

**NINTH REPORT OF THE COURT MONITOR  
ON PROGRESS TOWARD COMPLIANCE**

**WITH THE AGREEMENT:**

**U.S. v. STATE OF DELAWARE**

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

5/26/2016

1 **I. Introduction:**

2 This is the ninth report of the Court Monitor (Monitor) on the implementation by the State of  
3 Delaware (State) of the above-referenced Settlement Agreement (Agreement). This is an interim  
4 report that focuses on those provisions of the Agreement that the Monitor found the State to be in  
5 less than Substantial Compliance<sup>1</sup> in the eighth report to the Court.<sup>2</sup> These provisions relate to:

- 6 a. Crisis Stabilization Services
- 7 b. Discharge Planning
- 8 c. Quality Assurance and Performance Improvement
- 9 d. Risk Management

10 The eighth report found the State to be in Substantial Compliance with the remaining provisions  
11 of the Agreement, and it remains so at this time.

12 With regard to the four provisions being reviewed here, the State had been found to be in Partial  
13 Compliance, and it has been working closely with the Monitor to achieve Substantial  
14 Compliance with them, as well. The findings in this report are based upon discussions with State  
15 officials, providers, and individuals who have Serious and Persistent Mental Illness (SPMI) who  
16 are the intended primary beneficiaries of the Agreement; document and clinical record reviews;  
17 site visits; and compliance data that the State has generated since the last report.

18 As is reflected in the discussion that follows, the State has either achieved Substantial  
19 Compliance or is approaching Substantial Compliance with regard to each of the provisions  
20 discussed here. As such, the State is on track to fulfill its overall obligations under the  
21 Agreement. During the coming months, the State needs to demonstrate that it is continuing its  
22 implementation efforts with regard to all of the provisions of the Agreement and that it will  
23 sustain the programs and services for Delawareans with SPMI in accordance with the Americans  
24 with Disabilities Act (ADA).

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<sup>1</sup> Section VI.B.3.g of the Agreement defines the criteria on which the Monitor evaluates the State's level of compliance as "Substantial Compliance," "Partial Compliance," or "Non-Compliance."

<sup>2</sup> The Eighth report of the Court Monitor was filed on 12/26/15.

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**II. Ratings of Compliance**

A. Crisis Stabilization Services

*Moving Towards Substantial Compliance*

As has been discussed in prior Monitor reports, the Agreement required the State to have reduced by July 1, 2014 the annual State-funded acute-care<sup>3</sup> hospital bed-days used by people with SPMI by 30% of what it was in the year prior to the Agreement taking effect<sup>4</sup> (Section III.D.3). It did not meet that benchmark. In fact, as was described in the Monitor’s sixth report,<sup>5</sup> the acute care bed-days at that point were essentially unchanged relative to the base year.<sup>6</sup> They have since increased markedly. Section III.D.4 of the Agreement requires that the State achieve further reductions by July 1, 2016 by 50% of the base year level. As of the Monitor’s eighth report, State-funded acute bed-days used by people with SPMI—particularly in Delaware’s three private psychiatric hospitals (IMDs<sup>7</sup>)—had continued to increase<sup>8</sup> and that trend continues as of today. It is clear that the State will not meet either of the acute bed-day reduction targets in the foreseeable future.

The provisions for reduced hospital use were not conceived to be requirements that exist independently of other elements of the Agreement. In including them in the Agreement, the underlying assumption was that the array of community services that was to be developed pursuant to other provisions—mobile crisis services, crisis apartments, Assertive Community Treatment, peer services, supported housing, and so on—would have the effect of reducing the need for acute psychiatric hospitalization. Thus, reductions in hospital bed-use would be a natural outcome. The State has developed these services in accordance with the Agreement (and in some instances, beyond what the Agreement requires), and still bed-days for acute care have risen. However, as is reflected in the data presented below, people being served through the community programs required by the Agreement account for only a very small proportion of the psychiatric acute bed days being used. This is notable because, as is evidenced by their referral for specialized mental health services, these individuals have very significant and often complex psychiatric disabilities.

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<sup>3</sup> The Agreement defines “acute care” as hospitalizations lasting 14 days or fewer. Section II.C.2.d.i  
<sup>4</sup> The Agreement’s “base year” from which this is calculated is the fiscal year ending June 30, 2011.  
<sup>5</sup> The Monitor’s sixth report was filed with the Court on December 29, 2014.  
<sup>6</sup> The Monitor’s sixth report found that overall bed days in IMDs, where most of the acute care was being provided showed a reduction of 0.4% as of July, 2014 relative to the base year, and bed-days managed through DMMA showed an increase of 2.1%.  
<sup>7</sup> These hospitals—Rockford Center, MeadowWood Behavioral Health, and Dover Behavioral Health—are commonly referred to, in federal terminology, as “IMDs” or Institutions of Mental Diseases.  
<sup>8</sup> Delaware Psychiatric Center (DPC), the State-operated psychiatric hospital, has also increased its acute care bed-days relative to the base year, but this reflects an intentional transition of the facility from primarily being a long-term care setting to one providing acute psychiatric care. DPC’s total number of civil beds (i.e, non-forensic) has actually been reduced during the course of the Agreement.

54 Thus, the reasons for the increased bed-day trend are complicated, and not necessarily a  
55 reflection of the quality of the community alternatives the State has created in fulfillment of  
56 the Agreement. Among the factors that have likely contributed to increases in State-funded  
57 acute psychiatric care for people diagnosed with SPMI are: an epidemic of substance use  
58 whereby individuals with drug-related crises are admitted to psychiatric beds and given a  
59 discharge diagnosis of SPMI;<sup>9</sup> a convoluted bureaucratic structure—vastly improved over  
60 the past 18 months—whereby inpatient psychiatric care had been poorly coordinated, and  
61 managed variously through the State’s Division of Substance Abuse and Mental Health  
62 (DSAMH), its Division of Medicaid and Medical Assistance (DMMA), or both; and market  
63 forces attendant to the fact that Delaware has been among a small number of states whereby  
64 Medicaid has reimbursed for care in an IMD.<sup>10</sup>

65 In consultation with the Monitor, in May, 2014, the State developed a plan to address the  
66 requirements of sections III.D.3-4 that significantly relied upon PROMISE, an expansion of  
67 services covered by Medicaid for people with SPMI with improved coordination and  
68 accountability within the community and IMDs. As has been referenced in prior Monitor  
69 reports, PROMISE went into effect in January 2015. Given its complexity, it is taking time  
70 for the program to reach its full capacity and to show its full impact with respect to hospital  
71 bed-use. If properly implemented, PROMISE should address many of these systemic issues  
72 that underpin the increases in acute hospitalizations by the target population.

73 In light of these factors, the parties agreed to explore an alternative strategy to measure the  
74 State’s compliance with the *intent* of the Crisis Stabilization section. This approach would  
75 include, but not rely solely upon, the numerical bed-use requirements specified in sections  
76 III.D.3-4. Following extensive meetings and discussions, in February, 2016, the State, the  
77 U.S. Department of Justice, and the Monitor agreed that the State’s compliance with  
78 provisions III.D.3-4 of the Agreement will also be evaluated in terms of a broader set of  
79 Quality Assurance and Performance Improvement (QA) data that includes several additional  
80 measures of the State’s efforts to reduce hospital use to drive system improvements, and  
81 link individuals who are covered by the Agreement with needed community services and  
82 housing.

83 Table-1 presents an overview of the data dashboard that the State has developed pursuant to  
84 this agreement of the parties. Generally, these data are generated, analyzed, and provided to  
85 the Monitor on a monthly basis.

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<sup>9</sup> Early in the process of implementing the Agreement, the State and the Monitor agreed on a set of diagnoses that are indicative of SPMI and would be used in identifying members of the Agreement’s priority population.

<sup>10</sup> In most instances, under the federal “IMD exclusion,” states have been responsible for covering the cost of care in IMDs for Medicaid-covered individuals between the ages of 21 and 64. This has been, and remains the case, for such individuals who are hospitalized in DPC. In the three privately owned IMDs, federal dollars cover the majority of costs for adults who have Medicaid. Over the course of implementation, many informants have apprised the Monitor of fiscal incentives as a driver of hospital care in Delaware’s IMDs.

<b>Table-1</b> <b>Revised Measures of Compliance</b> <b>with Crisis Stabilization Provisions III.D.3-4<sup>11</sup></b>	
<b>Bed Days</b>	
1a	Monthly Bed-Day Reports
1b	FY16 DPC Admissions from an IMD, by IMD and the Total LOS
1c	Mean, median, mode, and range of Days for 1b who have been discharged
1d	Clients whose lengths of stay have exceeded 14 days
1e	Direct admissions to DPC (i.e. not via an IMD)
1f	Mean, median, mode, and range of Days for 1e who have been discharged
1g	Clients whose lengths of stay have exceeded 14 days
1h	ALOS at DPC by LOS Type: 0-14, 15-49, 50-179, 180+ days
1i	Number of persons & length of time for each person on DPC ready to discharge list
<b>Crisis Walk-In Centers</b>	
2a	Number of individuals evaluated at RRC
2b	Diversion from hospitalization by RRC
2c	IMD admissions (from 1a) via Crisis Walk-In Centers
2d	IMD admissions (from 1a) not evaluated via Crisis Walk-In Centers
<b>Engagement in Community Services Comprised by the Settlement Agreement</b>	
3a	Hospital admissions of people who are actively served by DSAMH/PROMISE
3b	DSAMH community provider participation in discharge planning of 3a at IMDs & DPC
3c	Hospital admissions relating to people NOT being served by DSAMH/PROMISE
3d	3c who were referred for specialized services
3e	3c approved for specialized services
3f	3c found ineligible for specialized services
3g	3c approved, but refusing specialized services
3h	3c actively receiving specialized services
3i	Breakdown of 3h by types of services (e.g. ACT)
3j	Timely engagement of community provider/TCM in discharge planning of 3c individuals
3k	State's progress on addressing the 454 high-risk consumers identified in 2014
<b>Co-Occurring Substance Abuse</b>	
4a	IMD admissions with substance abuse as one of the discharge diagnosis
4b	4a receiving mental health services via DSAMH/PROMISE prior to admission

<sup>11</sup> As agreed to by the parties on February 16, 2016.

<b>Homelessness</b>	
5a	3a who are homeless
5b	5a who have been referred for housing (newly referred + already active)
5c	3c who are homeless
5d	5c who have been referred for housing
5e	3a who were discharged from hospital to shelters
5f	3c who were discharged from hospital to shelters
<b>Hospital Readmissions</b>	
6a	Persons discharged from DPC and each IMD in FY15
6b	30-, 90-, 180-, and 365-day Readmission Rates by LOS type
6c	1, 2, 3, or 3+ readmits to an IMD/DPC during a Fiscal Year
<b>Reliance Upon Court-Ordered Treatment</b>	
7a	Involuntary Outpatient Commitments FY11 to FY15
7b	Involuntary Inpatient Commitments FY11 to FY15
<b>DPC Average Daily Census Report (Civil Units Only)</b>	

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88 In addition to these quantitative measures, the parties agreed that the State will work with  
89 the Monitor to establish QA initiatives that target significant issues identified by the above  
90 data, as well as additional factors relating to increased hospital bed use by people with  
91 SPMI. The quantitative data and these QA initiatives will be considered by the Monitor in  
92 evaluating the State’s compliance with III.D.3-4 for this fiscal year.<sup>12</sup>

93 It has been about 2½ months since the parties agreed to these revised measures. As is  
94 evidenced by the data below, during this time the State has made an earnest and effective  
95 effort to produce the required data dashboard. It has also begun to analyze this information  
96 to improve outcomes for the Agreement’s target population.

