EIGHTH 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

12/26/2015

I. Introduction:

This is the eighth report of the Court Monitor (Monitor) on the implementation by the State of Delaware (State) of the above-referenced Settlement Agreement (Agreement). Unless noted otherwise, it is based on compliance data through the State's 2015 fiscal year[1] and is reflective of four years of implementation efforts by the State.

As is detailed below, the State continues to demonstrate progress in meeting the requirements of the Agreement. In those areas where it has not yet demonstrated Substantial Compliance,[2] for the most part the State has put in place active plans toward achieving Substantial Compliance. Some of these plans entail extensive changes in how the State's systems operate in serving individuals with Serious and Persistent Mental Illness (SPMI), but they are not yet fully operational. As a consequence, data relevant to such provisions as inpatient bed-day reductions (Section III.D), Quality Assurance and Performance Improvement (Section V.A), and Risk Management (Section V.B) are either incomplete or not fully reflective of the impact of the State's plans.

In those areas where the State has been demonstrating Substantial Compliance, a core issue at this juncture is whether these reforms, which are directed to promote successful community integration among the targeted population, will be sustained beyond the Agreement's term. Several factors are working in the State's favor. First of all, the Americans with Disabilities Act (ADA) and the U.S. Supreme Court's decision in *Olmstead*[3] —laws that are central to the intent of the Agreement—required the State to make some fundamental changes in its service system relating to the targeted population and in how these services are delivered. Provisions of the Agreement relating to supported housing that is integrated within the larger community (Section II.E), comprehensive crisis services (Section II.C), and peer supports (Section II.G.2) are examples of areas where the State actively worked (and continues to do so) to reorient its workforce and the people it serves to promote person-centered services, personal responsibility, and community integration. The sustainability of these changes is bolstered not only by various

[1] Delaware's 2015 fiscal year runs from July 1, 2014 through June 30, 2015.
[2] 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."
[3] Olmstead v. L.C., 527 U.S. 581 (1999)

ongoing trainings and the emergence of a vibrant peer movement in Delaware, but also by the fact that the State has embedded the principles of the Agreement in its funding structures. Delaware's SRAP program, which provides rental subsidies for integrated housing to people with disabilities, and the modification of its Medicaid program through PROMISE, which captures federal funds for a wide array of services relevant to the Agreement are examples of funding streams that promote the requirements of the Agreement and that cut across bureaucratic boundaries.[4]

PROMISE, which is a modification of the Delaware's Medicaid waiver, received federal approval in late 2014, and the State began implementation of this program in January 2015. It has broad implications that cut across many provisions of the Agreement that are discussed in the next section. To briefly summarize what is a complicated endeavor, Medicaid's PROMISE program vastly expanded the array of covered services that are essential to people with SPMI living in the community in accordance with the goals of the Agreement—peer services, chore and personal support services, employment supports, and respite services are among them. PROMISE has not only affected funding for services, but it has also required the State to make significant changes in how DSAMH, DMMA, the MCOs,[5] and contracted providers interact with regard to services being provided to members of the target population, notably (but not solely) when these individuals are psychiatrically hospitalized. In developing PROMISE procedures, the State sought to address many of the issues of cross-bureaucracy accountability and responsibility that had plagued its prior service arrangements. Although these changes technically went into effect at the beginning of this calendar year, their potential impact is not yet being fully realized.[6] At this juncture, contracts for new or expanded community services are still being rolled out, and while DSAMH, DMMA, and the MCOs are meeting regularly, they are still working through the specific processes for collaboration and improving outcomes. As such, PROMISE was an important, long overdue, step towards creating a more coherent service system for the target population, but it is still a work in progress.

The following section presents the State's status with respect to fulfilling the requirements of the Agreement.

[4] In these instances, the Division of Substance Abuse and Mental Health (DSAMH), the Division of Medicaid and Medical Assistance (DMMA), and the Delaware State Housing Authority (DSHA).

[5] MCOs are Managed Care Organizations that, through contracts with DMMA, manage individuals' Medicaid benefits.

[6] For instance, bed-use for acute psychiatric hospitalization continues to rise, in conflict with the requirements of the Agreement. This is discussed further in the Crisis Stabilization section of this report.

II. Ratings of Compliance with Specific Provisions of the Agreement

Summary of Compliance Ratings

Factor	Reference in the Agreement	Compliance Rating
Crisis Hotline	III.A	Substantial Compliance
Mobile Crisis Services	III.B.1	Substantial Compliance
Crisis Walk-In Centers	III.C	Substantial Compliance
Crisis Stabilization Services	III.D.3-4	Partial Compliance
Crisis Diversion Training	III.A.2, III.B.2, III.C.2, III.D.2	Substantial Compliance
Crisis Apartments	III.E	Substantial Compliance
Assertive Community Treatment	III.F	Substantial Compliance
Intensive Case Management	II.D.2.b, III.G.1-2	Substantial Compliance
Case Management	II.D.2.c.ii, III.H	Substantial Compliance
Supported Housing	III.I.5	Substantial Compliance
Supported Employment	III.J.1-4	Substantial Compliance
Rehabilitation Services	III.K.4	Substantial Compliance
Family & Peer Supports	III.L.1-4	Substantial Compliance
Discharge Planning	III.C.2.d.iii-iv	Partial Compliance
Quality Assurance	V.A	Partial Compliance
Risk Management	V.B.1-10	Partial Compliance

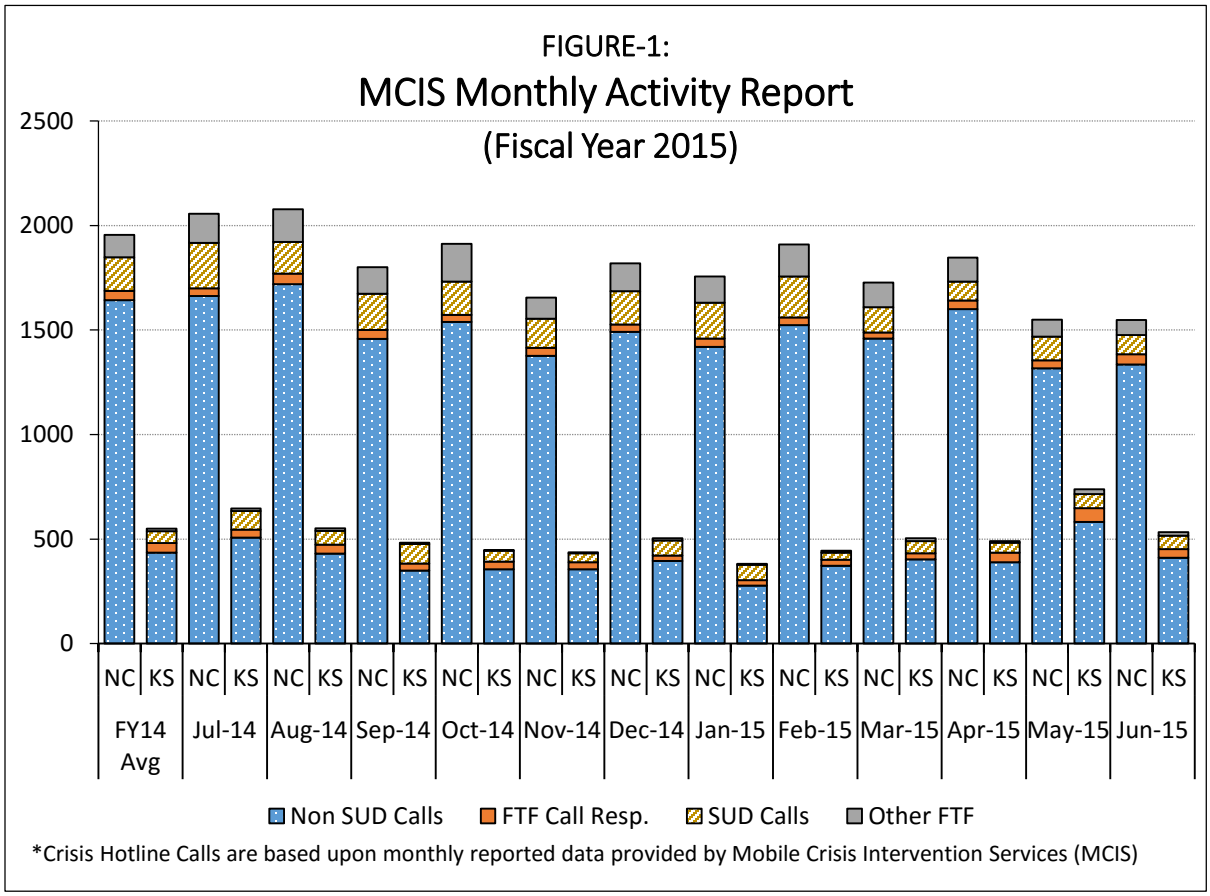
A. Crisis Hotline

Substantial Compliance.

In keeping with the requirements of Section III.A of the Agreement, the State has established and maintained 24-hour crisis hotlines that provide counseling services and, as may be indicated, enable timely access to face-to-face help for individuals who are experiencing mental health emergencies. The Crisis Hotlines are a resource for individuals who are already receiving some level of mental healthcare, and they are also an important point of service entry for individuals with mental health needs who are new to the system.

Figure-1 presents the State's monthly tracking of calls to the Crisis Hotlines from individuals in New Castle County ("NC"), where the bulk of the State's population resides, and for the southern counties of Kent and Sussex ("KS"), which are more rural. The hotlines are well integrated with Mobile Crisis Services, particularly so, because these programs are co-

located. As is indicated in this chart, the majority of the calls are received from individuals who have SPMI and who do not express problems relating to co-occurring substance use ("NON-SUD Calls"). Nevertheless, the State's analysis of Crisis Hotline data over time has revealed significant numbers of callers who are seeking help for substance use ("SUD Calls") and it is now promoting the hotlines for use by individuals who have mental health and/or substance abuse issues.



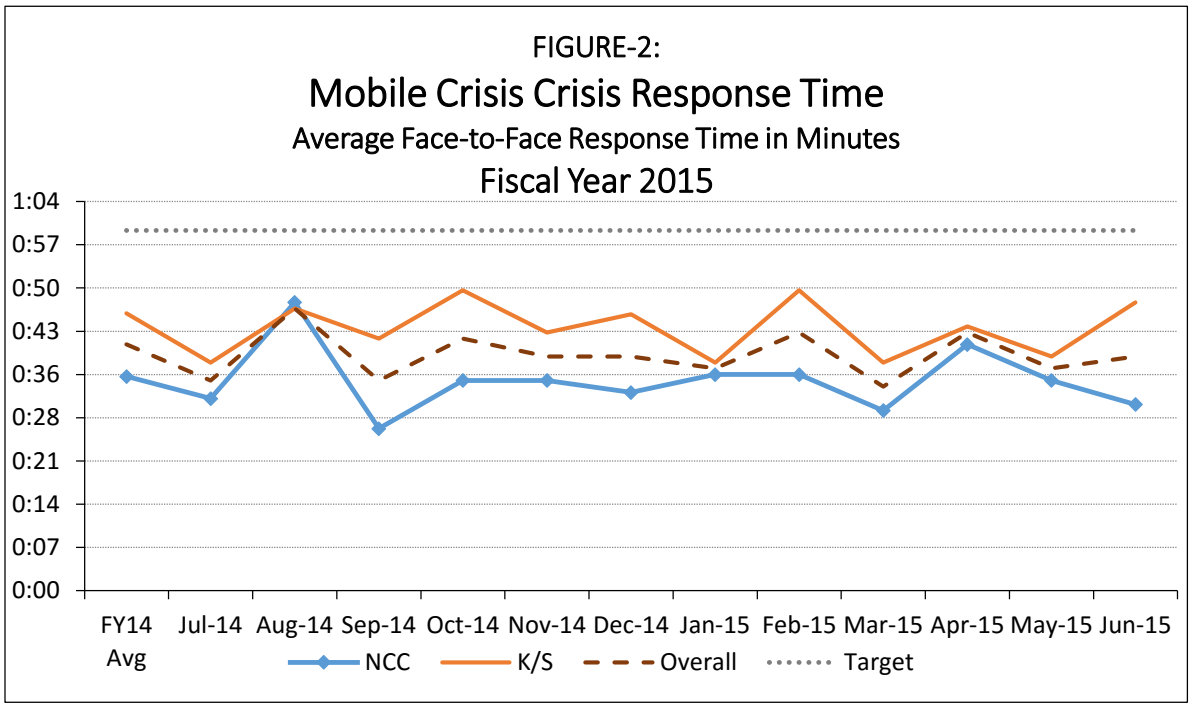
The State remains in Substantial Compliance with Section III.A of the Agreement.

B. Mobile Crisis Services

Substantial Compliance.

The State's Mobile Crisis Service programs provide rapid face-to-face responses to people who are in acute mental health crises. The State operates two such programs, one for New Castle County and one for Kent and Sussex Counties. Generally, calls for this service are received through the Crisis Hotlines, which provide preliminary screening, data-gathering and, as indicated, immediate phone counseling while the Mobile Crisis staff is en route. As is reflected in Figure-1, a substantial number of the calls received through the Hotlines are addressed

through interventions by phone; those that are determined to require a face-to-face response ("FTF Call Resp") present a need for rapid in-person intervention by a mental health professional.



In keeping with the urgent nature of such interventions, Section III.B.1 of the Agreement sets a standard that Mobile Crisis programs provide in-person services statewide within one hour of referral. The State maintains detailed data relating to this requirement. In the past, it has been able to meet the Agreement's standard and, as is reflected in Figure-2, it continues to maintain compliance. Often, the involvement of Mobile Crisis staff does not entail just a single encounter, but also a short-term, continuing role in resolving the emergency situation and ensuring a seamless transition to ongoing services. Depending upon specific circumstances, such involvement by Mobile Crisis may be carried out by phone or by additional face-to-face visits ("Other FTF" in Figure-1).

The State remains in Substantial Compliance with respect to the Agreement's requirements for Mobile Crisis Services.

