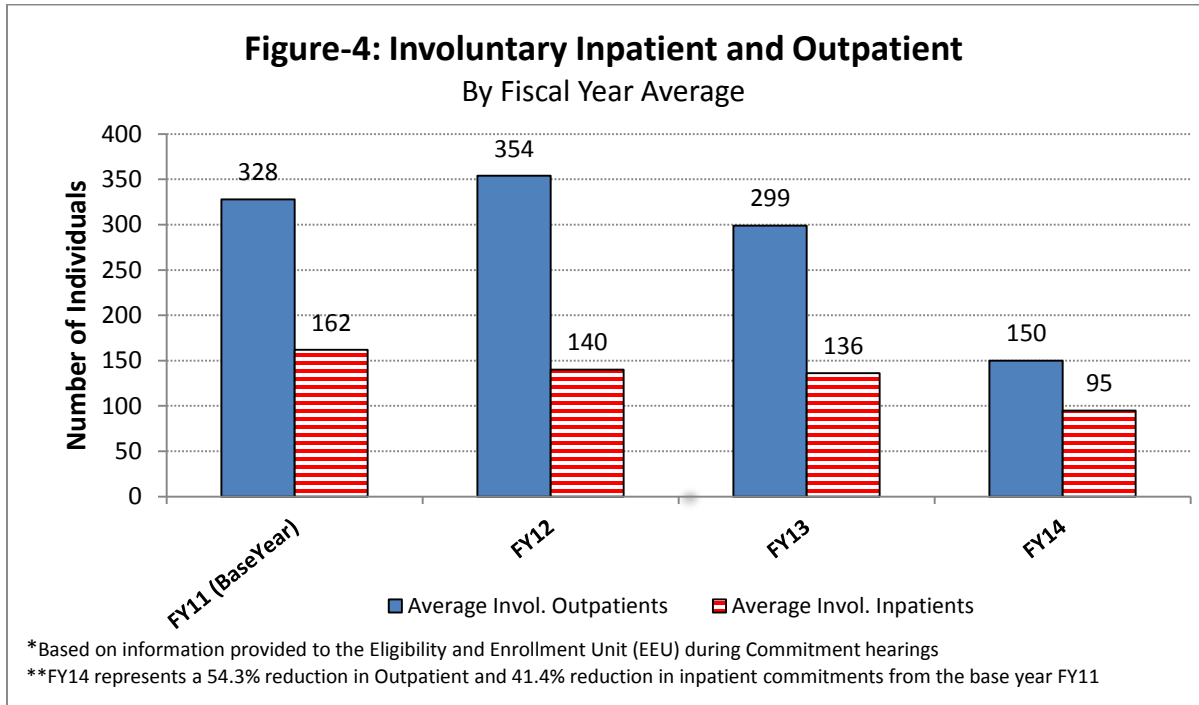


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207 Figure-4 presents these data in a slightly different format, showing the average number of
 208 inpatient and outpatient commitments for each fiscal year since 2011.

209 The revision in Delaware’s law requiring pre-detention evaluations by mental health
 210 screeners, became effective in fiscal year 2013. Based upon the Monitor’s spot checks,
 211 evidence of these screenings is consistently appearing in hospital records, both within DPC
 212 and the IMDs. DSAMH has established a database to track and begin to oversee the quality
 213 of these pre-detention screenings, by client, by screener, and by referring facility (e.g., a
 214 general hospital’s emergency department). While this process is still evolving, it is already
 215 revealing some trends that merit further investigation, for instance, patterns whereby
 216 individuals are identified as appropriate for involuntary detention—based both upon clinical
 217 need and a refusal of voluntary treatment—and within hours of transport to a hospital agree
 218 to voluntary care. While some individuals certainly may change their decision and be more
 219 open to voluntary treatment once they arrive at a hospital, the frequent occurrence of this
 220 scenario (based upon DSAMH’s tracking data, for some screeners, it exceeds 80% of the

221 individuals identified as requiring involuntary care) raises questions as to whether voluntary
 222 care is being appropriately presented as an option by the screener, or whether practices still
 223 persist whereby involuntary transfers by police are used for their convenience. In any event,
 224 it appears that the State is taking appropriate actions to monitor and, as may be indicated, to
 225 take corrective actions to improve the effectiveness of the overall process.



226
 227
 228 Overall, the data on court interventions and oversight of mental health screenings reflect very
 229 positively on the State’s efforts to serve people with SPMI in ways that promote recovery,
 230 reduce stigma, and emphasize that crises associated with mental illness are primarily aspects
 231 of healthcare, rather than police or court matters.

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 234 **III. Ratings of Compliance with Specific Provisions of the Agreement**

235 The following sections present ratings of the State’s compliance with respect to provisions
 236 comprised by Sections II-V of the Agreement, including those with specific numerical
 237 targets. As of July, 2014 and based upon available information (i.e., given the limitations in
 238 information about people served through DMMA, which were referenced at the beginning of
 239 this report), the State was in Substantial Compliance with each of these, except for Crisis
 240 Stabilization (Sections II.C.2.d.iii and iv), Assertive Community Treatment (Section III.F)
 241 and Risk Reduction (Section V.B); the State is in Partial Compliance with these provisions.

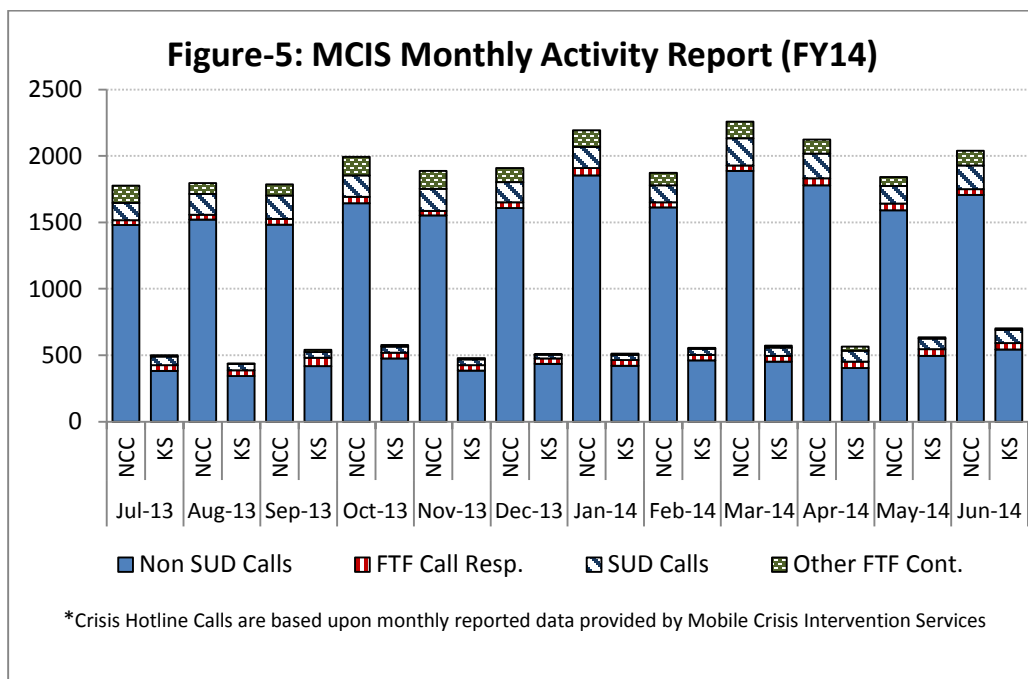
243 **A. Crisis Services**

244 Substantial Compliance.

245 Section III.A of the Agreement requires the State to establish a crisis hotline, allowing
 246 individuals 24-hour access to assistance and referral information. The State remains in
 247 substantial compliance with this provision. Figure-5 presents relevant monthly trending data
 248 for New Castle County (NCC), which includes Wilmington, and for Kent and Sussex
 249 Counties (KS) for the State’s 2014 fiscal year. Each month’s statistics are broken down by
 250 whether the calls represented problems not primarily associated with substance use (Non-
 251 SUD) and calls related to substance use (SUD calls). In addition, monthly statistics include
 252 the number of calls that resulted in a face-to-face contact by the Mobile Crisis Programs
 253 (FTF-Call Resp.), as well as face-to-face contacts that were not crisis in nature, for instance,
 254 wellness checks that may occur following an initial crisis intervention (Other FTF Cont.).

255 As would be expected based upon the population distribution in Delaware, the bulk of the
 256 calls come from New Castle County, where the State’s residents are most concentrated.
 257 However, staff reports indicate that calls emanating from Kent and Sussex Counties, which
 258 are more rural, tend to be more acute in nature; thus, the proportion of calls resulting in face-
 259 to-face interventions by Mobile Crisis is higher in these counties than in New Castle.

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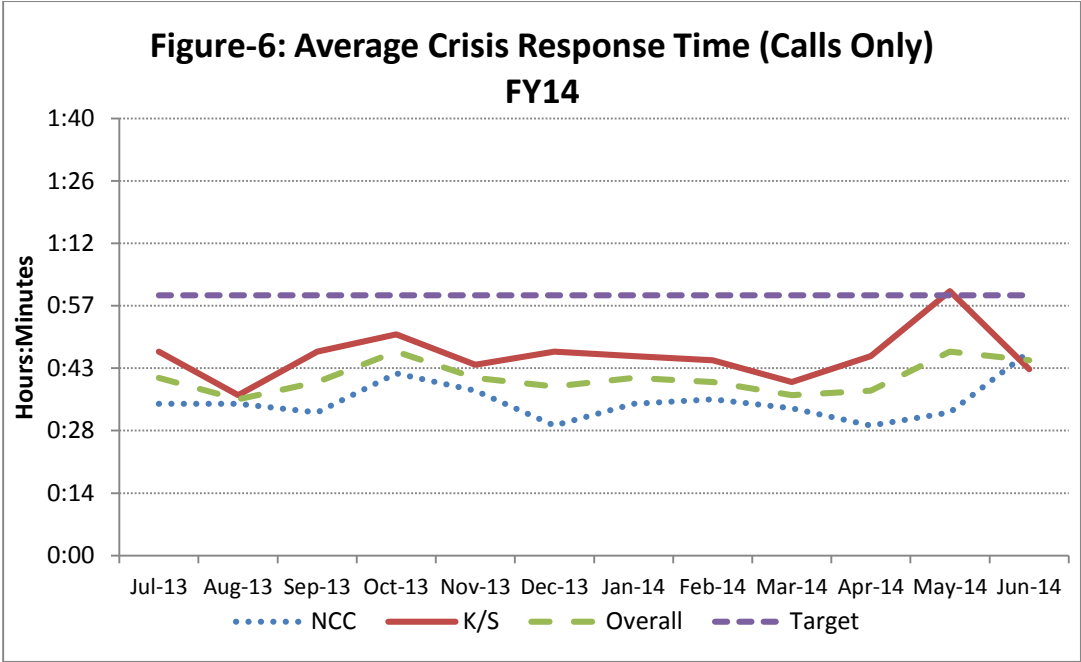
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262 Delaware’s Mobile Crisis programs (required by Section III.B of the Agreement) provide
 263 essential face-to-face services to individuals with SPMI who are experiencing psychiatric
 264 emergencies. Their goal is to quickly assess the nature of the crisis, taking into account
 265 environmental issues that can be assessed in the individual’s natural living setting; to provide

266 emergency interventions, including services directed toward de-escalating the crisis; and to
 267 make referrals or connections with individuals’ providers accordingly. Although face-to-face
 268 Mobile Crisis contacts are made when an individual is in an acute emergency and ostensibly
 269 at very high risk of hospitalization, anecdotal information from responders indicates that a
 270 high percentage of these encounters actually result in an alternative to hospital care—
 271 immediate de-escalation, referrals or coordination with current providers, or use of crisis
 272 apartments or walk-in services.

273 Figure-6 presents data demonstrating that the State is in compliance with Section III.B.1 of
 274 the Agreement, which requires a response time for face-to-face interventions of one hour or
 275 less. Although Delaware is small in size, fulfilling the one-hour requirement can be
 276 challenging, especially in Kent and Sussex Counties where there are no freeways and local
 277 roads seasonally get clogged with beach traffic.

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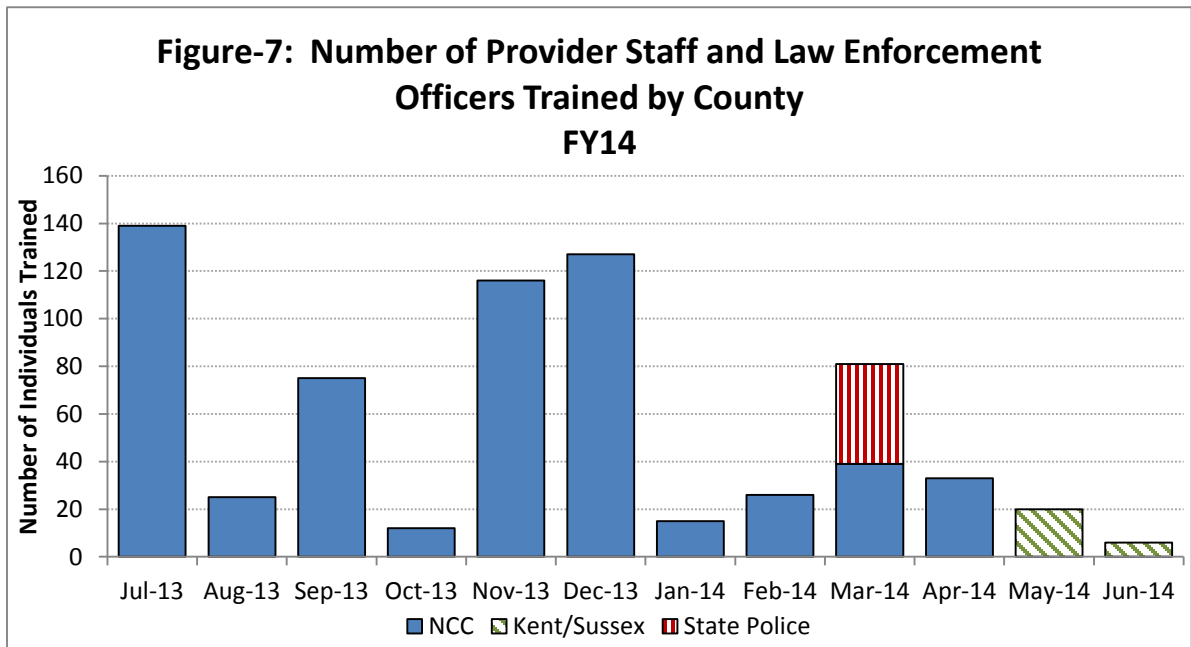


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 280 The State’s Mobile Crisis program is not limited to one-time emergency interventions.
 281 Mobile Crisis responders routinely reconnect with at-risk individuals, either in person or by
 282 telephone, for follow up activities such as wellness checks or to deliver medication. In
 283 addition, the program is well integrated with other services, such as Targeted Care
 284 Management (generally for individuals not currently receiving services) and the Crisis Walk-
 285 In Centers (for individuals who may need further assessment or immediate, short-term
 286 respite).

