

1 **FIFTH 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 May 19, 2014
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10 **I. Introduction**

11 This is the fifth report of the Court Monitor (Monitor) on the implementation of the
12 above-referenced Settlement Agreement (Agreement) between the United States, through
13 the U.S. Department of Justice (DOJ), and the State of Delaware (the State). This report
14 covers the six-month period July 15, 2013 through January 15, 2014; it also reflects the
15 State's overall progress in fulfilling its requirements under the Agreement during the past
16 2 ½ years.

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

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

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

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

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

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

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

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69 **II. Progress on Structural Improvements**

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

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

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A. Use of Data

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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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.

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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 DPC¹ (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.

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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.		

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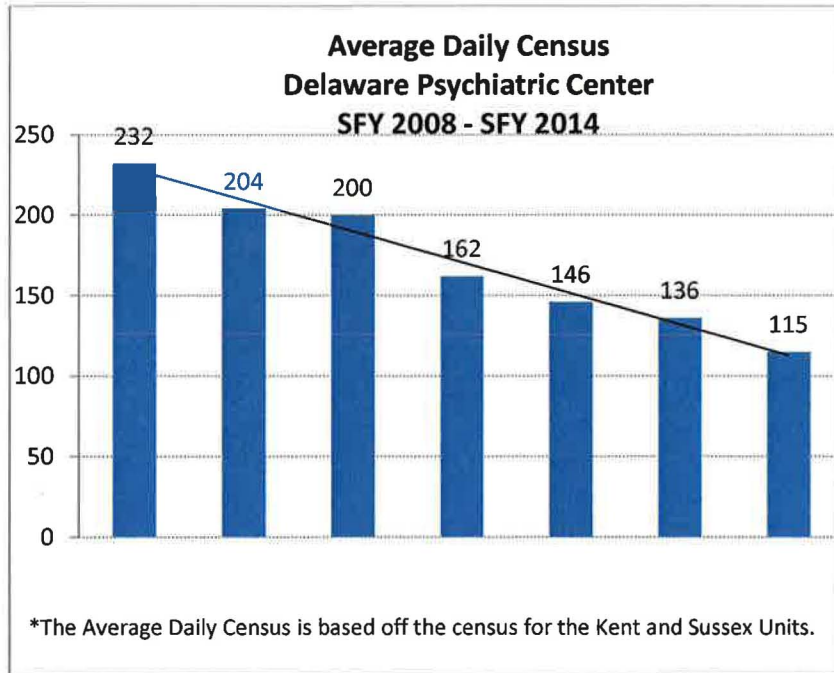
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As is reflected in their histories of protracted inpatient psychiatric treatment, members of this population have significant levels of disability, often complicated by physical health issues, addictions, and dependencies bred by long-term institutionalization. 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

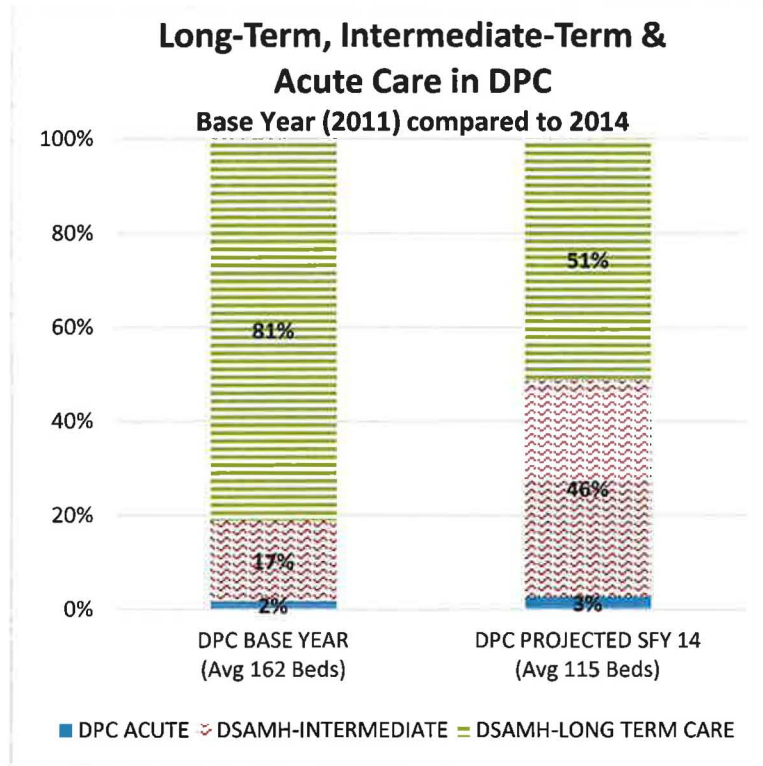
322 Section III.D.3) and to a reconfiguration of the facility towards more intermediate-term
323 and acute care. These discharges have also enabled significant reductions in the
324 hospital’s average daily census. As is reflected in the table that follows, DPC’s current
325 average daily census of 115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



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

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



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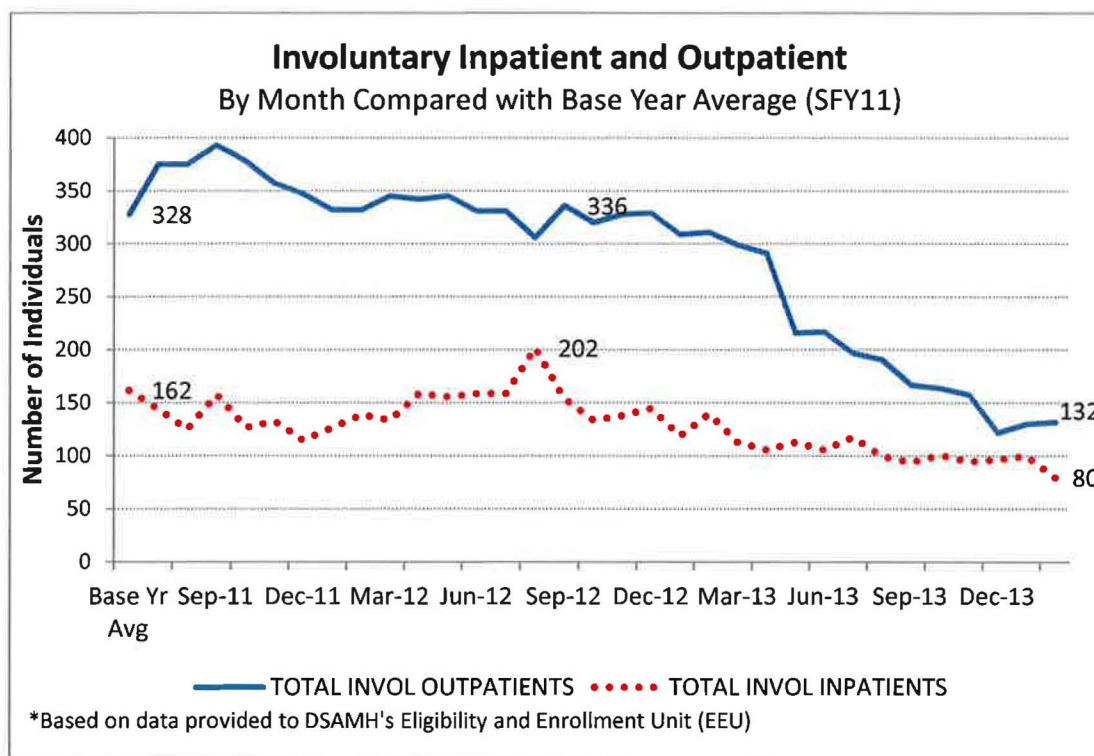
To assist DSAMH in its ongoing efforts to improve the quality of care at DPC and to assist DPC in its transition towards a more acute-care orientation, the Monitor has facilitated expert technical assistance relating to nursing services and the hospital’s Utilization Review program. This technical assistance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

D. Reliance on Court-Ordered Treatment

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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

364 a substitute for good consumer engagement—is not the “least-restrictive” approach
365 consistent individuals’ rights under the ADA and other laws.