97 The following section explains the rationale for changes in data reporting and highlights  
98 some of the data provided by the State in accordance with this new process.

99

100 Quantitative Measures:

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102 A. *Bed Days-*

103 The State is continuing to report State-funded hospital bed-days used by the target  
104 population on a monthly basis with some refinements that were agreed upon by the  
105 parties:

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<sup>12</sup> The 2016 fiscal year runs from July 1, 2015 through June 30, 2016.

- 106 a. Sections III.D.3-4 relate specifically to reductions in “acute inpatient settings”  
107 which, as described above, were expected to be achieved through the  
108 establishment of the community alternatives that are required elsewhere in the  
109 Agreement. While these reductions are certainly central to the overall goals  
110 of the Agreement, so too are reductions in longer term hospitalizations,  
111 including for individuals who have had protracted stays at DPC. Past Monitor  
112 reports have included data about the State’s success in reducing the number of  
113 days of long-term care at DPC and in shifting the facility’s focus toward more  
114 acute care services. Yet, there is no section of the Agreement that specifically  
115 requires such reductions. Recognizing that the State’s efforts to reduce long  
116 term hospitalizations is consistent with the ADA’s requirements, the parties  
117 agreed that such data should be included in the revised measurement process.
- 118 b. Previously, data on hospitalizations had been reported in terms of Acute Care,  
119 which the Agreement defines as having a duration of 14 days or fewer;  
120 Intermediate Care, defined as 15-180 days; and Long Term Care, defined as  
121 180 days or longer. Individuals receiving Long Term Care have complex  
122 clinical issues, and sometimes attendant legal barriers to discharge (e.g.,  
123 sexual offenses). However, those in the Intermediate Care category reflect an  
124 array of issues, ranging from those who remain in the hospital slightly beyond  
125 14 days as housing arrangements are made, to those who stay hospitalized for  
126 several months due to complicated clinical factors. For this reason, the parties  
127 agreed to a revised reporting structure to better differentiate among people  
128 with intermediate hospital stays. The State now categorizes stays in terms of  
129 Intermediate-I, which includes hospitalizations of 15-49 days, and  
130 Intermediate-II, which includes hospitalizations of 50-179 days. Acute and  
131 Long Term hospitalizations remain unchanged in terms of definitions.
- 132 c. Admissions to DPC include some individuals coming directly from the  
133 community or hospital emergency departments, and some individuals who  
134 were admitted to an IMD and could not be stabilized through the acute care  
135 that those facilities provide. When individuals are transferred from IMDs to  
136 DPC for continuing care, the State now calculates the duration of the  
137 hospitalization as a single—or “blended”—episode that reflects the combined  
138 number of bed-days in the two facilities. Calculating bed days in this way  
139 more accurately reflects the duration of inpatient care for crises falling into  
140 this category.

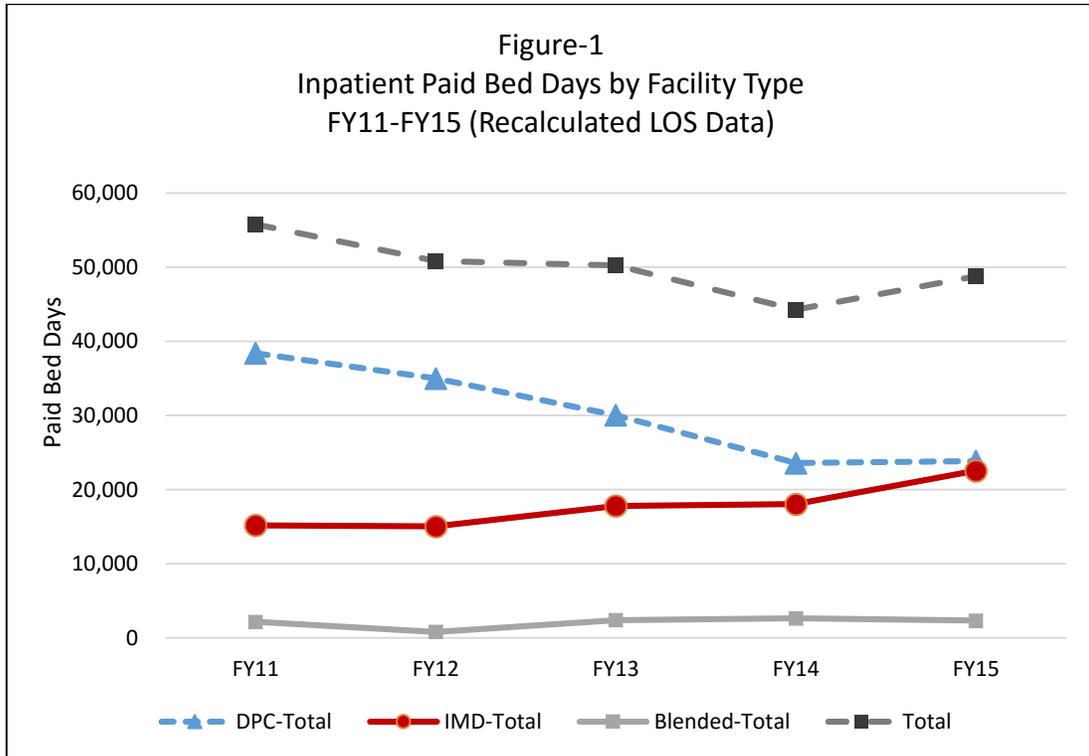
141 Figure-1 summarizes annual State-funded bed days for fiscal years 2011 through 2015,<sup>13</sup>  
142 including the blended admissions to DPC from an IMD. The total number of bed days  
143 declined from 2011 through 2014, and then began to tick upwards. Relative to the year  
144 2011, 2015 represented an overall reduction in bed-day use by 12.6%. The chart shows  
145 that the driver of these reductions is bed use at DPC, which declined by 37.9% relative to

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<sup>13</sup> The State is reporting 2016 data but, because the fiscal year is not yet complete, this information does not appear on this chart.

146 the 2011 base year. The rise in total bed use by the target population, including the  
147 increase between 2014 and 2015, is attributable to the IMDs. Relative to the base year,  
148 IMD bed-days have increased by 48.4%.

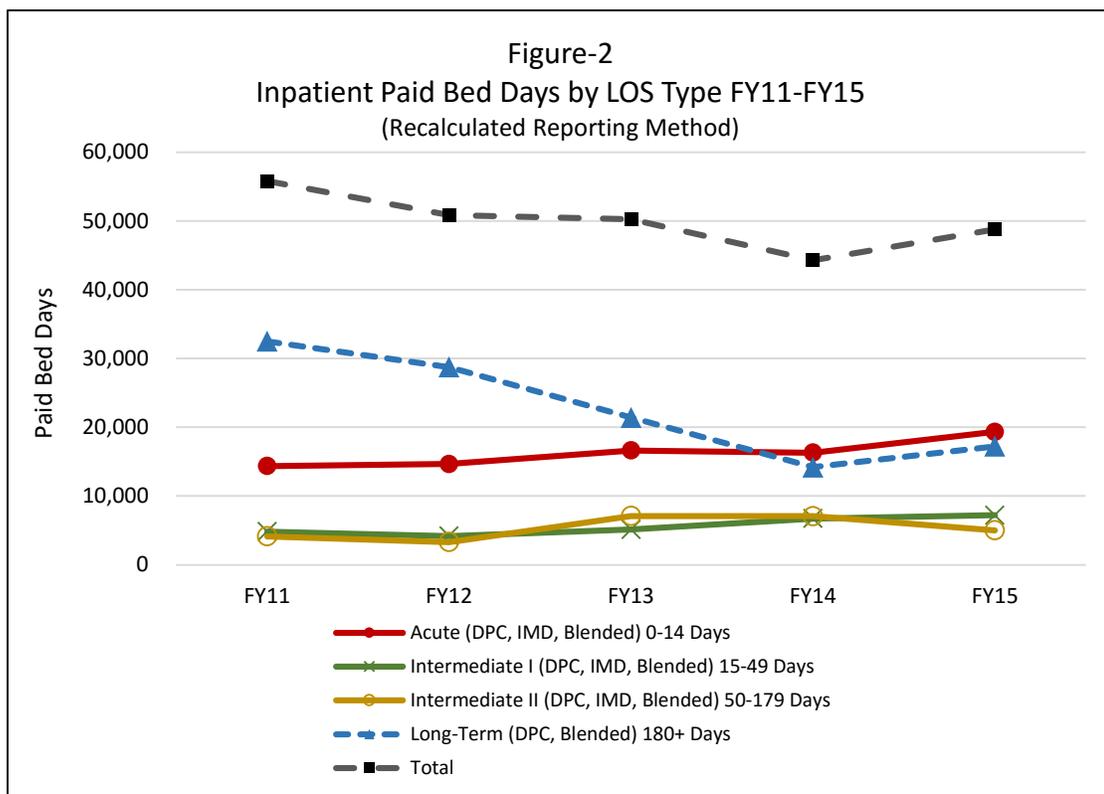
149 “Blended” bed days increased by 8.2% relative to the base year. However, other data  
150 now being reported by the State show that, notwithstanding this increase, the number of  
151 individuals transferred from IMDs to DPC for continuing hospital care has dropped by  
152 32.5% during this period, and the average length of blended hospitalizations (IMD plus  
153 DPC) has increased by 60.3% to 86.9 days. Collectively, these figures suggest that  
154 transfers for continuing hospitalization, while occurring less frequently, may be for



155  
156 individuals with complicated clinical issues and who require extended hospital stays—a  
157 finding that is consistent with the intended purpose of such transfers. The State should  
158 undertake a QA study to clarify whether this is, in fact, the case or whether other factors  
159 are at play; such a study could easily be conducted, given that only 27 transfers from  
160 IMDs to DPC occurred in fiscal year 2015.