287 Mobile Crisis, along with its seamless connections with the Targeted Care Management
 288 program, also serves as an alternative to the police for transporting individuals who need
 289 additional assessment. For instance, Mobile Crisis transported Ms. D from home to the

290 Recovery Response Center (“RRC,” the Crisis Walk-In Center in Ellendale) to address
 291 thoughts of suicide and Mr. E, who was under a 24-Hour Detention to and from a medical
 292 consultation that had been requested by the RRC. These functions are not only far less costly
 293 to the State, but also are likely far less traumatizing and demeaning than being handcuffed
 294 and transported in a police car, as had once been routine practice.

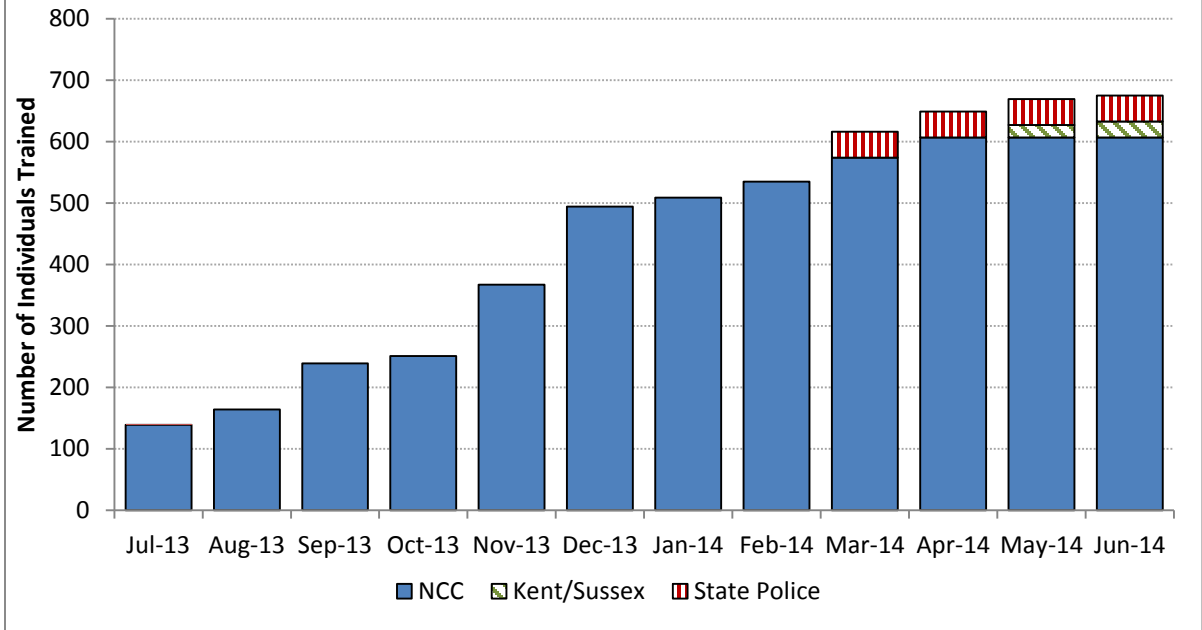
295 Section III.B.2 requires the State to train law enforcement personnel about the functions and
 296 means of accessing Mobile Crisis (Section III.C.2 has a similar requirement with regard to
 297 Crisis Walk-In Centers, which are inter-related to Mobile Crisis). The State remains in
 298 Substantial Compliance with these provisions. The following two figures present monthly
 299 tracking of trainings by county, and the cumulative number of trainings conducted during the



300
 301 fiscal year for local and state police officers. Figure-7 presents the number of trainings by
 302 county for each month of the fiscal year. Figure-8 presents these data as cumulative totals
 303 during this period. Almost 700 trainings took place, including trainings with State police and
 304 in small towns that have very small numbers of officers. The audiences for the trainings are
 305 not evenly distributed in size or location across the fiscal year, but are determined by the
 306 availability of participants and specific requests for assistance.

307 These trainings are incredibly important as a means of familiarizing officers with the array of
 308 services—including Mobile Crisis services—that can be utilized in responding to individuals
 309 who are having problems apparently associated with mental illness. Ultimately, they should
 310 also assist the State in reducing the routine involvement of the police as first responders in
 311 situations that do not represent immediate threats of danger to self or others—a goal that is
 312 very much welcomed by the police officials with whom the Monitor has had contact.

Figure-8: Cumulative Totals of Provider Staff and Law Enforcement Trained FY14



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B. Crisis Walk-in Centers

Substantial Compliance.

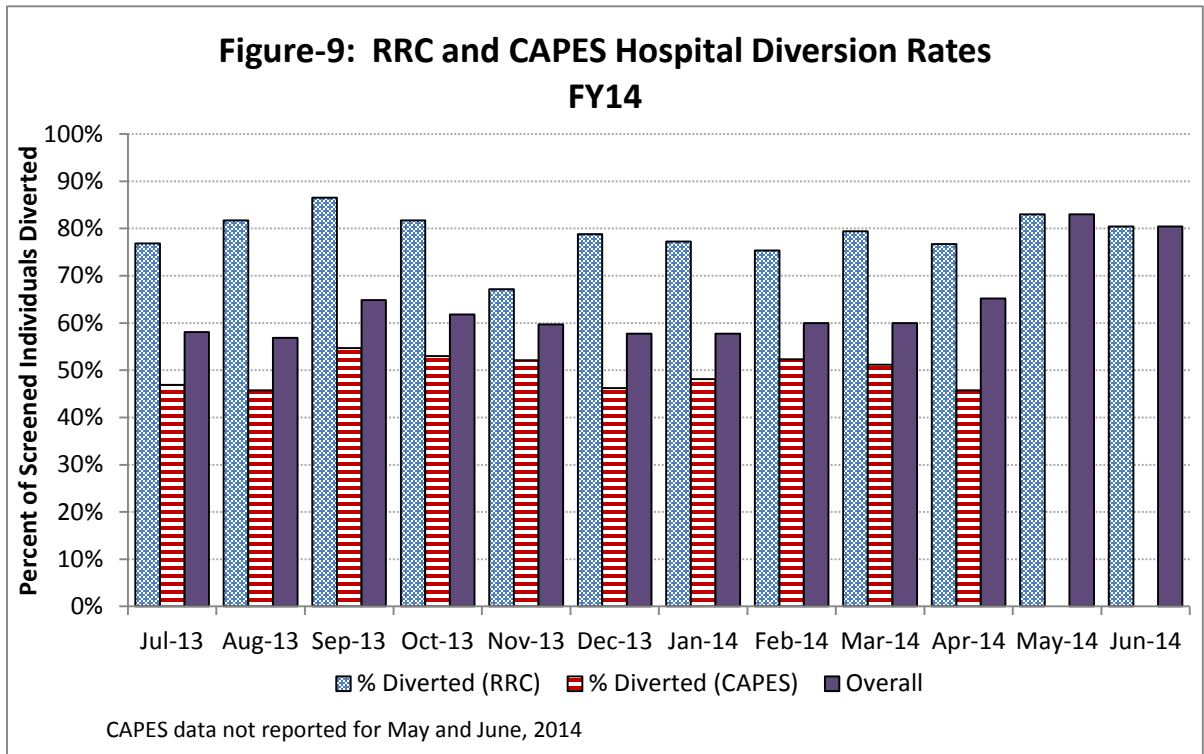
317 Crisis Walk-In Centers are another critical element of the State’s service system. Their goal
 318 is to provide intensive, short-term assessments of individuals who are in crisis and whose
 319 issues cannot be resolved at home (e.g., through Mobile Crisis), and to implement
 320 intervention plans that represent the most integrated, least-restrictive approaches to address
 321 them. Figure-9 presents the rates at which the State’s two Crisis Walk-In programs have
 322 been able to divert individuals who are in psychiatric crises from admission to a psychiatric
 323 hospital.

324 The two Crisis Walk-In programs—CAPES in New Castle County, and the RRC serving
 325 Kent and Sussex Counties—reflect different models of service. CAPES is located within a
 326 large general hospital; it represents the traditional, hospital-based approach of essentially
 327 creating a special emergency department for individuals in psychiatric crisis. The RRC
 328 reflects a recovery orientation along the lines of what is referred to as the “living room”
 329 model. Rather than assessing individuals within the sometimes daunting environment of an
 330 emergency room, the atmosphere and approaches at RRC are much more directed towards
 331 encouraging the individual to feel comfortable in a home-like setting where he or she is
 332 treated more as a “guest” than a “patient.” While the RRC has essentially the same
 333 complement of mental health professionals as a traditional crisis center, trained peers play a

334 very significant role in helping to understand what the individual is going through and in
335 establishing recovery-oriented interventions accordingly, with the individual as a partner.

336 As is depicted in Figure-9, the RRC has demonstrated high rates of diverting individuals
337 from hospitalization—higher than those achieved by the hospital-based program. In light of
338 the success of this program, the State has funded a counterpart to be established in New
339 Castle County. This program is slated to be implemented in 2015.

340



341

342 Beyond the benefits seen in the RRC’s diversion rates and the alignment of this program with
343 a recovery orientation, the establishment of this model for Crisis Walk-In services statewide
344 has an additional important and positive implication. As a part of its efforts to reduce
345 hospitalizations (see discussion of Section III.D.4 below), the State is wisely moving to carry
346 out assessments of individuals who are detained under 24-hour holds (the first step towards
347 civil inpatient commitment) outside of hospital settings and, instead, within Crisis Walk-In
348 Centers. Simply stated, the purpose of 24-hour psychiatric holds is to determine whether an
349 individual has a mental illness, whether hospitalization is the least restrictive approach to
350 address the individuals’ immediate clinical issues, and whether the individual meets the legal
351 criteria for involuntary treatment in the event that he or she refuses voluntary care. In the
352 past, these detention assessments have sometimes occurred within Crisis Walk-In Centers,
353 but they more routinely occurred within psychiatric hospitals. When these assessments occur
354 in hospitals, the individual has already been admitted as a patient, and the diversion rate—

355 i.e., the number of individuals found inappropriate for hospitalization and referred elsewhere
356 within 24-hours—is virtually zero.⁷

357 The State’s plan, which is already partially implemented, is to make the Crisis Walk-In
358 Centers the default locale for assessment of individuals under 24-hour detentions, unless
359 there is some overriding reason to admit the individual directly to a hospital (e.g., in
360 circumstances where there is an immediate and unremitting threat of harm to self or others—
361 a circumstance that is not as routinely encountered as might be expected). Given the State’s
362 success in diverting admissions when people are evaluated through the Crisis Walk-In
363 Centers, this approach may well significantly reduce the number of hospitalizations. As is
364 referenced later in this report, there are already some preliminary data suggesting that this
365 may be the case.

366 ***Recommendation-***

- 367 1. Use of the Crisis Walk-In Centers to assess individuals who are under 24-hour
368 psychiatric detentions is a very important, positive measure. It is recommended
369 that the State develop monthly “dashboard” measures to track the impact of this
370 initiative and, as may be indicated, to further refine or expand capacities within
371 the Crisis Walk-In Centers.

372
373 **C. Crisis Stabilization Services**

374 ***1. Reduction in Inpatient Bed Days:***

375 **Partial Compliance.**

376 **Issues in Measuring Compliance**

377 Section III.D.3 requires that by July 1, 2014, Delaware reduce State-funded hospital bed-days
378 for the population covered by the Agreement by 30%, relative to the base year; Section
379 III.D.4 requires further reductions—to 50%—by July 1, 2016. These represent very
380 important and seemingly straightforward measures. For hospital care that is managed
381 through DSAMH—that is, for individuals receiving its specialty mental health services, for
382 individuals treated at DPC, and for other individuals who are hospitalized but who don’t have
383 either Medicaid MCO or commercial coverage—monitoring of this provision has, in fact,
384 been straightforward.

385 For individuals whose care is managed through DMMA, monitoring has been quite
386 challenging. For well over a year, the State had asserted that it could not get accurate data
387 from MCOs about hospital stays until several months after the fact because bed-use days are

⁷ This is evidenced in IMDs’ lengths of stay data, which do not show any significant number of instances where a length of hospital stay is less than 24 hours, as would occur when an individual is diverted from hospitalization during the initial detention period.

388 a “moving target” until all claims have been paid out. The State vigorously maintained and
389 that “paid bed-days”—that is, data generated only after a hospital billing for care had actually
390 been paid by the State—represent the only appropriate metric for this provision of the
391 Agreement. Because hospitals are allowed a 90-day period following an individual’s
392 discharge to bill for services, at least a three-month delay was required in order to capture
393 useful data. The State further maintained that such a delay in data is not problematic in terms
394 of its oversight of services to the population covered by the Agreement (this, notwithstanding
395 increases in bed-day use discussed below), nor should it be problematic for the Monitor’s
396 purposes of evaluating ongoing implementation of the Agreement.

397 Paid bed-day information, of course, is one accurate measure of hospital use, but the
398 magnitude of delay that the State represented as unavoidable is impractical for monitoring
399 purposes. It would mean that the State would not be able to demonstrate compliance with the
400 requirements of the Agreement until more than three months after the fact. Further, it would
401 undermine both the State’s and the Monitor’s oversight of how Delaware’s plan to reduce
402 bed use (discussed later) was proceeding and whether it was having any impact. For
403 instance, the impact of the State’s initiative to use Crisis Walk-In Centers to conduct
404 assessments pursuant to 24-hour psychiatric detentions could not begin to be evaluated until
405 three months afterward and the effects of any efforts to improve upon this process could not
406 be evaluated for another three months. This is simply not good management of a critical
407 (and expensive) service that relates to an adverse event—a psychiatric crisis necessitating
408 hospitalization—nor does it allow appropriate monitoring of a provision that is critical to the
409 Agreement.

410 Beyond this matter, in response to the State’s data showing *increases* in IMD bed-day use
411 among people whose care is managed through MCOs, DHSS and DMMA strongly argued
412 that they now considered the diagnostic list that the State and the Monitor had been relying
413 upon to identify individuals covered by the Agreement since implementation began over
414 three years ago to be inappropriate because it might include people with Serious Mental
415 Illness (SMI) who may not have Serious and *Persistent* Mental Illness.

416 In an attempt to accommodate the State’s assertions with regard to its inability to provide
417 timely data and these diagnostic issues, the Monitor worked with the State for probably a
418 year or more to devise alternate approaches to extracting information needed from DMMA’s
419 data sets.⁸ This became an arduous, sometimes contentious and, in many ways, time-wasting
420 enterprise in which discussions of the service needs of individuals were set aside as various
421 ways of capturing DMMA data were explored. In effect, the State had made a decision to
422 defer improvements in DMMA-managed services to people covered by the Agreement
423 because (at that point, more than two years into implementation of the Agreement) it now

⁸ This was described in the Monitor’s last report.