C. Crisis Walk-In Centers

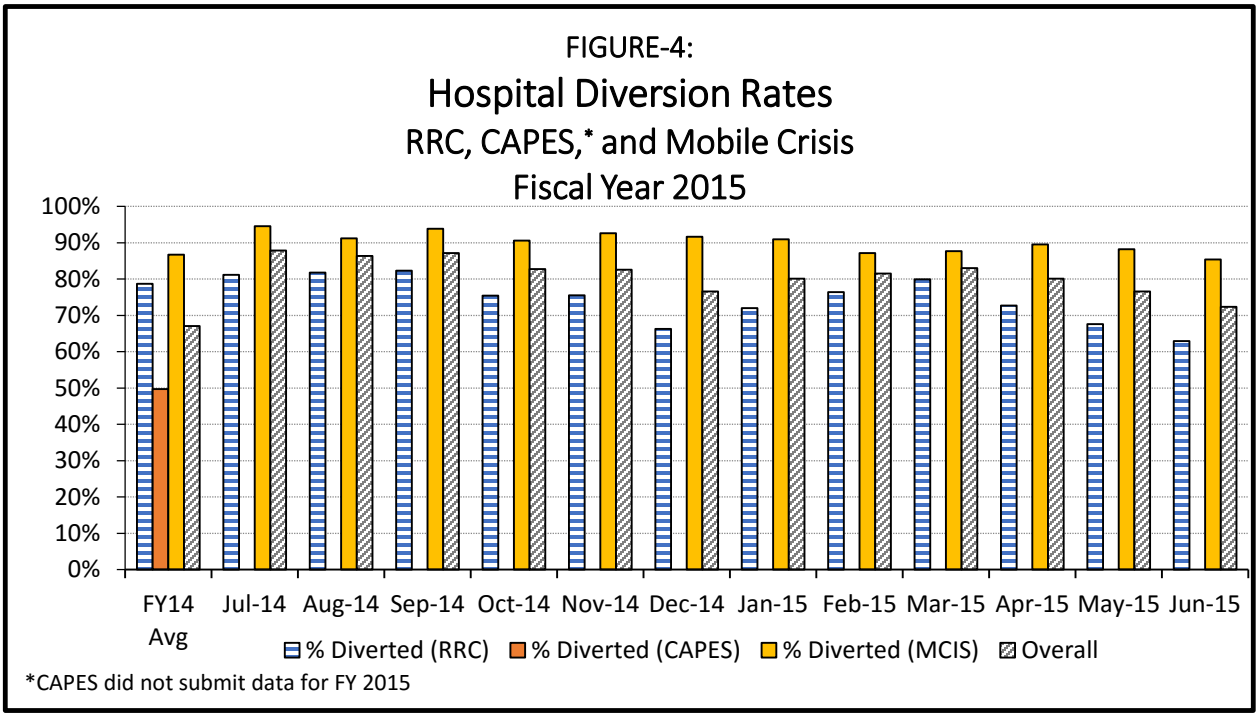
Substantial Compliance.

Section III.C of the Agreement requires the State to operate at least two 24-hour Crisis Walk-In Centers that provide assessment and short-term treatment services to individuals who are experiencing psychiatric emergencies. The term "walk-in center" may be a bit of a misnomer

in that it can suggest a program geared to people who have relatively low levels of need and who come in on their own for help. Indeed, there are such individuals being served through this program, but more typically, the State's Crisis Walk-In Centers serve people in acute crisis who are at very high risk of admission to a psychiatric hospital and whose needs are urgent. They commonly are transferred from the emergency rooms of general hospitals and are often brought to the Centers by police.

Delaware's mental health law includes provisions for the emergency detention of individuals at a designated psychiatric facility when, as a result of mental illness, there is a substantial risk of danger to self or others.[7] The purpose of such 24-hour detentions is to determine if the individual meets the legal criteria for involuntary hospitalization and whether such hospitalization is the least restrictive and most appropriate intervention to address the presenting issues. Historically, these evaluations have occurred at IMDs[8] where the detentions almost invariably result in hospitalization (either involuntary or voluntary). Recognizing this outcome and that the purpose of the 24-hour detention is to determine the need for hospitalization rather than to be an aspect of hospitalization, the State has taken measures to better differentiate these functions. Accordingly, in the southern counties, DSAMH's Enrollment and Eligibility Unit (EEU) directs the individuals subject to 24-hour detentions to the Recovery Resource Center (RRC)[9] unless there is a compelling reason to do otherwise.[10]

FIGURE-4:



[7] 16 Del.C § 5004.

[8] IMDs (Institutions for Mental Diseases, in Medicaid parlance) are freestanding psychiatric hospitals. Delaware has three such facilities: Rockford, MeadowWood, and Dover Behavioral Health.

[9] Prior reports of the Monitor have described this successful Crisis Walk-In program in Ellendale, Delaware.

[10] Examples of such reasons are that the RRC is full or that the individual presents an urgent danger of harm.

As is presented in Figure-4, RRC has demonstrated impressively high rates of diverting individuals from hospitalization, including those being evaluated under 24-hour detention orders. As has been discussed in previous Monitor reports, the State is developing a new Crisis Walk-In Center, patterned after the RRC and its "living room" model, to serve New Castle County. That facility is currently under construction. Once it is operational, EEU will direct individuals under 24-Hour Detention orders to that facility as it currently does in the State's southern counties. Until the new facility opens (likely early in 2016), CAPES—the Crisis Walk-In Center located in a general hospital—continues to provide services to the northern part of the state, including 24-Hour Detention evaluations for some individuals and a significant number of individuals continue to be evaluated at an IMD.

The State is in Substantial Compliance with the Agreement's requirements with respect to Crisis Walk-In Centers.

D. Crisis Stabilization Services

Partial Compliance.

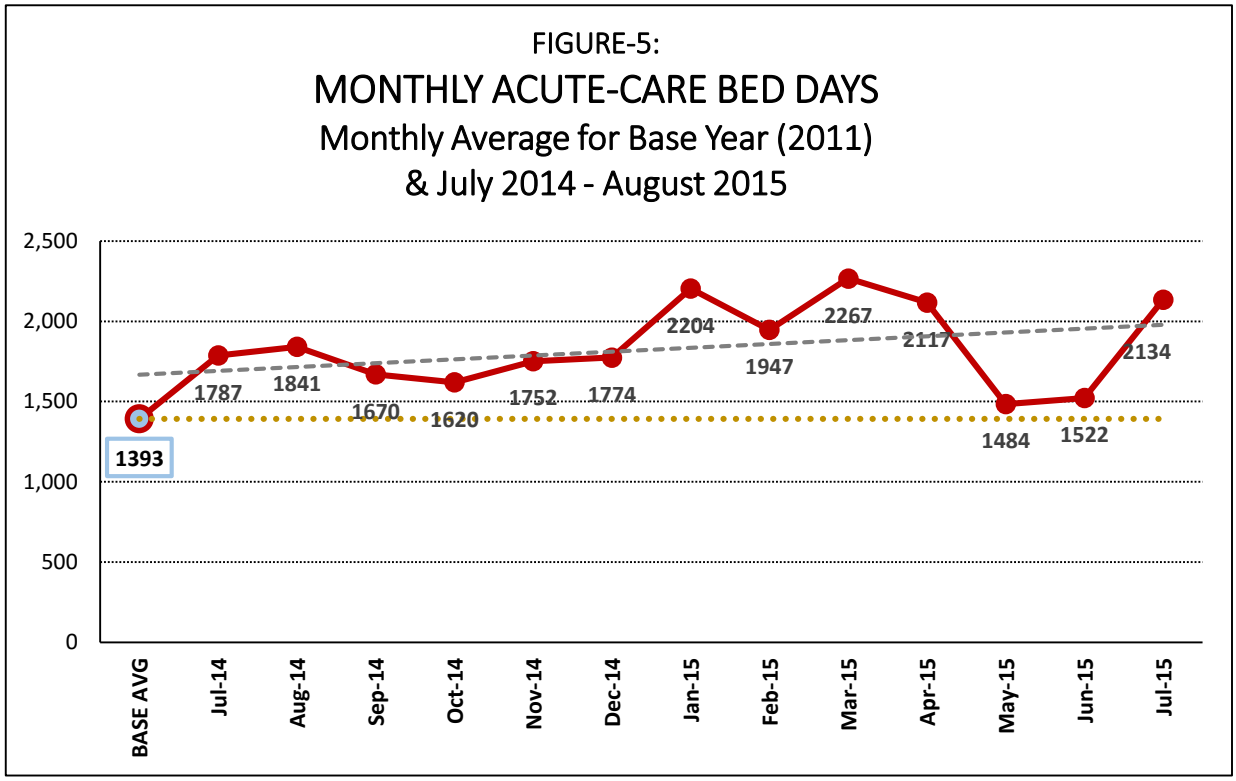
Section III.D.3 and III.D.4 of the Agreement delineate requirements for the State to reduce its acute inpatient bed days in the IMDs and in DPC[11] by 30% and 50%, respectively, relative to the base year of 2011. Prior reports of the Monitor have included extensive discussions of these provisions and the State's difficulties in meeting these targets. To briefly summarize the issue, the State's arrangements for oversight of acute psychiatric hospital care for people with SPMI had been quite complicated, with accountability dispersed among DSAMH, DMMA, and the MCOs operating under contract with DMMA. The entity or entities responsible for monitoring the quality and appropriateness of an individual's hospital care could shift, based upon limitations in Medicaid coverage or referral for more intensive specialized services including those required by the Agreement. Furthermore, the responsibility for ensuring that individuals were appropriately referred for such critically needed intensive services was vague, at best.

Inpatient psychiatric care is sometimes warranted, but it is also intrusive, it can be coercive or traumatic, and it is an expensive service that drains resources that could be used otherwise. The Agreement anticipates that the array of community program alternatives required in its provisions, once fully operational, will significantly reduce the State's reliance upon hospital care by the percentages referenced above. As such, the number of inpatient days used by the target population reflects the culmination of these new programs. For all of these reasons, the Crisis Stabilization provisions of the Agreement are particularly important in demonstrating the State's alignment with the requirements of the ADA and *Olmstead,* around which it was substantially crafted.

[11] Delaware Psychiatric Center (DPC) is the state-operated psychiatric hospital located in New Castle, Delaware.

Data presented in prior reports of the Monitor showed that the State has been successful in reducing inpatient days dedicated to long-term care at DPC,[12] but the State was not only failing to decrease the acute inpatient days referenced in Section III.D, these bed-days were increasing.

Figure-5 presents the State's monthly totals for acute-care psychiatric hospital bed days used by the target population.[13] The monthly average number of acute-care bed days in the base year (2011) preceding the agreement was 1,393 (indicated by a dotted line). As is indicated in this chart, acute-care bed days for each of the months since July 2014—including the months since PROMISE was implemented in January 2015—have exceeded this level, sometimes significantly. Likewise, the trend line (the dashed line in the chart) shows a general upward trajectory with respect to acute care bed-day use.



The increases in acute care bed-days are essentially attributable to hospital stays at the IMDs. 87% of the bed-days categorized by the State as acute care occurred in the IMDs[14] and

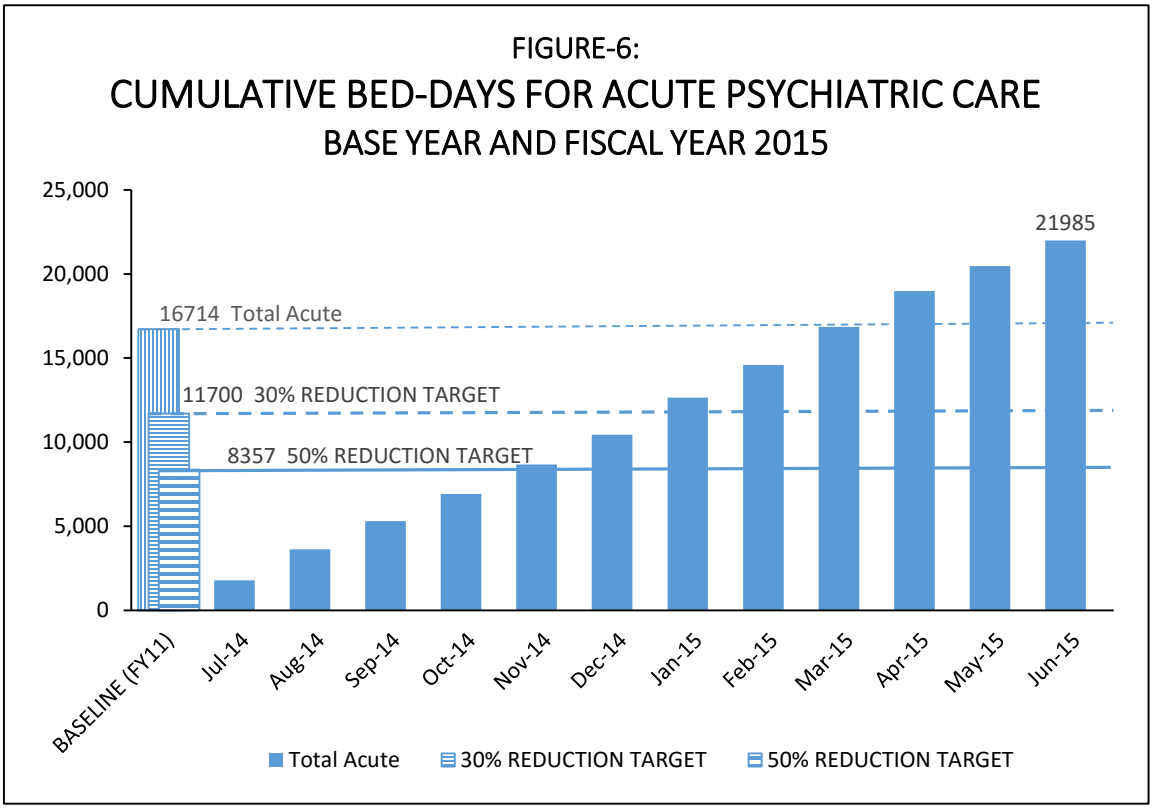
[12] Provisions in Section III.D relating to bed day reductions refer to acute care bed use only. The Agreement does not include specific numerical targets for long-term psychiatric hospitalization, but it does incorporate provisions to reduce unwarranted long-term care (e.g., Section IV.A-B).

[13] In the past, these data have been broken out by the State division responsible for oversight (DSAMH and DMMA); given the changes since January 1, 2015, this differentiation is no longer relevant.

[14] It is noted that the State is now analyzing data with respect to individuals transferred to DPC from IMDs (e.g., because they could not be stabilized within a short period in those settings), and those moving from acute-care

were managed through DMMA (15,510 out of 17,771). As is explained later (and detailed in prior Monitor reports), at least a part of these increases may have been due to the State's lack of appropriate controls over the process by which individuals whose behavioral healthcare was managed through MCOs were referred to DSAMH for the specialized services and housing required by the Agreement that can reduce the vulnerability for hospitalization. The protocols for such referrals and lines of accountability have been significantly improved since January 1, 2015. However, acute bed-days have continued to rise this calendar year. Given this pattern of increasing hospital use, plans that are now being discussed to further expand hospital capacity by building a new IMD in southern Delaware[15] raise additional questions as to whether the State will be able to curtail hospital rates for the target population.