161 Figure-2 presents the State’s bed-day utilization data for the target population in terms of  
162 the new method of categorizing lengths of stay, that is, by more precisely differentiating  
163 intermediate lengths of stay. It shows that the most dramatic decreases in inpatient bed  
164 days occurred among individuals receiving long-term inpatient care at DPC, some of  
165 whom had been hospitalized for decades before being discharged to much more  
166 integrated community settings, such as supported housing. These individuals have  
167 significant service needs, generally with complex behavioral issues co-occurring with  
168 major physical health and social issues. (i.e., they often lack close connections with the

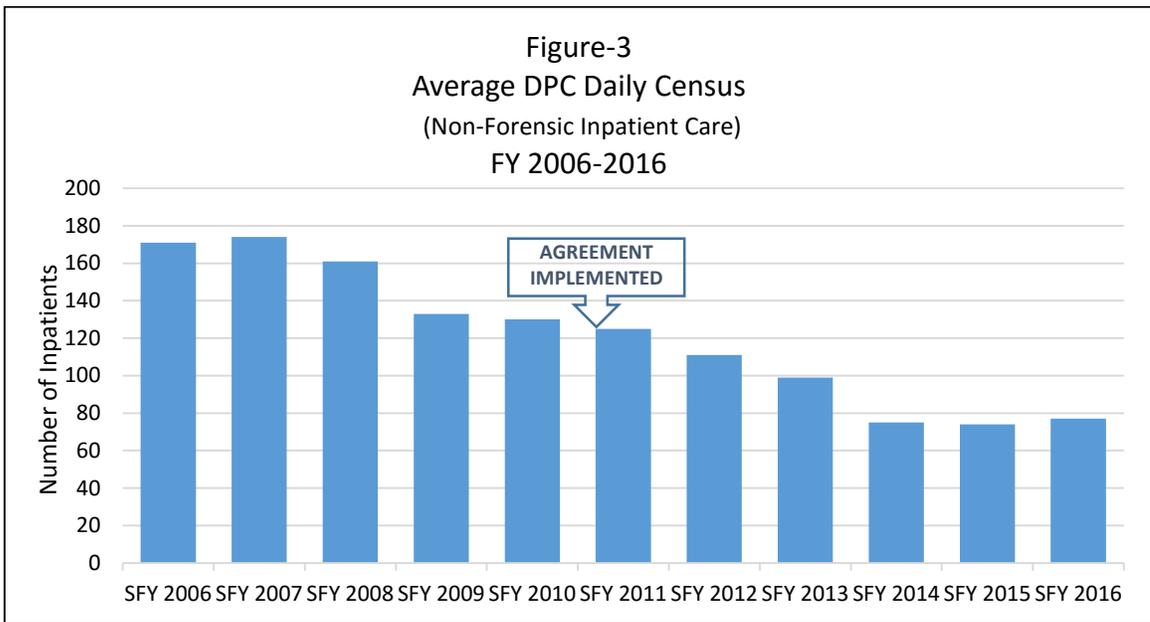
169 social networks within the community, have become dependent upon institutional  
 170 services for addressing routine daily needs, and may have ongoing legal problems).  
 171 Documenting the State’s success in shifting from institutional to community services for  
 172 this population, there was a 47% reduction in bed days for long term care at DPC in  
 173 2015, relative to the 2011 base year. Furthermore, the average length of stay for people  
 174 receiving long term care at DPC has been reduced during this period by 16.3% (from  
 175 270.7 days in 2011 to 226.7 days in 2015), and the number of individuals discharged  
 176 following long term hospitalizations has declined from 120 in 2011 to 55 in 2015 (a  
 177 36.7% reduction). Again, all of these factors point to the State’s success in shifting  
 178 services for people with SPMI who have complex needs to integrated community  
 179 settings—a core requirement of the ADA.



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 181 Figure-3 summarizes the State’s success over the past decade in downsizing DPC. Since  
 182 2014, the average daily census for “civil” (i.e., non-forensic) patients has been less than  
 183 80 patients. This represents about a 35% reduction of the facility’s census from when  
 184 implementation of the Agreement began at the beginning of fiscal year 2011.

185 The State’s new method of reporting intermediate length hospital care gives further  
 186 clarity to trends occurring in the system concurrent with the implementation of the  
 187 Agreement. Bed days in both categories of intermediate care increased since 2011, but  
 188 short-term intermediate stays (Intermediate-I) increased at more than double the rate of  
 189 longer intermediate stays (Intermediate-II); 49.5% versus 21.6%, respectively.  
 190 Furthermore, in 2015 the number of episodes of Intermediate-I (334) were almost five  
 191 times that of Intermediate-II (67). The average lengths of stay in Intermediate-I have

192 been fairly consistent over time, reported as 21.6 days in 2015; this figure is at the low  
 193 end of the range comprised by Intermediate-I (15-49 days), indicating that these  
 194 individuals are not staying much beyond the acute care period. The average lengths of  
 195 stay for individuals whose hospitalizations are categorized as Intermediate-II has also  
 196 been fairly consistent over time, reported as 74.9 days in 2015. Again, the data suggest  
 197 that Intermediate-II hospitalizations tend not to be at the high end of this category (179  
 198 days is the upper limit). Overall, these data suggest that while shorter-term intermediate  
 199 care (of about 21 days) is increasing, the increases are generally among individuals who  
 200 are hospitalized only slightly longer than the 14 days that constitute acute care. In fact,  
 201 stays of 50 days or more have decreased dramatically (by about 40%) since the base year  
 202 of 2011. In other words, it does not appear that intermediate care is becoming a pathway  
 203 into long term care.



204  
 205 Tables 2, 3 and 4 present detailed information about these trends, including partial year  
 206 data for 2016.

207 In addition to data aggregating facilities, the State maintains and reports information  
 208 specific to each of the three private psychiatric hospitals and DPC, and thus it is able to  
 209 evaluate trends underlying bed use and to target interventions accordingly to reduce  
 210 hospitalizations. Because of the volume of these statistics, the full data sets are not  
 211 included in this report. In general, they show that the mean and median length of stay for  
 212 acute care in IMDs is around seven days. Only a small proportion of admissions to IMDs  
 213 exceed fourteen days, but because DPC has more complex admission and discharge  
 214 processes than the IMDs, 76.4% of the direct admissions to DPC (i.e., those not  
 215 representing transfers from IMDs) extend into intermediate care. As was noted above, on  
 216 average these admissions last a week or so beyond the acute care period.

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Table-2 Bed Days by Stay Type FY 2011-2016 (Recalculated Report Method)							
Stay Type	FY11	FY12	FY13	FY14	FY15	FY16 (Part Year)	% Change (FY15-FY11)
Acute (DPC, IMD, Blended) 0-14 Days	14,346	14,657	16,616	16,291	19,317	8,581	34.7% Inc.
Intermediate-I (DPC, IMD, Blended) 15-49 Days	4,825	4,169	5,128	6,718	7,215	3,089	49.5% Inc.
Intermediate-II (DPC, IMD, Blended) 50-179 Days	4,125	3,287	7,103	7,072	5,015	1,772	21.6% Inc.
Long-Term (DPC, Blended) 180+ Days	32,489	28,748	21,417	14,190	17,230	7,854	47.0% Red.
<b>Total</b>	<b>55,785</b>	<b>50,861</b>	<b>50,264</b>	<b>44,271</b>	<b>48,777</b>	<b>21,296</b>	<b>12.6% Red.</b>

Table-3 Number of Episodes by Stay Type FY 2011-2016 (Recalculated Reporting Method)							
Stay Type	FY11	FY12	FY13	FY14	FY15	FY16 (Part Year)	% Change (FY15-FY11)
Acute (DPC, IMD, Blended) 0-14 Days	2,367	2,307	2,479	2,462	2,790	1,342	17.9% Inc.
Intermediate-I (DPC, IMD, Blended) 15-49 Days	195	196	247	287	334	140	71.3% Inc.
Intermediate-II (DPC, IMD, Blended) 50-179 Days	55	45	90	101	67	28	21.8% Inc.
Long-Term (DPC, Blended) 180+ Days	120	105	88	66	76	55	36.7% Red.
<b>Total</b>	<b>2,737</b>	<b>2,653</b>	<b>2,904</b>	<b>2,916</b>	<b>3,267</b>	<b>1,565</b>	<b>19.4% Inc.</b>

Table-4 Average Length of Stay by Stay Type FY 2011-2016 (Recalculated Report Method)							
Stay Type	FY11	FY12	FY13	FY14	FY15	FY16 (Part Year)	% Change (FY15-FY11)
Acute (DPC, IMD, Blended) 0-14 Days	6.1	6.4	6.7	6.6	6.9	6.4	14.2% Inc.
Intermediate-I (DPC, IMD, Blended) 15-49 Days	24.7	21.3	20.8	23.4	21.6	22.1	12.7% Red.
Intermediate-II (DPC, IMD, Blended) 50-179 Days	75.0	73.0	78.9	70.0	74.9	63.3	0.2% Red.
Long-Term (DPC, Blended) 180+ Days	270.7	273.8	243.4	215.0	226.7	142.8	16.3% Red.
<b>Total</b>	<b>20.4</b>	<b>19.2</b>	<b>17.3</b>	<b>15.2</b>	<b>14.9</b>	<b>13.6</b>	<b>26.7% Red.</b>

219 All things considered, the State might be able to further streamline discharges from DPC,  
220 but a far more critical issue—both programmatically and fiscally—relates to the high  
221 number of brief admissions to IMDs and whether the presenting issues could be  
222 addressed through a service other than inpatient psychiatric care. These issues are  
223 discussed later in this report; an analysis of individuals in DPC who are ready for  
224 discharge but whose discharge is delayed, and two new QA initiatives relating to  
225 individuals with one-time admissions to IMDs and those with multiple admissions to  
226 IMDs, whose needs might have been better addressed through other avenues.

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228 *B. Timeliness of Discharge-*

229 Section IV.B.4 of the Agreement requires that by July 1, 2015, the State will discharge at  
230 least 75% of hospitalized individuals to the community with necessary supports within 30  
231 days of a determination that hospital care is no longer needed, and that by July 1, 2016,  
232 the State shall meet this target for 95% of discharge-ready individuals. While this  
233 provision is not one of the four that are the specific focus of this report, clearly discharges  
234 that are unnecessarily delayed would contribute to the overall bed-day use and could  
235 signal a larger systemic issue about the capacity of community programs to meet the  
236 needs of the target population. For this reason, this factor has been included among the  
237 new measures relating to sections III.D.3-4 and the State has incorporated detailed data  
238 relating to discharge readiness it in its monthly data dashboard.

239 The requirement for discharge within 30 days of readiness is not relevant to acute care,  
240 which by definition reflects stays of fourteen days or fewer. Only a small number of  
241 discharges from IMDs relate to stays in excess of fourteen days; in 2015, only 188 (or  
242 6%) of IMD hospitalizations lasted longer than fourteen days, and only one of these  
243 lasted beyond the 49-day period that is categorized as Intermediate-I.<sup>14</sup> Setting that one  
244 exception aside, the mean length of stay for individuals who were hospitalized in IMDs  
245 beyond fourteen days was 19.4 days. In fact, within the IMDs, 99.7% of discharges  
246 occurred within 30 days of a determination of discharge readiness. As such, the  
247 requirements of IV.B.4 overwhelmingly relate to discharge practices at DPC, which (in  
248 part, by design) has a much larger population whose clinical needs are such that  
249 hospitalizations may last in excess of 30 days.