424 had questions as to whether the TPPL was over-inclusive.⁹ In addition, it chose to defer
425 immediate action because it anticipated major revisions in its MCO contracts beginning in
426 January, 2015. Neither the Monitor nor DOJ were consulted about or concurred with this
427 approach. In fact, the Monitor repeatedly requested that, notwithstanding definitional issues
428 or future MCO contractual refinements, the State demonstrate that, in keeping with the
429 Agreement, it was taking measures to address the *immediate* needs of individuals being
430 hospitalized in IMDs. The Monitor believes that since the Agreement took effect, the State
431 could (and should) have taken several actions on behalf of people whose care is managed
432 through DMMA to improve outcomes and to demonstrate its efforts to appropriately meet its
433 obligations. It could have done so without fundamentally altering its programs.¹⁰

434 Ultimately, in October, 2014, with intervention by DOJ and Delaware’s Attorney General’s
435 office, a meeting with DMMA and an MCO readily (i.e., reportedly within one hour)
436 resolved the issue of timely data. They determined that largely accurate paid bed-day data
437 *could*, in fact, be provided shortly after the end of each month through a database that is
438 routinely used in the managed care industry.¹¹ The reason that DMMA had not addressed this
439 issue well over a year prior remains unclear; had it done so, significant time and effort
440 dedicated to a data “workaround” could have been avoided and, instead, issues relating to
441 individuals’ service needs could have been the focus of attention.

442 Later in October, the State agreed to set aside its challenges to the diagnostic criteria used to
443 identify the population being monitored and to revert to the original approach. Accordingly,
444 IMD bed-days would once again be counted for individuals whose care is managed through
445 DMMA when one or more of their discharge diagnoses appear on a diagnostic list that the
446 Monitor constructed in 2011 in collaboration with DSAMH, DMMA, and the MCOs. These
447 data are presented in Figure-10.¹² As has been the case throughout the Agreement, all

⁹ Whether public services to individuals who have disabilities are ultimately “credited” under the Agreement should not affect referrals to address unmet needs. The State is aware that the Agreement and the TPPL cover only a portion of the population for whom it has obligations under the ADA and other laws. Moreover, as has been referenced in past reports by the Monitor, the DHSS Cabinet Secretary has articulated the State’s commitment to appropriately serve all Delawareans, regardless of their status with respect to the Agreement.

¹⁰ One example would be to systematically refer homeless individuals to DSAMH upon their hospitalization in an IMD so that they might access supportive housing and other alternatives not available through DMMA.

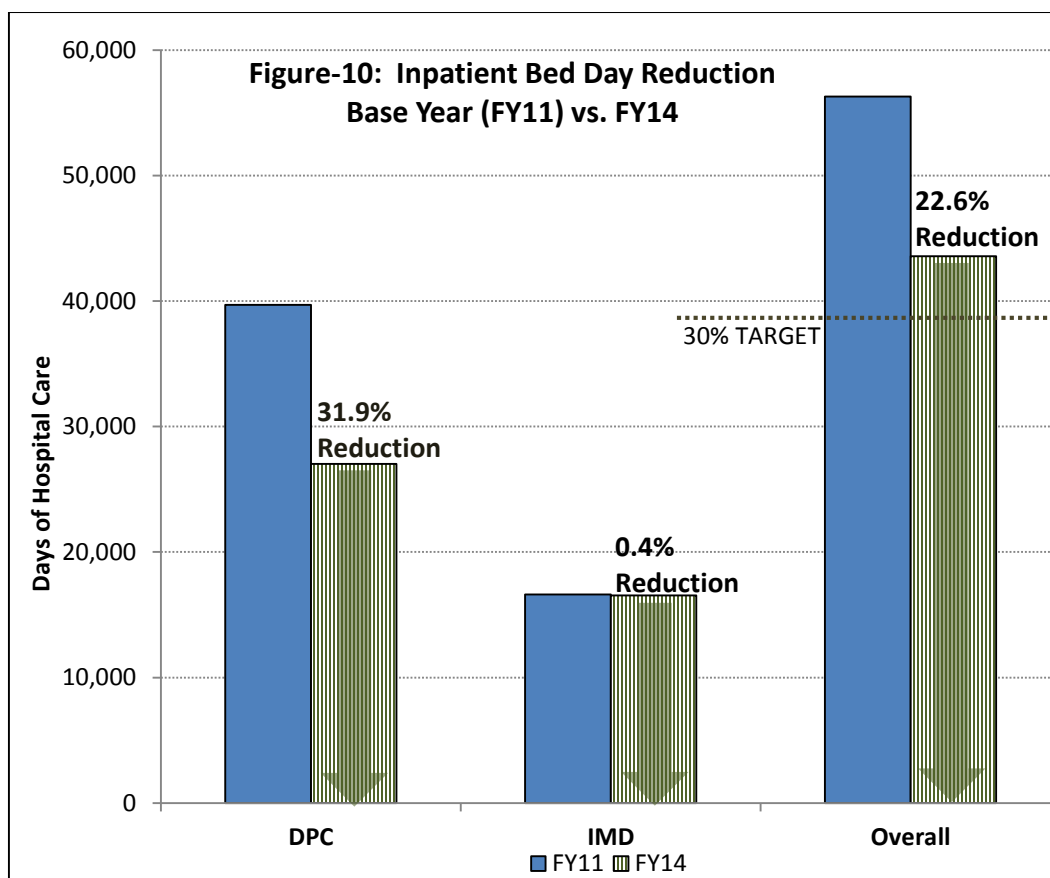
¹¹ The MCO explained that hospitals have up to 90-days to bill for care, but that claims are overwhelmingly settled much sooner, within 30 days.

¹² The data presented in the Monitor’s May 19, 2014 report incorporated revisions in calculating bed-days for individuals whose care is managed through DMMA that were made to accommodate the State’s assertion that it could not provide timely data and that the available diagnostic data were insufficient to determine that individuals had SPMI. As is explained in the current report, these factors are no longer relevant and the data presented here reflect the

448 individuals managed through DSAMH are presumed to have SPMI, and their bed use is
449 counted accordingly.

450 **Bed-Use Data**

451 Figure-10 indicates that the State has not reached the 30% reduction in bed-use that is
452 required by July 1, 2014, per the Agreement. Its overall rate of bed-use reduction was
453 22.6%, largely achieved as a consequence of significant reductions at DPC —31.9% —in
454 long- and intermediate- term care. This reduction, while unquestionably a positive
455 achievement for the State, will not continue to carry the State to compliance with the 2016
456 benchmark of a 50% reduction (Section III.D.4), in large part, because DPC’s long-term care
457 population is now only about ¼ of what it was in 2011. Further reductions will need to be
458 seen in bed use for acute care, both within DPC and in the IMDs. As of July 1, 2014, bed-
459 use in IMDs by the population covered in the Agreement was essentially flat relative to the
460 base year, showing only a 0.4% reduction.

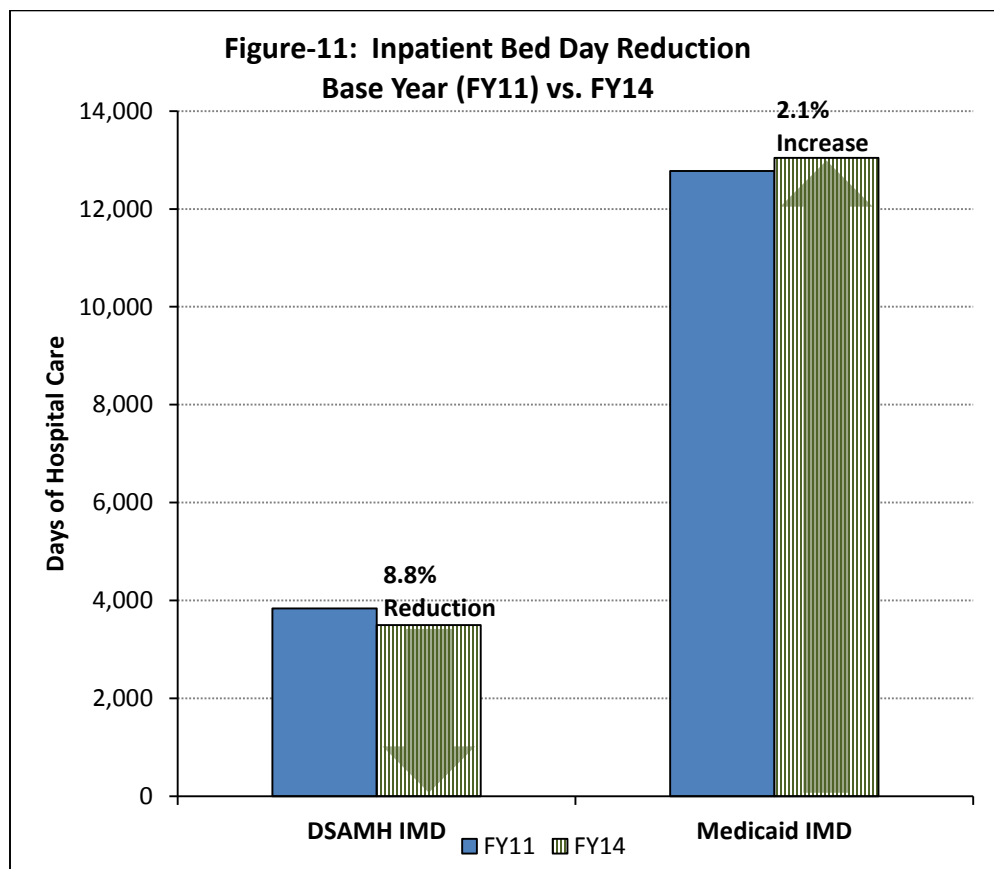


461
462 Because of its relevance to the Agreement and the ADA, with concurrence of the parties, the
463 Monitor has been including the long-term care population at DPC in calculations of hospital

methodology that had been originally used in implementation monitoring. As such, comparisons of bed-use data presented here with those presented in the last report are not meaningful.

464 bed-use. Technically, though, the language of Sections III.D.3 and 4 refers to requirements
 465 only for reductions in “acute” (i.e., not long-term) inpatient settings, which would represent
 466 stays of 14 days or fewer in the IMDs and the acute-care units of DPC. Although the State’s
 467 overall acute-care bed use is essentially unchanged from 2011, further analysis of the data
 468 shows important differences in acute care bed-days in IMDs based upon what entity is
 469 managing the inpatient care and, likely as well, what processes exist to divert individuals
 470 from hospital admissions.

471 Figure-11 presents data about the first of these factors, demonstrating that there are
 472 significant differences in bed-use managed through DSAMH, compared with that managed
 473 through DMMA. Clinically, these populations are similar. And to the extent that differences
 474 do exist, DSAMH is managing hospital care for a generally more complex group of
 475 individuals (e.g., people who have been referred for its specialized services or DMMA-
 476 managed individuals whose needs are such that they had exhausted their Medicaid inpatient
 477 benefit¹³). As is depicted in Figure-11, relative to the base year, DSAMH-managed acute
 478 hospital days have decreased by 8.8%—a divergence from the 30% target of 21.2%—while
 479 DMMA-managed hospital days have *increased* by 2.1%—a divergence from the July target
 480 by 32.1%.



481

¹³ Medicaid coverage of inpatient psychiatric care is no longer limited in this way.

482 This difference may be attributable to a number of factors. During the past two years,
483 DSAMH has been ramping up its Utilization Review program, in part through technical
484 assistance secured through the Monitor. Data over the past year or more have indicated that
485 this effort is resulting in reductions in bed-use for the acute care it manages within the IMDs.
486 Although it is currently renegotiating its contracts with MCOs, DMMA has not provided
487 specific information about how the MCOs conduct their Utilization Review, nor has it sought
488 technical assistance in regard to fulfilling related provisions of the Agreement.¹⁴ Past
489 Monitor reports have shown bed-use among the DMMA-managed population to be trending
490 upward and anecdotal reports suggest that five- to seven-day authorizations by MCOs for
491 hospital care have been routine.¹⁵

492 Another potential factor, which is suggested by the individual stories presented at the
493 beginning of this report, is that hospital use is increasing among the population managed
494 through DMMA because it includes a significant number of individuals who are not being
495 referred to DSAMH for the specialized services or housing they need and, thus, in conflict
496 with the goals of the Agreement, they remain at elevated risk of hospitalization. If DMMA
497 pursues its recent efforts to more systematically monitor the referral of ostensibly high-need
498 individuals to DSAMH, their more ready access to intensive community based mental health
499 services, as well as the closer linkages to community providers before, during, and after
500 episodes of hospitalization may ultimately reduce the reliance on hospital care, or at least
501 shorten stays.

502 Finally, as was discussed earlier, the RRC in Ellendale is showing impressive progress in
503 diverting individuals from hospitalization in the first place, including those being evaluated
504 under 24-hour detentions. Significantly, bed-day use among individuals whose care is
505 managed through DMMA has dropped in the IMD that is located in southern Delaware,
506 which is served by the RRC—in fact, by a factor of almost 26% relative to the base year. In
507 contrast, bed-day use managed through DMMA in hospitals in the northern part of the state,
508 where the RRC is far less likely to be involved in pre-admission interventions and where 24-
509 hour detention evaluations tend to occur within the IMDs themselves, has increased by over
510 15% during the same period. These data suggest that the pending launch of an RRC to serve
511 New Castle County may be pivotal in reversing the increases in bed use by individuals whose
512 care is managed through MCOs and furthering the reductions in bed use that have been
513 achieved through DSAMH's Utilization Review process.

¹⁴ The State is not, of course, required to seek technical assistance, but such assistance might have been helpful in improving its performance with respect to this and related provisions of the Agreement.

¹⁵ The State has not provided data refuting this anecdotal information.

Delaware's Plan to Reduce Days of Hospitalization

UR that carefully considers the State's community alternatives to hospitalization, referral of high-risk individuals to DSAMH, and use of the Crisis Walk-In Centers for psychiatric detention assessments collectively lay a foundation for achieving the reductions in acute care bed use that are required in the Agreement. The State has incorporated these and other elements in an overall plan to reduce the use of acute psychiatric hospital beds which was developed collaboratively by DMMA and DSAMH. The plan also includes measures to create better linkages to substance use services and enhanced reimbursement for essential mental health services through "PROMISE," an amendment to a State Medicaid waiver.