Figure-6 presents the data contained in Figure-5 on a cumulative basis, that is, not as monthly totals, but as running totals for the fiscal year. This presentation allows ready analysis of bed use against the 30% and 50% reductions (from the base year) that are specified in the Agreement.



status to intermediate-status in DPC to ensure that the above data correctly reflect the entire duration of an individual's hospitalization episode.

[15] The proposal that has been shared with the Monitor calls for a 90-bed hospital. Although the full plan for this facility has not yet been completed, it is noted that conditions for approval include requirements to prevent the unnecessary admission of individuals and to collaborate with DSAMH and its network of community providers to ensure least-restrictive treatment and service continuity.

This chart shows that last fiscal year the State's total overall bed-day use met and exceeded the 50% reduction level (which is to be met by July 1, 2016 per Section III.D.4 of the Agreement) in November 2014, with seven months still remaining in the fiscal year. By January 2015—with five months remaining in the fiscal year—it had already exceeded the 30% reduction level which was to have been met in July 2014 (Section III.D.3). And in March 2015 it had almost reached the point of utilizing the full Baseline bed-use from which these reduction targets are calculated. By the end of the 2015 fiscal year, the State reported 21,985 acute care bed days, which is greater than a 30% increase in acute care bed use by the target population, relative to the Baseline year. These increases not only run counter to the requirements of the Agreement, but they raise systemic issues of quality and performance. As is discussed in the section of this report relating to Quality Assurance and Performance Improvement, the State is not taking appropriate advantage of data that could clarify the characteristics of the population responsible for bed-use increases, as well as their utilization of services earlier on that could reduce their hospitalization rates.

Additional Factors

In assessing the State's performance with regard to Crisis Stabilization provisions of the Agreement, there are some additional factors worth noting.

Reductions in Longer-Term Care at DPC

FIGURE-7:

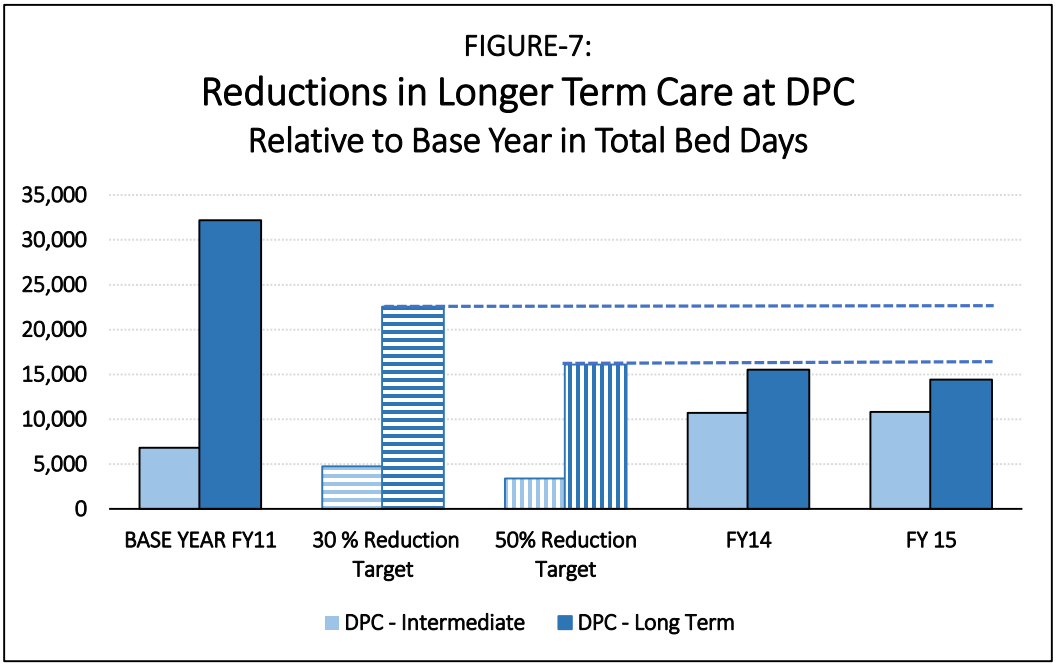


Figure-7 presents data demonstrating the State's success in reducing reliance on long term care at DPC. Applying the 30% and 50% reduction targets which the Agreement contains with respect to acute care to longer term care at DPC, the State is performing much better.[16] The State defines "acute care" as hospitalization lasting 14 days or fewer. "Intermediate" term care at DPC is defined as lasting 15 to 179 days and "long term" hospital care is defined as longer than 179 days. As is reflected in this chart, the State has dramatically reduced bed-days in long term care, meeting a 50% reduction target in both fiscal years 2014 and 2015. These rates have remained stable for some time. Whereas DPC used approximately 40,000 bed days for intermediate- and long-term care in the base year, as of fiscal year 2015 the combined total for these categories of care was only about 25,000 bed days—a reduction of about 38%.

Referrals for Specialized Mental Health Services

Prior Monitor reports have described significant problems in the State ensuring that members of the Agreement's target population whose behavioral healthcare was managed through DMMA were being appropriately referred to DSAMH for the specialized services and housing required in the Agreement. The arrangements that had been in place for years were wholly unclear not only as to what entity was responsible for making such referrals—the IMD, the MCO, or DMMA—but even what criteria would be applied for determining that such referrals were necessary.

As was discussed in the Monitor's last report, the State identified a group of 454 individuals with SPMI who had not been referred for specialized services even though they were obviously not doing well in the community, as evidenced by multiple re-hospitalizations in IMDs in a short period of time. That report described an initiative by the State that was launched in March 2015 to reach out to these ostensibly very high-risk individuals, including through phone contact and in-person visits, to ascertain their wellbeing and to make specialized services available to them. For reasons that are not at all clear, the State delayed action on this initiative, thereby further lengthening the time between individuals' hospital discharge and the outreach to offer specialized services. Accordingly, it was unable to make contact with a large proportion of this group of 454 (had referrals been made routinely as a part of discharge planning at the IMDs, this would not have been an issue). Once the initiative got underway, however, the State made a good-faith effort using Targeted Care Managers (TCM) to attempt to connect with each of these individuals.

Figure-8 summarizes the outcomes of this effort, as well as the detailed data the State maintained to track its progress. Notwithstanding their intensive efforts, the TCM staff were able to make contact with only about 23% of the group; they were unable make contact with about 77% of this group. With respect to those actually contacted, about 13% of the group of 454 declined the offer of services and just under10% were brought to some level of either receiving services or enrollment in services. For those individuals not among those on track to be served (and who are still in the State's Medicaid program), the applicable MCOs have been notified of

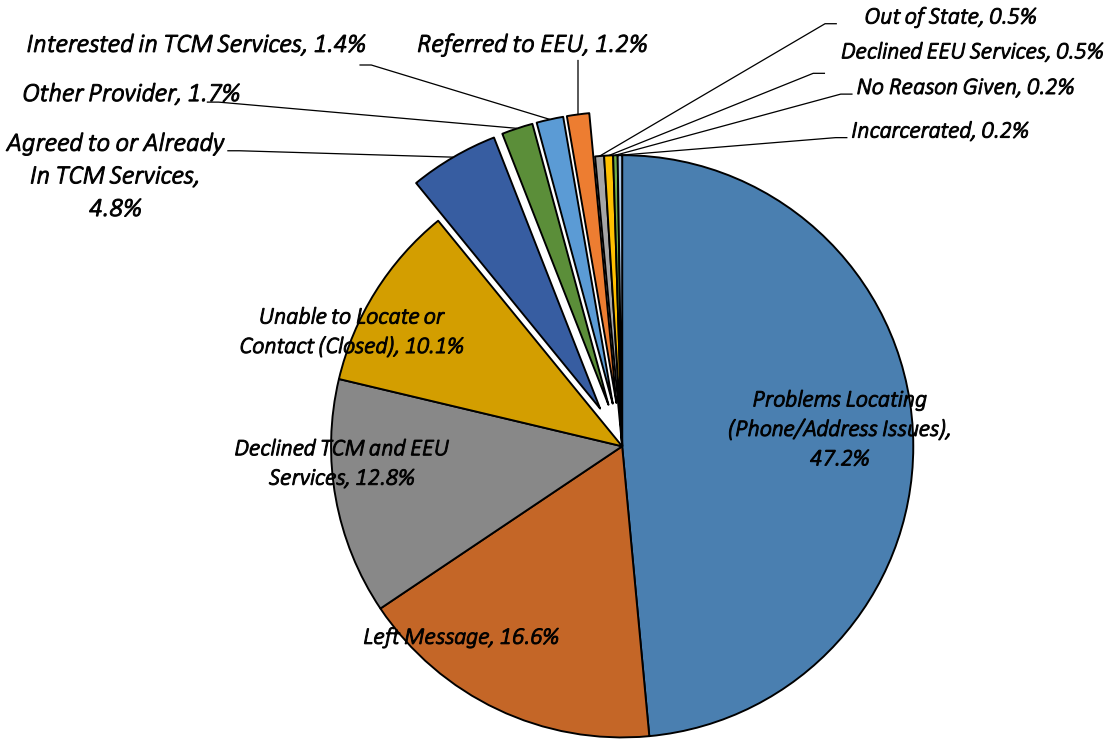
[16] Such targets for long-term care, however, are not a part of the Agreement.

their high-risk status so they can pursue referrals should opportunities present themselves in the future.

FIGURE-8:

TCM Outreach Status to High-Risk Individuals Whose MH Care Is Managed Through MCOs*

as of November 10, 2015



Priority groups 1a to 2d; individuals with prior TCM contact were not included.

In addition, as a part of the new collaboration agreements that went into effect this calendar year, DSAMH, DMMA and the MCOs now have specific criteria—for instance, hospital readmission—that trigger a referral for specialized services. The State has created a tracking dashboard with such measures as the number of monthly hospital admissions, the status of these individual relative to PROMISE/DSAMH, and the number of individuals not receiving specialized services who are referred. While the numbers are still preliminary, there has already been a significant increase in referrals of individuals with SPMI who had not been receiving these services. It is too soon to say whether this effort will have the effect of reducing the number of inpatient days used by the target population.

Referrals of Homeless Individuals for Housing

Among the problems relating to referrals for specialized services was the finding, discussed in past Monitor reports, that individuals were being admitted to IMDs from homelessness or from unstable housing situations, and that they were being discharged to the same situations—often without even a plan to secure housing.[17] In some instances, individuals were discharged to shelters, which are inherently problematic for people with SPMI. Aside from the issues of accountability in the referral process discussed earlier, it had been difficult to ascertain which individuals had issues relating to housing because this information, when it appeared at all, tended to be buried within progress notes or psychosocial assessments in the IMD charts. From the perspective of the bed-day reduction provisions of the Agreement, homelessness or instability in housing is a known risk factor for untoward outcomes such as re-hospitalization.

The State has taken affirmative measures to correct this problem. It now requires IMDs to complete a Housing Assessment form upon admission of all members of the target population. This form, which is submitted to DSAMH, clearly identifies which individuals are homeless or unstably housed, and whether a referral was made to TCM to link them to housing and other

FIGURE-9:

Outcomes of Housing Assessments by IMDs

March-April 2015

IMD	Month	Housing Assessmts Completed	Have a Home	Homeless	Status of Homeless Individuals			
					Referred to EEU/TCM	Referred to TCM	Active w/ Service Provider	Referred Living in Shelter
Rockford	March	53	40	13	4	5		4
Dover BH	March	11	8	3		2		1
MeadoWd	March	14	10	4			3	1
Rockford	April	38	31	7	1	4		2
Dover BH	April	40	37	3			3	
MeadoWd	April	15	14	1		1		
Totals		**171**	**140**	**31**	**5**	**12**	**6**	**8**

[17] The Monitor had not found this to be an issue at DPC.

needed services. The State has also developed a decision tree that delineates the appropriate measures to be taken, based upon stability of an individual's housing and that the individual's existing linkages to services.

Figure-9 presents early data from this initiative. Although it covers only two months, March and April of 2015, the chart shows the sizable proportion of individuals among the target population who were admitted to IMDs and identified as being homeless, as well as referrals now being made to TCM to address this issue. Out of 171 housing assessments completed by IMDs on individuals with SPMI who were admitted to their facilities during this two-month period, almost one in five were homeless. As is reflected in the data presented here, the State has begun to address this longstanding problem by referring individuals for services and housing in a much more systematic way than had been the case in the past. As is discussed later in this report, such findings relating to homeless individuals may affect the State's status with respect to Section III.I.6 of the Agreement. Furthermore, they may highlight a need to further explore the underutilization of Crisis Apartment beds, which is discussed later.

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In summary, with respect to the Agreement's requirements relating to Crisis Stabilization Services, the State has not met the bed-use reduction targets of Section III.D.3 of the Agreement and it is very unlikely that it will meet the further reductions specified in Section III.D.4 to be in effect by July 1, 2016. It has made—and maintained—its progress in reducing long-term care at DPC, where some individuals had been consigned for decades. Particularly since the beginning of this calendar year, the State has begun to take important steps in linking individuals who are at elevated risk of hospitalization to the services and housing they need to be successful in the community. As is discussed in the Quality Assurance and Performance Improvement section of this report, there are steps that the State can take to better understand factors underlying the increasing number of bed-days used by the target population and to devise interventions accordingly.

The State is in Partial Compliance with the Agreement's Crisis Stabilization requirements.

E. Training Relating To Crisis Diversion Services

Substantial Compliance.