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

373 The State has achieved about a 60% reduction in its use of outpatient commitments,
374 dropping from an average of 328 active orders in the base year to just 132 in February,
375 2014. This reduction is particularly significant since the number of people being served
376 in outpatient programs has increased during this period, including (as discussed above) a
377 sizable population of individuals with high levels of disability who had been served on
378 DPC’s long-term care units.

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

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

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

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395 **E. Mental Health Screeners**

396 In July, 2012, Governor Markell signed into law a bill requiring that an assessment be
397 conducted by a certified mental health screener prior to an individual being detained on a
398 24-hour hold, which is the first step in the State's civil commitment process. Among
399 other things, the screener is qualified to certify that the individual indeed appears to have
400 a serious mental illness (as defined by law) and the screener must also certify that
401 voluntary treatment options were considered and appropriately offered. Following the
402 development of processes for screeners' certification and training by DHSS, mental
403 health screenings were implemented statewide on July 1, 2013.

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

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

429 **F. Management of Clinical Services**

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

443

DMMA	DSAMH
<ul style="list-style-type: none"> • Community-based services for individuals in Medicaid Managed Care • Acute Inpatient Care at an IMD for individuals in Medicaid Managed Care 	<ul style="list-style-type: none"> • 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.

444

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

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

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

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

478

479 **III. Ratings of Compliance with the Agreement**

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

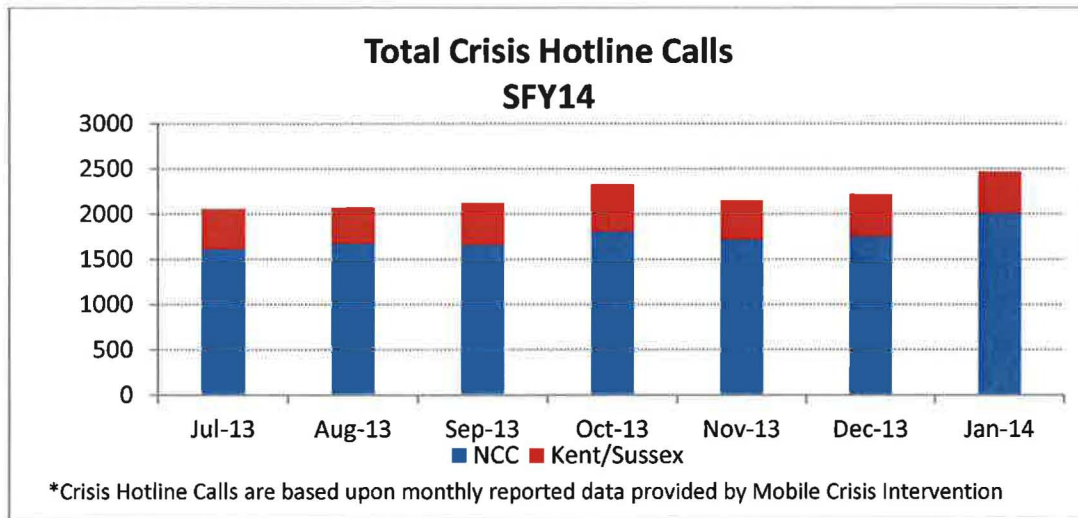
489 For the period covered by this report, the State is in Substantial Compliance with each of
490 the targets that are required under the Agreement, except for Crisis Stabilization
491 (Sections II.C.2.d.iii and iv) and Risk Reduction (Section V.B); the State is in Partial
492 Compliance with these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

493
494 **A. Crisis Hotline**

495 **Substantial Compliance.**

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

502

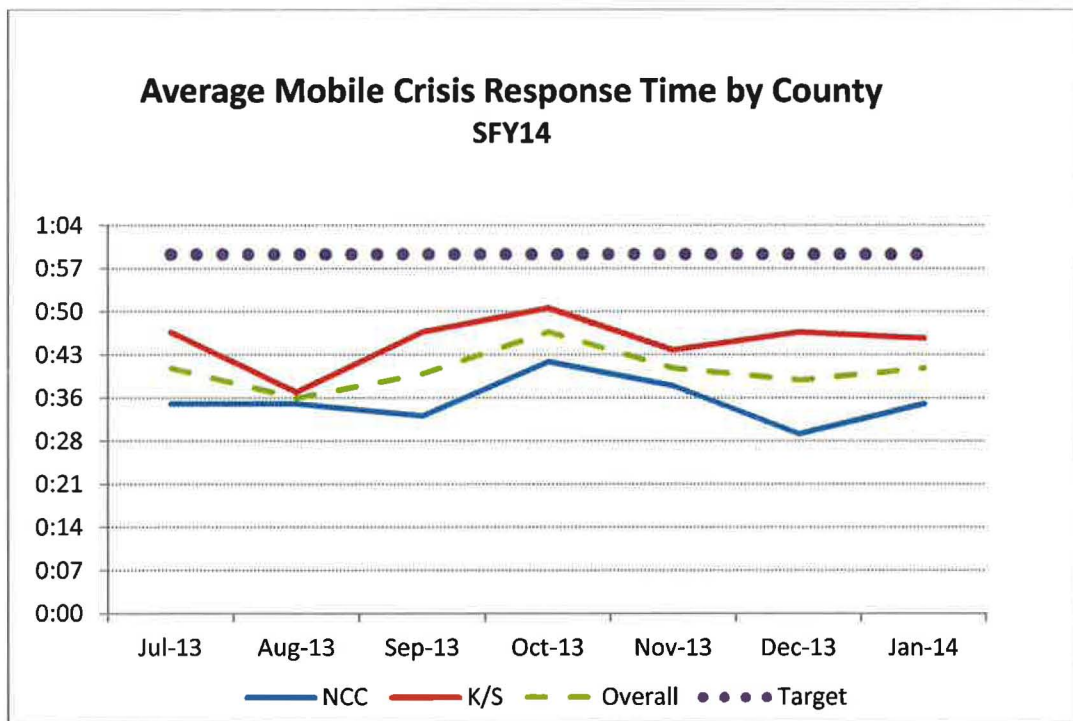


503

504 **B. Mobile Crisis Services**

505 Substantial Compliance.

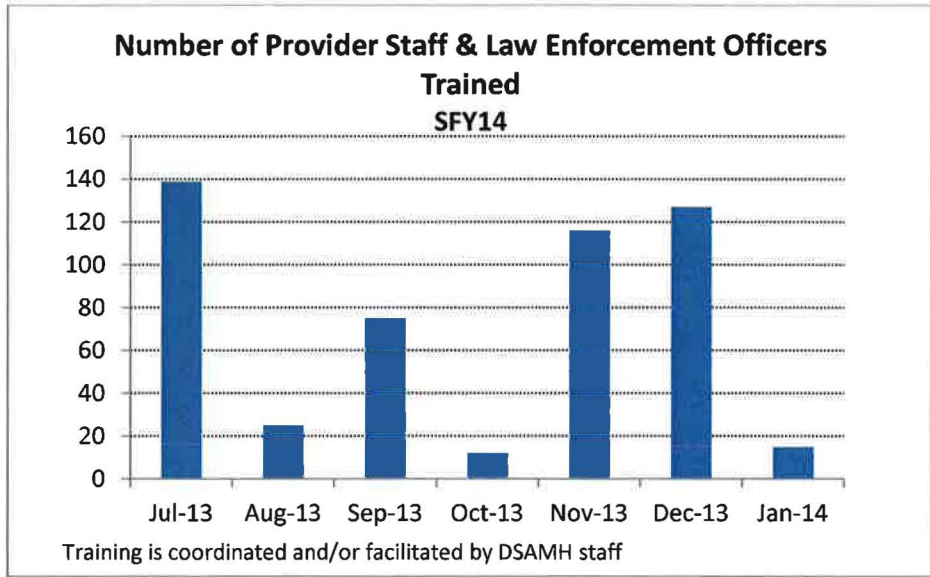
506 Mobile Crisis programs are a critical element of the State’s emergency response system
507 for people with SPMI in that they allow an opportunity for on-site evaluation and, ideally,
508 de-escalation of a crisis, as well as the referral of the individual to the most appropriate
509 service needed.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