PROMISE is an important and positive initiative that the State has presented as a centerpiece of its plans to reduce bed-use and to assure that individuals with SPMI who are served through DMMA have access to a broad array of needed mental health services. In reality, most of the services comprised by the PROMISE program are already available to individuals served through DSAMH, but they are provided at State expense. PROMISE will allow the State to capture Medicaid reimbursement that is not currently offered for these services. Individuals whose care is managed through DMMA and who need the types of services that will be covered by PROMISE can now, and have been able to, receive them through DSAMH. An essential problem is that access to these specialty mental health services—and, indeed, access to PROMISE—requires that such individuals first be referred to DSAMH. As is explained elsewhere in this report, the State has not been managing this referral process in ways that fulfill its obligations under the Agreement.¹⁶

At the suggestion of the Monitor, the State is now beginning to explore specific "triggers" for referrals, but when these triggers will go into effect, what entity will have responsibility for actually making the referrals to DSAMH, and how the State will monitor the process to ensure that the requirements of the Agreement are met have not yet been determined. Furthermore, the referral initiative now underway (which relates to an initial group of about 460 very high-risk individuals) is working well, but as noted earlier, the time lag in initiating referrals has resulted in the State being unable to now locate many of these individuals, and DSAMH has indicated a capacity to process only about 60 referrals per month. There may be a much larger backlog of people with significant unmet needs. Based upon the TPPL, the pool of individuals with SPMI who are now served through DMMA and who *may* be appropriate for PROMISE (the State has not compiled good data about what these individuals' service needs actually are) might be as large as 6,000 or more. How the State plans to assess their needs and assure their timely access to needed services remains unknown.

¹⁶ As was described in the Monitor's May 16, 2014 report, the State has streamlined its referral process for DSAMH services, but it has not had—and does not now have—a system to ensure that referrals of individuals with SPMI whose care is managed through DMMA are appropriately being made.

549 Another aspect of the State’s bed-use reduction plan requires consultation between MCOs
550 and DSAMH with regard to individuals managed through MCOs who have SPMI. As of this
551 writing, and although these changes are slated to go into effect in less than one month, the
552 specific nature of this consultation has not yet been worked out, including plans for a
553 collaborative approach to Utilization Review of individuals who are hospitalized in IMDs.
554 This issue is of particular importance because when the PROMISE program is implemented,
555 DSAMH will no longer independently conduct Utilization Reviews in IMDs for individuals
556 it serves if they are covered by Medicaid.

557 It is critical that the State give high priority to its bed-use reduction plan, closely tracking its
558 impact and making adjustments accordingly. The plan, which was finalized in June of this
559 year, would correct some of the problems described in the Introduction section of this report
560 relating to the referral of individuals by DMMA to DSAMH for specialized services,
561 housing, and other supports not otherwise readily available to them. Given recent
562 developments—namely, the resolution of problems with DMMA in timeliness of data and
563 the diagnostic disputes discussed above—the State should now be in a position to
564 aggressively move forward on its bed-use reduction plan and, as urged in the Monitor’s May
565 report, to appropriately prioritize other efforts to ensure that the needs of individuals whose
566 care is managed through MCOs are being met in compliance with the Agreement. The
567 following recommendations from the May report are being reiterated:

568 ***Recommendations:***

- 569 1. It is strongly recommended that DHSS ensure that DMMA appropriately
570 prioritizes compliance with the Agreement and associated monitoring
571 requirements.
- 572 2. As these measures go into effect, it is critical that the State has unified data
573 systems in place (i.e., with the capacity to integrate timely information
574 about bed use from DSAMH and DMMA) to allow for meaningful UR,
575 ongoing program monitoring and refinement, and to demonstrate these
576 measures’ impact on bed use. This information is important in itself, and,
577 in light of the challenges of meeting this requirement, can also help
578 demonstrate that the State is making its best efforts to achieve compliance.
- 579 3. It is strongly recommended that the State immediately implement measures
580 to ensure that all individuals putatively having SPMI and meeting the
581 criteria for inclusion in the TPPL be evaluated for carve-out and access to
582 the more intensive services and supports that are available through
583 DSAMH.

584

585 **2. Discharge Planning:**

586 Partial Compliance.

587 Sections II.C.2.d.iii-iv of the Agreement require the timely involvement of a community
588 provider to assist in discharge planning when an individual is admitted to DPC or an IMD for
589 acute care. The Monitor’s last report found that this requirement was being inconsistently
590 met with regard to individuals whose care is managed through DSAMH and that the
591 requirement was essentially not being met at all with regard to those whose care is managed
592 through DMMA.

593 With regard to DSAMH clients, the State has since taken measures to ensure that
594 involvement by community providers is uniformly documented across providers and across
595 hospitals so that the timeliness and extent of participation by the community program can be
596 readily monitored. Community providers are notified at the time of an individual’s hospital
597 admission both by DSAMH’s Eligibility Enrollment Unit (EEU) and the hospital itself.
598 DSAMH’s contracts with ACT and Intensive Care Management (ICM) providers now
599 require their direct involvement when a client is psychiatrically hospitalized, at the time of
600 admission, at least three times per week during the course of inpatient care, and at the time of
601 discharge. Documentation of providers’ involvement is an additional requirement. DSAMH
602 is presently monitoring adherence to these requirements and is reviewing options to not only
603 improve performance with respect to the requirements of the Agreement, but to also assure
604 that involvement by community providers is meaningfully contributing to the services
605 afforded the individual.

606 As of this writing, the State is negotiating improved collaboration in discharge planning
607 between DMMA, the MCOs, and DSAMH, but it has reported no concrete measures actually
608 taken over the past 3 ½ years with regard to implementing this provision for the population
609 managed through DMMA. This is a serious matter, given that in excess of 75% of acute care
610 bed days associated with the population covered by the Agreement occur with regard to
611 individuals whose care is managed through DMMA.¹⁷

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613 **D. Crisis Apartments**

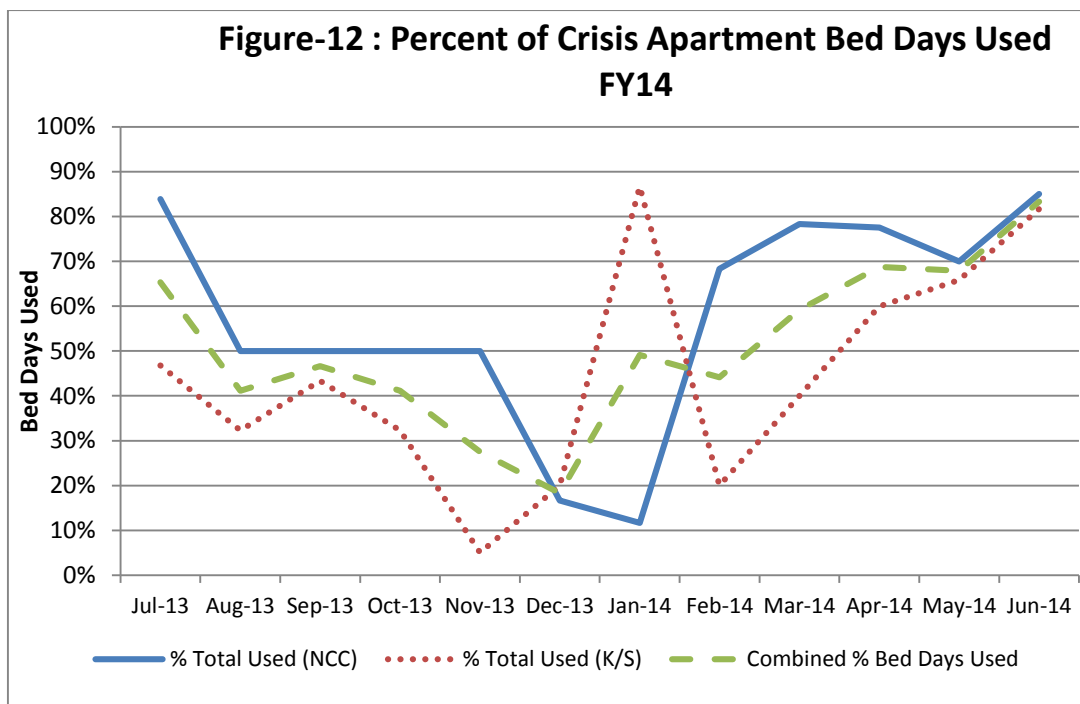
614 Substantial Compliance.

615 Section III.E.2 of the Agreement requires that the State develop 4 crisis beds to serve as an
616 alternative for individuals who are experiencing mental health crises, but do not need hospital
617 care. Although referred to as “Crisis Apartments,” these are no longer actual apartments.

¹⁷ For Fiscal Year 2014-5, the State reported 3,497 IMD acute care bed days managed by DSAMH and 13,045 managed by DMMA.

618 Landlords that had been leasing units to house this program became concerned about their
 619 use by transient residents who were not only unknown to them but, by program design, were
 620 experiencing psychiatric emergencies. Accordingly, during the 2014 fiscal year, the State
 621 relocated its crisis apartment programs serving New Castle and the southern counties to
 622 freestanding houses. These provide a total of 8 beds, which significantly exceeds the
 623 required number. These beds are augmented by additional community “Resource Beds,”
 624 which DSAMH accesses for a variety of purposes on an as-needed basis.

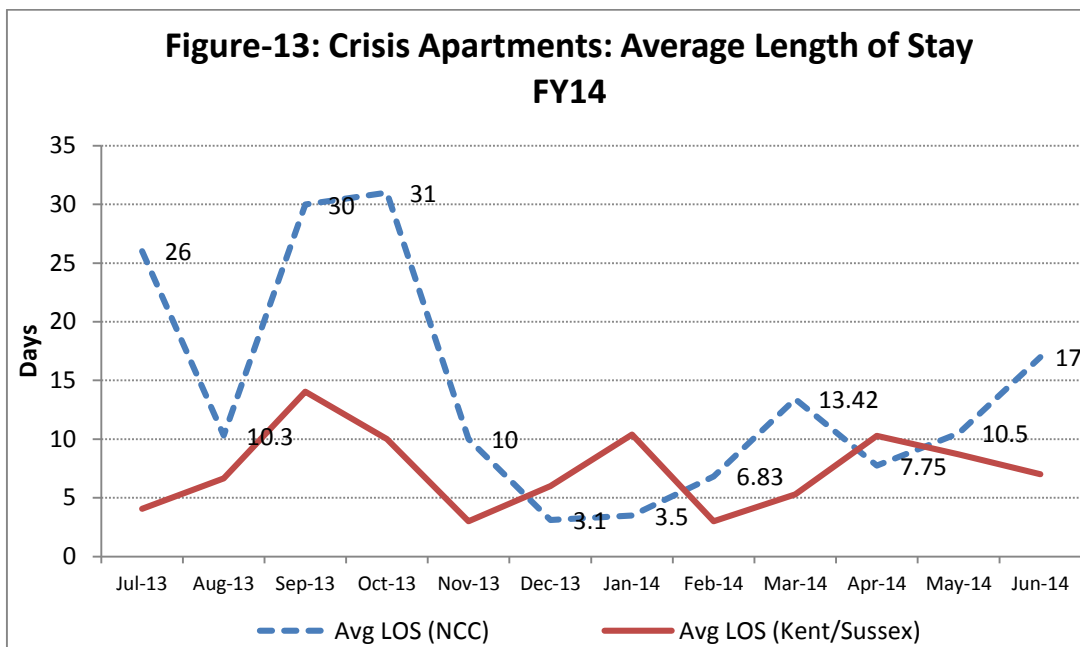
625 As a result of the newness of the Crisis Apartment program, and some confusion about which
 626 consumers were eligible to use these beds (all individuals covered by the Agreement are
 627 eligible, whether clients of DSAMH or with care managed through MCOs), use of the crisis
 628 beds has been limited at some points, and there were some periods when they were
 629 essentially empty. Responding to the tracking data which is presented in Figure-12, DSAMH
 630 initiated measures to better assure that key referral sources—for instance Mobile Crisis
 631 responders—were aware of vacancies. As is reflected in this trend chart, use of these crisis
 632 beds has steadily increased, and by June the use for both counties had exceeded 80% of the
 633 potential bed-days.



634
 635 The Agreement contemplates that the length of stay in Crisis Apartments will be up to seven
 636 days. As is depicted in the Figure-13, individuals have tended on average to stay longer than
 637 that, with New Castle showing a mean of 17 days in June, 2014 and Kent/Sussex showing
 638 10.5 days for the same period. The State is closely monitoring use of these beds, and is
 639 working to improve the involvement of ACT teams when one of their clients is occupying a
 640 crisis bed. For some individuals, the length of stay surpasses expectations because other
 641 issues, such as the inability of the person to return to his or her previous living arrangement,

642 delay things. The essential issue, of course, is not strict adherence to the length of stay
 643 contemplated by the Agreement, but whether, given clinical and social needs of the
 644 individuals being served, the crisis beds are being used effectively to fulfill the goals
 645 community integration. Overall, the State is appropriately monitoring and making
 646 increasingly good use of this resource.

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651 **E. Assertive Community Treatment**

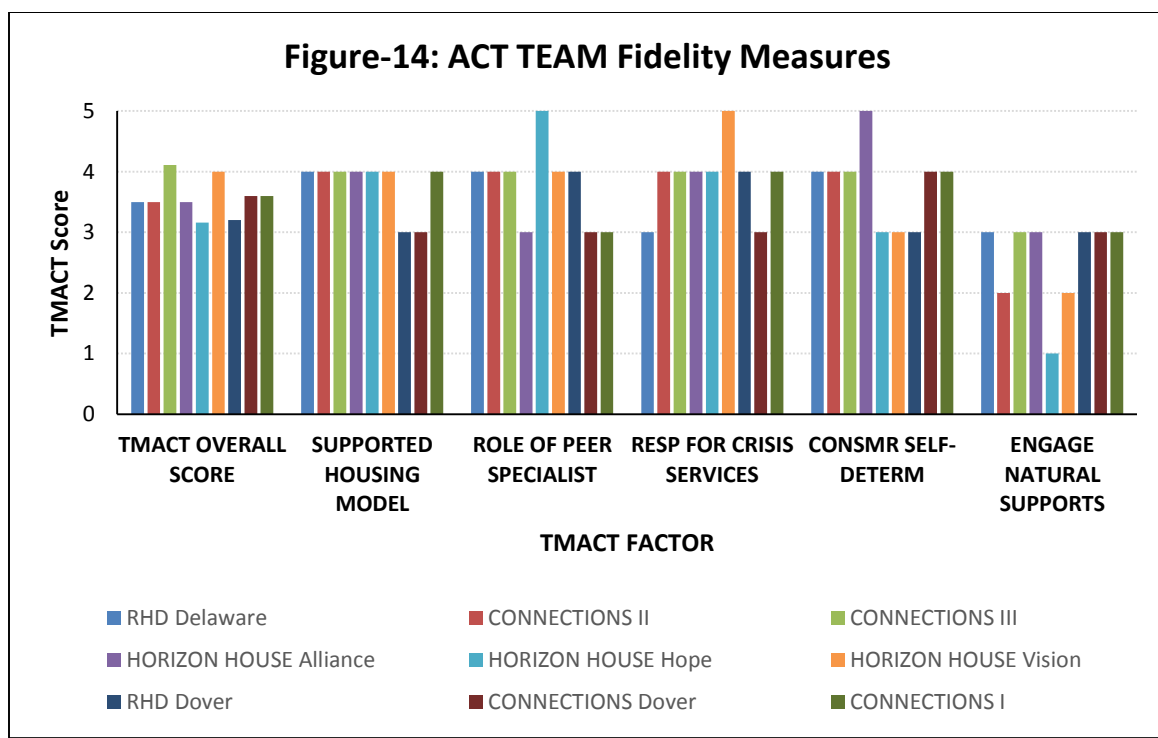
652 Partial Compliance.