Sections IIIA.2, III.B.2, III.C.2, and III.D.2 of the Agreement require that the State train providers and law enforcement personnel in regard to its various diversion programs: its Crisis Hotlines, Mobile Crisis, Crisis Walk-In Centers, and Crisis Stabilization Services, respectively. Such training remains ongoing since implementation of the Agreement began, and DSAMH provides monthly data regarding the number of individuals trained and the counties where the trainings occur. During Fiscal Year 2015, approximately 600 individuals received training in

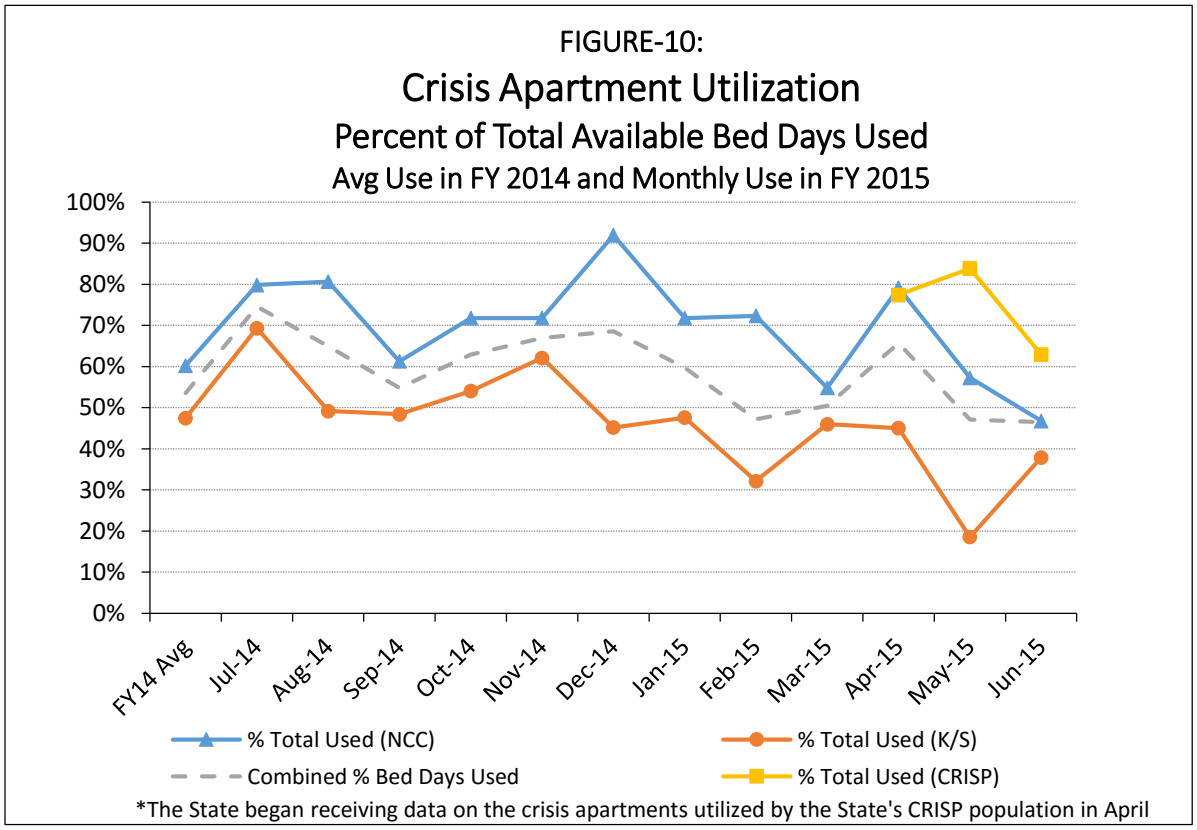
crisis alternatives, a very substantial number of whom were from state and local police departments.

The State is in Substantial Compliance with regard to the staff and law enforcement training provisions of the Agreement referenced above.

E. Crisis Apartments

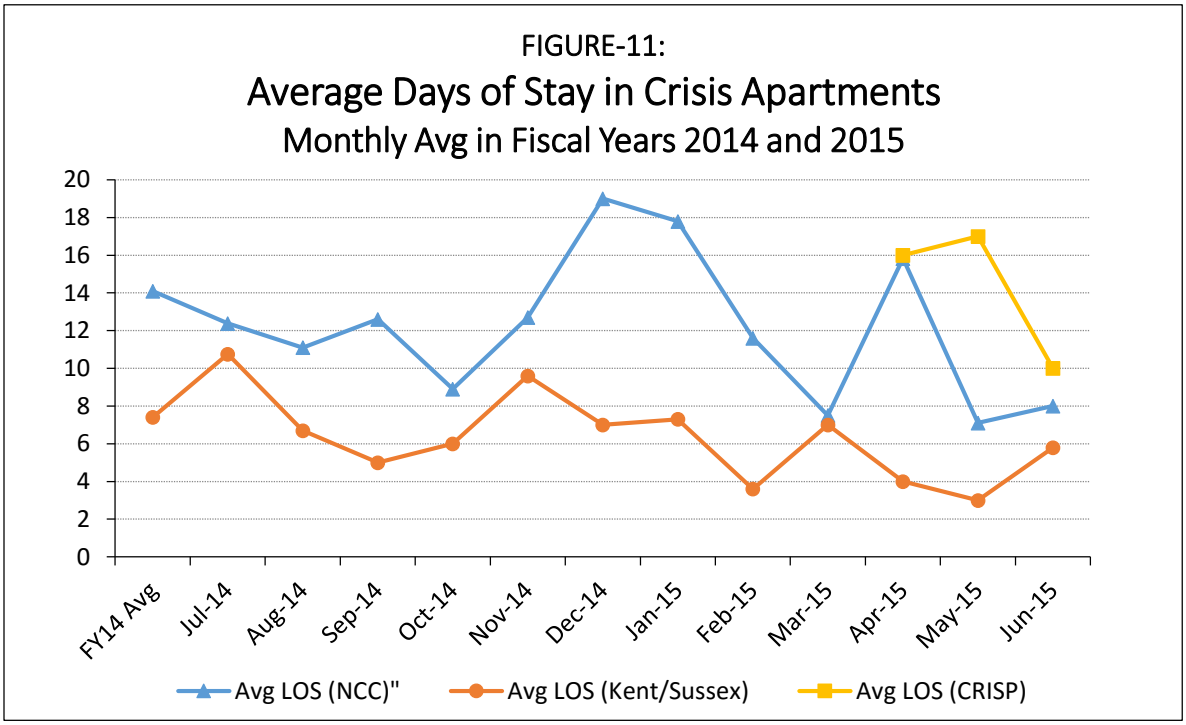
Substantial Compliance.

Crisis Apartments represent a critically important component of the State's mental health service system; they provide respite housing for individuals who are in crisis, cannot resolve their crisis within their current living situation, and do not present an immediate danger to themselves or to others. The apartments—which are, in actuality freestanding houses—are staffed by peers; clinical services and TCM are provided through the responsible community programs. Section III.E of the Agreement requires that the State make operational at least four Crisis Apartments to provide statewide coverage. The State continues to exceed this requirement in that, in addition to the four apartments required (the State fulfills this through the Princeton and Harrington Restart programs in New Castle and Kent Counties, respectively), it also operates an additional four respite beds and ten "resource beds" that can be used flexibly as needed.



Prior Monitor reports have described how the use of these beds has been variable, particularly in the southern counties, as well as the State's efforts to better integrate these resources with day-to-day service operations (for instance, by frequently sharing vacancy information through its Mobile Crisis programs). Figure-10 presents the State's tracking of bed use in the four crisis apartments required by the Agreement. Although there is variation month-to-month, this chart shows that the very low utilization rates in years past are no longer in evidence and that Crisis Apartment are, indeed, becoming integrated within service plans for individuals experiencing psychiatric emergencies. Utilization rates remain lower in the southern counties, where for seven months of the fiscal year, more than half of the beds were empty, on average. Also included, beginning in April 2015 is information from the CRISP program.[18]

FIGURE-11:



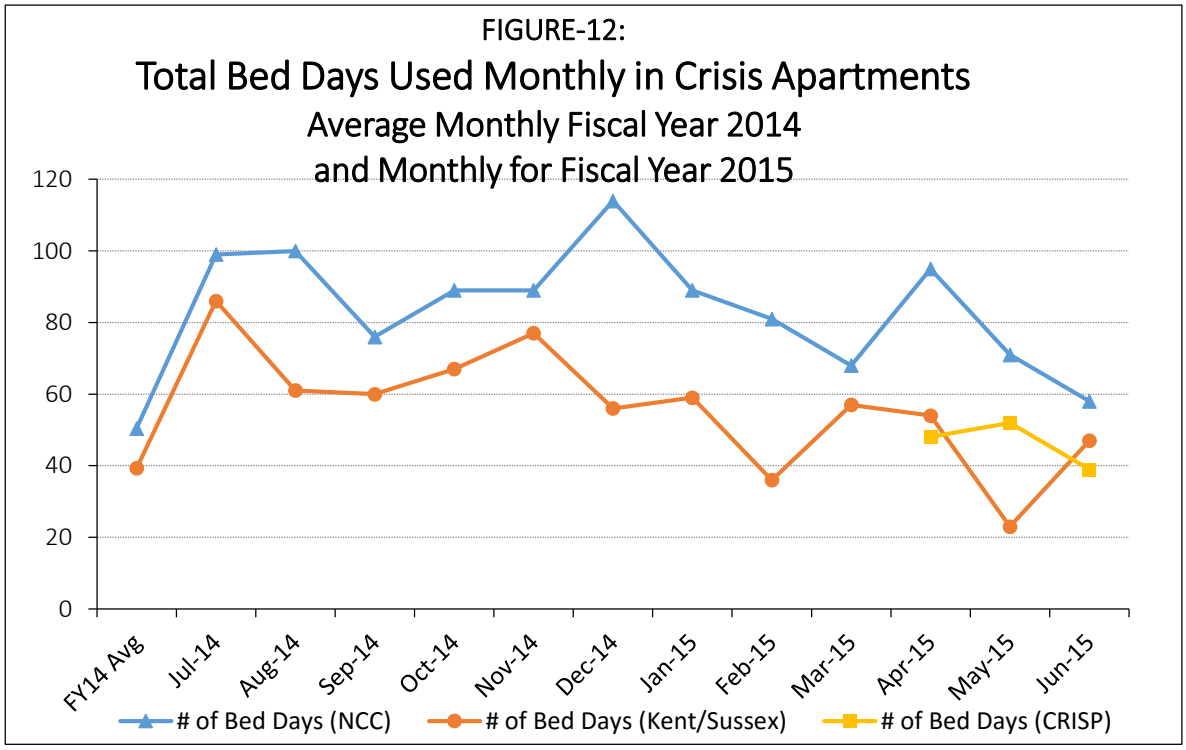
The Agreement contemplated that the Crisis Apartments would be used for up to seven days and that, thereafter, the individual would return home,[19] however, the State has found that this is not how they have come to be used in practice. Often, individuals who use this program have mental health crises that cannot be resolved with in-home services because their living arrangements are unstable or incompatible with their needs. Accordingly—particularly in New Castle County—average lengths of stays in Crisis Apartment have been double this time frame or even longer as arrangements are made to secure stable housing. Figure-11 presents the average lengths of stay in Crisis Apartments by county, and Figure-12 presents the same data,

[18] CRISP has been described in detail in prior Monitor reports; it is an ACT-like program that serves high-need individuals and that enables providers to flexibly use capitated funds to address their clients' needs, including for crisis apartments.

[19] Agreement, Section II.C.2.e

but as total numbers of bed-days used each month. While not always the case, considering that the individuals occupying the Crisis Apartment beds have not only acute mental health issues, but also often housing issues as well, their risk of hospital admission would likely be very high would this program not be available.

FIGURE-12:



The State is in Substantial Compliance with respect to the requirements for Crisis Apartments.

F. Assertive Community Treatment

Substantial Compliance.

Assertive Community Treatment (ACT) is a critically important service for people with SPMI, particularly those with complex clinical issues in combination with trauma histories, repeated episodes of institutionalization, criminal justice involvement, and/or co-occurring substance use problems. Section III.F of the Agreement requires the State to have eleven ACT teams in conformance with evidence-based TMACT standards.[20] There are now fifteen ACT programs serving the target population,[21] plus the CRISP program which, while not held to

[20] The Agreement calls for fidelity with the Dartmouth model, but early in the implementation process, the parties agreed that the TMACT model would be used.

[21] One team, Connections ACT-IV, is new and has not yet had its full TMACT evaluation.

TMACT standards, provides similarly intense mobile services to individuals who have service needs that are at least as significant as those served through ACT.[22]

The State provides monthly data with regard to the number of clients served by each ACT team, which generally approximate 100 clients per team except in the southern counties where logistics have required smaller caseloads, of around 80.

TMACT fidelity is one means of evaluating the quality of ACT services being provided in Delaware. As in any system, there is variation among the ACT teams in the fidelity scores achieved, and notwithstanding efforts to improve a specific team's score, performance may drop due to such factors as staff turnover. The State continues its rigorous program of conducting TMACT assessments of each team at least annually and, as indicated, assisting teams in fulfilling resultant corrective action plans through consultation by very experienced experts.

During the past year, the State has also identified patterns of issues in ACT services that cut across teams. For instance, its own assessments and those of the Monitor revealed that the living environments of some individuals being served in supported housing were not adequate, sometimes not only as a result of clinical issues presented by the clients, but landlord responsiveness to maintenance needs, as well. As a consequence, the State has taken action to more intensively evaluate the quality of individuals' living environments, whether care plans are appropriately addressing these issues, and whether ACT is the appropriate service for these individuals. In at least one instance, the State concluded that an apartment complex was not providing adequate repair and maintenance services, and alternative apartments are being secured as a result. In addition, recognizing the level of need presented by some clients of ACT programs, the State has made arrangements for new personal care and chore services covered through the PROMISE program to supplement ACT services on a case-by-case basis. This has not yet gone into effect, though.