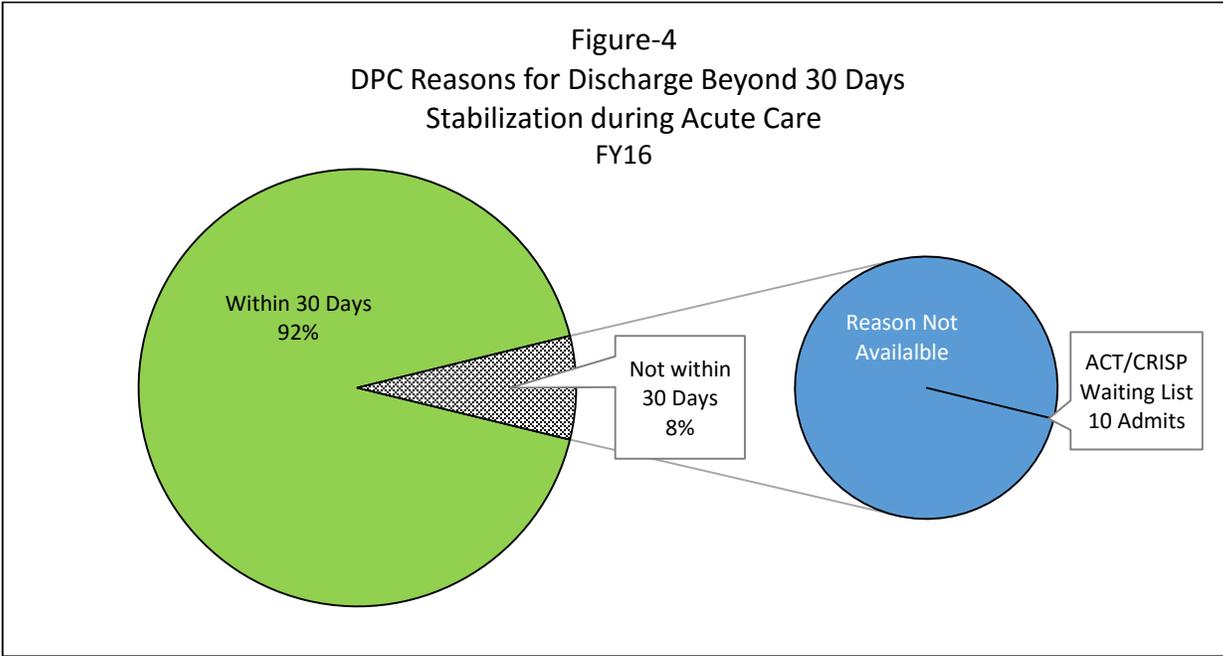
250 At this juncture, the State is in Substantial Compliance with the requirements of IV.B.4.  
251 In July, 2015, at which point the Agreement requires 75% compliance with the 30-day  
252 target, the State met this target for 81.8% of individuals at DPC. In calculating this  
253 figure, the State takes the date on which an individual is determined by the clinical team  
254 to be ready for discharge and subtracts this from the date of actual discharge to the  
255 community. It has compiled data that go beyond the sheer numerical targets of the

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<sup>14</sup> That hospitalization lasted 59 days, which is at the low end of the Intermediate-II category.

256 Agreement and that allow it to conduct analyses of why discharges sometimes are not  
257 occurring within 30 days of readiness.

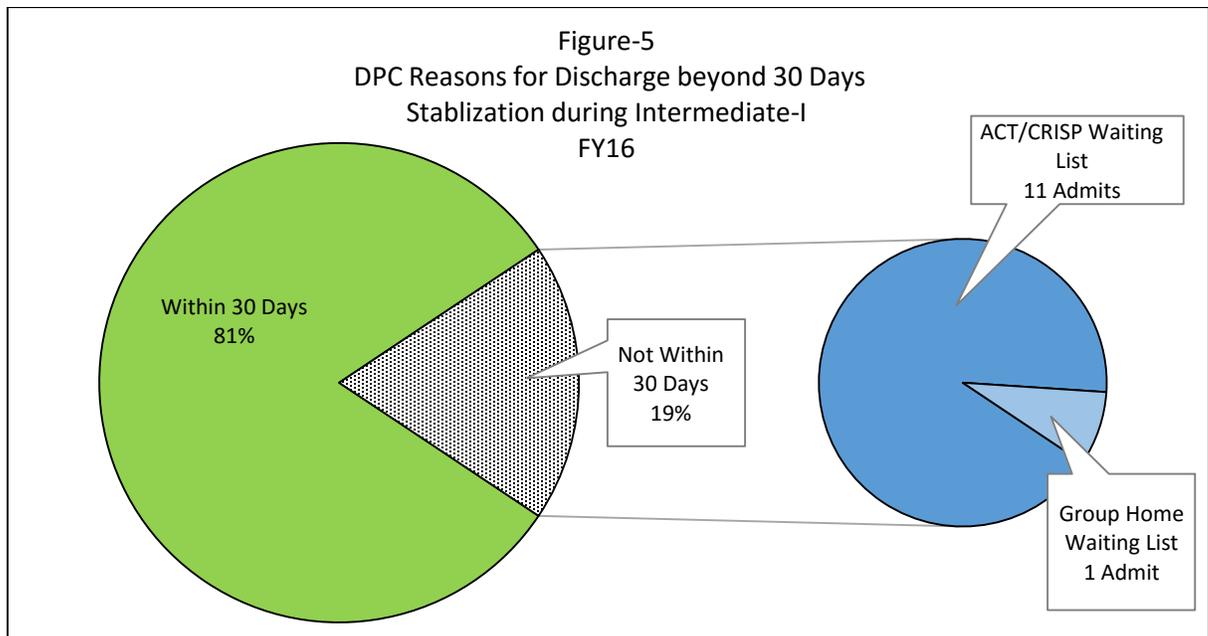
258 Figure-4 presents data on individuals who were admitted to DPC, were determined to be  
259 appropriate for discharge during the acute care phase of treatment (i.e., 14 days or fewer),  
260 but remained hospitalized beyond 30 days of this determination. This scenario occurred  
261 with respect to 131 discharges in 2015, which represent 8% of the total number of  
262 hospitalizations where the clinical teams determined that the individual was discharge-  
263 ready within the acute care period. Because this is a new initiative, the State does not  
264 always have complete retrospective data on the reasons that discharge did not occur in a  
265 timely way (thus, the “Reason not Available” category in this chart). In at least ten of the  
266 instances where individuals who were determined to be discharge-ready from DPC  
267 during the acute care period, delays were attributed to waiting lists for Assertive  
268 Community Treatment (ACT) or CRISP, the State’s program of providing intensive and  
269 flexible community services through a capitated case rate.<sup>15</sup>



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271 Figure-5 presents similar data for individuals at DPC who were determined to be  
272 discharge ready during the Intermediate-I period. Of the 19% of these discharges that did  
273 not occur within 30 days, eleven individuals were awaiting ACT or CRISP services, and  
274 one individual was awaiting a bed in a group home.

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<sup>15</sup> ACT and CRISP have been described more fully in past Monitor reports.



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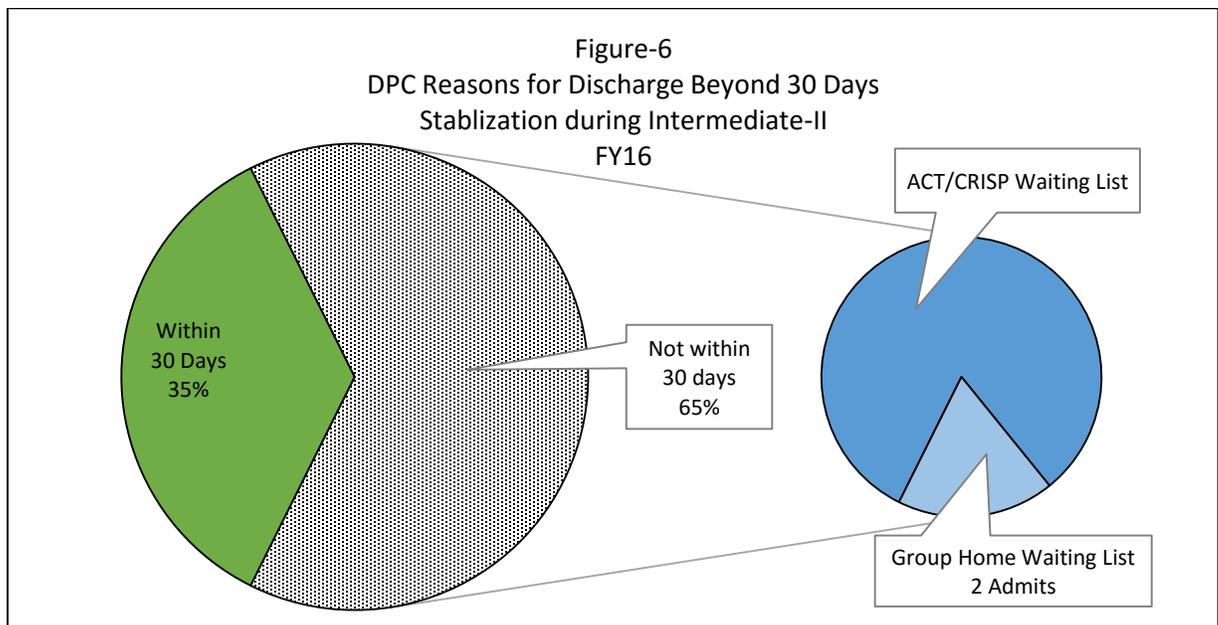
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Figure-6 presents the data for individuals at DPC who were determined to be discharge-ready during the Intermediate-II period. Although the proportion of Intermediate-II discharges is large, the actual number of individuals included in this group is small—12 people. The issues delaying their discharges remain access to ACT or CRISP services and, less frequently, the availability of beds in group homes.



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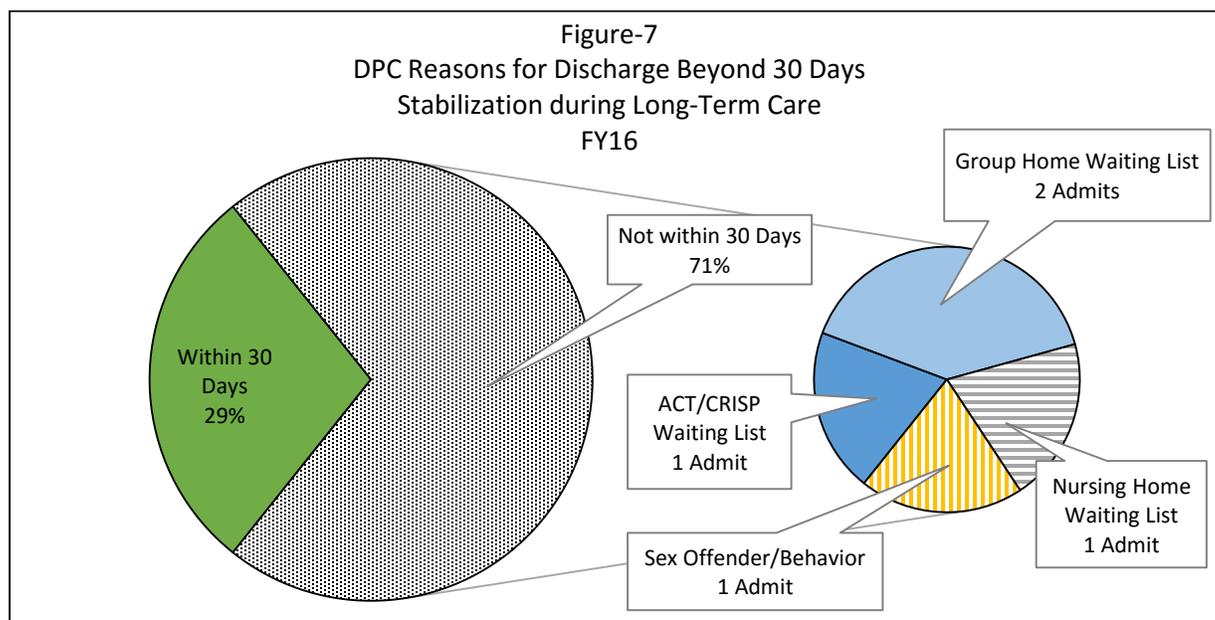
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Figure-7 presents data on individuals whose readiness for discharge was determined during periods of long-term care, that is, hospitalizations lasting 180 days or longer. Thus far this fiscal year, five individuals fell into this category. In addition to ACT/CRISP and group home availability being factors delaying their discharges following long term care, one of these individuals had medical issues requiring nursing home care and another had

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issues relating to inappropriate sexual conduct that presented challenges in making arrangements for discharge.