653 ACT is an essential service for people with SPMI who have intensive service needs in the
 654 community. This service model provides flexible, mobile services to such individuals
 655 through teams including mental health professionals, peers, and case managers. Section
 656 III.F.2 of the Agreement required that the State have 9 ACT teams operational by September
 657 1, 2013. The State has established 11 ACT teams and is essentially already in compliance
 658 with requirements that go into effect in September 2014 and 2015 (Sections III.F.2-3).

659 By agreement of the parties, the State is measuring fidelity of its ACT programs not through
 660 the Dartmouth model referenced in the Agreement, but through the TMACT model, which is
 661 more heavily oriented towards a recovery model of service. The TMACT fidelity instrument
 662 comprises 47 indicators of quality that are rated according to 5-point scales. These measures
 663 produce six subscale measures and an overall composite score. Figure-14 presents ratings for
 664 nine of the ACT teams, including their Overall Scores and ratings on five specific items that

665 are among those having particular relevance to the Agreement: Adherence to the Supported
 666 Housing Model, the Role of the Peer Specialist on the Team, the team’s Responsibility for
 667 Crisis Services, Consumers’ Self-Determination, and Engagement of Natural Supports that
 668 are important to the individual’s recovery.

669 The State has a system in place to conduct preliminary TMACT assessments as the ACT
 670 teams become fully operational, and then to conduct formal reviews annually thereafter.
 671 Figure-14 presents data from formal reviews that were available at the time this report was
 672 being written.¹⁸ Assessments of teams’ fidelity include specific recommendations about
 673 improving the quality of services; as indicated, technical assistance or more focused
 674 monitoring may occur as these recommendations are implemented.



675 .

676 The average Overall Score for the teams surveyed is 3.6 out of 5. Average scores for the
 677 other selected measures are as follows: Supported Housing Model 3.8, Role of Peer
 678 Specialists 3.8, Responsibility for Crisis Services 3.9, Consumer Self-Determination 3.8, and
 679 Engagement of Natural Supports 2.6. While the State is moving to improve performance
 680 across the board, teams’ engagement with natural supports, i.e., family members, friends,
 681 employers, and others who are not a part of the formal service network is one area that has
 682 been in particular need of improvement. As a general matter, fidelity and quality
 683 improvement of ACT teams is an ongoing processes, and—particularly with relatively new
 684 teams such as these—not some sort of absolute, fixed status. What is important is that the

¹⁸ Two of the teams had not yet reached the point where a formal review is conducted. A number of teams were about to have their annual reviews, so more current data are forthcoming.

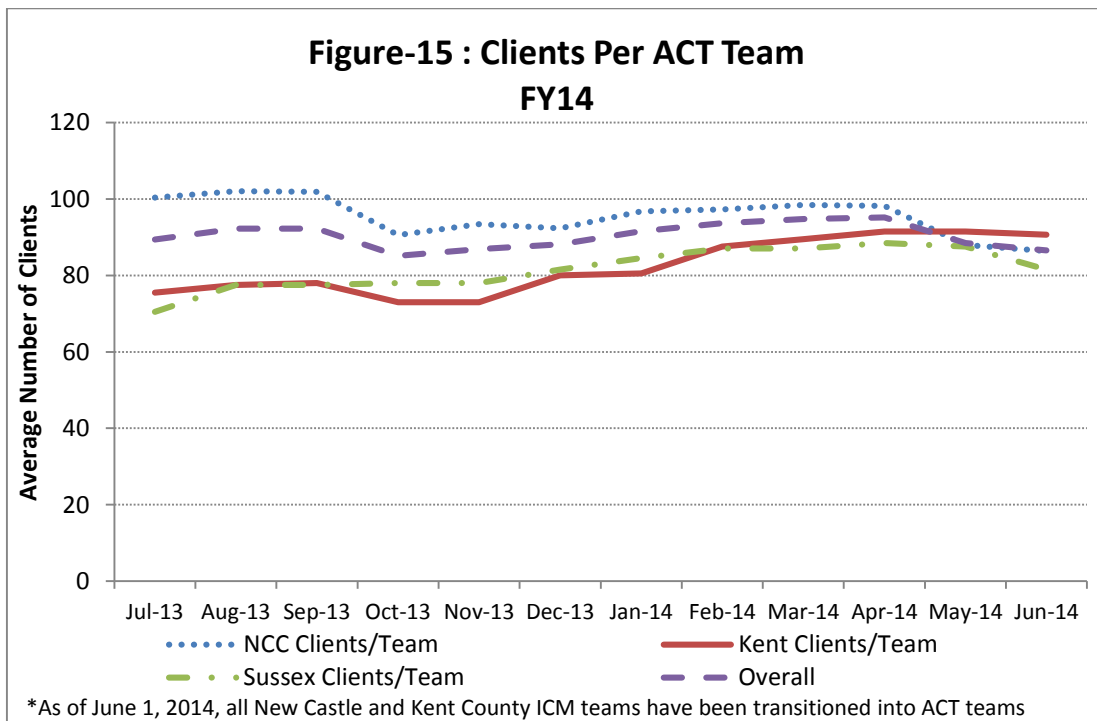
685 State has in place a working system aimed at monitoring fidelity and promoting continuous
686 improvement. The next round of data will give a clearer picture as to how the State is faring
687 in bringing all of its ACT teams into fidelity with TMACT standards, in keeping with Section
688 II.D.2.a of the Agreement. At this juncture, it is in Partial Compliance with this provision.

689 As has been discussed in past reports, DSAMH is making significant improvements in its
690 capacities to capture timely data and to conduct trend analyses of key indicators of quality.

691 The figures that follow evidence this commendable progress and reflect the State's success in
692 meeting its obligations around Quality Assurance and Performance Improvement (Section V
693 of the Agreement).

694 Figure-15 presents the average number of clients per ACT team in each county across the
695 fiscal year. In general, teams are designed to serve about 100 individuals; some of the
696 numbers reflected below are lower than this because new teams are still adding clients—a
697 process that, by design, occurs at a limited pace.

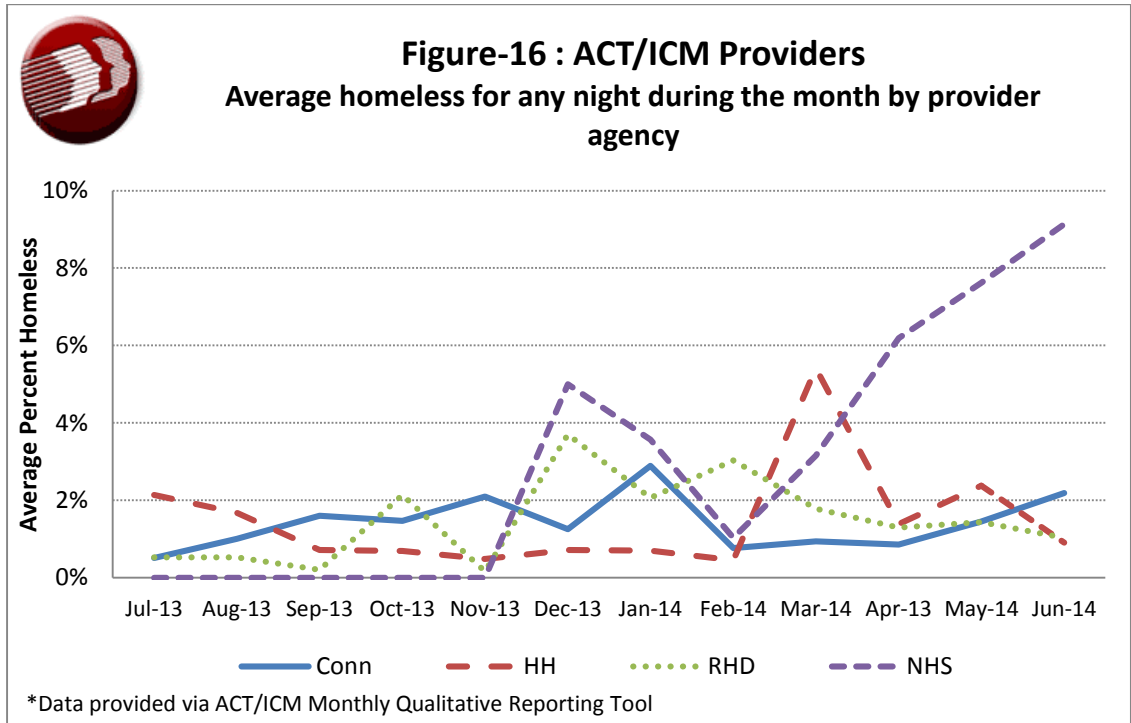
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701 Figures 16-21 reflect a number of outcome indicators that the State tracks to evaluate the
702 performance of its ACT teams. Figure-16 presents the average number of individuals who
703 were homeless for any night during the month. This situation may reflect an individual who
704 is served by ACT and who loses his or her housing during the month, but much more
705 commonly, it reflects the housing status of individuals who are just entering an ACT program
706 and with whom the team is working to secure permanent housing.



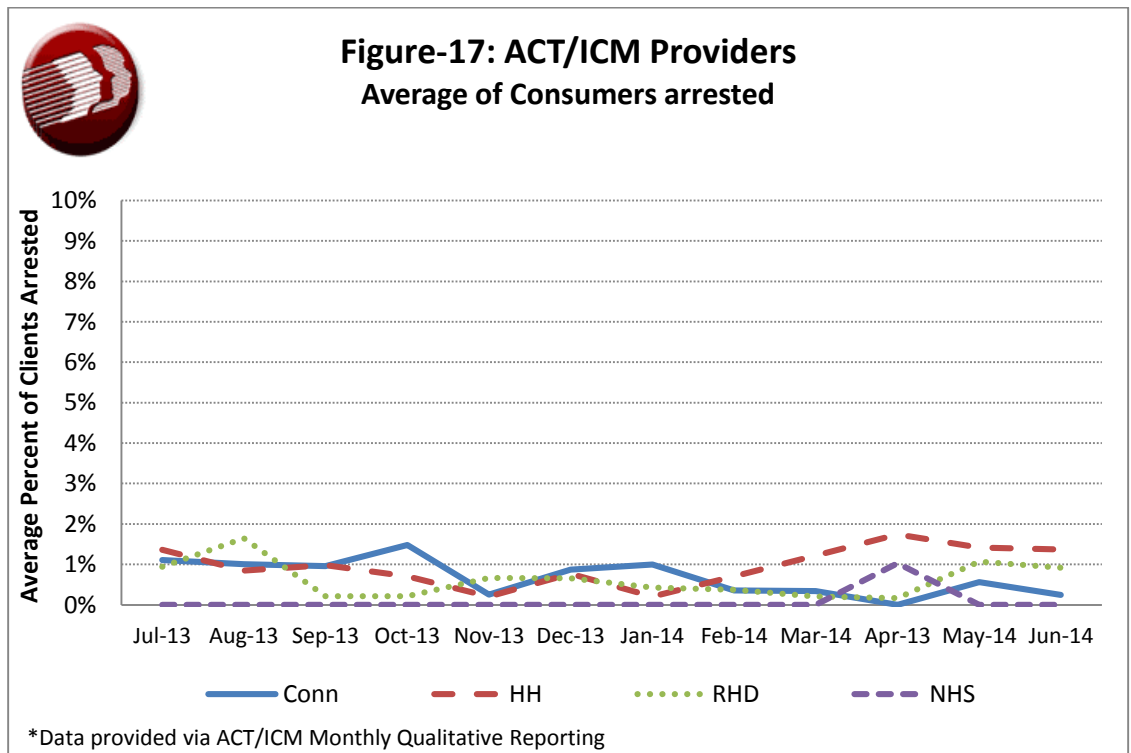
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Figure-17 presents the State’s tracking of the number of ACT clients who were arrested each month, a risk factor specifically referenced in the Agreement. A substantial number of individuals served by ACT have histories of contact with the criminal justice system,

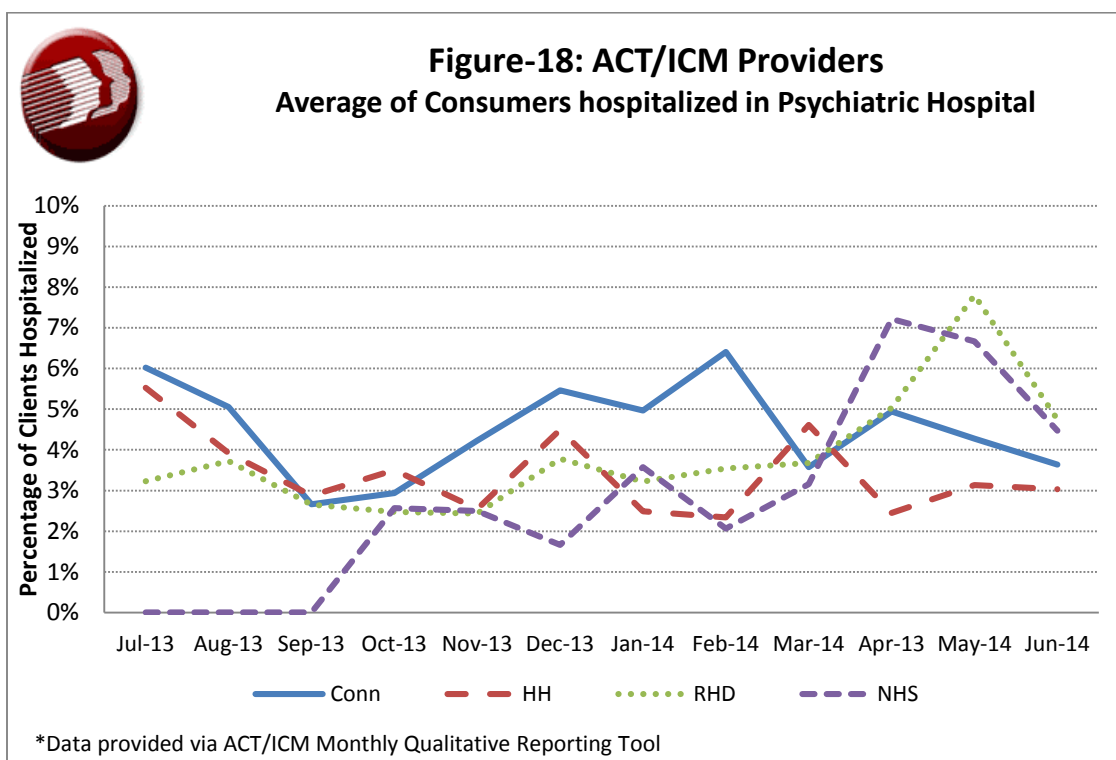


712

713 often associated with co-occurring substance use. There are no national standards against
714 which these data can be compared, but the number of individuals arrested—generally,
715 about 1% or fewer each month—appears to be low, given the population being served.