Figure-13 presents TMACT "overall" scores for the State's ACT teams, reflecting evaluations conducted in Fiscal Year 2015 and, where they exist, comparative evaluations for Fiscal Year 2014.[23,24] These overall scores are composite measures reflecting six subscales that comprise 47 measures. Some teams' overall scores reflect consistency among the subscales, while in other instances, there may be considerable internal variance. As is indicated in this chart, eleven out of the fourteen ACT teams that were scored obtained overall TMACT scores of 3.0 or higher; even within these teams, there may be deficiencies identified through the subscales for which the State is requiring corrective measures. The three ACT teams with overall scores

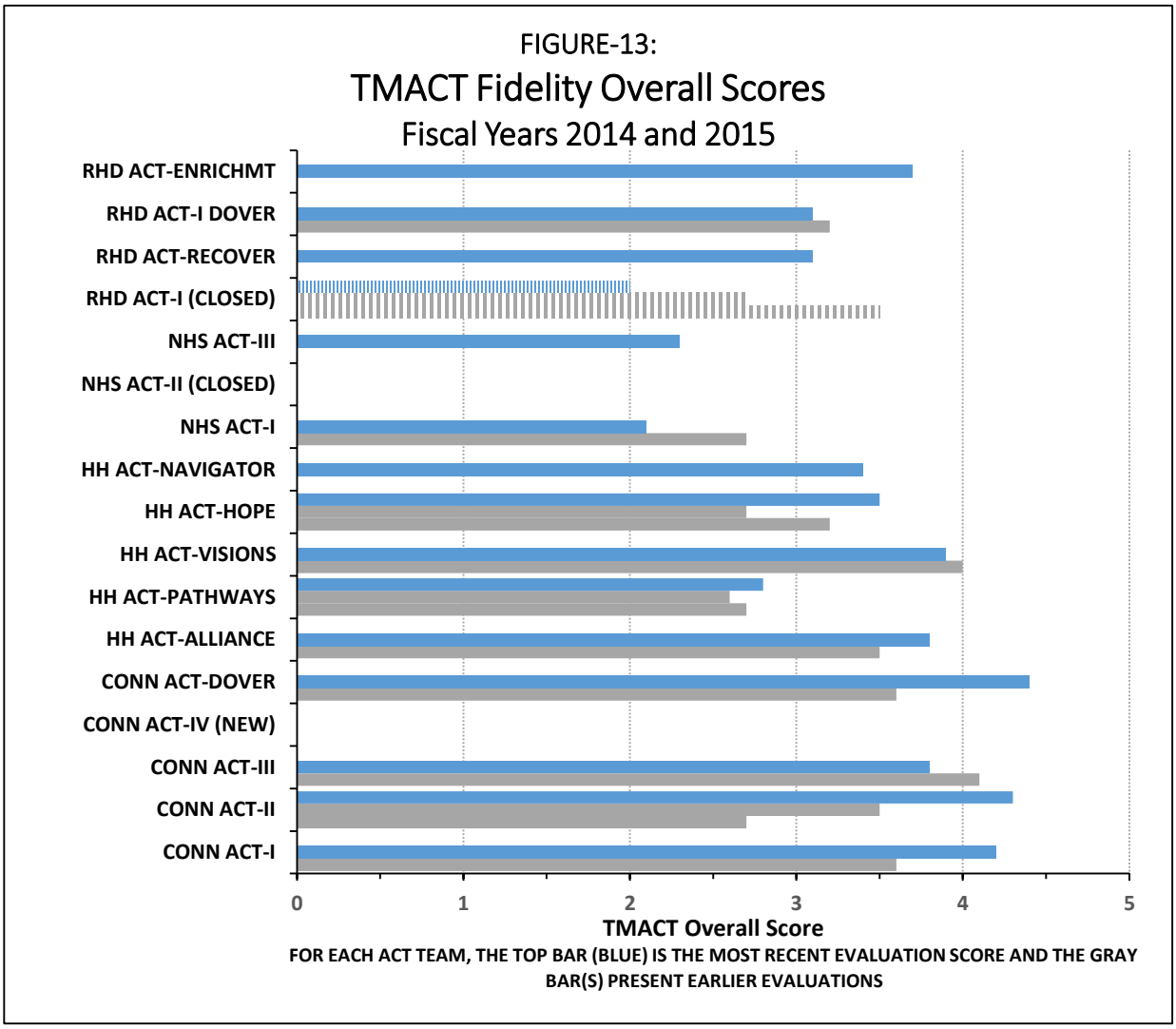
[22] Reconciling the State's compliance with the numerical targets of Section III.F (ACT) and III.G (Intensive Case Management, or ICM) has been a bit challenging because, with the concurrence of the parties and the Monitor, the State converted some of its ICM teams to ACT. Furthermore, the CRISP program represents additional capacity (approximately 100 clients) for ACT-like services. This was explained more fully in the Monitor's Seventh Report. All factors considered, the Monitor has determined that the State is exceeding the combined numerical requirements for ACT and ICM.

[23] Full evaluations are only conducted after one year to eighteen months of start-up and preliminary evaluations, so newly formed teams may not have evaluations from FY 2014.

[24] It is noted that Figure-4 in the Monitor's Seventh Report (May 1, 2015) incorrectly presented the TMACT scores obtained by the Connections I ACT team. The scores presented here, in Figure 13, are correct.

below 3.0 [NHS ACT-I, NHS ACT-III, and Horizon House (HH) ACT-Pathways] all have corrective action plans, although in some instances they may already be performing well on specific subscales. The State has shown that it takes action when TMACT evaluations are poor and those teams' responsiveness to corrective action plans are inadequate. Accordingly, the RHD ACT-I team, whose overall score declined to 2.0, was closed by the DSAMH; in its place, a new ICM team is now being operated by Horizon House. Another team, NHS ACT-II was closed by the State before a full evaluation occurred because of poor performance at the preliminary stages; The Connections ACT-IV team is its replacement.

FIGURE-13:



In addition to TMACT measures, which heavily focus on process, the State conducts assessments of a number of outcome indicators reflecting the success of ACT teams (and ICM, as well) in achieving the goals of the Agreement. A sample of these measures is presented below as aggregate data for teams operated by each provider. The State's data system allows it to not

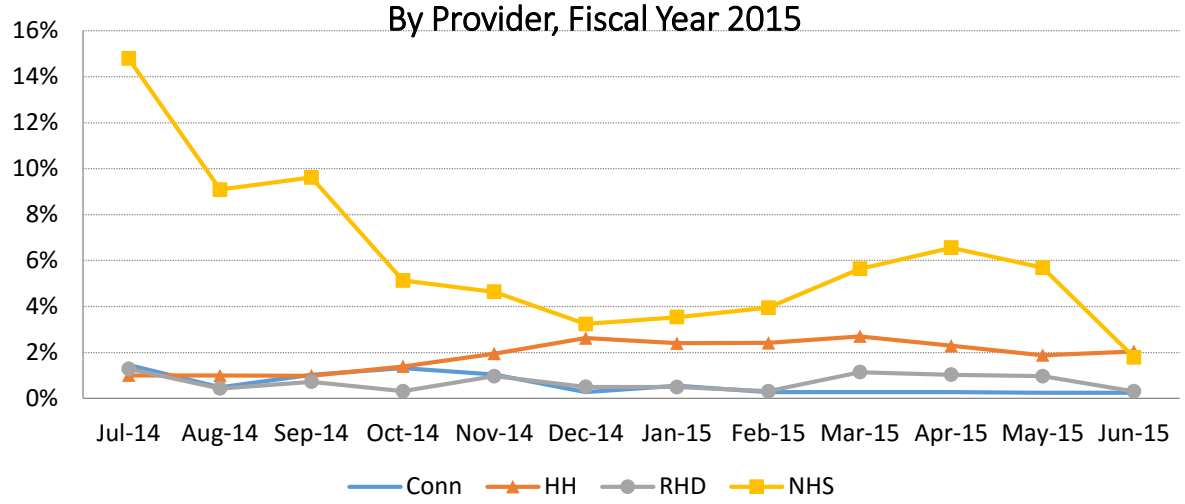
only evaluate performance on this level, but to drill down to a specific ACT/ICM team or even individual clients.

Figure-14 summarizes the number of homeless individual served by these programs each month. Although some clients lose their housing while being served by ACT (an example is a tenant with co-occurring substance abuse who engages in unacceptable behaviors), more

FIGURE 14:

Percent of ACT/ICM Clients Homeless for Any Night During the Month

By Provider, Fiscal Year 2015



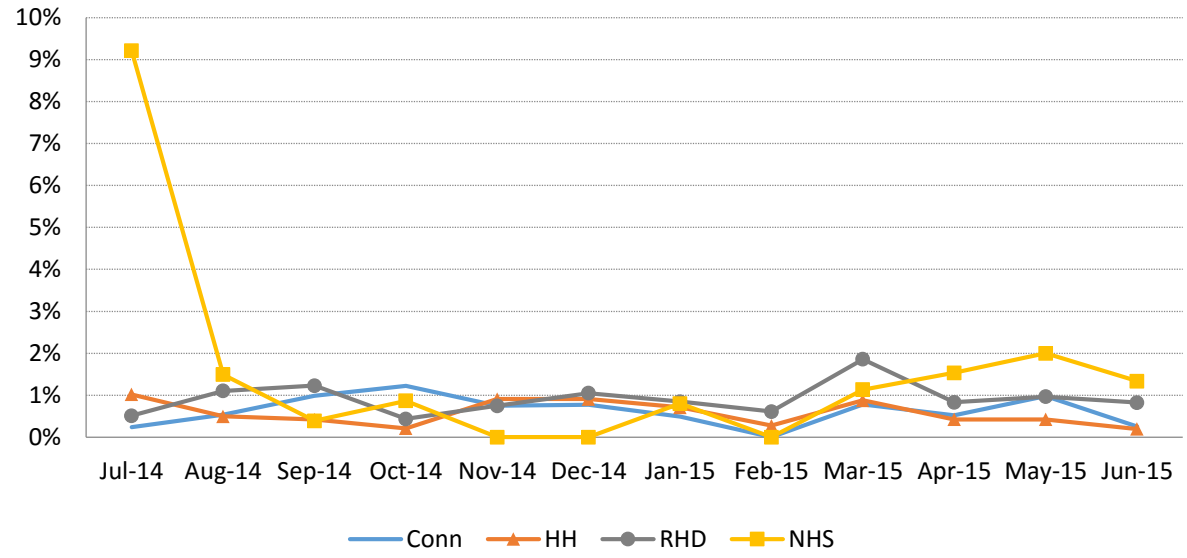
*Data provided via ACT/ICM Monthly Qualitative Reporting Tool

typically, homelessness among ACT clients occurs upon entry to the program while housing arrangements are still being worked out; as such, this issue is particularly applicable to newer ACT teams which do not yet have their full complement of clients. As is indicated Figure-14, NHS shows the highest levels of homelessness among its clients, the State is working with this provider to address this issue.

Figure-15 presents the percentages of clients arrested each month by ACT/ICM provider. The arrest rates have remained fairly stable and low—generally hovering at around 1%. This is a significant outcome indicator in that arrests are among the target population's risk factors referenced in the Agreement (Section II.B.2.e). The individuals served by ACT and ICM are at elevated risk of encounters with police, not only because of the intensity of mental health issues that qualify them for these levels of service, but also because co-occurring substance use is common among them. The large majority of these individuals are now living independently in integrated supported housing (i.e., per Section III.I of the Agreement), that is, outside of the daily "structure" that characterizes the institutions in which they once lived.

FIGURE-15:

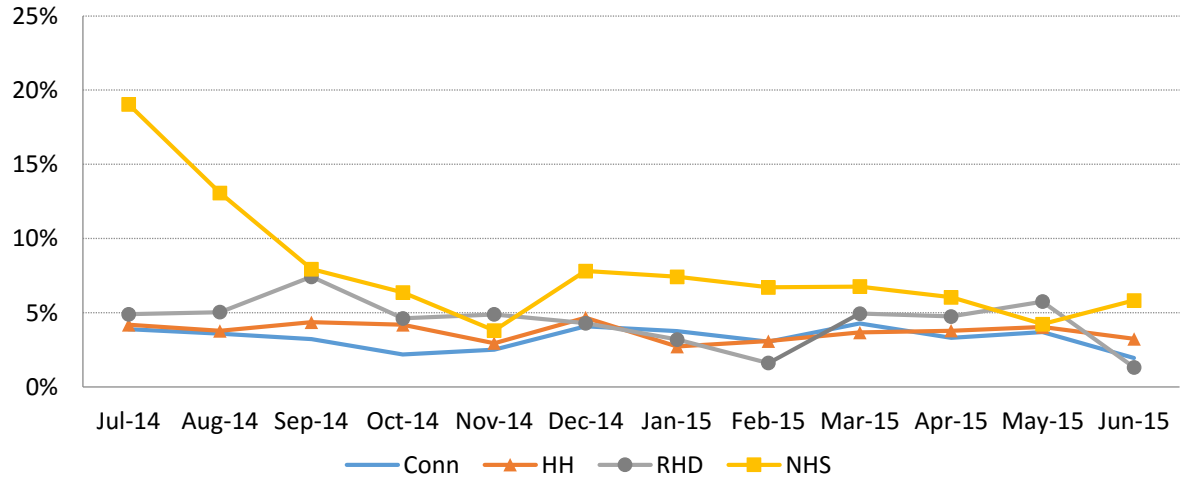
Percent of ACT/ICM Clients Arrested
By Provider, Fiscal Year 2015



*Data provided via ACT/ICM Monthly Qualitative Reporting Tool

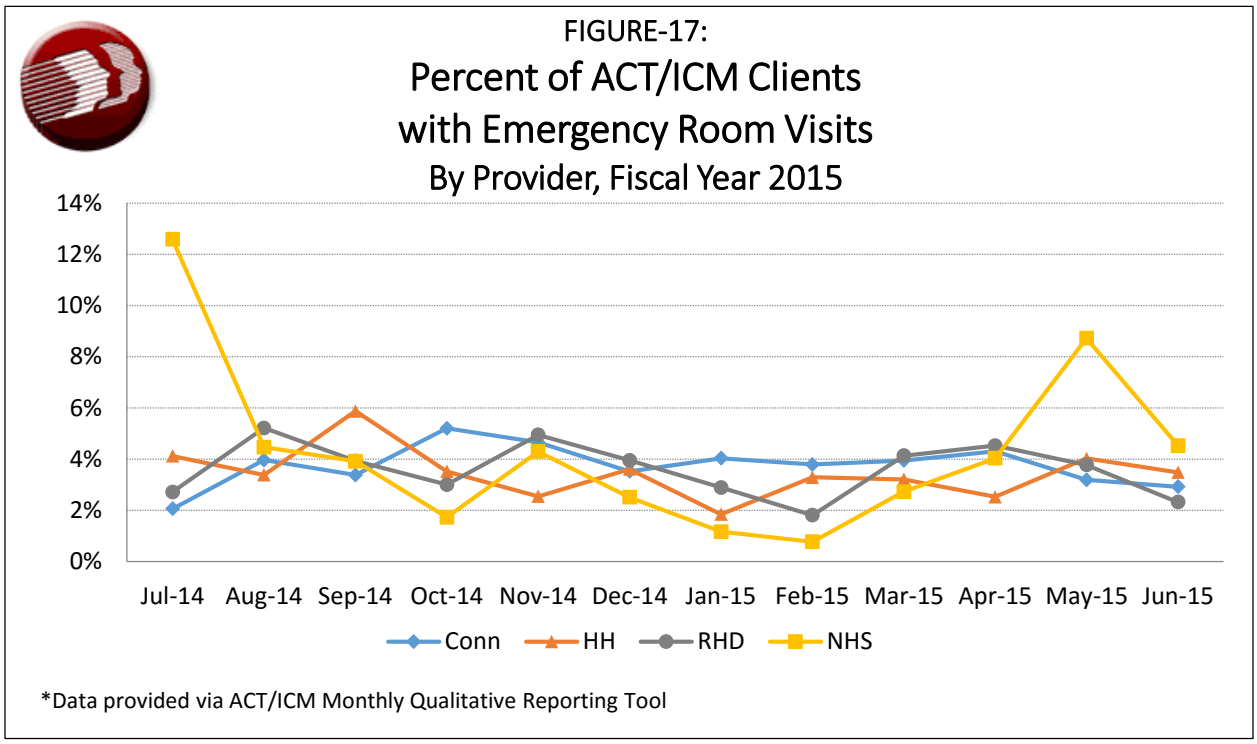
FIGURE-16:

Percent of ACT/ICM Clients Psychiatrically Hospitalized
By Provider, Fiscal Year 2015



*Data provided via ACT/ICM Monthly Qualitative Reporting Tool

Figures -16 and -17 present the monthly psychiatric re-hospitalization rates and emergency room use, respectively, for clients of ACT and ICM. For the same reasons specified for Figure-15, these are also an important measures of performance with respect to the high-risk population being served.