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The State has only recently begun compiling these discharge-readiness data, and overall, the number of individuals whose discharges exceed the 30-day standard specified in the Agreement is relatively small. Nevertheless, the analyses that can now be conducted position the State to further improve how the hospitals and the community programs interact to ensure that individuals do not remain institutionalized significantly beyond the point where inpatient care is no longer needed. Ostensibly, an initial issue to be explored is whether the State has appropriate capacity in its ACT or CRISP programs, or whether individuals are moving through those programs appropriately so that others in need of those services can access them in a timely way.

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### C. Crisis Walk-In Centers

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As has been discussed in past reports, the Crisis Walk-In Center in the southern part of the state is playing an important role in applying a recovery model to evaluating and assisting individuals with SPMI who are at imminent risk of admission to a psychiatric hospital. The program, the Recovery Resource Center (RRC), is located in Ellendale. It works seamlessly with southern Delaware's mobile crisis and targeted care management programs. The Ellendale RRC's success motivated the State to replicate it in the northern part of Delaware. However, delays mostly associated with physical plant construction have thus far delayed its opening. It is anticipated that the new Crisis Walk-In Center, which will be located in Newark, will begin operations sometime this spring. Because Crisis Walk-In Centers play a major role in diverting people from hospital admissions, data relating to their operations were incorporated among the new measures relating to sections III.D.3-4. Table-5 presents the Ellendale RRC outcome data for fiscal years

314 2014 and 2015. The State has included Crisis Walk-In Center data in its monthly  
 315 dashboard, and will be including data relating to the new center once it becomes  
 316 operational.

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Table-5 RRC Crisis Walk-In Center Referral and Diversion Breakdown (All figures relate to individuals with SPMI who are a part of the Agreement's Target Population) FY 2014-2015		
	FY14	FY15
Number of Individuals Evaluated at RRC (Total)	1760	2183
Number Diverted from Hospitalizations	1386	1627
% Diverted	78.75%	74.53%
Number Admitted to IMD [Dover Behavioral Health (DBH)]	476	658
Number of DBH Admissions Evaluated by RRC	374	556
% of DBH Admissions Evaluated by RRC	78.57%	84.50%
Number of DBH Admissions Not Evaluated by RRC	102	102
% of DBH Admissions Not Evaluated by RRC	21.43%	15.50%

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319 The data show that between 2014 and 2015, the number of individuals evaluated at RRC  
 320 increased by 24%. Although the program's hospital diversion rate dropped somewhat in  
 321 2015, about three-quarters of the people who are evaluated at the RRC are diverted from  
 322 inpatient treatment. Given that the majority of the people seen at the center are brought  
 323 by police, referred by Mobile Crisis, or transferred from general hospital emergency  
 324 departments, it is reasonable to conclude that the population served includes significant  
 325 numbers of individuals who are experiencing serious mental health crises and are at high  
 326 risk of hospitalization. Thus, this diversion rate is impressive. During the past year,  
 327 DSAMH has made a concerted effort to ensure that members of the target population  
 328 who may require inpatient psychiatric care at Dover Behavioral Health (DBH), the IMD  
 329 that serves southern Delaware, are first evaluated at the RRC unless there is some  
 330 compelling reason (e.g., an immediate danger to self or others) to authorize a direct  
 331 admission to the hospital. As is reflected in Table-5, the State is having some success in  
 332 that 78.57% of the relevant admissions to DBH were pre-evaluated at the RRC in 2014,  
 333 and this increased to 84.50% in 2015.

334 Because of the delays in launching the Crisis Walk-In Center to serve northern Delaware,  
 335 it is not yet known what impact the new program will have in terms of reducing hospital  
 336 use. Most of the State's IMD admissions come from the northern part of the State, which  
 337 is more heavily populated. And if the new program can replicate the successes of the  
 338 RRC, it is possible that the overall bed use numbers for the State can be reduced  
 339 substantially.

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341 *D. Engagement in Community Services Comprised by the Agreement*

342 As was discussed earlier, one premise underlying the bed-use reductions contained in  
343 sections III.D.3-4 was that the demand for hospital use would decline as the community  
344 services required elsewhere in the Agreement ramped up. Past Monitor reports have  
345 explained how, notwithstanding the State’s success in creating these programs, the  
346 disjointed structure of service management was a barrier for members of the target  
347 population in accessing putatively needed specialized mental health services. The  
348 responsibility for oversight of hospitalized individuals had been disbursed between  
349 DSAMH and DMMA, and the responsibility for referring individuals for the  
350 Agreement’s specialized services was ambiguous, at best. PROMISE not only included a  
351 structure for capturing federal reimbursement for a wide range of community services  
352 relevant to the Agreement’s goals, but it also vastly improved coordination across  
353 systems. Furthermore, over the past year and in collaboration with the Monitor, the State  
354 devised protocols for systematically referring individuals who have SPMI and significant  
355 service needs to DSAMH for its specialized services and supported housing. This was a  
356 very important measure, and one directly related to III.D.3-4 in that, as a threshold  
357 matter, Delaware’s specialized mental health services cannot have an impact on hospital  
358 use if at-risk individuals are not referred for such services. Accordingly, a number of  
359 indices relating to referrals to PROMISE<sup>16</sup> were included in the new approach to  
360 measuring the State’s compliance with these provisions.

361 Table-6 presents data on hospital admissions among individuals who are, or are not,  
362 receiving PROMISE services. It does not present information relating to a full fiscal year  
363 because the program went into effect in January, 2015 (6 months into FY 2015) and 6-  
364 month data for FY 2016 (July through December, 2015).<sup>17</sup> These statistics provide  
365 important information about who is being admitted to hospitals and what community  
366 services they were receiving at the time of admission. In FY 2015 and FY 2016, the  
367 available data show that only 13.5% and 11.4%, respectively, of hospital admissions  
368 related to individuals who were receiving DSAMH/PROMISE services—in other words,  
369 the specialized services required by the Agreement. Over 85% of acute admissions,  
370 whether considered in absolute numbers or as unduplicated counts, related to individuals  
371 diagnosed with SPMI upon discharge who were not receiving specialized mental health  
372 services. The full implications of this are not clear cut. For instance, it is likely that a  
373 large number of these admissions, particularly the “one-and-done” admissions that are  
374 discussed later in this report, relate to individuals who actually do not have SPMI  
375 (notwithstanding their hospital discharge diagnoses) and who primarily require treatment  
376 for substance use, rather than mental illness. DSAMH has a QA initiative, which is  
377 discussed later, that may help clarify whether this is, in fact, the case. Nevertheless, the  
378 low representation of people who are receiving DSAMH or PROMISE services among

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<sup>16</sup> Referrals to PROMISE are essentially referrals for DSAMH services.

<sup>17</sup> Unless otherwise noted, all FY 2016 data referenced in this report is for the 6-month period July through December, 2015.

	FY15 (Jan thru Jun)		FY16 (Jul thru Dec)	
	Number	%	Number	%
<b>Total Hospital Admissions</b>	<b>1813</b>		<b>1661</b>	
DSAMH/PROMISE Clients*	245	13.5%	189	11.4%
Others w/ SPMI and Medicaid Coverage	1568	86.5%	1472	88.6%
<b>Unduplicated Hospital Admissions</b>	<b>1369</b>		<b>1243</b>	
DSAMH/PROMISE Clients	161	11.8%	130	10.5%
Others w/ SPMI and Medicaid Coverage	1199	87.6%	1109	89.2%
Admissions of the same individual with and without PROMISE	9	0.7%	4	0.3%
*These individuals have been presumptively determined to be eligible for PROMISE because they are being served by ACT, Intensive Care Management, or in a group home.				

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381 those admitted to psychiatric hospitals does lend credence to the hypothesis underlying  
 382 the bed-use reduction targets in III.D.3-4 that intensive community services reduce the  
 383 risk of hospitalization—particularly so, because these individuals have been determined  
 384 through the DSAMH/PROMISE eligibility processes to have SPMI and significant  
 385 service needs.

386 Table-7 presents data on the State’s progress in referring new individuals for specialized  
 387 mental health services, to reiterate, a process that had been very poorly coordinated and  
 388 managed prior to PROMISE. Since PROMISE went into effect in January, 2015, the  
 389 State has streamlined the application process for specialty mental health services and has  
 390 been working closely with the Managed Care Organizations (MCOs)<sup>18</sup> to ensure that  
 391 people with SPMI are systematically referred when they meet certain triggers (such as  
 392 repeated hospitalizations). Between January, 2015 and May 1, 2016, 2,877 individuals  
 393 were referred to PROMISE. Of these, 843 individuals had been diagnosed with SPMI,  
 394 but had not been receiving specialized mental health services. In other words, one in  
 395 three referrals to PROMISE relate to individuals who had not been receiving ACT,  
 396 Intensive Care Management (ICM), CRISP, or supported housing. Of this group, 541  
 397 referrals were made by the MCOs. The data presented in Table-7 are new, and the State  
 398 plans to present more detailed information in the future (for instance with regard to  
 399 determination of ineligibility, client refusal, the number of individuals receiving the  
 400 various services covered by PROMISE, and so on), but for purposes here, they do  
 401 demonstrate that the State has made a significant effort to enroll members of the target

<sup>18</sup> Two MCOs operate under contract with DMMA as part of the administration of the State’s Medicaid program.

402 population in PROMISE, thereby affording them access to the array of services required  
 403 by the Agreement as well as other community supports.