514
515 within its response-time requirements, even in the downstate counties of Kent and Sussex
516 (K/S), which are more rural and where travel tends to be more challenging. Response
517 times are recorded from the time a call is completed until the point at which a face-to-
518 face contact occurs. In reporting to the State, the mobile crisis programs provide
519 information when specific calls result in longer response times, for example, in situations
520 when callers request that the mobile crisis responder come at a particular time of day;
521 these are not included in the chart above.

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

526 purposes). The State remains in substantial compliance with these provisions. The table
527 below presents trainings that have occurred this fiscal year.
528



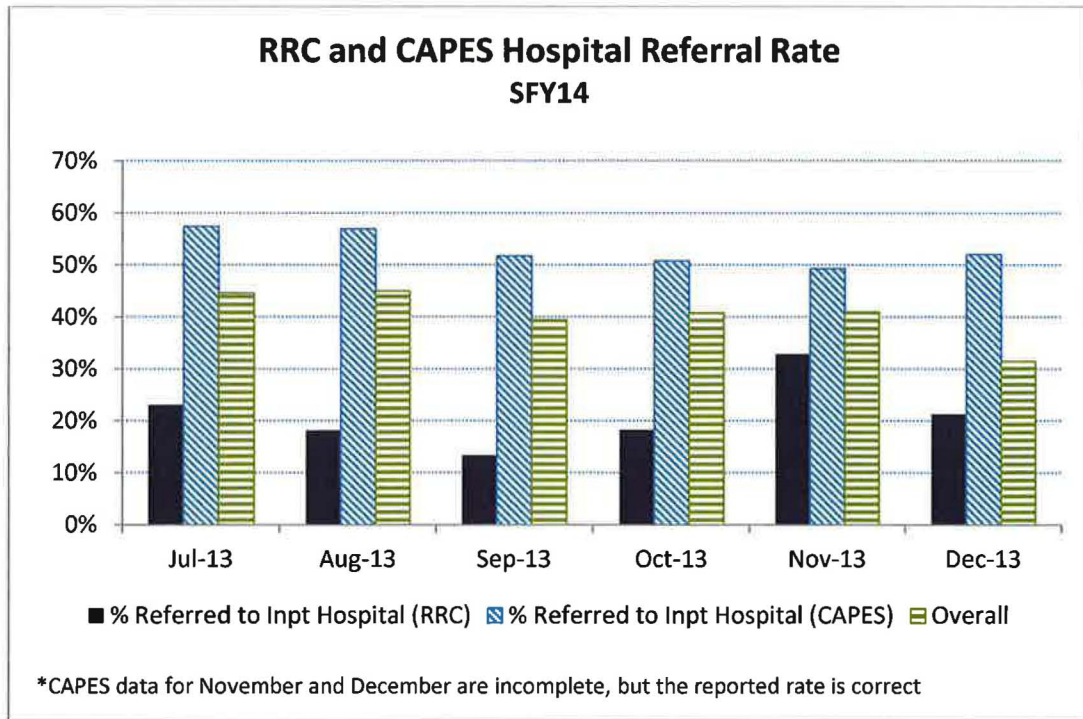
529
530

531 **C. Crisis Walk-in Centers**

532 Substantial Compliance.

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

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



550

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

556

D. Crisis Stabilization Services

557

1. Reduction in Inpatient Bed Days:

558

Trending Towards at Least Partial Compliance.

559

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

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

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

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

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

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

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

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

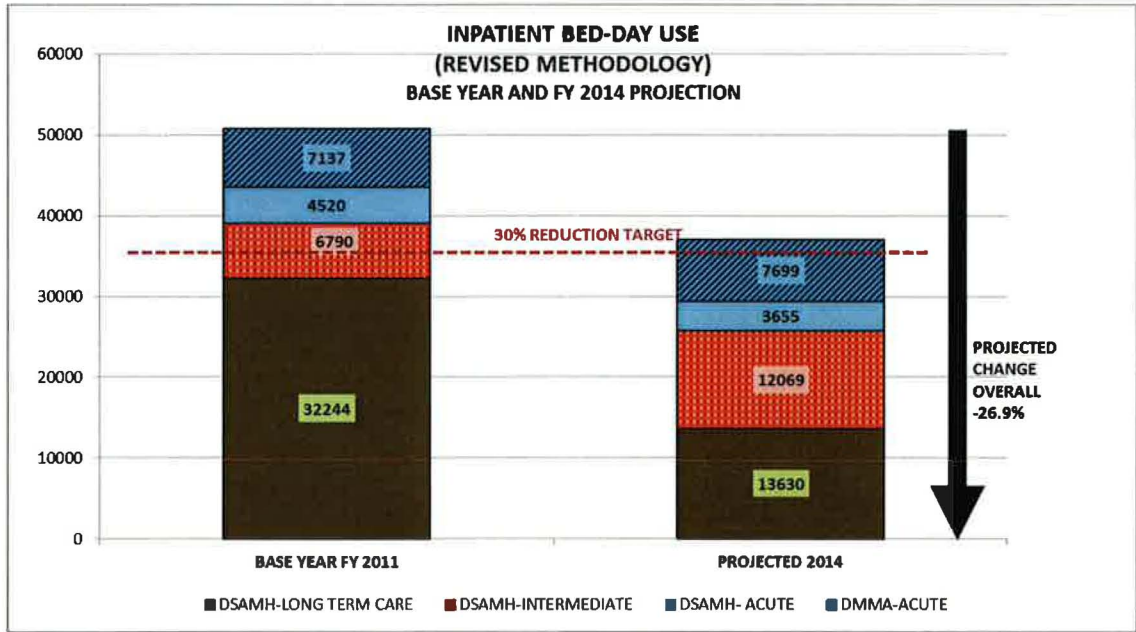
618 DMMA has responsibility for a sizable population of individuals who have been
619 diagnosed with serious mental illness. In theory, at least, individuals with SPMI who
620 require the higher intensity or scope of services provided by DSAMH are carved-out of
621 DMMA’s Medicaid managed care programs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