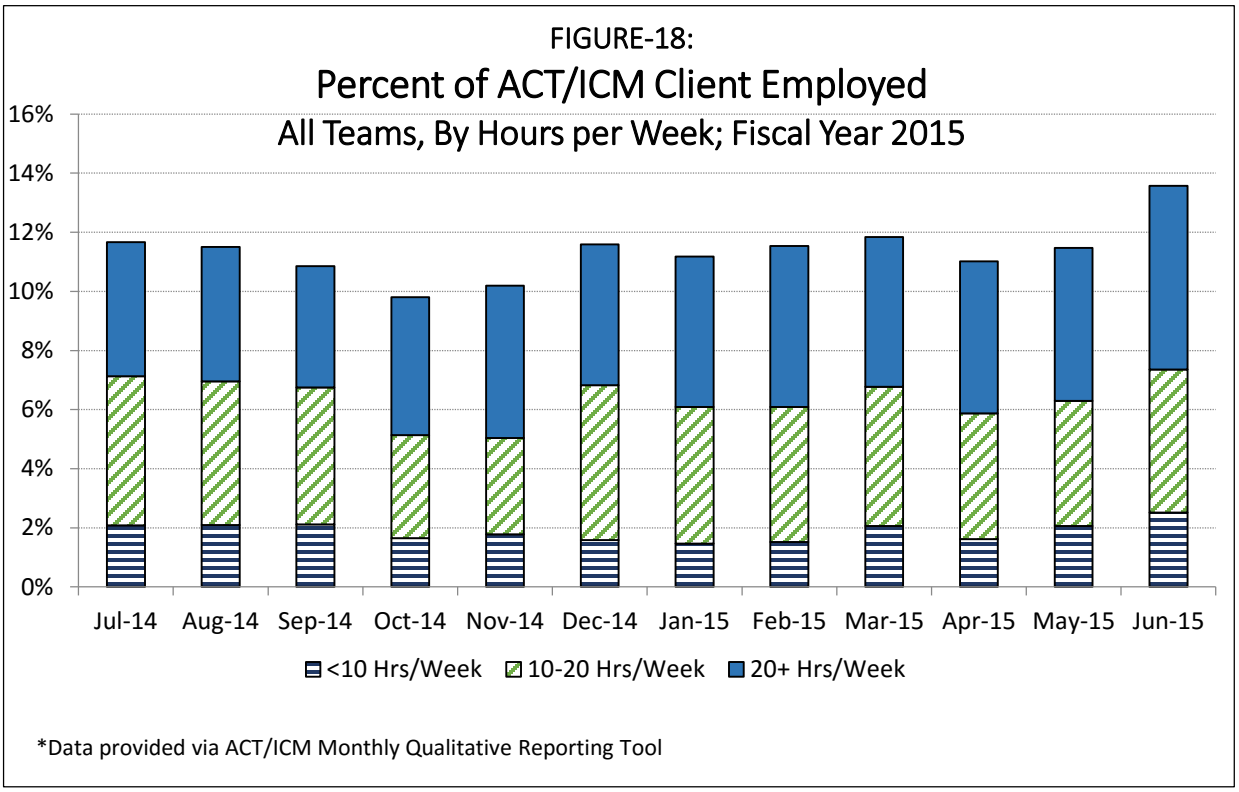
As is explained later (with regard to Quality Assurance and Performance Improvement), an ongoing study through the University of Pennsylvania is looking at how different cohorts of the target population are faring as new services and refinements in processes roll out through the course of the Agreement's implementation. This research is showing that, while the likelihood of an individual being re-hospitalized is declining somewhat for successive cohorts (e.g., members of the target population who entered service during the first year of the Agreement's implementation, as compared to those entering service during the second year), there is a high use of emergency rooms by individuals who are not hospitalized.[25] This research includes not only individuals served through ACT/ICM as represented in Figure-17, but also a sizable number whose care is managed through DMMA and MCOs. Relevant here, such findings point to the importance of looking "upstream" from hospital admissions to see where earlier opportunities for intervention may be appropriate.

In contrast to the negative outcomes reflected in the tracking on the above four measures, the State's quality measurements for ACT and ICM also include positive outcomes. Figure-18 presents data relating to the employment status of clients served through these programs.

[25] It is not clear whether these emergency room visits reflect behavioral health crises or issues reflective of a need to better address physical health needs.

Employment is an extremely important outcome with respect to the goals of the Agreement. It is also a difficult outcome to achieve. Typically, the individuals being served through ACT and ICM do not have stable work histories; they are challenged by a lack of marketable skills, the harms attendant to recurrent or protracted institutionalization, and often by criminal justice histories, as well. As is explained further, with regard to Section III.J, the State has been working aggressively to promote mainstream employment for members of the population targeted by the Agreement (and for all Delawareans with disabilities, as well, per an initiative of the Governor). Figure-18 reflects the slow, but important, progress the State is making with respect to the target population, not only in the percentage of ACT/ICM clients who are employed in regular jobs in their communities, but in the proportion that are working 20 hours per week or more.

FIGURE-18:



Taking into consideration all of the factors discussed in this section, the State is rated as being in Substantial Compliance with the Agreement's requirements with respect to Assertive Community Treatment.

G. Intensive Case Management

Substantial Compliance.

Intensive Case Management (ICM) is a program designed to serve individuals with SPMI who do not require the very high level of services associated with ACT, but who nevertheless, need ongoing and mobile support to live successfully in the community. As has been explained

in prior reports of the Monitor, the State initially developed four ICM teams per the requirements of Sections III.G.1 and III.G.2 of the Agreement. Once operationalized, however, it found that these teams were not able to provide the level of support needed by the individuals being served and, with the concurrence of the Monitor and DOJ, DSAMH upgraded some of its ICM teams to conform to ACT requirements (these additional ACT teams are included in the TMACT surveys discussed above). The State now operates two ICM teams.

While there are no standardized fidelity measures for ICM, the State is including its ICM teams in the quality outcome monitoring discussed above and summarized in Figures-14 through 18. It is maintaining ICM staffing ratios in keeping with Section II.D.2.b of the Agreement.

The State remains in Substantial Compliance with the Intensive Case Management requirements of the Agreement.

H. Case Management

Substantial Compliance.

Case Management, which the State refers to as Targeted Care Management (TCM), is a program that provides time-limited services to individuals who require linkage to mental health, housing, employment, or other programs. For many individuals, TCM is the front door to community services, including those offered through the PROMISE program. Accordingly, TCM is intimately connected with the State's Mobile Crisis programs, its Crisis Walk-In programs, and (increasingly with routineness) discharge processes at the IMDs. Targeted Care Managers also play a pivotal role in the in-person and telephone outreach to high-risk individuals that was discussed above in the section "Referrals for Specialized Mental Health Services."

The Agreement requires that TCM staff be responsible for no more than 35 individuals (Section II.D.2.c.ii), however, the State has found that in practice this staffing ratio is not sufficiently intensive. Instead, its TCMs tend to maintain caseloads of about 10-14 individuals. By its nature, there is considerable turnover among individuals served; some may only require (or agree to) a single visit, while others (particularly those who require housing) may require multiple visits and sustained involvement over a period of months. Provisions included in Section III.H of the Agreement require that the State utilize 25 case managers. DSAMH's TCM program includes a total of 25 case managers between sites in New Castle County, a site in southern Delaware that is co-located in the Ellendale Walk-In Center, and a state-operated program. On average, about 286 individuals were served through Delaware's TCM program each month in fiscal year 2015.

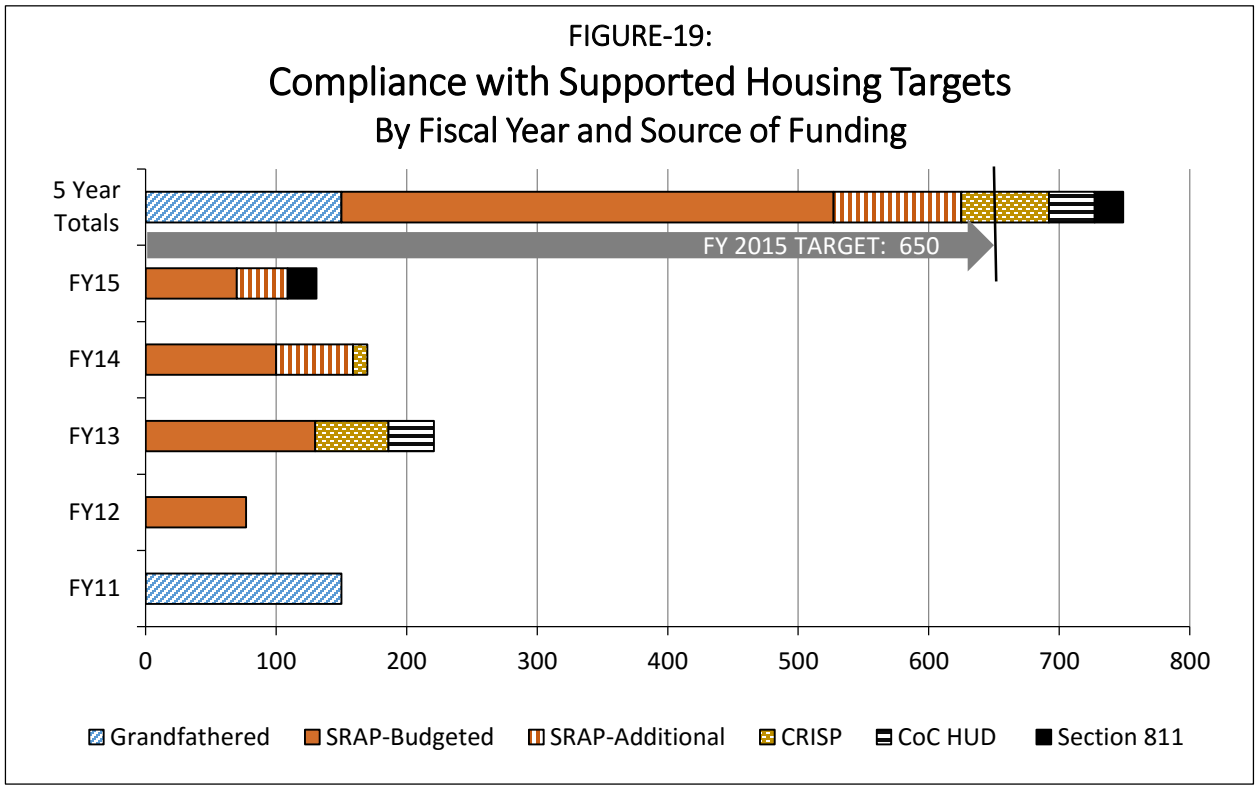
The State is in Substantial Compliance with the Agreement's provisions relating to Case Management.

I. Supported Housing

Substantial Compliance.

The Supported Housing provisions of the Agreement are among the pivotal indicators of the State's success in complying with *Olmstead*, including the goal of enabling individuals who have SPMI to live "like the rest of Delawareans, in their own homes..."[26] A substantial number of the individuals targeted by the Agreement have long histories of residing in segregated facilities, including psychiatric hospitals, group homes, and other congregate settings that set them apart from the community mainstream. Recognizing the importance of creating integrated housing alternatives, supported housing was an early priority in DSAMH's implementation efforts, and it remains an area where the State has achieved success.

FIGURE-19:



Section III.I.5 of the Agreement requires the State to provide vouchers or subsidies for scattered-site integrated supported housing to a total of 650 individuals. The State has consistently exceeded this target, relying on a combination of opportunities through its SRAP program, HUD programs, and DSAMH funds (e.g., CRISP). As is represented in Figure-19, it continues to exceed the Agreement's requirements, in fact, substantially so.

Section III.I.6 of the Agreement commits the State, with certain considerations, to provide bridge funding and housing subsidies to anyone in the target population who needs such

[26] Agreement, Section II.2.E1.a

support. Particularly relevant here will be whether or not existing resources are sufficient to address the ongoing and already known housing needs of the target population, as well as those of homeless individuals with SPMI who are identified when admitted to an IMD (this was discussed above in the section "Referrals of Homeless Individuals for Housing") and newly identified individuals arising from DSAMH's interactions with the State's Homeless Planning Council.[27]

The State is in Substantial Compliance with the Agreement's requirements with respect to Supported Housing.

J. Supported Employment

Substantial Compliance.

As is the case with respect to integrated supported housing, supported employment that enables members of the target population to hold ordinary jobs in their communities is a very significant "bottom line" measure of whether the array of new services required by the Agreement is actually working to achieve the goals of the ADA and *Olmstead.*

Past reports of the Monitor have referenced the positive working relationship between DSAMH and the Division of Vocational Rehabilitation (DVR) of the Delaware Department of Labor. People with SPMI represent a large portion of the population served by DVR, and DVR has allocated resources to enhance the capacity of DSAMH's ACT programs to assist their clients in entering the mainstream workforce. Figure-18, discussed earlier, reflects the products of this interagency collaboration.