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Table-7 PROMISE Referral Breakdown 1-1-15 through 4/30/16	
<b>Sources of Referrals</b>	
Number of referrals for PROMISE services	2877
Active DSAMH clients (ACT, CRISP, ICM, etc.)	2024
New referrals	853
via direct MCO referral	541
via other referral sources	312
<b>Determination Status</b>	
Number of referrals for PROMISE services	2877
Approved	1808
Pending	356
Closed (Ineligible, Moved, Refused, etc.)	713

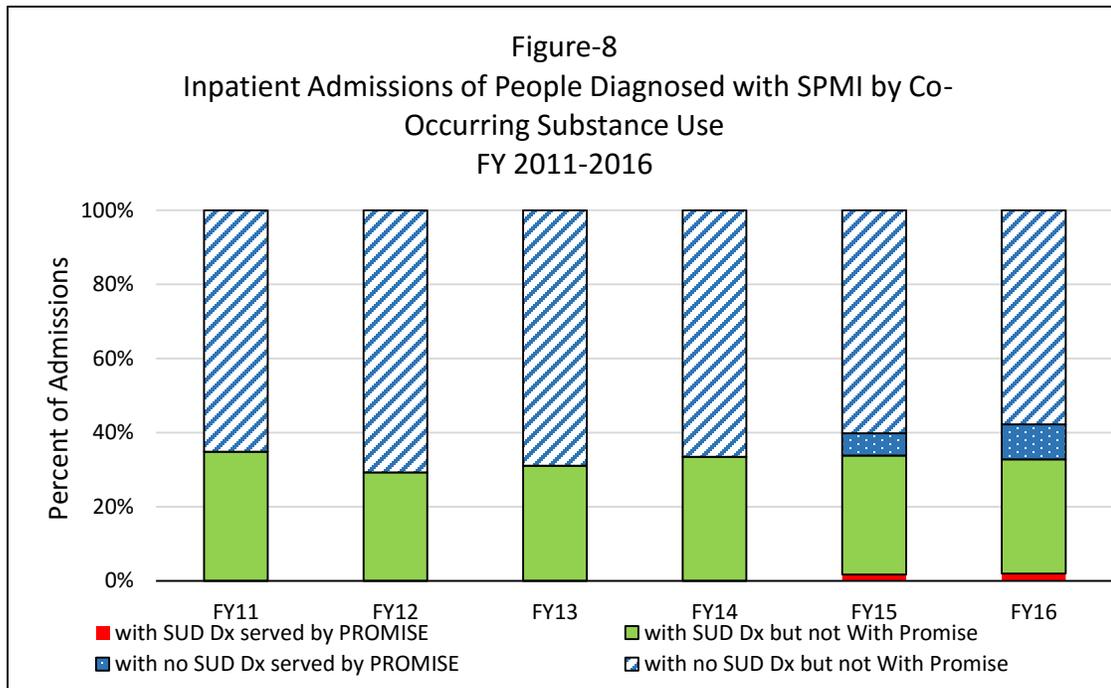
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407 *E. Co-Occurring Substance Use*

408 Based upon consultation with a number of parties active in monitoring or implementing  
 409 inpatient psychiatric admissions (among them, the two MCOs) and IMD chart reviews, it  
 410 is likely that a sizable number of the acute care psychiatric admissions to the IMDs  
 411 associated with SPMI diagnoses actually relate primarily to problems attendant to  
 412 substance use. To the extent that this is the case, these admissions may artificially inflate  
 413 the count of bed-days that the State is reporting by relying upon Medicaid claims data. To  
 414 further understand this issue, as well as the degree to which substance use problems are  
 415 being appropriately addressed for the target population, as a part of the new process for  
 416 evaluating sections III.D.3-4 the State is now reporting data relating to co-occurring  
 417 substance use among people diagnosed with SPMI who are admitted for acute psychiatric  
 418 care.

419 Figure-8 summarizes this information for all inpatient admissions (IMDs and DPC) from  
 420 fiscal year 2011 through the first six months of fiscal year 2016. Overall, substance use  
 421 diagnoses co-occur with diagnoses of SPMI in about 30-35% of the acute care  
 422 admissions during the period reported. While this proportion has remained relatively  
 423 stable since the base year, since the number of hospital admissions has risen, the absolute  
 424 numbers of admissions and bed-days represented by people with substance use diagnoses  
 425 has increased as well. The State has data relating to individuals in PROMISE only from  
 426 January 1, 2015 forward, and these early statistics show that somewhere in the



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neighborhood of 5% of total admissions related to individuals who have been reviewed by DSAMH and determined eligible for PROMISE services (and thus, with a fairly high degree of certainty, have SPMI). A total of 1,650 individuals who were admitted for acute psychiatric care during fiscal year 2015 and the first six months of 2016 who had both SPMI and substance use diagnoses. Of them, only 85—or 5%—related to individuals in PROMISE (most of whom received specialized mental health services through DSAMH). The remaining 95% of these admissions (1,565) who were not in PROMISE and may include the individuals referenced above whose needs are primarily for substance use treatment. In other words, based on the diagnoses of record upon their hospital discharge, about one-third of the hospital admissions related to people with co-occurring substance use and SPMI, but only 5% of them were determined to need specialized serves funded by the State to address the needs of individuals who have SPMI.

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443 *F. Homelessness*

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The Agreement identifies homelessness as a factor that places members of the target population at elevated risk of unnecessary institutionalization (section II.B.2.f). Particularly in light of past reporting by the Monitor that found that IMDs were sometimes discharging homeless individuals back to unstable living environments, the measures relating to the State’s efforts to address this issue were included among the new measures of compliance with III.D.3-4. As was described in the Monitor’s Eighth report, beginning in March, 2015, the State launched a new initiative to ensure that members of

451 the target population were not being discharged from hospitals back into cycles of  
 452 homelessness.

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<b>Table-8</b> Target Population IMD Homelessness Initiative Outcomes March, 2015 Through November, 2015				
	FY15 (Mar thru Jun)		FY16 (Jul thru Nov)	
	Number	%	Number	%
<b>Total State-Funded IMD Admissions</b>	<b>966</b>		<b>1,248</b>	
<b>Homeless</b>	<b>47</b>	<b>4.87%</b>	<b>81</b>	<b>6.49%</b>
Receiving DSAMH Services	9	19.15%	11	13.58%
Referred for EEU/TCM	11	23.40%	21	25.93%
Referred for TCM Only	19	40.43%	40	49.38%
<b>Discharged to shelters</b>	<b>8</b>	<b>17.02%</b>	<b>10</b>	<b>12.35%</b>
Dover	1	12.50%	9	90.00%
MeadowWood	1	12.50%	1	10.00%
Rockford	6	75.00%	0	0.00%

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455 Table-8 presents data from the inception of this initiative through November of 2015  
 456 reflecting the identification of homelessness among hospitalized members of the target  
 457 population and actions taken.<sup>19</sup> The table shows that for the portion of fiscal years 2015  
 458 and 2016 that are reported, 4.87% and 6.49%, respectively, of IMD admissions of the  
 459 target population were identified as being homeless. A minority of these homeless  
 460 individuals—19.15% in 2015 and 13.58% in 2016—were receiving some level of  
 461 DSAMH services at the time of admission. The remainder were either referred for  
 462 specialized services (via DSAMH’s Eligibility and Enrollment Unit, or “EEU”) or to  
 463 Targeted Care Management (“TCM”) through which they can be linked to other services,  
 464 including substance use services. All of the individuals identified with SPMI who were  
 465 not already referred for housing services were referred for such services through this  
 466 important initiative. Table-8 also includes data relating to discharges from specific IMDs  
 467 to homeless shelters.<sup>20</sup> Although the numbers are small and preliminary, it is notable that

<sup>19</sup> It is noted that these data reflect only those homeless individuals who were admitted for psychiatric inpatient care. Homeless individuals touching the mental health system at other points are also referred for housing services as indicated, but they are not included in this initiative.

<sup>20</sup> The data in this table relate to the three IMDs only, not to DPC. Except in extraordinary circumstances, DPC does not discharge individuals to shelters, and referrals for housing have been a routine component of DPC’s discharge process for some time.

468 in fiscal year 2016, 90% of the shelter discharges were from Dover Behavioral Health  
 469 IMD, which serves the southern part of the State where resources have been historically  
 470 scarcer than in northern Delaware.

471

472 *G. Readmissions*

473 Representing another measure of the State’s effectiveness in linking members of the  
 474 target population with needed services and reducing unnecessary hospitalizations, the  
 475 State is now reporting readmission rates associated with each of the categories reflecting  
 476 the duration of hospitalizations. Table-9 present readmission data for individuals who  
 477 were hospitalized in fiscal year 2014, the most recent year for which it compiled data in

Table-9 Hospital Readmission Rates by Duration of Hospitalization for Individuals Discharged in FY 2014									
Duration of Hospitalization	Number of Discharges	1-30 Days		31-90 Days		91-180 Days		181-365 Days	
		n	%	n	%	n	%	n	%
Acute Care	2042	349	17.09%	231	11.31%	204	9.99%	236	11.56%
Intermediate-I	238	44	18.49%	25	10.50%	20	8.40%	31	13.03%
Intermediate-II	90	8	8.89%	6	6.67%	5	5.56%	8	8.89%
Long Term	27	0	0.00%	0	0.00%	0	0.00%	0	0.00%
<b>Total</b>	<b>2397</b>	<b>401</b>	<b>16.73%</b>	<b>262</b>	<b>10.93%</b>	<b>229</b>	<b>9.55%</b>	<b>275</b>	<b>11.47%</b>

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479 reporting this new measure. The Acute Care data relate to individuals with hospital  
 480 episodes lasting 14 days or fewer; most of these were in the IMDs, but some also  
 481 occurred among individuals treated at DPC. In the Intermediate categories and in Long  
 482 Term care, overwhelmingly, the discharges relate to individuals who were treated at  
 483 DPC. From a clinical perspective, as the hospitalization classifications proceed from  
 484 Acute Care to Long Term care, individuals are presenting increasingly complex issues  
 485 that necessitate extended inpatient stays. Nevertheless, with only a couple of exceptions,  
 486 the readmission rates are successively lower as the clinical complexity increases, to the  
 487 point that *none* of the 27 individuals who were discharged to the community following  
 488 long-term stays at DPC were readmitted within a year.

489

490 *H. Quality Assurance Initiatives relating to Inpatient Bed Use*

491 In addition to the measures highlighted above, the parties agreed that the State would  
 492 initiate and report on QA activities that are specifically directed to factors identified

493 through the data dashboard (Table-1) that appear to underlie the increases in acute-care  
494 bed use. Some of these initiatives were ongoing within DSAMH and others were  
495 planned in collaboration with the Monitor. Among the QA actions the State has taken in  
496 this regard are:

- 497 1. A study of high-end users (at DPC and/or an IMD), as defined by: four or  
498 more hospitalizations, 30 days of inpatient care within a one-year period, or  
499 three hospital admissions within any 90-day period. A scan of various data  
500 sources revealed that 41 individuals met one or more of these criteria within  
501 the 2015 calendar year. DSAMH established a High-End User Review  
502 Committee which is monitoring the status of and treatment afforded to these  
503 individuals, and is guiding actions to reduce their use of inpatient care.
- 504 2. A study of homeless individuals being admitted to IMDs, aimed at identifying  
505 this population and ensuring referrals to supportive housing or other housing  
506 services. This initiative, which is ongoing, produced the data presented in  
507 Table-8.
- 508 3. A study of Single-Episode Hospital Utilization, now underway, which is  
509 examining case records of a sample of individuals who have diagnoses of  
510 SPMI upon discharge from an IMD, but who have no further encounters with  
511 the system for extended periods of time, thus raising questions about their  
512 diagnoses and possibly skewing data relating to inpatient bed use of the target  
513 population. This study was referenced above in Section D.

514 These QA studies are in various stages of implementation, but the State should be able to  
515 demonstrate how they are being used to drive refinements in practices aimed at reducing  
516 psychiatric hospital use among the target population. Further information about the  
517 State's QA processes is presented later in this report.