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

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

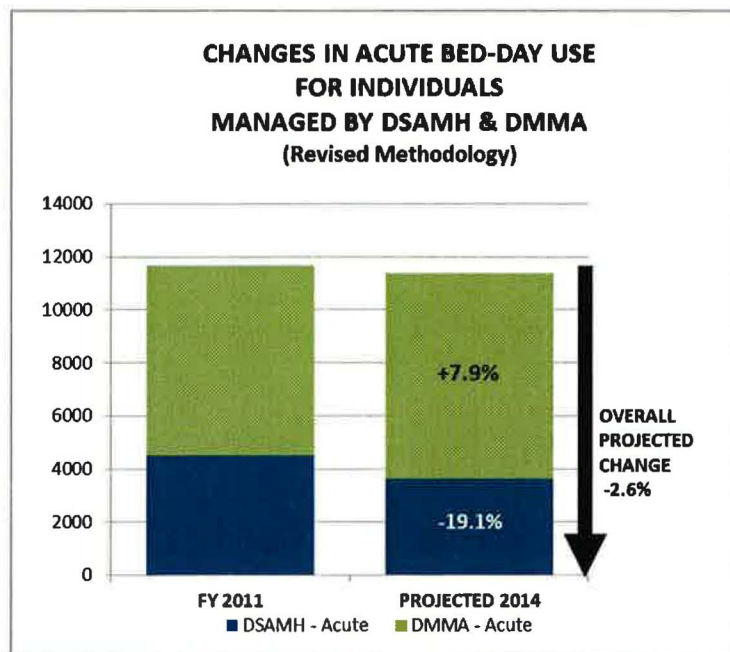
641 The table below presents projections as to bed-day use for this fiscal year, applying the
642 revised methodology—as it now stands—for DMMA-managed care. As was noted
643 earlier, the Monitor’s continuing discussions with the State around DMMA’s data may
644 result in additional revisions (either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

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



652
 653 overall population of DPC is reducing, particularly with respect to long-term care, the
 654 State will find it difficult to achieve the further bed-day reductions that are required in the
 655 Agreement if it remains heavily reliant on practices in that facility.

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



660 As was described earlier, DMMA has oversight responsibility for acute inpatient care—
661 14 days or fewer—within IMDs for individuals whose behavioral health is covered
662 through Medicaid Managed Care. DSAMH manages acute care in IMDs or DPC for
663 individuals who have been carved-out from these programs based upon a need for the
664 more intensive services that it offers through its system, as well as for individuals who
665 are uninsured. Individuals whose behavior health is covered by Medicaid managed care
666 generally are not admitted to DPC unless they require intermediate- or long-term care
667 services.

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

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

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

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

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

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

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

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

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

- 737 ○ the creation of Quality Improvement scorecards with data relating to services
738 in each IMD;
 - 739 ○ pending modifications in the State’s Medicaid Plan, through which DSAMH
740 will have expanded responsibilities for coordinating a broad array of new
741 services, including case management, through its “PROMISE” program;
 - 742 ○ the potential for DSAMH to expand its Utilization Reviews within IMDs to
743 include DMMA-managed individuals, and
 - 744 ○ the collection of data relating to the impact and quality of newly required
745 mental health screening prior to the issuance of involuntary holds and hospital
746 admissions.
- 747 ● A streamlined process for referring individuals with SPMI who are in DMMA’s
748 Medicaid managed care program for carved-out mental healthcare through DSAMH
749 (albeit with the limitations discussed earlier).

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

754
755 **Recommendations:**

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

767
768 ***2. Discharge Planning:***

769 **Partial Compliance.**

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

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

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

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

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

799

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%

800

801 **Recommendations:**

802

803

804

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

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

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

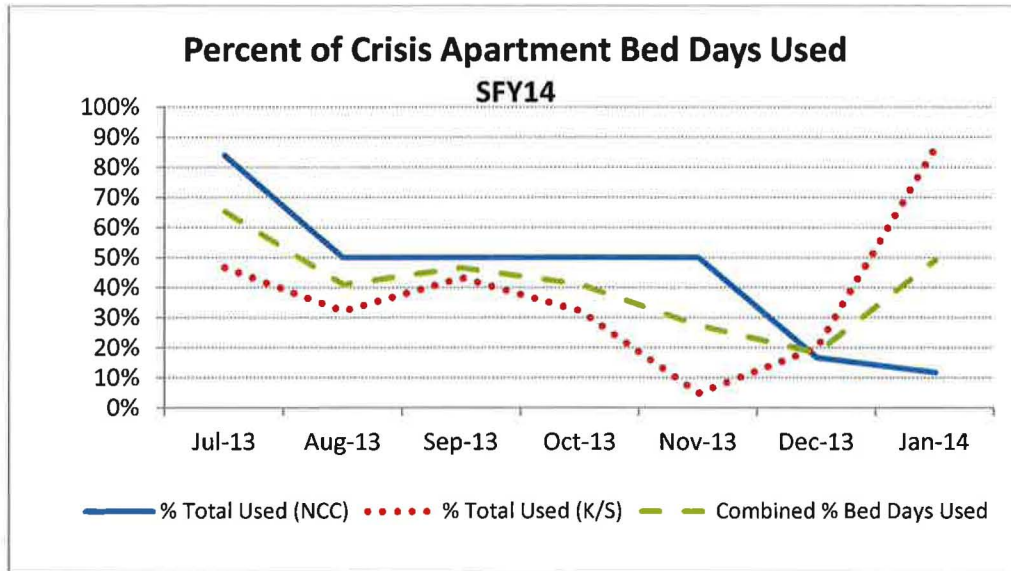
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820 **E. Crisis Apartments**

821 Substantial Compliance.

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

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



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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.

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845 **F. Assertive Community Treatment**

846 Substantial Compliance.

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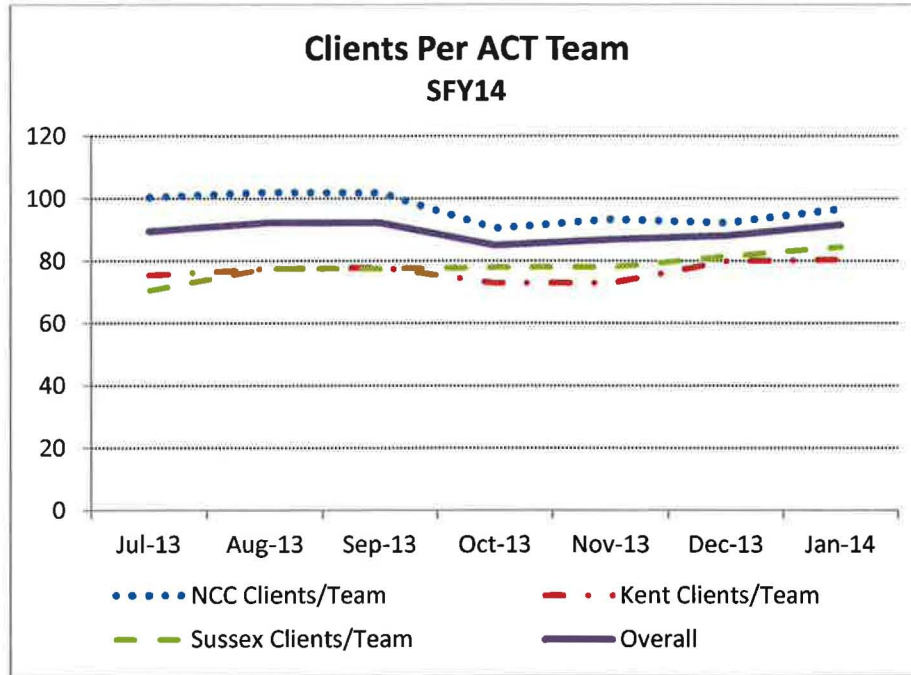
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ACT is a critically important service for people with SPMI who have intensive service needs in the community. It is a well-established, evidence-based practice whereby individuals received flexible, mobile services to promote their recovery and to 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.