716 Figure-18 presents the State’s tracking of the percent of ACT clients who are hospitalized
717 for psychiatric care each month. These data do not show the duration of time in the
718 community (for instance, as is reflected in the 30- and 180-day readmission rates to DPC
719 discussed above), nor do they show whether some individuals are being repeatedly
720 readmitted due to special challenges in care. Again, in the absence of national norms,
721 and based upon anecdotal information about ACT teams elsewhere, the admission rates
722 appear to be consistent with what would be expected for this population.

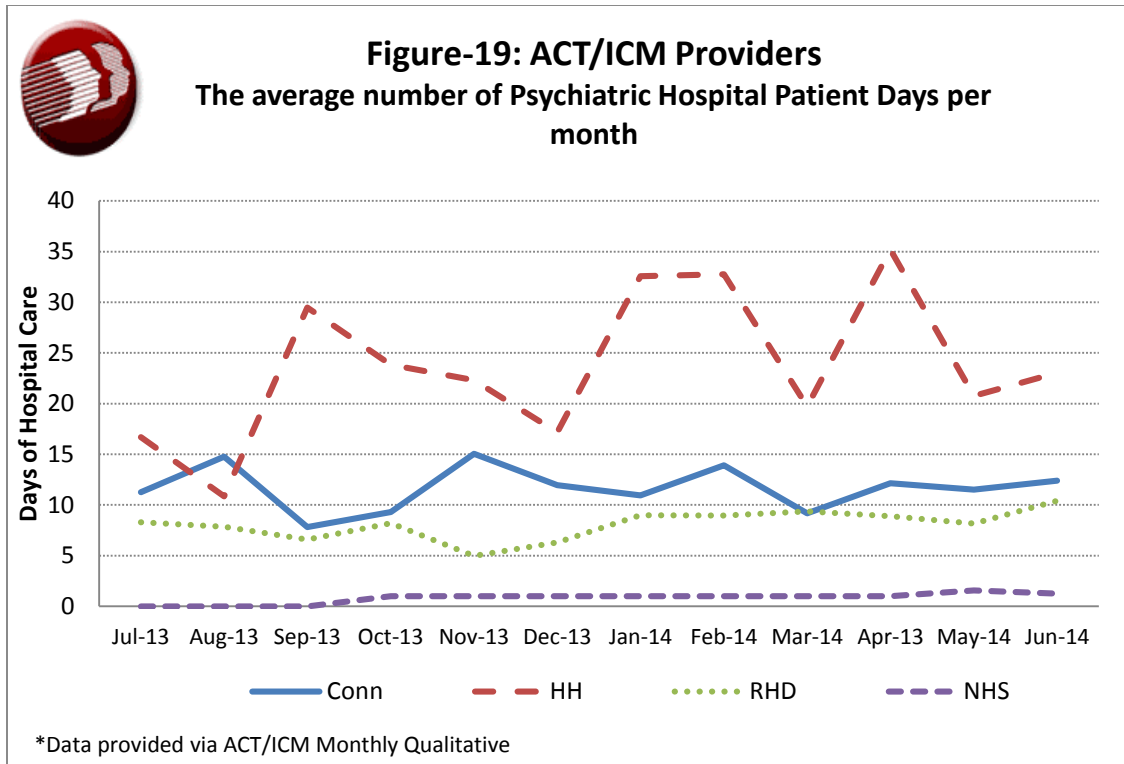
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726 Figure-19 presents data on the average number of days individuals being served by ACT
727 spent in psychiatric inpatient care for each month of the fiscal year. Interestingly, NHS,
728 which showed relatively high rates of hospitalization in Figure-18, showed low numbers
729 of days clients spent in the hospital; in other words, the data suggest a high number of
730 brief admissions. On the other hand, Horizon House (HH), which has remained average
731 in the number of hospital admissions, has shown long lengths of stay for its hospitalized
732 clients, suggesting that one or more of the individuals being served has particularly
733 complex needs.



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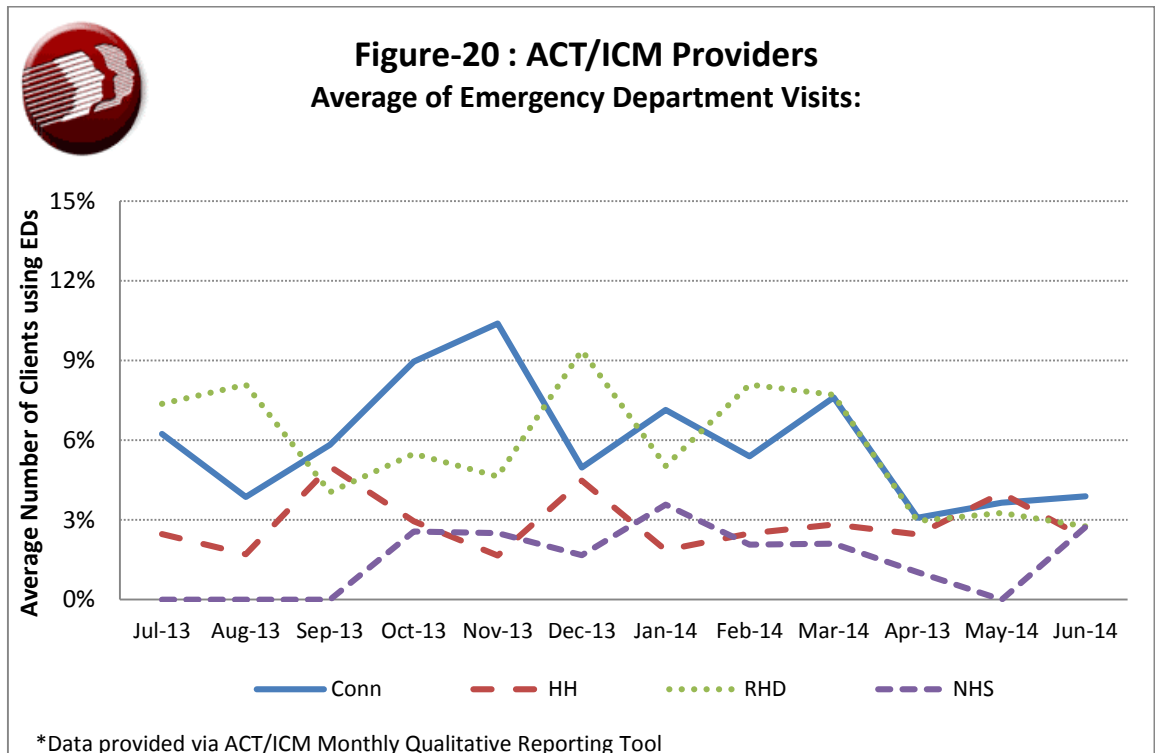
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Figure-20 shows the average percentages of ACT clients who utilized emergency rooms of general hospitals each month, another risk indicator that is specifically referenced in the Agreement. Although clients may go to emergency rooms for a variety of reasons, as the State accumulates more performance data, it might wish to see if there is a relationship

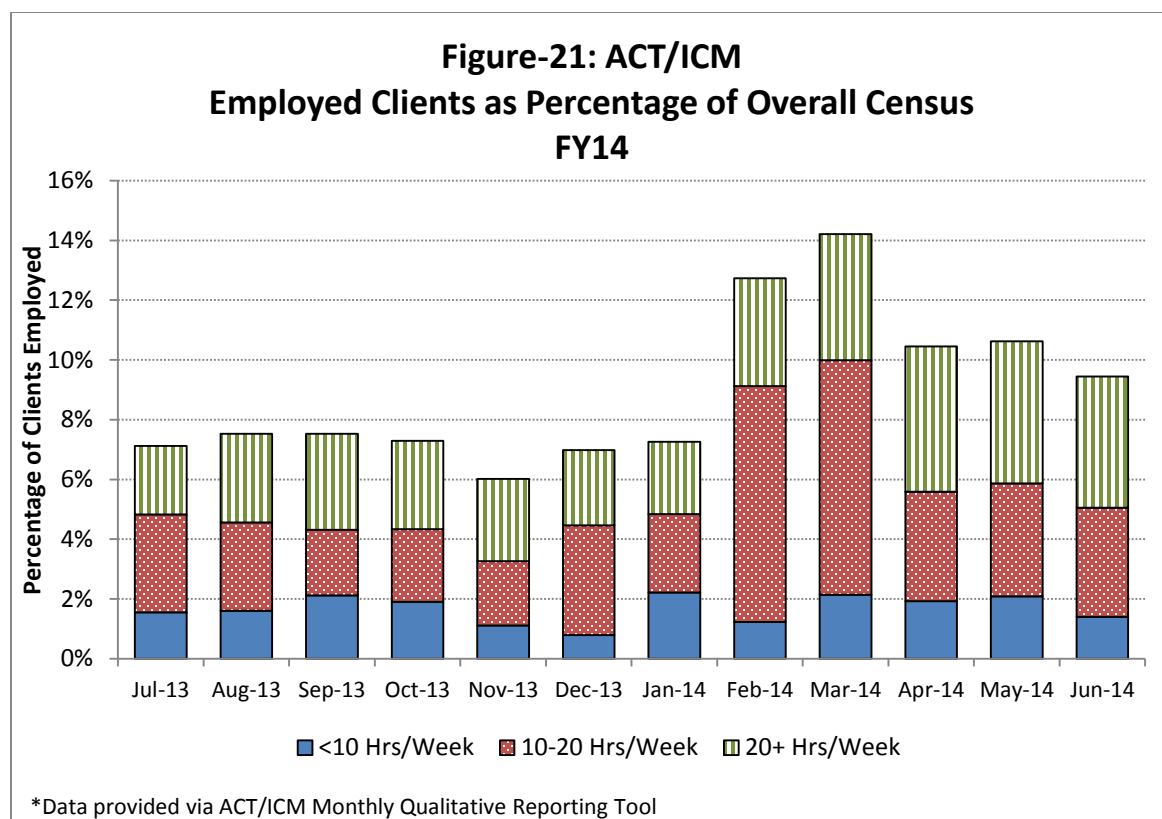


739

740 between the use of emergency departments and how specific ACT teams perform on
 741 TMACT measures relating to teams' crisis response capabilities. At this juncture, the State is
 742 using these data more for purposes of monitoring whether ACT teams are consistently
 743 showing up as outliers on measures such as these.

744 Finally, Figure-21 presents a positive outcome that the State is monitoring with respect to
 745 ACT and Intensive Care Management (ICM) clients (discussed immediately below); the
 746 percentage employed, broken out by the average number of hours worked per week. The
 747 numbers reflect work in mainstream employment, not sheltered workshops or other settings
 748 that segregate individuals with disabilities.

749



750

751

752 **F. Intensive Care Management**

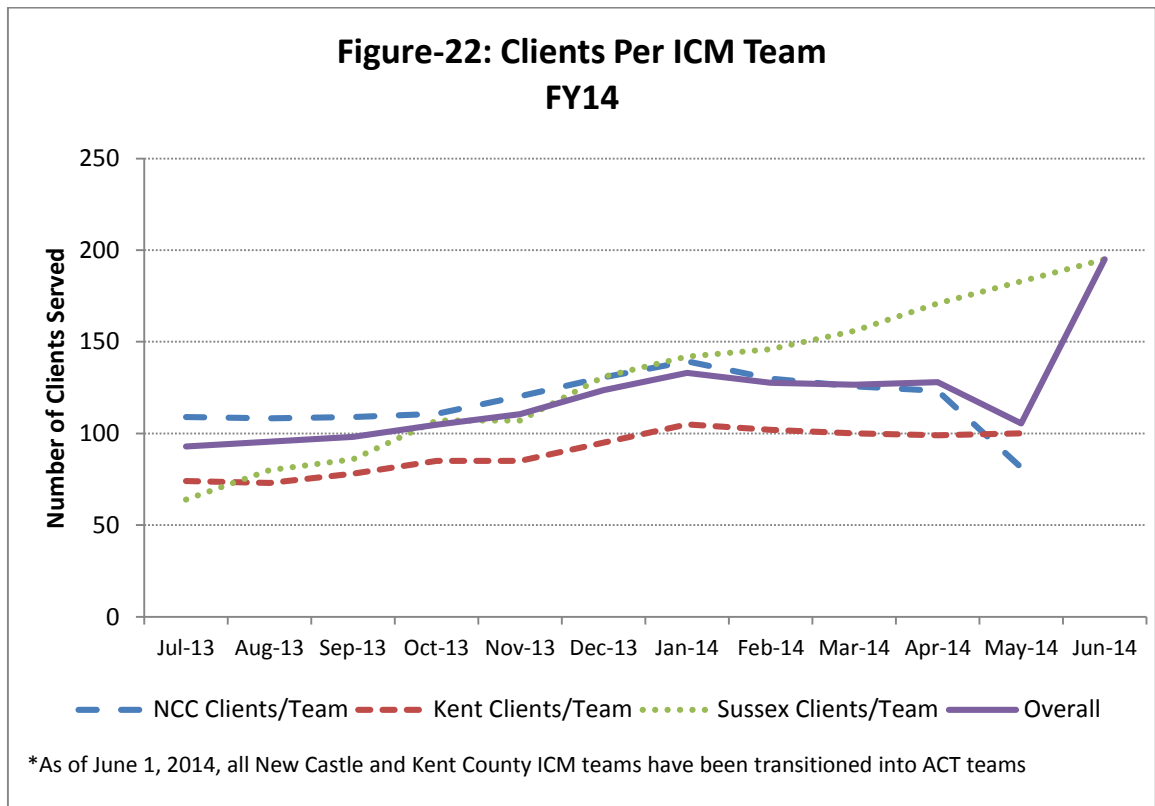
753 Substantial Compliance.

754 Section III.G.2 of the Agreement required the State to have a total of 4 Intensive Care
 755 Management (ICM) teams operational by January 1, 2013. As was reported in the May
 756 report, the State surpassed this requirement by establishing a total of 5 ICM teams with
 757 staffing ratios consistent with the requirements of the Agreement. In monitoring the
 758 performance of these teams, DSAMH determined that the level of need characterizing the
 759 individuals being referred for ICM was generally indistinguishable from that characterizing

760 people being served by ACT teams. In consultation with the Monitor, DOJ supported the
 761 State’s plan to convert all but one of its ICM teams to ACT, serving the same number of
 762 individuals, but having the capacity to provide supports that exceed what could be provided
 763 through ICM. Accordingly, as of June 1, 2014, the ICM teams serving New Castle and Kent
 764 Counties converted to ACT¹⁹ and there is now one ICM team in the State that serves Sussex
 765 County (DSAMH has indicated that it will convert that team to ACT, as well, if warranted).

766 Figure-22 presents the number of clients served through ICM in each of the counties, as well
 767 as the overall State average of individuals served. The numbers in April and May were
 768 affected by the conversion process. Looking forward, the relevant data relate to the Sussex
 769 team, which was serving about 200 individuals as of June, 2014.