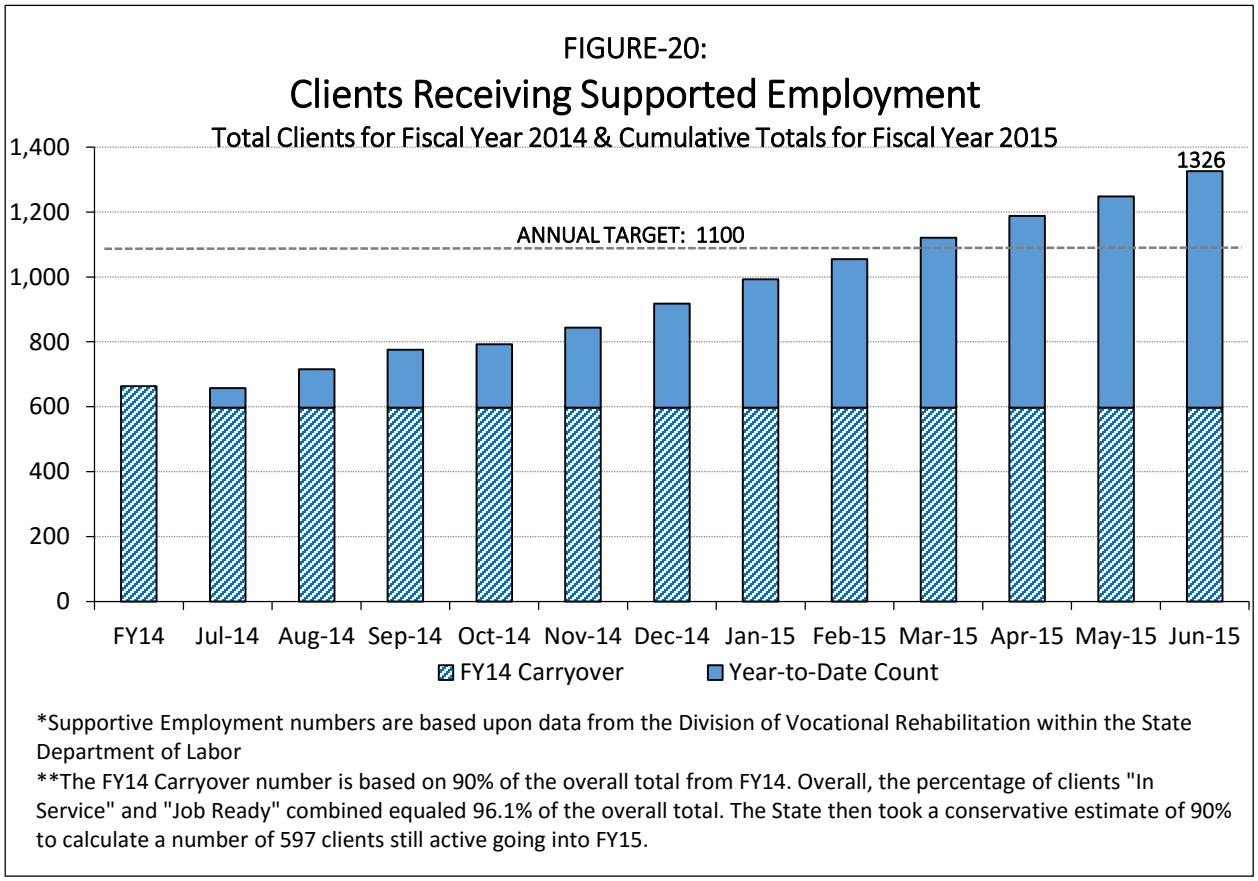
Sections III.J.1-4 of the Agreement require that the State provide supported employment services to a total of 1,100 individuals as of July 1, 2015. As is presented in Figure-20, the State is surpassing this requirement in that 1,326 members of the target population were receiving Supported Employment Services in the fiscal year by that date.

There are some factors in the federal program that is administered by DVR that present challenges to individuals with SPMI. Generally, DVR supported employment services terminate after an individual is employed in a job for 90 days, a federal limitation that was not designed with a mind to the needs of individuals with psychiatric disabilities. Given the combination of clinical, educational, and social factors confronting many members of the Agreement's target population, however, the State has recognized that these individuals may have a need for more extended supported employment services if their job success is to be sustained and enhanced. Accordingly, the PROMISE program includes coverage of individual and small-group employment supports that, as appropriate, may extend services well beyond federal limitations in DVR programs. The State is finalizing contracts with providers that will be certified to offer supported employment services through PROMISE to individuals who are not served by ACT or ICM; these are expected to go into effect in mid-December 2015. In addition, PROMISE includes other services that may directly assist members of the target population who are

[27] The 2016 Delaware Homeless Planning Council Point in Time count is specifically referenced in Section III.I.6.

participating in the mainstream workforce, including non-medical transportation, financial coaching and benefits counseling.

FIGURE-20:



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

**The FY14 Carryover number is based on 90% of the overall total from FY14. Overall, the percentage of clients "In Service" and "Job Ready" combined equaled 96.1% of the overall total. The State then took a conservative estimate of 90% to calculate a number of 597 clients still active going into FY15.

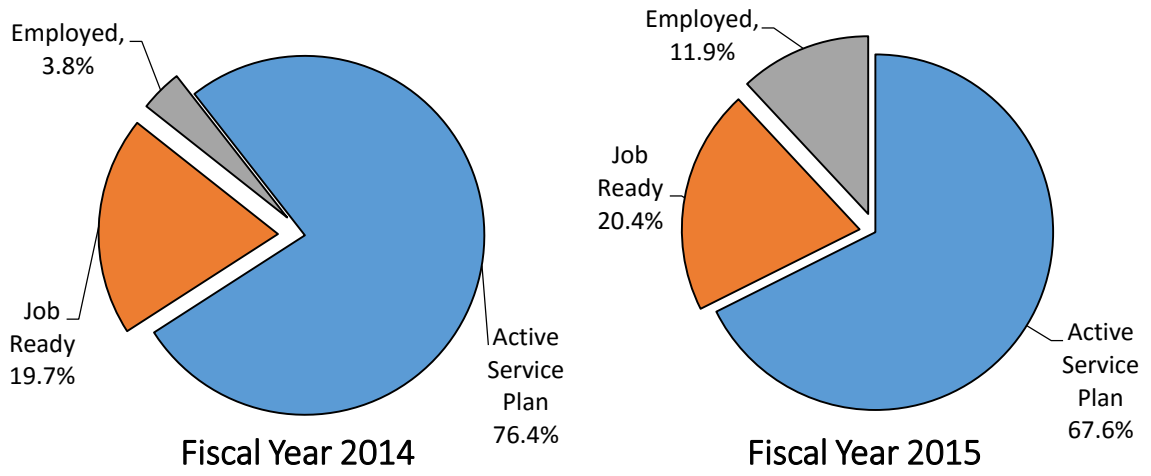
Figure-21 shows the State's progress in moving individuals through the Active Service Planning phase[28] and into Job Readiness and mainstream Employment. Each of the fiscal years presented represents a cohort of about 700 individuals, so a comparison based upon the percentages of individuals in each category can be easily made. In both years, about 20% of the target population receiving supported employment services was categorized as "Job Ready," meaning that they were at the point of actively seeking employment. In 2015, the State made dramatic gains in the proportion actually employed, increasing from 3.8% in 2014 to 11.9% — more than a threefold increase. Based upon the Monitor's consultation with vocational experts in the State, the primary barrier to even further improving this outcome has been limitations in the number of employment counselors. Although the effect will not be immediate, the new contracts for supported employment services through PROMISE should significantly address this limitation.

[28] As has been the case through monitoring of this provision, individuals are only counted toward compliance if they have an active service plan in effect or have move into stages of service beyond this, i.e., job readiness or actual employment.

FIGURE-21:

SUPPORTED EMPLOYMENT

CATEGORIAL BREAKDOWN OF CLIENT STATUS



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

The State is in Substantial Compliance with the Agreement's provisions relative to Supported Employment.

K. Rehabilitation Services

Substantial Compliance.

Rehabilitation Services comprise a diverse array of supports that enable the individual to advance social, functional, or educational skills within integrated settings. They include various training, substance abuse treatment and recreational activities. Section III.K.4 of the Agreement requires that the State provide Rehabilitation Services to at least 1,100 members of the target population. Replicating measures that have been used in past reports of the Monitor, DSAMH was providing services as follows to the targeted population during Fiscal Year 2015:

Psychosocial Rehab Services, Psychosocial Group Services, or Family Psychosocial Education —at least twice/month for at least 6 months .....517 individuals

Some level of Substance Abuse Treatment for a co-occurring disorder.....1,593 individuals

Total.....2,110 individuals[29]

[29] There may be some duplication among individuals receiving the two categories of Psychosocial Services, however, the Substance Abuse Treatment category, alone, fulfills the requirements of Section III.L.4.

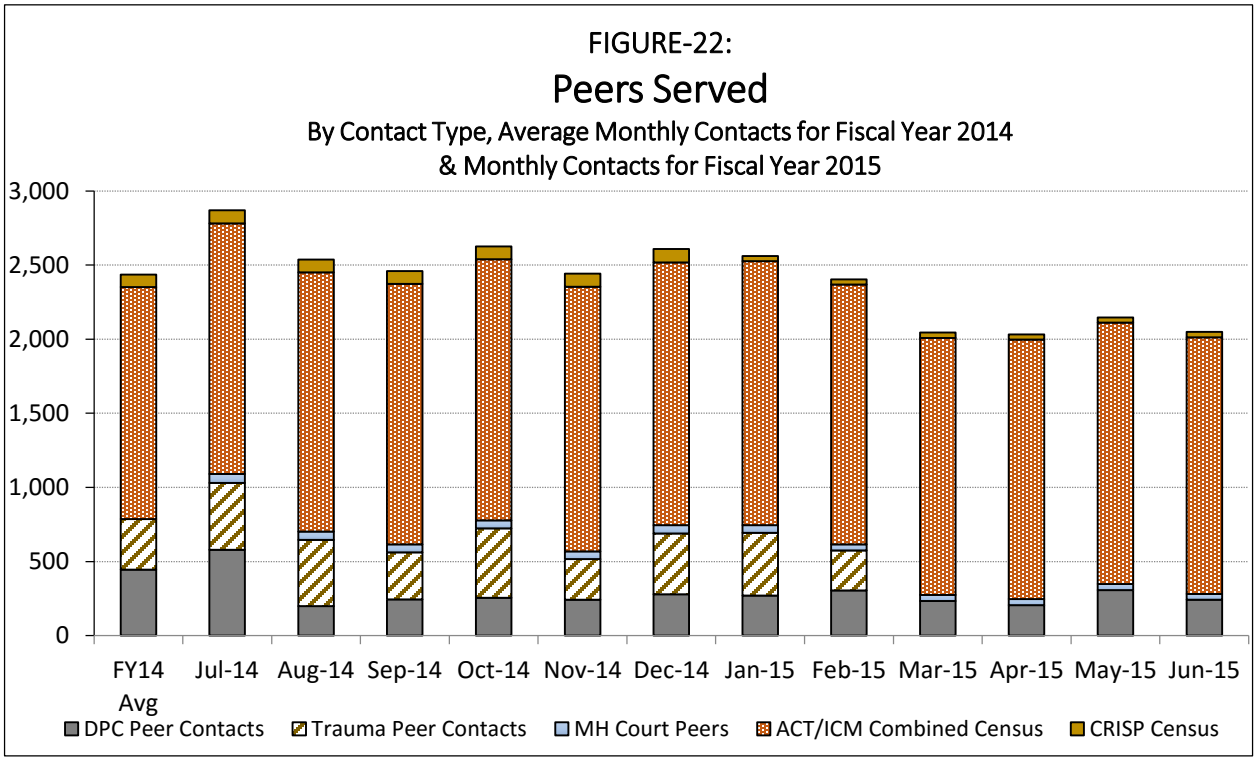
The State is in Substantial Compliance with the requirements of the Agreement relating to Psychosocial Services.

L. Family and Peer Supports

Substantial Compliance.

Sections III.L.1-4 of the Agreement require that, by July 1, 2015 the State provide 1,000 individuals with family or peer supports. The State's data systems are best able to track the provision of peer supports and, on this aspect alone, it has met its requirements. As is presented in Figure-22, about 2,000 individuals received peer services each month. This number represents a reduction from past months because a federal grant supporting an important peer-operated trauma program ended March 1, 2015. Nevertheless, the State is exceeding the requirements of the Agreement.

Past reports of the Monitor have referenced the impressive growth in DSAMH's peer network, whereby individuals who have "lived experience" with SPMI provide a variety of support services to members of the target population, including innovative approaches to individuals at the point of admission to or discharge from DPC; engagement with individuals who have received long term services within the hospital; participation as members of ACT, ICM, and some TCM teams; on-site staffing of Crisis Apartments; and operation of peer-run centers such as the Rick VanStory Center and the Creative Vision Factory in Wilmington (which



have been referenced in past reports). During the past several months, the Monitor had an opportunity to visit another peer-run program serving individuals in southern Delaware, the ACE (Acceptance, Change, and Empowerment) Peer Resource Center in Seaford. The ACE Center, which is funded by DSAMH, serves over 200 individuals. It is a vibrant program that welcomes individuals with SPMI who typically are confronting multiple challenges, such as substance use, homelessness, unemployment, and histories of trauma or incarceration. The Center works closely with other community programs, including the Crisis Walk-In Center in Ellendale and the southern Delaware Mobile Crisis program. It demonstrates an approach that is present in other peer programs the Monitor has visited in the state that is characterized by acceptance, fellowship, mutual support, and sharing. Members of the ACE Center with whom the Monitor met are rightfully proud of their accomplishments and eager to expand their program through extending its hours of operations and overcoming transportation challenges that are inherent to its rural service area.

The State is in Substantial Compliance with respect to the Agreement's requirements relating to Family and Peer Supports.

M. Community Involvement in Discharge Planning

Partial Compliance.