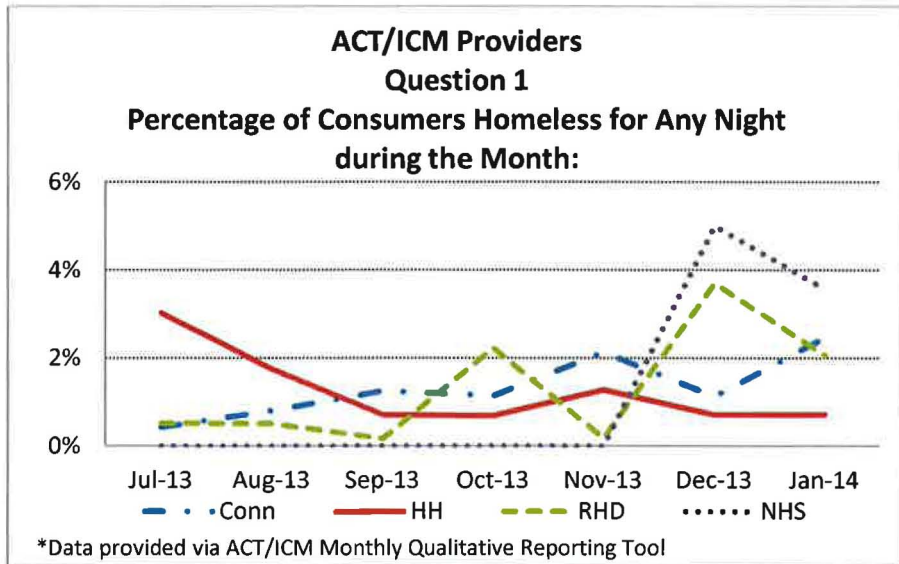


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859 DSAMH has an active program of surveying each ACT team for program fidelity (as is
 860 required in Section II.D.2.a) and providing needed consultation. The survey process
 861 includes written appraisals of each team’s adherence to the program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

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

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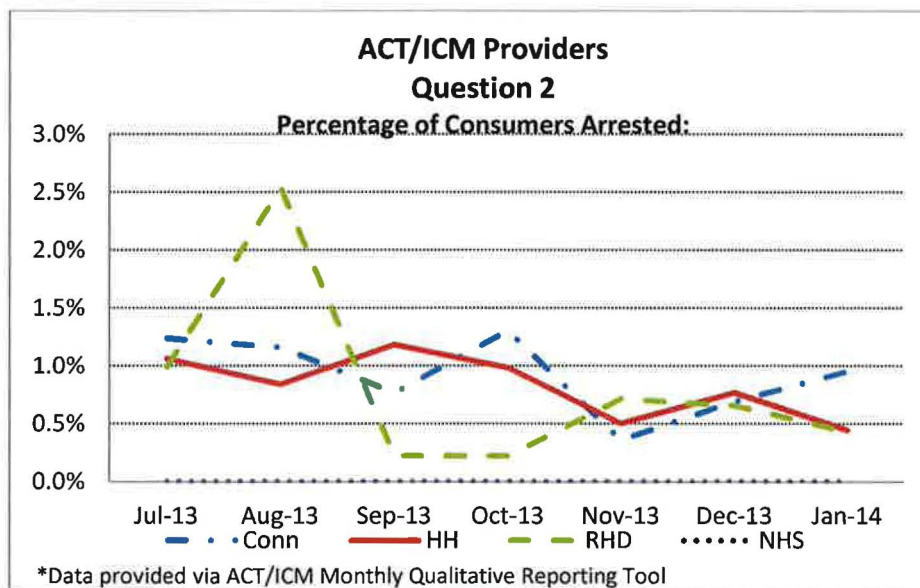
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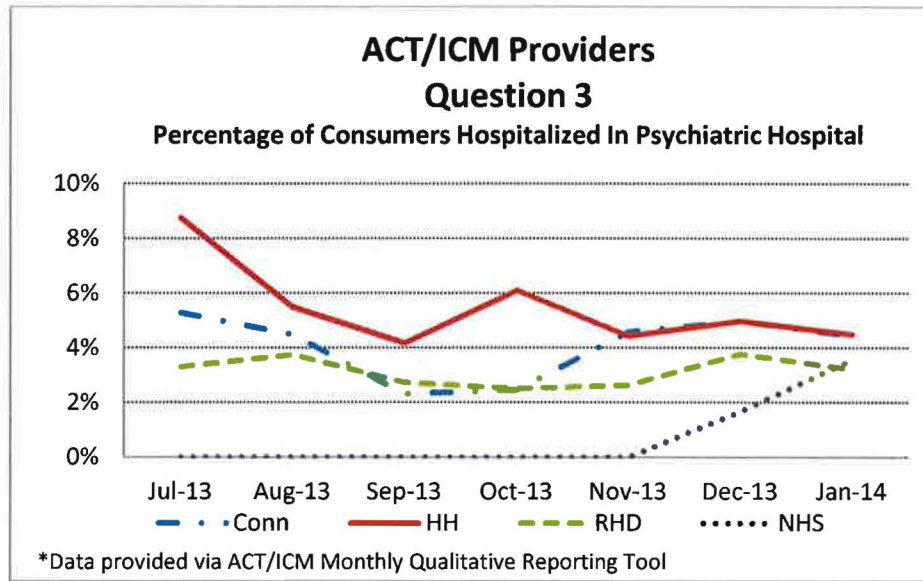
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The following trending charts present additional quality measures being monitored by DSAMH. The first shows the percentages of ACT clients who were arrested each month—rather low figures given the level of disability of these individuals and the frequency 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.