770



771

772 The State is rated as being in Substantial Compliance with Section III.G.2 of the Agreement
 773 in that it developed—and even surpassed—the number of ICM teams required and then, with
 774 the concurrence of the parties, is now providing services that exceed this requirement in
 775 keeping with the needs of the individuals being served.

776

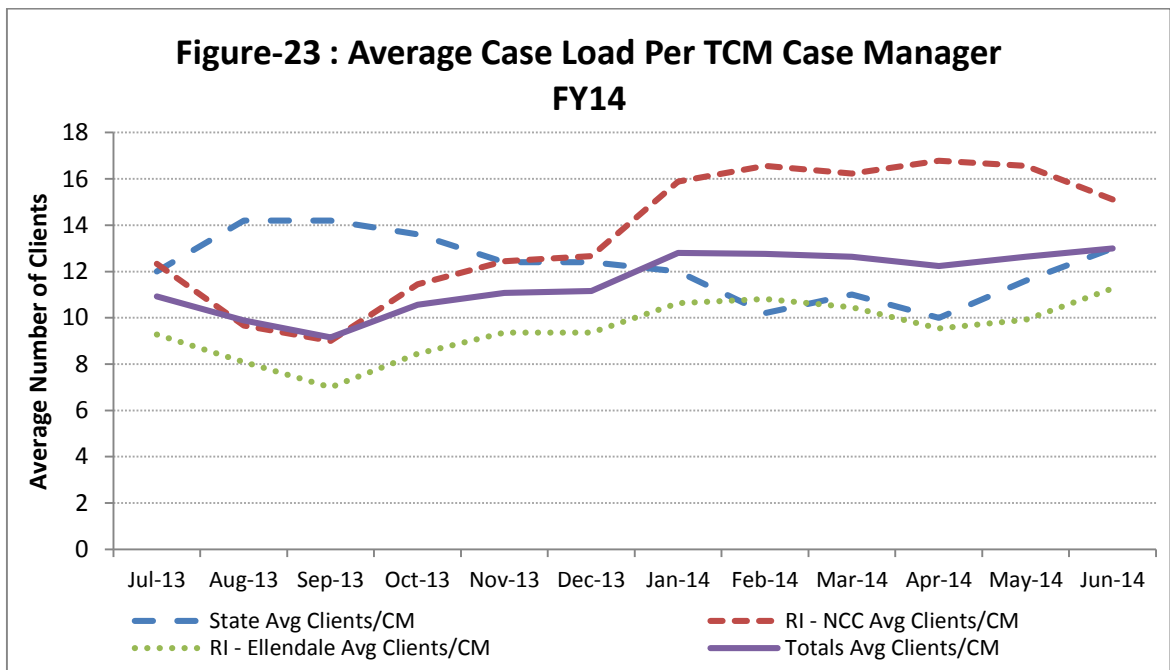
¹⁹ Because these ACT teams are new, they are not included in the data presented in the previous section, including the data relating to fidelity. They will be incorporated in these measures in the 2015 fiscal year.

777 **G. Case Management**

778 Substantial Compliance.

779 Section III.H.2 requires a total of 18 Targeted Care Managers (TCM), who play a key role in
780 connecting individuals—generally those not currently being served through DSAMH—with
781 the community-based services and supports they need. The State continues to exceed this
782 requirement in that it has a total of 25 TCMs serving such individuals statewide. Over 6% of
783 the individuals on the TPPL have received, or are receiving, TCM services, generally during
784 a period of transition until there is a hand-off to a service provider for ongoing services. The
785 Agreement requires that each care manager serve no greater than 35 individuals at a time;
786 Figure-23 shows that the State is well within this guideline.

787



788

789

790 **H. Supported Housing**

791 Substantial Compliance.

792 Since the inception of the Agreement, Delaware has made the requirements for integrated
793 supported housing a priority. This has required an internal culture change within DSAMH
794 away from pre-classifying individuals for various congregate living arrangements (as has
795 been the practice in public mental health systems nationwide) and towards an orientation that
796 considers individuals' preferences and the wrap-around services needed to support an
797 individual in an ordinary living environment. It has also required collaboration with other
798 governmental divisions, such as the State's housing authority. While, of course, not
799 everybody being served is now in his or her preferred living situation, the State has made

800 palpable moves to increase access to scattered-site supported housing (as defined in the
801 Agreement). Only about 2% of individuals on the TPPL live in state-funded group homes,
802 increasingly due to medical care needs that co-occur with SPMI.

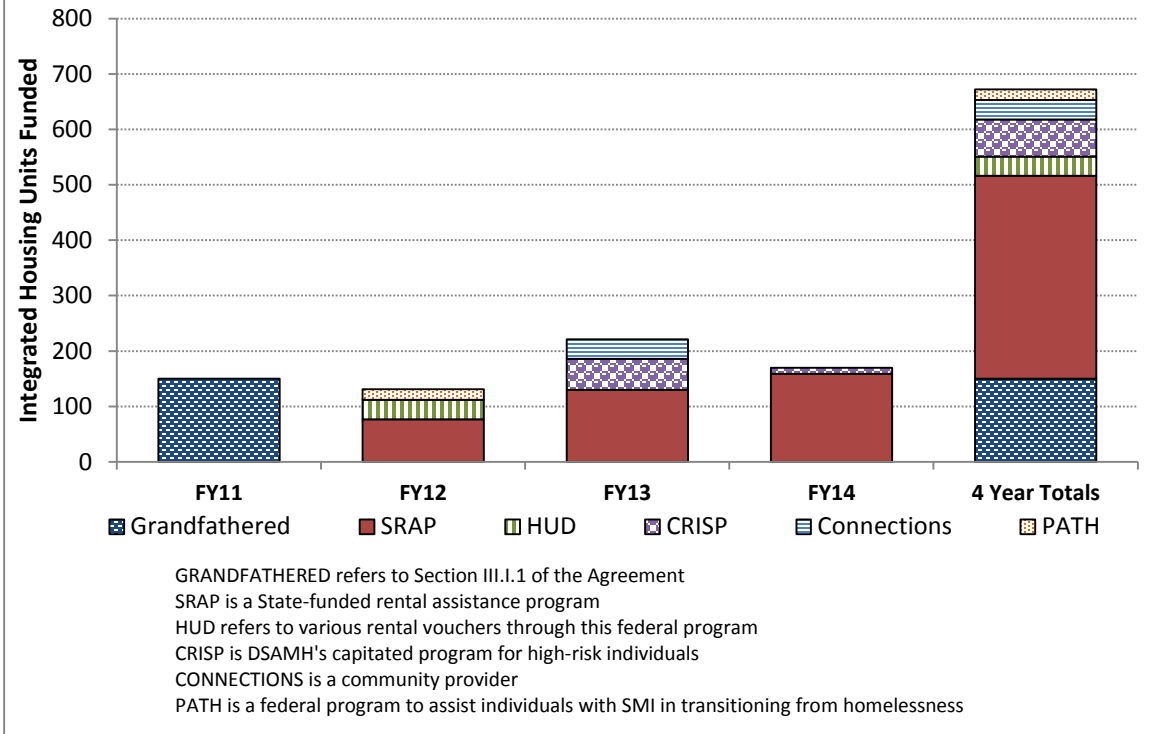
803 Developing supported housing in keeping with the requirements of the Agreement is a
804 complicated endeavor. It requires a comprehensive assessment of individual’s preferences
805 and needs—sometimes not an easy task to accomplish given that many do not have histories
806 of stable housing and have difficulties making informed choices. Furthermore, their abilities
807 to address day-to-day living requirements in their own homes are not always easy to predict
808 from what is known about them while living in an institution or in the community without the
809 supports that are now available. Securing housing is also challenging in finding landlords
810 willing to accept housing vouchers (either through HUD or the State’s housing program for
811 the target population, “SRAP”) or tenants who, as many in the target group do, have histories
812 of criminal justice contact. Finally, once housing arrangements are made, many individuals
813 thrive, but some move away on their own, are re-hospitalized, or are unsuccessful tenants.
814 As such, while the State funds new vouchers per the Agreement, it is also backfilling
815 vacancies relating to vouchers previously issued.²⁰ Thus, while counting the number of
816 vouchers made available pursuant to the Agreement is straightforward, tracking their
817 utilization is somewhat dynamic because the number of unused vouchers fluctuates and
818 individuals are in various stages of securing housing of their choice.

819 Section III.I.4 of the Agreement required that, by July 1, 2014, the State fund a total of 550
820 supported housing vouchers or rental subsidies for the targeted population. As is represented
821 in Figure-24, it has exceeded that number, funding 651 vouchers. This chart shows the
822 number of units funded for each year of the Agreement, differentiated by funding source. It
823 also presents the cumulative total as of July, 2014, which demonstrates that the State has
824 surpassed the requirements of the Agreement.

825 Figure-25 presents the State’s monthly tracking data relating to that portion of the housing
826 vouchers that are processed through DSAMH in collaboration with the Delaware State
827 Housing Authority; it does not include information with regard to the “grandfathered” semi-
828 integrated housing referenced in Section III.I.1. Its intent is to provide snapshot information
829 about the proportion of individuals in integrated supported housing and the proportion in
830 various phases of transition in to supported housing. In September, 2014, for instance, 284
831 individuals were using vouchers to support them in their own apartments. An additional 115
832 individuals had vouchers and were actively looking for an apartment. Applications for

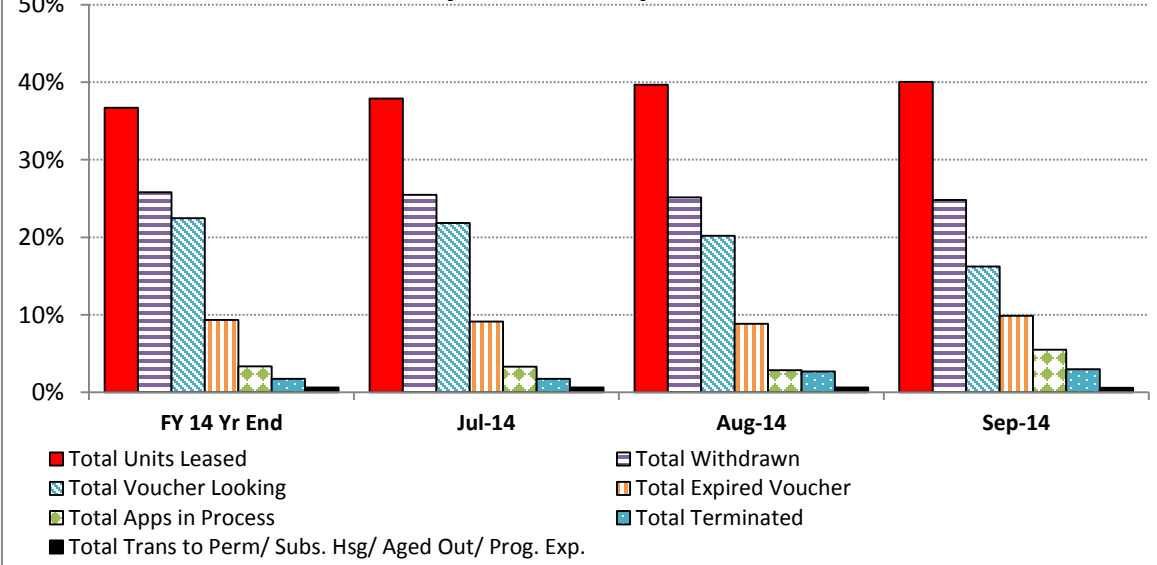
²⁰ The Monitor has learned that these circumstances also exist in other states that are creating new supported housing for people with SPMI.

**Figure-24 : Settlement Agreement
Housing Targets by Fiscal Year**



833

**Figure-25 : Total Applications Breakdown
July, 2012 to Sept, 2014**



834

835 housing vouchers were being processed for an additional 39 individuals. The percentages
 836 shown in the chart relate to the total number of applications that have been received (709) for
 837 the 651 vouchers the State has made available. Thus, for instance, the 284 figure is 40% of
 838 this 709.

839 With respect to the specifics of the Agreement, the State was required to fund 550 housing
 840 units by July 1, 2014, 150 of which were grandfathered in, leaving a total of 400 scattered-
 841 site supported housing units to be funded. Applying the housing data to what is required in
 842 the Agreement (rather than the larger number of vouchers that the State is actually funding),
 843 Figure-26 shows the State’s standing. As was referenced in the May report, some vouchers
 844 that had been counted in previous years are no longer available to fulfill the State’s
 845 requirements under the Agreement. This, as well as individuals relocating out of state,
 846 moving in with family, and other factors mentioned above, contribute to the number of
 847 individuals now in transition to supported housing.

848

| Figure-26: Status of Housing Vouchers as of September, 2014 | | |
|--|-----------------|----------------------------------|
| | Vouchers | Percent of Target |
| Supported Housing Units Required (Target) | 400 | |
| Vouchers Issued: Units Rented | 284 | 71.0% |
| Vouchers Issued: Housing Being Arranged | 115 | 28.8% |
| Applications Submitted: Vouchers Pending | 39 | 9.8% |
| Total Vouchers Issued and Pending | 438 | 109.5% |

849

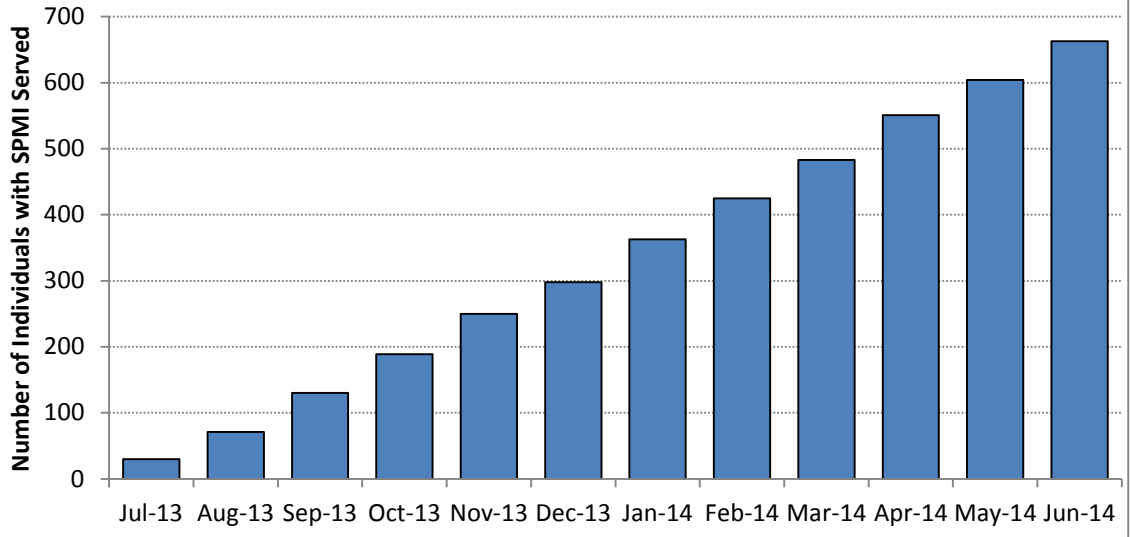
850 **I. Supported Employment**

851 Substantial Compliance.

852 Section III.J.2 of the Agreement requires the state to provide supported employment services
 853 to a total of 400 individuals. DSAMH continues to have a strong partnership with the State’s
 854 Division of Vocational Rehabilitation, which places strong emphasis upon people with SPMI
 855 entering the mainstream workforce. Furthermore, DSAMH has an admirable record of
 856 employing individuals who have been diagnosed with SMI in positions as peer supporters,
 857 research assistants and other important roles. Figure-27 presents cumulative data on the
 858 number of individuals covered by the Agreement who are receiving supported employment
 859 services, at a minimum with active employment plans in effect. As of the end of the fiscal
 860 year, 663 individuals were being served, thereby surpassing the requirements of the
 861 Agreement.