518

### 519 Summary

520 The qualified rating with regard to Crisis Stabilization Services, "Moving Towards  
521 Substantial Compliance," is not based on any single measure, but on the totality of  
522 quantitative measures and QA activities that are summarized above. The State has made a  
523 significant effort to generate the required data and to move forward with QA measures  
524 pursuant to the agreed upon plan for evaluating hospital use by the target population.  
525 Given that the agreement of the parties about how compliance with sections III.D.3-4  
526 would be evaluated occurred only about three months ago, the State's ability to create a  
527 new data dashboard, to compile underlying data, and to begin analyses is, without  
528 question, impressive.

529 Further, the data show areas where the State is being successful in addressing issues  
530 closely related to sections III.D.3-4, for instance:

- 531 a. It has significantly reduced the census at DPC, particularly with respect to long-  
532 term institutionalization.
- 533 b. While acute psychiatric hospitalizations have increased, these are of short  
534 duration (averaging 6.4 days).
- 535 c. Only a small number of hospitalizations exceed the acute care period of 14 days;  
536 out of 3,267 admissions in fiscal year 2015, 2,790—or 85%—lasted 14 days or  
537 fewer and only 15% exceeded 14 days.
- 538 d. Of those hospitalizations extending beyond 14 days, 70% (334 admissions out of  
539 477 in fiscal year 2015) were classified as Intermediate-I, with an average length  
540 of stay of 21.6 days.
- 541 e. Only a small number of people who remain hospitalized longer than 14 days are  
542 not discharged within 30 days of a determination that they no longer need  
543 hospital care. The State is examining systemic barriers to their timely discharge,  
544 for instance, whether ACT teams and other high-end services are appropriately  
545 moving clients through their programs, thereby creating vacancies to  
546 accommodate hospitalized individuals.
- 547 f. People who are receiving the services required under the Agreement account for  
548 only 10.5% of hospital admissions.
- 549 g. The State is actively enrolling individuals in PROMISE services.
- 550 h. The State has working plan in place to identify homeless individuals and to link  
551 them with housing and other services.

552

553 Not surprisingly, the data also show some areas that require further investigation and  
554 action to address what may well be unnecessary psychiatric hospitalizations (e.g., single  
555 episode hospitalizations by individuals who may actually have primary needs for  
556 substance use treatment) or repeated hospitalizations (e.g., high-end users). In these  
557 instances, the State has launched efforts to further understand underlying factors so that it  
558 can implement interventions accordingly. Largely as a result of the recency of the  
559 parties' agreement about these measures, there is not yet sufficient evidence of the State's  
560 use of these data or of the impact of its related QA activities. For this reason, it is being  
561 rated as "Moving Towards Substantial Compliance" at this time with regard to these  
562 important Crisis Stabilization provisions.

563 To demonstrate that it is fully meeting and sustaining the agreed upon requirements, the  
564 State will need to:

- 565 1. Continue its collection of data, as delineated in Table-1;
- 566 2. Provide the Monitor with findings, action steps, and outcome measures  
567 associated with QA activities, including those referenced above;

- 568 3. Evaluate and address the factors that are creating delays in discharging
- 569 individuals from DPC when they need ACT or CRISP services, including
- 570 whether individuals currently served through those programs could be
- 571 more appropriately served elsewhere in the system, thereby creating
- 572 vacancies for people at DPC; and
  
- 573 4. Provide the Monitor with documentation of how the agreed upon data sets
- 574 and QA findings are being used to better understand hospital use by the
- 575 Agreement’s targeted priority population and to drive activities aimed at
- 576 reducing hospitalizations among this group.

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578 B. Discharge Planning

579 *Substantial Compliance*

580 The Monitor’s eighth report found that the State was making progress with respect to the

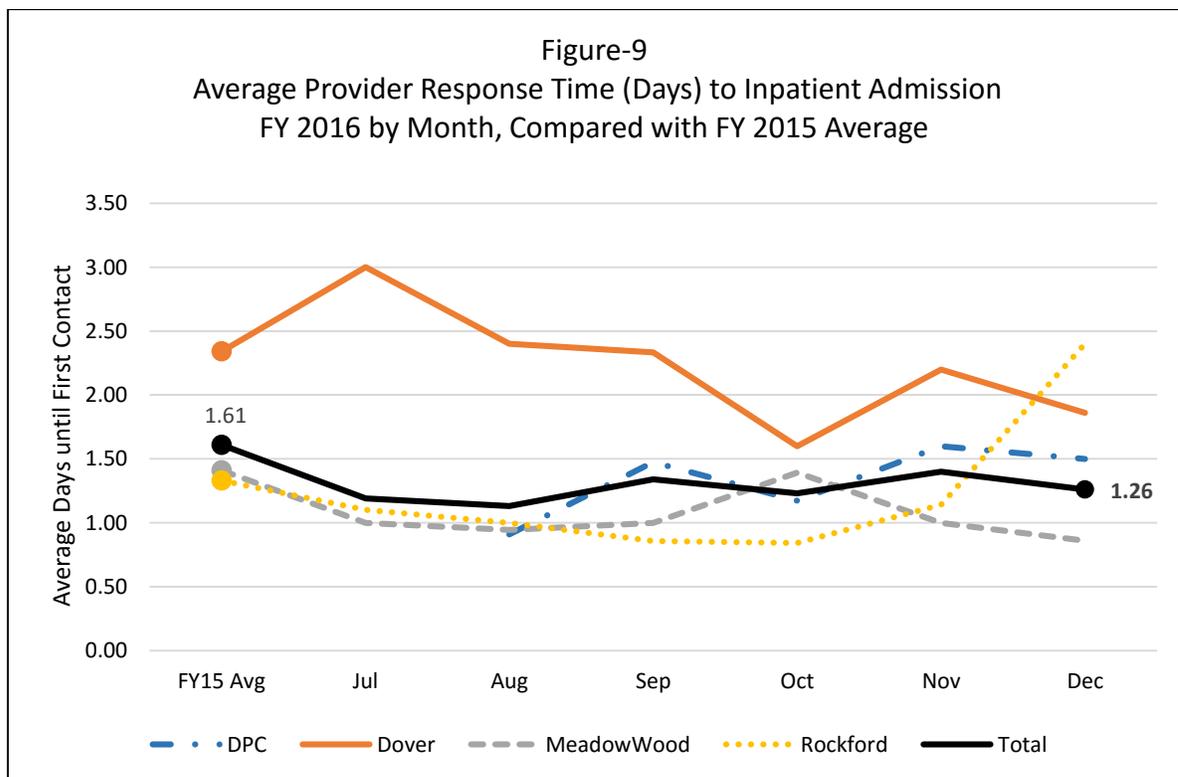
581 Agreement’s discharge planning provisions II.C.2.d.iii-iv, but that additional documentation

582 was required to demonstrate that it is meeting its obligations. Notably, it was missing

583 tracking data relating to the timely engagement of community providers at DPC. It has

584 since provided the necessary data to demonstrate Substantial Compliance.

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587 Figure-9 presents response time tracking for community providers in each inpatient  
588 setting. This information is a part of the State’s monthly data dashboard and trends are  
589 being monitored accordingly. Figure-9 also shows that the average length of time  
590 between an individual’s hospital admission and contact from the individual’s community  
591 provider was 1.61 days in fiscal year 2015, but that figure dropped to 1.26 days as of  
592 December, 2015. As has been described in earlier Monitor reports, many of these  
593 encounters are doctor-to-doctor, which are important interactions to facilitate  
594 coordination of care.

595

## 596 C. Quality Assurance and Performance Improvement

### 597 *Substantial Compliance*

598 The last Monitor’s report noted that the State has been conducting Quality Assurance and  
599 Performance Improvement (QA) activities and that sometimes these drive system  
600 improvements, but that too often these activities existed in isolation and were not part of the  
601 system wide QA program required by the Agreement in section V.A. Since that report, the  
602 DSAMH has reconfigured its QA system and formed a Quality Control Steering Committee  
603 as the hub of its QA activities. This committee, which is advisory to the DSAMH Director,  
604 the DSAMH Medical Director, and the Secretary of Health and Social Services, coordinates  
605 QA activities, data analyses, and corrective actions. Its scope includes inpatient mental  
606 health settings (including DPC and the IMDs), mental health community programs, and  
607 DSAMH’s substance use programs. In addition to the three QA initiatives referenced earlier  
608 with regard to Crisis Stabilization Services, the QA program includes a number of initiatives  
609 relevant to the requirements of the Agreement, including:

- 610 1. A Quality Process Review of Assertive Community Treatment (ACT) and Intensive  
611 Care Management (ICM)<sup>21</sup> that has been ongoing since 2015.
- 612 2. An investigation of how homelessness affected lengths of stay among members of  
613 the target population who were hospitalized at DPC, which was initiated in 2015.
- 614 3. A study of rates of court commitment for inpatient or outpatient treatment (initiated  
615 in 2014 and referenced in past Monitor reports), which shows the systems impressive  
616 move toward voluntary treatment.<sup>22</sup>
- 617 4. Monthly QA meetings between DSAMH and the IMDs to resolve problems in care,  
618 including coordination and information sharing between hospital and community  
619 providers; this initiative was launched early in 2016.
- 620 5. An initiative to incorporate into practice data from the evaluation of DSAMH’s  
621 CRISP program that has been a product of the ongoing partnership between the State

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<sup>21</sup> ACT and ICM are programs required by the Agreement.

<sup>22</sup> The State’s new data dashboard includes related data (see Table-1, items 7a and 7b).

622 and the University of Pennsylvania (this research has been noted in past Monitor  
623 reports).

624 6. An investigation of the needs of individuals living in community housing who have  
625 complex challenges, particularly with respect to addressing Activities of Daily  
626 Living. This program was initiated in 2015.

627 7. A Client Death Review investigation focusing on deaths occurring outside of  
628 hospital settings. This study is a component of DSAMH’s risk management  
629 activities, which are discussed below.  
630

631 In summary, DSAMH has made palpable progress in not only expanding its program of  
632 Quality Assurance and Performance Improvement, but in reconfiguring it to effectively  
633 provide system-wide monitoring and refinement. It is now in Substantial Compliance with  
634 the requirements of the Agreement contained in section V.A.

635

#### 636 D. Risk Management

##### 637 *Partial Compliance*

638 The last report of the Monitor referenced the State’s disjointed risk management system that  
639 largely represented an accumulation of various isolated measures over many years. That  
640 report also noted that measures were underway to restructure and streamline the reporting of  
641 adverse events system-wide and to create a centralized process for investigating these  
642 events, implementing corrective actions, and identifying and addressing patterns of elevated  
643 risk. While these reforms are still being phased in, the State has reached the point where a  
644 functional risk management system is now operational, but not completely so.