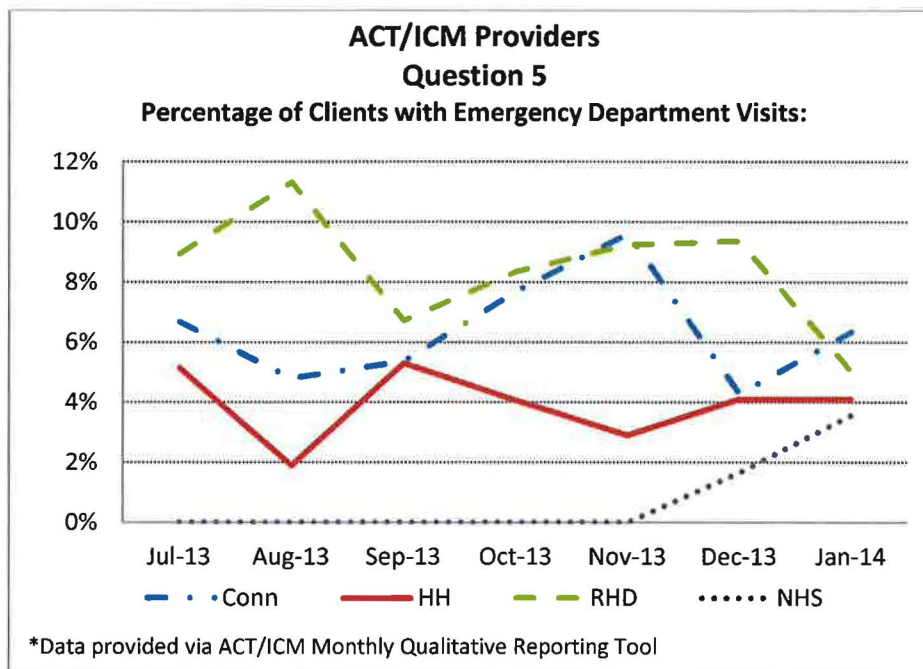


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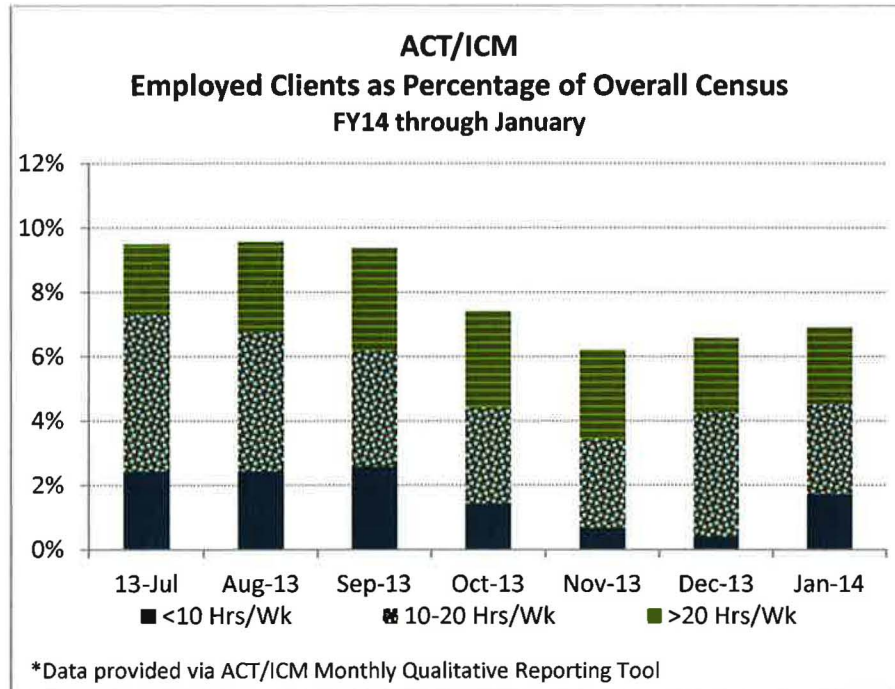
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The table below presents the percentages of ACT clients who used a hospital emergency room during each month. These encounters could reflect either physical health issues, or behavioral issues.



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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.



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

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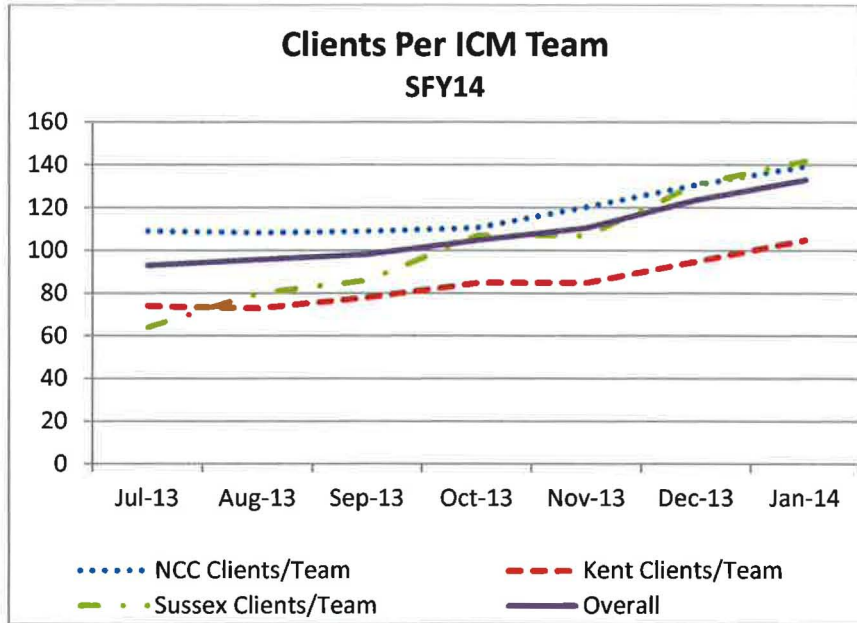
G. Intensive Care Management

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Substantial Compliance.

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



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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.

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H. Case Management

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Substantial Compliance.

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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.

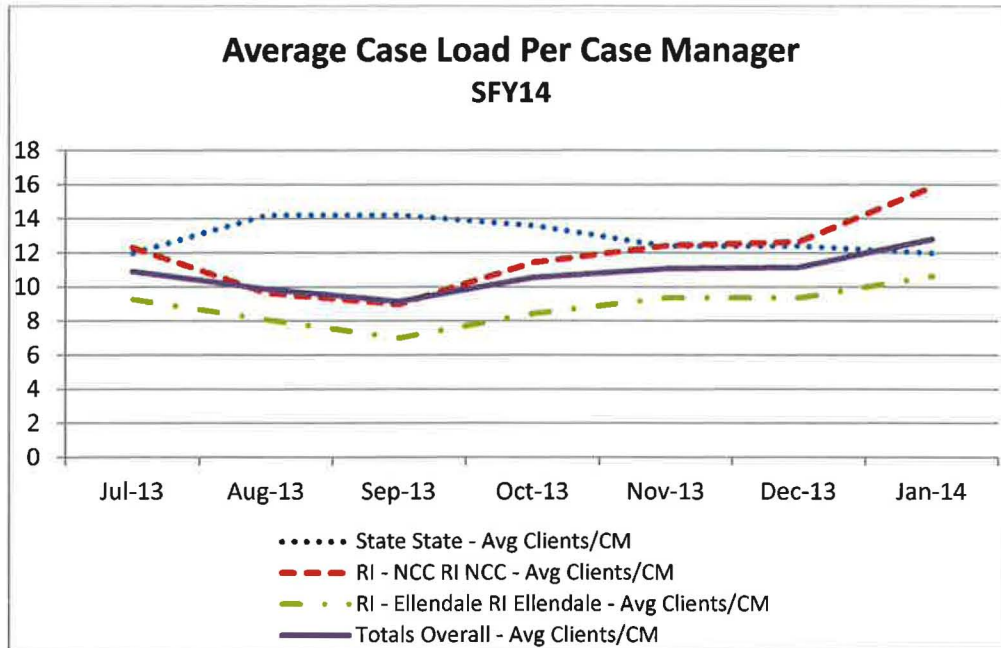
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Both within hospital and in the community, TCMs play a critical role in linking individuals who have SPMI to needed services. For many such individuals, they are the “front door” the State’s mental health service system. Depending upon the specific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



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I. Supported Housing

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Substantial Compliance.

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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.

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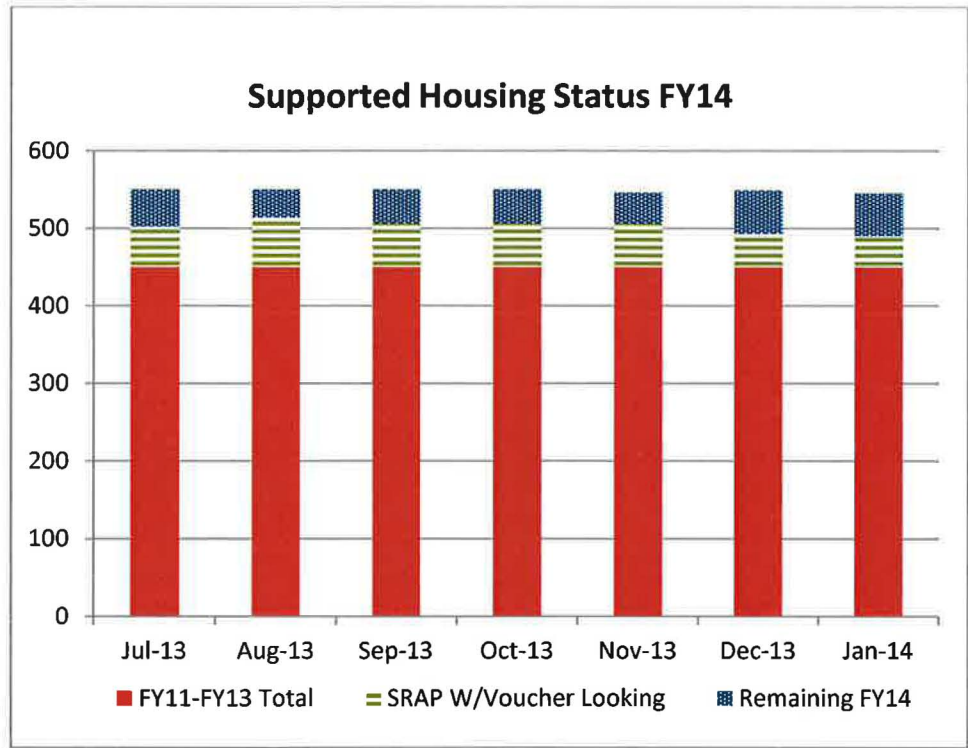
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Section III.I.4 of the Agreement will require the State to fund a total of 550 supported housing vouchers or subsidies by July 1, 2014. The State is already in compliance with this provision in that it has funded at this level. As would be expected, 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