862 Figure-28 summarizes the status of these individuals. The data presented below represent the
 863 status of the 663 individuals served last fiscal year in the supported employment

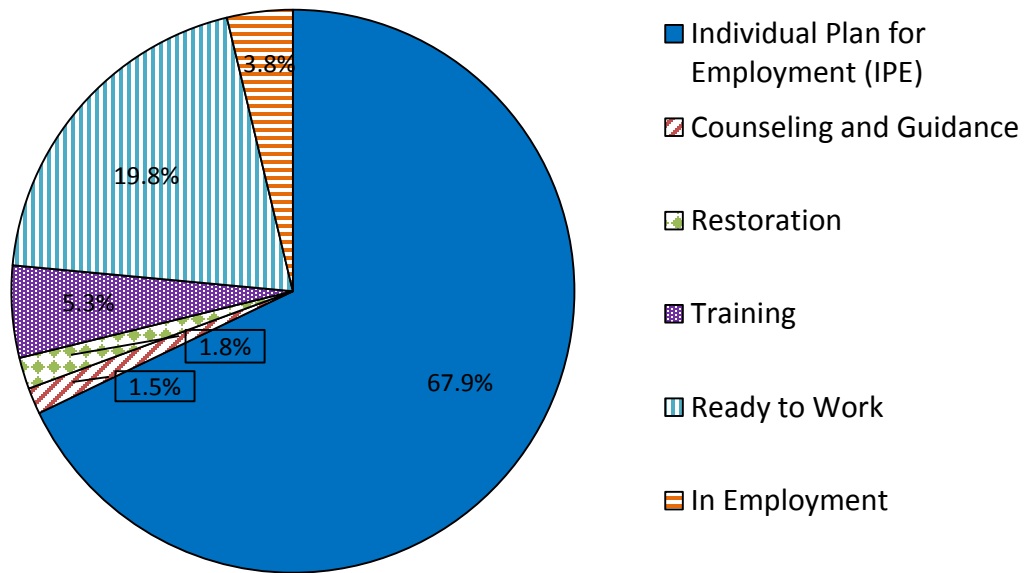
Figure-27: Cumulative Number of Clients Receiving Supported Employment FY14



*Supportive Employment numbers are based upon data from the Division of Vocational Rehabilitation within

864

Figure-28: Employment Support Categorical Breakdown of the 663 Individuals Served in FY14



*Supportive Employment numbers are based upon data from the Division of Vocational Rehabilitation within the State Department of Labor

865

866

867

process; although the numbers are not large, other individuals in the targeted group have received supported employment in earlier years and are no longer counted in this data set.

868 Less than 4% of the group served is employed; almost 20% are considered job-ready and are
869 actively seeking work.

870

871 ***Recommendations:***

- 872 1. It is recommended that the State focus intensely on securing employment for the
873 substantial population of individuals who are categorized as “Ready to Work.”
- 874 2. The Monitor plans to make technical assistance available to the State in support of
875 this effort.

876

877 **J. Rehabilitation Services**

878 Substantial Compliance.

879 Section III.K.3 of the Agreement requires that the State provide rehabilitation services to a
880 total of 1,100 individuals by July 1, 2014. These services include activities such as education,
881 substance abuse treatment, and recreational activities. As has been explained in past reports,
882 the State’s data systems do not readily capture meaningful information about the provision of
883 these services. For this reason, the Monitor and the State have agreed upon measures that
884 could be used to demonstrate compliance with this provision. The State was unable to
885 provide an update to its May, 2014 data with respect to Rehabilitation Services, but the data
886 available at the time of that report demonstrated that it had already surpassed the
887 requirements of the Agreement for the fiscal year. Those data are re-presented below:

- 888 • Psychosocial Rehabilitative Services, Psychosocial Group
889 Services, or Family Psychosocial Education at least twice
890 per month for at least 6 months..... 259 individuals
- 891 • Some level of substance abuse treatment for a co-occurring
892 disorder 978 individuals
- 893 • Total Unduplicated Count..... 1,222 individuals

894

895 The State is in Substantial Compliance with this provision.

896

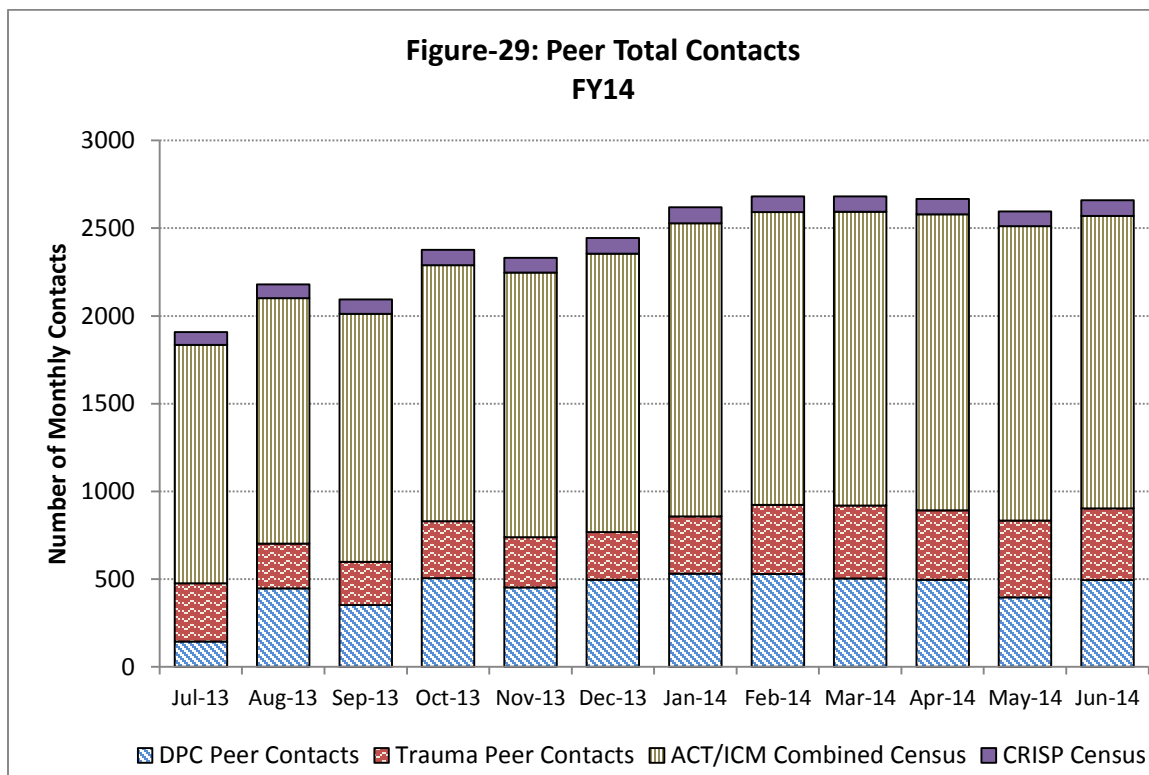
897 **K. Family and Peer Supports**

898 Substantial Compliance.

899 Section III.L.3 of the Agreement requires the State to provide family or peer supports to a
900 total of 750 individuals by July 1, 2014. As has been described in past Monitor reports,
901 Delaware has developed a robust and innovative program of peer supports, whereby
902 individuals who have “lived experience” with mental illness provide an array of services to

903 peers who are hospitalized or living in the community. Beyond their work with individuals,
 904 peers in Delaware have actively participated in such systemic work as the recent reforms in
 905 the State’s mental health laws, and representatives periodically meet with the Monitor to
 906 provide information about aspects of services around which they are seeking improvements.
 907 Peers have been trained as research assistants and carry out quality of service interviews in
 908 an initiative being conducted through the University of Pennsylvania. From not only a
 909 numerical perspective, but qualitatively, as well, the State is in Substantial Compliance with
 910 the requirements of the Agreement relating to peer services. DSAMH should be commended
 911 for the ways in which it has incorporated these services in its operations and the
 912 encouragement the Division has offered peers in helping to shape innovative solutions to
 913 service challenges.

914



915

916 Figure-29 presents only a portion of the picture of the role of peer services in DSAMH
 917 programs. It shows the number of peer contacts with individuals who are hospitalized at
 918 DPC, as well as those served through ACT Teams or DSAMH’s CRISP program, which
 919 focuses mostly on individuals with histories of protracted care at DPC and special challenges
 920 to living in the community. In addition, it presents data relating to a special peer-initiated
 921 program to provide supports to individuals who have histories of trauma, an issue which is
 922 widespread among people with SPMI and which is gaining increasing traction nationwide
 923 within public mental health systems. Each month anywhere from about 1,900 to over 2,500
 924 peer contacts occur. Because of the nature of services being provided and differences among

925 the various peer programs, it is difficult to ascertain a specific unduplicated count of the
926 number of individuals receiving these services, but based upon the Monitor’s interviews with
927 peer leaders and DSAMH staff, the number far exceeds the 750 required in the Agreement.
928 The State is in Substantial Compliance with this provision.

929

930 **L. Quality Assurance and Performance Improvement**

931 Substantial Compliance.

932 The State remains in Substantial Compliance with Section V of the Agreement—at least with
933 respect to DSAMH—which requires that it develop Quality Assurance (QA) and
934 Performance Improvement (PI) programs to ensure the services are appropriate to achieving
935 the goals of the Agreement. Although the State is now negotiating new contracts with the
936 MCOs, it has not provided information indicating how, if at all, it has fulfilled this
937 requirement in the period being reviewed here with respect to individuals served through
938 DMMA, nor has it sought assistance in this regard from the Monitor.²¹

939 Within DSAMH, QA and PI functions reflect an array of efforts, including those relating to
940 services within DPC; the ACT fidelity and qualitative reviews presented earlier; and a
941 number of ongoing studies conducted through the University of Pennsylvania that examine
942 clinical and subjective outcomes associated with the CRISP program, as well as longitudinal
943 service outcomes relating to cohorts of individuals newly appearing on the TPPL.

944 The charts presented throughout this report evidence how the State has moved to the point
945 where it can trend critical performance indicators over time, identify successes or problems
946 in services, and make adjustments accordingly. The creation of an RRC to serve the northern
947 part of the State, adjustments to the ICM program (transitioning all but one to ACT teams),
948 dramatic reductions in court-ordered treatment, and better use of Crisis Apartments are all
949 palpable examples of the ways DSAMH is using these data to improve quality and
950 performance. As with any well-functioning QA/PI program, these initiatives are always a
951 work in progress; new items for inclusion in the monthly data dashboard are continually
952 being identified (the referral of high-risk individuals from DMMA to DSAMH is one
953 example) for monitoring and program improvement.

954

955 **M. Risk Management**

956 Partial Compliance.

957 Section V.B requires that the State develop a Risk Management program that reduces the risk
958 of harm to individuals covered by the Agreement both within hospital settings and within the

²¹ Such technical assistance, of course, is not required by the Agreement.

959 community. As was described in the Monitor’s May, 2014 report, Delaware had been
960 carrying out essential risk management functions through a set of idiosyncratic, parallel
961 systems of reporting and oversight that varied considerably depending upon where an event
962 possibly representing abuse, neglect, or injury occurred. Furthermore, these various data sets
963 remained largely segregated from each other and were not consolidated before any single risk
964 management entity. As a result, the State has not been in a position to compile information
965 across systems and settings to identify patterns of risks and adverse events. Corrective
966 actions, when they were required, thus remained specific to the setting in which an adverse
967 event occurred, and the State had no mechanism to alert the field to the need for related
968 preventive measures.

969 At least with respect to DSAMH programs, the State has since taken important steps to
970 overhaul its risk management system. It is now developing decision trees for consistent,
971 system-wide actions to be taken and reporting of adverse events. The resultant data will feed
972 into a central committee that is responsible for oversight and corrective measures—both for
973 individual events and systemic. Because this reflects a major restructuring of risk
974 management functions, involving a multitude of players within and outside of State
975 government, this is a complex and labor-intensive endeavor. Nevertheless, the State has
976 made significant progress since the May report. It expects its new risk management system
977 to become operational early in 2015.

978

979 **IV. Summary**

980 As is explained in this this report, 3 ½ into its implementation of the Agreement, the State of
981 Delaware presents a mixed picture.

982 With respect to the population of people with SPMI that is served through DSAMH, the State
983 is either in Substantial Compliance with the provisions of the Agreement or is on track to
984 achieve compliance. DSAMH’s service system has evolved dramatically since 2011. The
985 Division has expanded services and developed data systems that allow it to increasingly
986 understand the needs of individuals being served, to track critical aspects of services intended
987 to promote their community integration, and to capture information allowing it to engage in
988 ongoing improvements in its programs.

989 At this juncture, there is far less known about the significant population covered by the
990 Agreement whose services are managed through DMMA, including such essentials as what
991 individuals’ needs are, whether they are appropriately housed, and how this population’s
992 increased hospital use may be reversed. With few exceptions, the State has largely continued
993 to serve the DMMA-managed population as it had prior to the Agreement. Although there
994 are measures the State might have taken thus far to serve these individuals in keeping with
995 the Agreement’s requirements and without fundamentally changing its programs, it instead
996 elected to defer action until new MCO contracts and the Medicaid PROMISE program go

997 into effect on January 1, 2015. These initiatives are positive steps but, setting aside the
998 human impact of the State's foregoing interim measures to comply with the Agreement with
999 regard to the DMMA-managed population, these programs will likely be fully operational for
1000 only a little over one year at the point the State is aiming to be able to demonstrate full
1001 compliance with the Agreement, in July of 2016. Accordingly, it is critical that the State
1002 redouble its efforts to ensure that all populations covered by the Agreement are appropriately
1003 served and that it be able to provide meaningful, comprehensive, and timely data to
1004 document that this is the case. The Monitor remains available to assist the State in this effort.

1005

1006

A handwritten signature in black ink, appearing to read "Robert Bernstein". The signature is written in a cursive style with a large, prominent initial "R".

1007

Robert Bernstein, Ph.D.

1008

1009

Court Monitor