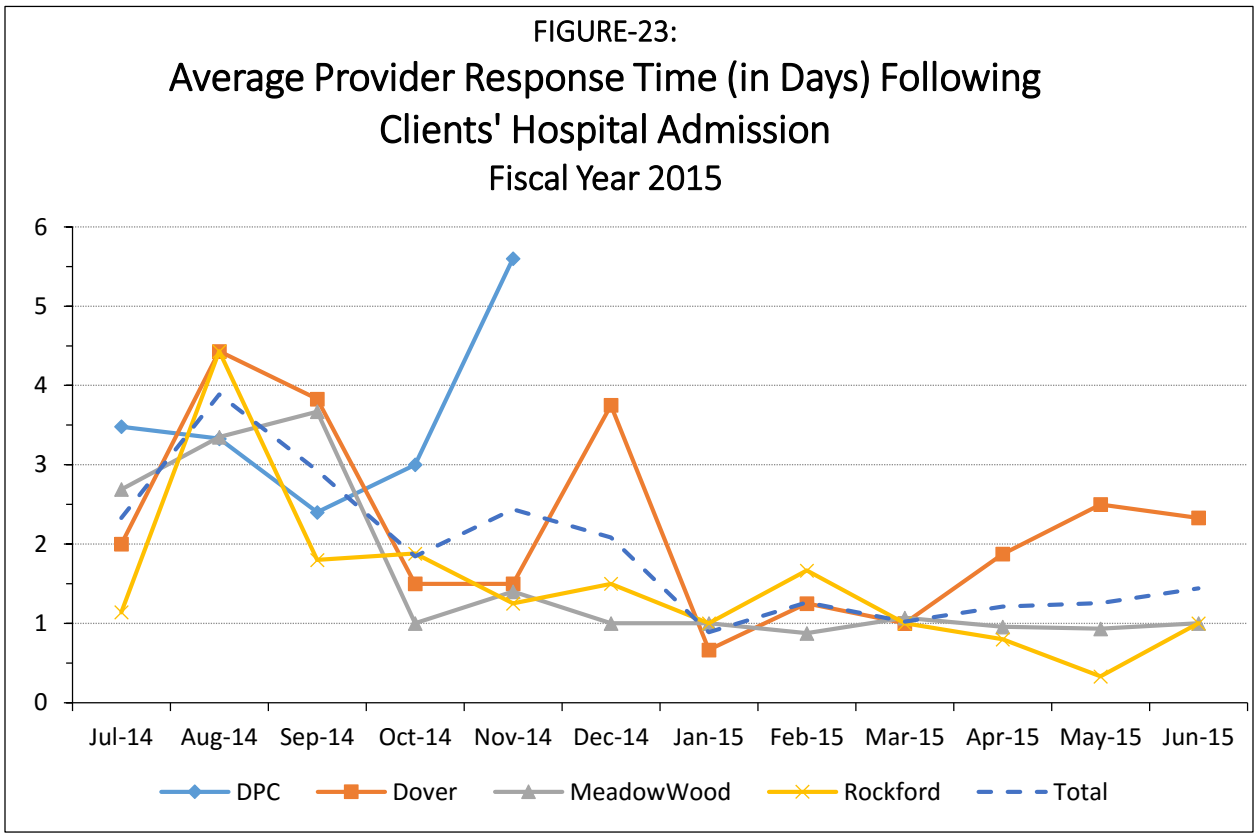
Sections II.C.2.d.iii-iv of the Agreement require the timely involvement of a community provider to assist in discharge planning when an individual is admitted to DPC or an IMD for acute care.[30] In the past, the Monitor had found that this requirement was being inconsistently met with regard to individuals whose care is managed through DSAMH and that the requirement was essentially not being met at all with regard to those whose care is managed through DMMA. At the time of the Monitor's last report, the State was implementing significant new changes in processes and oversight relating, directly or indirectly, to its compliance with these requirements. Because it had not yet begun reporting data on the impact of these changes with respect to timely provider involvement in discharge planning, this aspect of discharge planning was not evaluated in the Monitor's last report. These data are now available and, as is discussed below, the State is beginning to show progress.

To briefly summarize these requirements and related discussions, the Agreement specifies that community providers become involved with an individual within 24 hours of admission to an IMD or DPC for acute care, with the goal of coordinating treatment and ensuring timely and seamless discharge. For a number of reasons, this proved to be challenging to the State. For instance, a substantial number of individuals whose care was managed through DMMA and the MCOs had no community provider with whom to coordinate. Furthermore, the State raised the reasonable point that critically important communication upon admission was

[30] A related provision of the Agreement is Section IV.B.4, which sets standards for the timeliness of community placement for discharge-ready individuals. This provision is mostly relevant to people at DPC who are receiving intermediate- or long-term care. The Monitor's next report will include an evaluation of the State's compliance with this provision.

often not so much with a community case manager (who would be tasked with making face-to-face contact), but between the hospital psychiatrist and the individual's community psychiatrist (where one exists). This could most readily take place via phone. With concurrence of the Monitor, the State has moved forward with requiring such doctor-to-doctor consultations and with initiating mechanisms to track the timeliness of community involvement, whether on the physician level or otherwise. Figure-23 presents the State's data showing the first contact—either between physicians or social workers. While one IMD (Dover Behavioral Health) is an outlier, the overall trend has been toward more timely involvement. The State did not provide current data with regard to the timeliness of community involvement at DPC, however, the last reported period was very much out of compliance with the Agreement's requirements. It is noted, though, that DPC has greatly improved its processes for notifying providers and inviting their participation when one of their clients is admitted.

FIGURE-23:



For Medicaid-covered individuals who are not served through DSAMH or the PROMISE program and who do not have a community provider, there have been procedural improvements, as well. The State's agreements between DMMA and DSAMH, as well as its new contracts with MCOs, encourage collaborative communication upon an individual's hospital admission, including timely involvement of TCM to link these individuals with the community services they need.

Overall, the State remains in Partial Compliance with these provisions concerning discharge planning, but it is making progress. Data reports by DPC that align with those being provided by the IMDs, as well as data relating to the involvement of TCM with individuals who do not have a community provider can further document the impact of the service improvements referenced.

N. Quality Assurance and Performance Improvement

Partial Compliance.

Section V.A of the Agreement requires the State to maintain a system of Quality Assurance and Performance Improvement (QA/PI) to ensure that services are of appropriate quality to achieve the Agreement's goals and to promote ongoing improvements. The Agreement covers services within hospitals, those of community providers, those provided or managed through DHSS divisions (DSAMH and DMMA), and those of other State Departments (e.g., DVR and the Delaware Housing Authority). Accordingly, QA/PI activities are quite diverse, sometimes entailing formal research protocols and sometimes simply entailing the use of data to monitor outcomes and drive system improvements. With regard to the latter, a number of QA/PI initiatives have already been referenced in this report. These include the State's actions to evaluate the adequacy of ACT services with respect to clients appropriately maintaining their living environments; resultant measures include more intensive ongoing monitoring, termination of relationships with problematic landlords, and plans to use PROMISE services to bolster the capacities of ACT teams to address personal care and chore service needs. A second example is the State's effort to address the underuse of the Crisis Apartments; the identification of this problem, as well as the State's progress in remedying it, are reflected in the Figure-10's trending data. Finally, TMACT and the numerous ACT/ICM outcomes measures (Figures-13 through -18) demonstrate the State's QA/PI efforts with respect to these important programs. As was discussed in the relevant section of this report, these data drive corrective action plans of the various teams and, in some instances, have resulted in termination of poorly performing programs.

There are additional, more formal QA/PI efforts that the State carries out in collaboration with the University of Pennsylvania's Perelman School of Medicine (UPenn). These include a QA/PI initiative entailing Quality Process Reviews of ACT/ICM services. This research incorporates consumer interviews and chart reviews with regard to such issues as: the perceived impact of services on housing, employment, one's sense of autonomy, and physical and mental health; where services are being provided; and how services could be improved. The State is pursuing practical application of its findings by reviewing them with providers and requiring that they formulate plans to improve services accordingly.

Another initiative being carried out through UPenn that has great significance to its QA/PI requirements is a comprehensive study (referenced earlier) of cohorts of the target population that enter services for each year of the Agreement's implementation. The overarching goal of this research is to examine how each of these groups is served as Delaware's community system expands in scope and capacity, in keeping with the Agreement's requirements. This

initiative provides a rich data set characterizing patterns of care that, when more fully used by the State, can define and drive important system improvements. This is particularly relevant to the challenges the State is facing with regard to reducing the number hospital bed-days.[31] Among the pivotal QA/PI issues that the State might examine and incorporate in service practices are the characteristics of the individuals that account for the increases in hospital bed use, including their diagnoses and patterns of service utilization prior to admission. Such information could be helpful in identifying gaps in the access to, scope of, or timeliness of services prior to admission. For individuals who have already had episodes of inpatient psychiatric care, the data set can help identify the clinical profiles and patterns of service use that define heightened vulnerability to re-hospitalization or, in the alternative, factors that appear to insulate individuals from hospital admission. One significant finding arising from UPenn's data is that individuals who have not been hospitalized during the duration of the study may still be experiencing crises; they have high use of emergency rooms.[32] Relevant to this finding, the State might examine the more specific predictors of emergency room episodes and what "upstream" services might avert the underlying crises. Unfortunately, as things now stand, the State appears to do little beyond receiving the data from the researchers relating to its cohort analyses of service patterns.[33]

In summary, the State is collecting very good data relating to quality measures and, in some instances, is using this information to drive system improvements. But there are also many instances where important data remain just that; sets of statistics where there is no evident analysis or application of findings. Past evaluations by the Monitor have found the State to be in Substantial Compliance with respect to QA/PI, however, in consultation with the State, the Monitor has strongly encouraged that it move forward in incorporating relevant data into service refinements.[34] The Agreement requires that the State maintain a "Quality Assurance and Performance Improvement *System*,"[35] and at this point in implementation, such a program should be operational. Unfortunately, QA/PI functions remain much more piecemeal than systemic. DSAMH has recently presented plans to better unify, align, and evaluate the various QA/PI efforts affecting the target population, a move that may well address what is currently lacking, particularly if it includes members of the target population who are served through DMMA and are not receiving specialized services. At this juncture, the State is in Partial Compliance with the Agreement's requirements relative to Quality Assurance and Performance Improvement.

[31] This was discussed in the section of this report relating to Crisis Stabilization.

[32] Of 752 individuals in the study's Cohort 2 who were not hospitalized between 2010 and 2014, 64.2% had an emergency room visit. Of the 47 individuals who were very high users of hospital care, in that they were hospitalized in each of these 4 years, emergency room use was 80.9%.

[33] The State has noted that its work pursuant to the State Innovation Model is relevant to averting intensive services through earlier intervention, but it has provided the Monitor with no data demonstrating how this initiative has bearing on the Agreement and the population it targets, or how service utilization patterns identified through UPenn's analyses integrate with this initiative.

[34] One example is in reference with UPenn's cohort analysis, where the State has repeatedly cited declining rates of readmission between successive cohorts, but (as discussed above) has not taken any evident measures beyond citing these statistics.

[35] Agreement, Section V.A. Emphasis added.

O. Risk Management

Partial Compliance.

Previous reports of the Monitor have described how, mostly as a result of an accumulation of bureaucratic requirements over the years, Risk Management functions affecting the target population have been dispersed over various offices and divisions within DHSS. The Monitor's past reports discussed a major restructuring of these functions that is underway and that should greatly consolidate information and position the State to take measures to reduce the risk of harm to service recipients.

At the same time, it is essential that the State fulfill its obligations relative to Risk Management as these improvements are being rolled out. The State is conducting mortality reviews, in some instances, including detailed analyses of individuals' clinical records and meetings with providers. Other actions to identify and address risks of harm, which the Agreement defines as "any physical or emotional injury, whether caused by abuse, neglect, or accidental causes,"[36] are being carried out in a much less systematic way. The State has been providing the Monitor with incident reports relating to those members of the target population that are being served by community providers operating under contract by DSAMH. It has not been providing data relating to Risk Management at DPC, although it certainly has access to such information. Furthermore, it has provided no data relating to IMDs and it is unclear whether the State is even receiving such information, in conformance with Sections V.B.8. It is noted that the IMDs provide care to the vast majority of individuals among the target population who are being hospitalized. As such, it is critical that the State's Risk Management program incorporate these facilities, as well.

A spreadsheet provided by the State summarizing its actions relating to abuse and neglect allegations shows that only *nine* investigations were carried out during the 2015 fiscal year. In none of these instances was a root-cause analysis carried out, per Section V.B.4-5, although some level of corrective action was recorded for each. There is no evidence that the State is taking measures to ensure the effectiveness of these corrective actions (Section V.B.6). Furthermore, there is no evidence that the State is evaluating patterns of risk of harm and making related systemic improvements (Section V.B.9). None of these investigations related to treatment in DPC or the IMDs, and none related to members of the target population whose care is managed via DMMA.

In summary, the State has been moving forward with comprehensive improvements to its Risk Management program for about one year now,[37] but these reforms are not yet fully implemented and there remain very significant immediate gaps in meeting the requirements of Section V.B.1-9. Not only do these require immediate attention because risk reduction is inherently a serious matter, but to achieve Substantial Compliance with regard to Risk Management the State will need to produce comprehensive, timely, and consistent data demonstrating that it is meeting its requirements within the framework of the new processes it is

[36] Agreement, Section V.B.1.

[37] See "Sixth Report of the Monitor," December 29, 2014, p. 41.

putting in place. The State is rated as being in Partial Compliance with regard to the provisions contained in Section V.B, although in some important respects it is only "slightly above a non-compliance rating."[38]

III. Conclusion

As is detailed above, for the most part, the State is maintaining its progress in those areas of the Agreement where it has been in Substantial Compliance, but there are some other areas where it needs to accelerate its implementation of plans for improvements if it is to demonstrate that it has fulfilled the Agreement's requirements. Its greatest challenge relates to the hospital-use reductions that appear in Section III.D; these are important in themselves, but they are also closely intertwined with the effectiveness of the broad array of services and supports that are required in provisions throughout the Agreement. The State's long overdue action to insert some coherence and accountability into the process of referring Medicaid-covered members of the target population for these specialized services was an important step forward with regard to reducing hospitalizations, but this process was only implemented mid-way into the fiscal year covered by this report and, furthermore, some elements of the PROMISE program are still being launched. Properly applied, data discussed with regard to Quality Assurance/Performance Improvement (notably, data arising through the UPenn cohort research) can further drive system improvements and document a concerted effort by the State (both through DSAMH and DMMA) to address the root causes behind hospital admissions. There are significant and longstanding gaps in its Risk Management system and it has yet to be seen whether the improvements now being initiated will address them. In summary, in many respect Delaware has responded to the requirements of the Agreement in admirable—even exemplary—ways. For those areas still needing improvements, it has the tools required to achieve Substantial Compliance and with a focused effort, it can do so.

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Court Monitor

[38] "A partial compliance rating encompasses a wide range of performance by the State. Specifically, a partial compliance rating can signify that the State is nearly in substantial compliance, or it can mean that the State is only slightly above a non-compliance rating." Agreement, Section VI.B.3.g.ii.