957 compliance. The following chart demonstrates how DSAMH is tracking the utilization of
 958 Supported Housing vouchers, including individuals with vouchers who are in the process
 959 of seeking housing and the number of additional vouchers available. As has been noted in
 960 prior reports, DSAMH has been diligent in monitoring both the quality of housing and
 961 compliance with respect to the requirements for integration that are delineated in the
 962 Agreement.
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 966 Making arrangements for permanent supported housing can take several months—
 967 securing an apartment of an individual’s choice, getting furnishings, putting benefits in
 968 order, and so on. To enable individuals to leave hospital settings while these
 969 arrangements are being made, DSAMH has established 17 transitional beds. In addition,
 970 the Division has created 10 Resource Beds in the community that can be flexibly used for
 971 housing transition purposes or for respite, according to the immediate need.

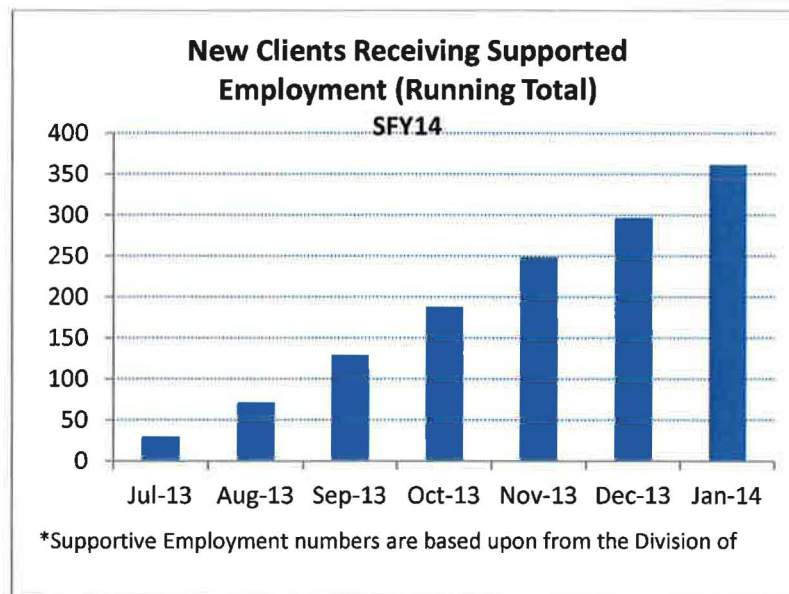
972 In summary, the State is creating integrated supported housing opportunities for
 973 individuals with SPMI who, in the past, would remain institutionalized or whose options
 974 would be largely limited to congregate settings. The supported housing efforts the State
 975 has made pursuant to the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

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979 **J. Supported Employment**

980 Substantial Compliance.

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



988 effect. Given the current rates, DSAMH estimates that approximately 600 individuals on
989 the TPPL will receive supported employment services this fiscal year, thereby again
990 exceeding the requirements of the Agreement.
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993 It has been noted in previous reports that there is an unusually positive working
994 relationship between DVR, which is situated within the State’s Department of Labor, and
995 DSAMH, which is a division of DHSS. Accordingly, a large percentage of the
996 individuals receiving services through DVR have SPMI. This very much benefits the
997 State’s fulfillment of the requirements of the Agreement. Nationwide, unemployment
998 among individuals with SPMI is shamefully high. As is the case with where one lives
999 (e.g., in integrated supported housing, as opposed to a specialized facility), whether an
1000 adult with disabilities such as SPMI is in the mainstream workforce is an important
1001 “bottom line” indication of the impact of the ADA. The State is making admirable
1002 progress in this regard.

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1004 **K. Rehabilitation Services**

1005 Substantial Compliance.

1006 Section III.K.2 of the Agreement requires the State to provide rehabilitation services to a
1007 total of 600 individuals. As was discussed in the last report, rehabilitation services
1008 comprise an array of activities, such as education, substance abuse treatment, and
1009 recreational activities. Some of these components are not well defined in the State’s data
1010 systems. Furthermore, without sufficient intensity the meaning of the service is
1011 questionable. Applying the criteria used in the last report, figures are as follows:

- 1012 • Psychosocial Rehabilitative Services, Psychosocial
1013 Group Services, or Family Psychosocial Education was
1014 provided at least twice per month for at least 6 months 259 individuals
- 1015 • Some level of substance abuse service for a co-occurring
1016 disorder was provided during the year..... 978 individuals
- 1017 • Total Unduplicated Count..... 1,222 individuals

1018 The State is surpassing its requirements with respect to Rehabilitation Services and has
1019 already met the July, 2014 target of 1,100.

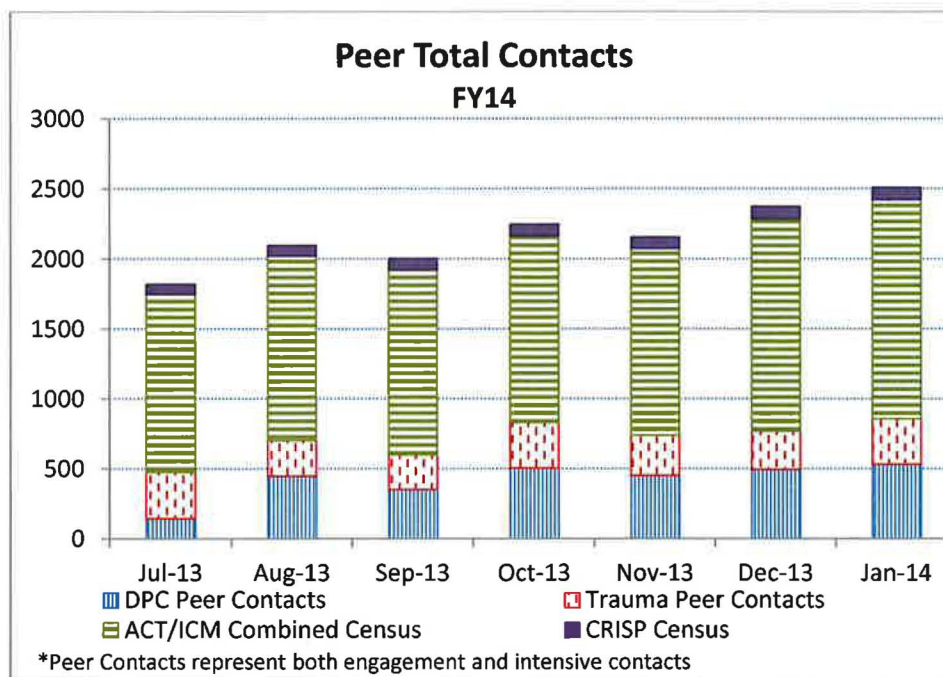
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1021 **L. Family and Peer Supports**

1022 Substantial Compliance.

1023 Family and peer supports are incredibly important means of enhancing individual’s
1024 natural social connections. Peer supports in particular allow individuals to connect with
1025 people who have “lived experience” with mental illness and the various systems that
1026 provide services to them; they are a crucial element in promoting recovery. Section III.L
1027 of the Agreement required the State to provide Family and Peer Supports to a total of 500
1028 individuals by July of 2013, and will require services to an additional 250 individuals by
1029 July 1, 2014. The State’s data system makes it difficult to extract an unduplicated count
1030 of peers and families being served, but the numbers of contacts—2,500 in January, 2014
1031 alone—strongly suggest that it is meeting, if not exceeding this requirement. Past reports
1032 have recognized the State’s successful promotion of very robust peer programs at DPC
1033 and in the community. The chart below demonstrates the degree to which peer supports
1034 have become a routine and important part of the various elements of DSAMH’s system.