645 The Monitor’s December, 2015, report noted a key, longstanding issue with respect to  
646 evaluating the State’s compliance with the Agreement:<sup>23</sup> “[the State] has provided no data  
647 relating to IMDs and it is unclear whether the State is even receiving such information in  
648 conformance with Sections V.B.8.”<sup>24</sup> An effective Risk Management program that includes  
649 the IMDs is highly relevant to the Agreement. As a general matter, Risk Management deals  
650 with abuse, neglect and serious issues up to and including deaths, so it plays a very  
651 important role with respect to reducing the possibility of physical and psychological harm.  
652 Secondly, the IMDs play a very significant role in serving the target population; in 2015,  
653 they accounted for 89% of the hospitalizations covered by the Agreement (2,926 out of a  
654 total of 3,267 admissions). Thirdly, by virtue of the fact that these admissions involve  
655 individuals in acute mental health crises—including situations where there is an immediate  
656 danger to self or others—and sometimes involuntary treatment orders, IMD hospitalizations  
657 may entail an elevated risk of adverse events, allegations of abuse, and so on. Finally, IMDs

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<sup>23</sup> The risk management provisions of the Agreement pertain to individuals with SPMI who receive mental health services (whether in the community, DCP or IMDs) paid for by the State (i.e., DSAMH or DMMA).

<sup>24</sup> Monitor’s Eighth Report, line 788.

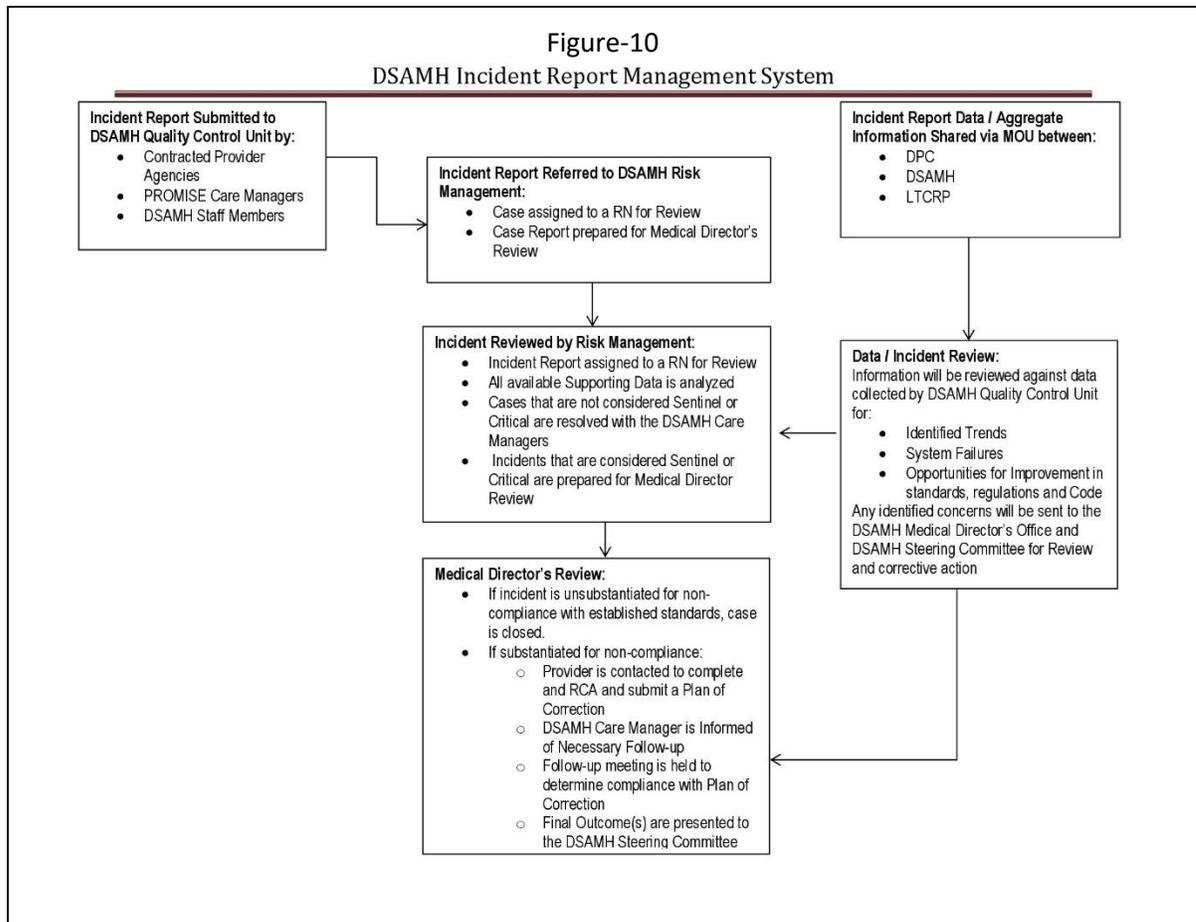
658 are specifically referenced in the Risk Management provisions of the Agreement (sections  
659 V.B.1, 4, 5, 6, 8, and 9). For all of these reasons, it is critical that IMDs be fully integrated  
660 into Risk Management activities relevant to the Agreement for the State to demonstrate  
661 Substantial Compliance.

662 A key barrier to such integration is that reporting and investigations of adverse events in  
663 IMDs do not automatically go to DSAMH, but instead to other state agencies within the  
664 Department of Health and Social Services. In May, 2016, the State drafted a Memorandum  
665 of Understanding (MOU) between DSAMH, the Division of Long Term Care Residents  
666 Protection, and the Division of Public Health that is intended to remedy this disjointed  
667 reporting arrangement, but it may not go far enough. It would allow a sharing of  
668 information relating to reports of abuse, neglect, mistreatment, financial exploitation, and  
669 deaths occurring due to the use of seclusion or restraints in IMDs. The draft MOU does not  
670 specifically address serious injuries or deaths that may occur in situations not involving the  
671 use of seclusion or restraints in IMDs, and therefore, may limit the reach of the risk  
672 management process discussed below (see Figure-10). The MOU calls for regular  
673 collaborative meetings among the Divisions affected, as well as joint risk management  
674 activities, including oversight of needed corrective actions within the IMDs. As of this  
675 writing, the MOU has not yet been executed.

676 In response to a request for examples of recent investigations in IMDs, the State provided  
677 documents that do not allow a meaningful assessment of how risk management processes  
678 now being carried out through other DHSS divisions align with the requirements of the  
679 Agreement. These examples of recent investigations—some of which were conducted by  
680 the federal Centers for Medicare and Medicaid Services and others by the State—were  
681 redacted so that any patient-level information was missing (even though numeric patient  
682 identifiers, rather than names were apparently used). Thus, essential information relating to  
683 the specific nature of the complaints and investigatory findings was deleted. While there  
684 were some instances where corrective actions by the IMDs were referenced, whether they  
685 were appropriately responsive to the presenting complaint and how they connect to any  
686 larger risk management endeavor were not at all apparent. Furthermore, the State provided  
687 no aggregate information as to the overall number of investigations, the nature of complaints  
688 being received, actions taken by the responsible state agency, and so on.

689 Within DSAMH programs, including DPC and community providers relevant to the  
690 Agreement, the situation is quite different. The State has made improvements in its Risk  
691 Management system, including the reporting of adverse events, the investigation process,  
692 and tracking of corrective measures. DSAMH provided several examples of investigations  
693 of critical incidents, including its new process for reporting incidents that includes reviews  
694 of relevant clinical documentation by a registered nurse and final reviews by the DSAMH  
695 medical director. As a part of the medical director's review, there is a determination as to  
696 whether a root cause analysis (RCA) is indicated. DSAMH also provided documentation  
697 showing that when RCAs are conducted, as has been noted in past Monitor reports, they are  
698 thorough and are used as opportunities to identify areas for program improvement.

699 Figure-10 presents an overview of how DSAMH’s risk management system functions,  
 700 including how information relating to incidents in the IMDs (i.e., information to be shared  
 701 via the inter-divisional MOU) will be incorporated into the process. As is depicted in this  
 702 flow chart, the medical director plays a direct and key role in ensuring that appropriate  
 703 actions are taken in response to sentinel events<sup>25</sup> or other critical incidents. In addition, the  
 704 medical director reviews trending data, performance improvement data, and other  
 705 information collected by the DSAMH Quality Control staff. Ultimately, information  
 706 relating to risk management is integrated with the Division’s overall QA functions through  
 707 the Quality Control Steering Committee which is referenced in the previous section.



708  
 709 For instance, the ongoing QA initiative that is analyzing deaths occurring outside of hospital  
 710 settings has very important implications in terms of risk management.

711 In summary, the State continues to make progress in its Risk Management system, as  
 712 required by the Agreement, but such progress with respect to the IMDs is notably lagging  
 713 behind. Largely for this reason, the State is evaluated as being in Partial Compliance with  
 714 respect to sections V.B.1-9.

<sup>25</sup> A Sentinel Event is a term used by The Joint Commission, a healthcare accrediting body, to refer to any unanticipated event resulting in death or serious physical or psychological injury to a patient.

715 For the State to demonstrate Substantial Compliance with the Agreement’s Risk  
716 Management provisions, it is recommended that it:

- 717 1. Continue its progress in improving Risk Management for events occurring at  
718 DPC or in community programs operating under contract with DSAMH;
- 719 2. Meaningfully integrate reporting, investigations, and corrective actions  
720 associated with events occurring within IMDs relating to the target  
721 population, including all events relating to serious injury or deaths in IMDs  
722 involving members of the target population;
- 723 3. Provide documentation to the Monitor on how events relating to care in IMDs  
724 are reported, including legal or regulatory requirements for such reporting;  
725 how consumers or other stakeholders can file complaints and how they are  
726 apprised of this process; and what actions ensue once a report of an incident is  
727 received;
- 728 4. Collect and analyze monthly information relating to the number of incidents,  
729 categories of incidents (e.g., death, serious injury, abuse), actions taken  
730 (investigations, root cause analyses, corrective plans), and resolutions with  
731 respect to members of the target population, beginning in fiscal year 2015;
- 732 5. Provide to the Monitor unredacted documentation relating to each incident of  
733 death or serious injury occurring in an IMD (including any incidents of death  
734 or serious injury proximate to care an IMD) with respect to members of the  
735 target population, beginning in fiscal year 2013 forward, including  
736 investigations and all actions taken;
- 737 6. Provide to the Monitor documentation of how events and findings associated  
738 with the care of the target population in IMDs is incorporated in the Quality  
739 Control Steering Committee; and
- 740 7. Otherwise demonstrate that the system is fully in conformance with each of  
741 the provisions of section V.B

742

### 743 **III. Summary:**

744 As is described above, the State has achieved Substantial Compliance for two of the four  
745 provisions found to be in Partial Compliance in the Monitor’s December, 2015 report; it is rated  
746 as Moving Towards Substantial Compliance for a third provision (Crisis Stabilization); and it  
747 remains in Partial Compliance with respect to Risk Management. With regard to the latter two  
748 provisions, this report details specific measures that it should take to demonstrate that it has  
749 achieved Substantial Compliance in accordance with the Agreement’s requirements. The  
750 Agreement includes one additional provision relating to Supported Housing (III.I.6) which has a  
751 target date of July, 1, 2016 and, thus, has not yet been evaluated. Assuming that the State meets  
752 the requirement of that provision, takes the steps detailed above relating to sections III.D and

753 V.B in a complete and timely way, and demonstrates that it will sustain its efforts with respect to  
754 other provisions (as documented in the Monitor's eighth report), it appears to well positioned to  
755 establish that it is fully meeting its obligations under the Agreement.

756

A handwritten signature in cursive script that reads "Robert Bernstein".

757

758 Robert Bernstein, Ph.D.  
759 Court Monitor