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1038 **M. Quality Assurance and Performance Improvement**

1039 Substantial Compliance.

1040 Section V of the Agreement requires the State to develop systems to ensure the quality of
 1041 services offered and to improve service outcomes. Aided by its improving data
 1042 capacities, DSAMH is increasingly enhancing its Quality Assurance (QA) and
 1043 Performance Improvement (PI) efforts. In addition, the Monitor has arranged for
 1044 ongoing technical assistance with respect to these important functions. Evidence of
 1045 measures taken by DSAMH in this regard appears throughout this report.

1046 In addition, DSAMH has contracted with the University of Pennsylvania to provide
 1047 quality of service research with regard to service outcomes for individuals on the TPPL
 1048 and for the CRISP program (a program providing flexible, intensive services and
 1049 supports primarily to former long-term inpatients of DPC). UPenn’s research with regard
 1050 to the TPPL is comprehensive, allowing longitudinal evaluations of cohorts of individuals
 1051 appearing on the list. In plain language, this means that the researchers are examining
 1052 outcomes for individuals who were placed on the TPPL during the initial year of
 1053 implementation, and that they will be able to track how these individuals fare in the
 1054 following year, the year following that, etc., with regard to such factors as
 1055 hospitalizations and emergency room use. The researchers will be able to conduct similar
 1056 assessments for people placed on the TPPL in year 2 of implementation, and so on. This
 1057 study is ongoing. It should be able to provide invaluable information about service
 1058 outcomes for individuals with SPMI and how these outcomes change as the various new

1059 programs that have been launched mature. This is important not only for Delawareans,
1060 but for other states that are pursuing reforms in their systems in fulfillment of the ADA.

1061 The CRISP research includes periodic clinical and functional assessments of individuals
1062 in the program, as well as interviews with clients and staff about their perceptions of the
1063 program and its impact. The UPenn research relating to the TPPL includes individuals
1064 whose care is managed by DSAMH and by DMMA. The research relating to CRISP,
1065 which is a program administered by DSAMH, includes only individuals whose care is
1066 managed by that entity.

1067 UPenn’s longitudinal studies are in relatively early phases. As significant findings come
1068 to be generated, they will be incorporated in DSAMH’s QA and PI processes and, no
1069 doubt will be included in monitoring reports.

1070 At this juncture, the State is in Substantial Compliance with the provisions of the
1071 Agreement relating to Quality Assurance and Performance Improvement. This rating
1072 does not mean that the relevant systems are all in place, and properly and fully
1073 functioning, but it does reflect the finding that DSAMH is taking appropriate steps to
1074 develop comprehensive and meaningful programs to fulfill these requirements. Meeting
1075 the Agreement’s requirements for QA and PI requires a long-term, ongoing endeavor
1076 which will likely extend through the term of its implementation.

1077 Although QA and PI efforts are far less clear with respect to individuals managed via
1078 DMMA, overall the State is where it should be with respect to the requirements of
1079 Section V and, for this reason, is in Substantial Compliance. Maintaining this rating, of
1080 course, will require a continuing effort and more focused consideration of individuals
1081 whose behavioral health care is coordinated through Medicaid managed care.

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1083 **N. Risk Management**

1084 Partial Compliance.

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1086 Section V.B of the Agreement requires the State to have risk management systems in
1087 place that address adverse outcomes for individuals in DPC, IMDs or community
1088 programs. There are currently multiple systems at multiple levels within DHSS,
1089 DSAMH, DPC, the IMDs, and community programs that are intended to capture
1090 information about adverse events, including abuse, neglect, injury and death, and to
1091 ensure appropriate corrective action. The multitude and idiosyncratic nature of these
1092 processes significantly dissipates the overall impact of any system-wide risk-reduction
1093 efforts. What entity reports an adverse event affecting an individual covered by the
1094 Agreement, to whom the report is made, and with what consequences may depend largely
1095 upon where the incident happened to occur. For instance, an event in a State-operated
1096 setting (such as DPC or a group home) may trigger a “PM-46” report that ultimately

1097 lands in the Division of Long Term Care. The same event happening in an IMD or in a
1098 community program may be subject to reporting and, as indicated, investigation by
1099 DSAMH. Similarly, DHSS has a Mortality Review Committee that examines deaths and,
1100 as indicated, their root causes, but only within programs operated by the State. In
1101 summary, there is no single system-wide repository for reports of adverse events and
1102 there is no single system-wide authority that conducts investigations, for oversees
1103 corrective actions, and implements risk reduction measures.

1104 As a concrete example, there was an adverse event in DPC that involved an individual on
1105 the TPPL choking on food that was a not a part of the individual's prescribed diet. Just by
1106 happenstance, the Monitor learned of a very similar event that occurred with another
1107 individual who was living in a community setting. These events were reported according
1108 to the required protocols, investigated, and corrective action plans were developed. Yet,
1109 the reporting, investigations, and corrective measures taken occurred in isolated
1110 bureaucratic streams. There is no mechanism for capturing information about the
1111 frequency of choking episodes within the overall service system—both those that result
1112 in injury and those that are “near-misses” as a result of timely staff intervention.
1113 Likewise, there is no mechanism whereby DHSS might use these data as a basis for
1114 taking some system-wide preventive measures, such as issuing an alert about appropriate
1115 procedures to prevent choking. Without question, there are similar instances relating to
1116 other adverse events that are not being captured.

1117 The State's various parallel, disconnected systems of incident reporting and risk
1118 reduction are very difficult to understand, either individually or collectively. Properly
1119 configured, risk-reduction measures should be straightforward, transparent, and
1120 accountable. The systems that are currently in place appear to be largely an accumulation
1121 of measures that have been taken over the years, either in response to an adverse event or
1122 to comply with some specific certification or regulatory requirements. What is sorely
1123 lacking is an overall blueprint for risk reduction.

1124 **Recommendation:**

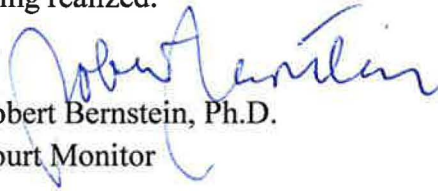
1125 It is strongly recommended that DHSS establish a unified, system-wide process
1126 for reporting adverse events, conducting investigations and root cause analyses,
1127 ensuring corrective actions, and broadly implementing preventive measures.
1128 Embedded in the various processes now in place may well be some model
1129 practices or promising approaches; an initial first step might be to map out current
1130 systems and to explore the feasibility of making them universal. Critical to any
1131 reconfiguration is that there be data systems in place that provide timely and
1132 usable information.

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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.



Robert Bernstein, Ph.D.
Court Monitor