SIXTH 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

December 29, 2014

I. Introduction

This is the sixth report of the Court Monitor (Monitor) on the implementation of the above-referenced Settlement Agreement (Agreement) between the United States, through the U.S. Department of Justice (DOJ), and the State of Delaware (the State). This report presents compliance data and ratings covering the six-month period January 16, 2014 through July15, 2014, and it also includes more recent findings with respect to certain aspects of the State's implementation efforts.

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

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

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

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

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

- Mr. A is a young man with a long history of substance abuse, a co-occurring mood disorder (possibly schizoaffective disorder), and history of suicide attempts, for instance, attempting to hang himself while in jail. He was hospitalized after slicing his neck with a knife.

- Ms. B is a middle-age woman who has been homeless for about 9 years, has a history of bipolar disorder and co-occurring substance use and psychiatric hospitalizations. She was re-hospitalized after she stopped eating, discontinued her medication in an attempt to trigger a diabetic coma, and threatened to shoot herself.

- Ms. C is a young woman who was homeless and living in a hotel. She is reported to have a long history of violence and is diagnosed with Bipolar Disorder and co-occurring substance use. Ms. C has had multiple admissions to psychiatric hospitals and was complaining of depression at the time of this hospital admission. At some

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

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

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

As is described later in this report, the State has only recently launched an initiative whereby DMMA has begun to systematically refer at least some of the individuals with the most obvious need for specialized services (as evidenced by multiple admissions to psychiatric hospitals) to DSAMH for services[4]. Up until now, not only has there been no such concerted effort, but even the entity responsible for making such referrals—an MCO, DMMA, or an IMD—has remained vague. For the State to meet its obligations under the Agreement, it will need to aggressively move forward on initiatives such as this to ensure that individuals are appropriately referred for specialized services and that those whose care remains managed through DMMA are also afforded access to needed services.

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

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

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

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

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

II. Progress on Structural Improvements

A. Targeted Priority Population List:

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

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

- Treatment at DPC 9.1%
- Treatment in an IMD 59.3%
- Criminal justice contact 18.0%
- Homeless 11.1%
- Emergency Room use for mental health 33.6%

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

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

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

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

B. Delaware Psychiatric Center:

Evaluation of Individuals Discharged Following Long Hospitalizations:

The Monitor's prior reports presented data relating to the positive outcomes for individuals who were discharged from Delaware Psychiatric Center (DPC) following extended continuous hospitalizations, defined as 60-days or longer. As is evidenced by their protracted hospitalizations—in some instances, decades-long—such individuals tend to present special service challenges. Thus, how they fare is an important indicator of the effectiveness of community alternatives to inpatient care. Figure-1 presents an update on this

Figure-1: Readmission Rates for Individuals Discharged from DPC Following Long-Term Care (FY 2014)

	30-DAY READMISSION RATE	180-DAY READMISSION RATE
Post-Discharge DPC Population of 102 Individuals:		
Readmission Rates*	8.8%	15.7%
Comparison Rates:		
U.S. Rates (SAMHSA, 2013)**	8.6%	20.3%
DPC Rates (2013)**	16.0%	32.0%

* Based upon all clients discharged within FY14 from DPC following lengths of stay of 60+ days

** U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, National Outcomes Measures, 2013.

population for Fiscal Year 2014[6] with respect to 102 such individuals. The vast majority of them receive ACT or other intensive mental health services within the community.

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

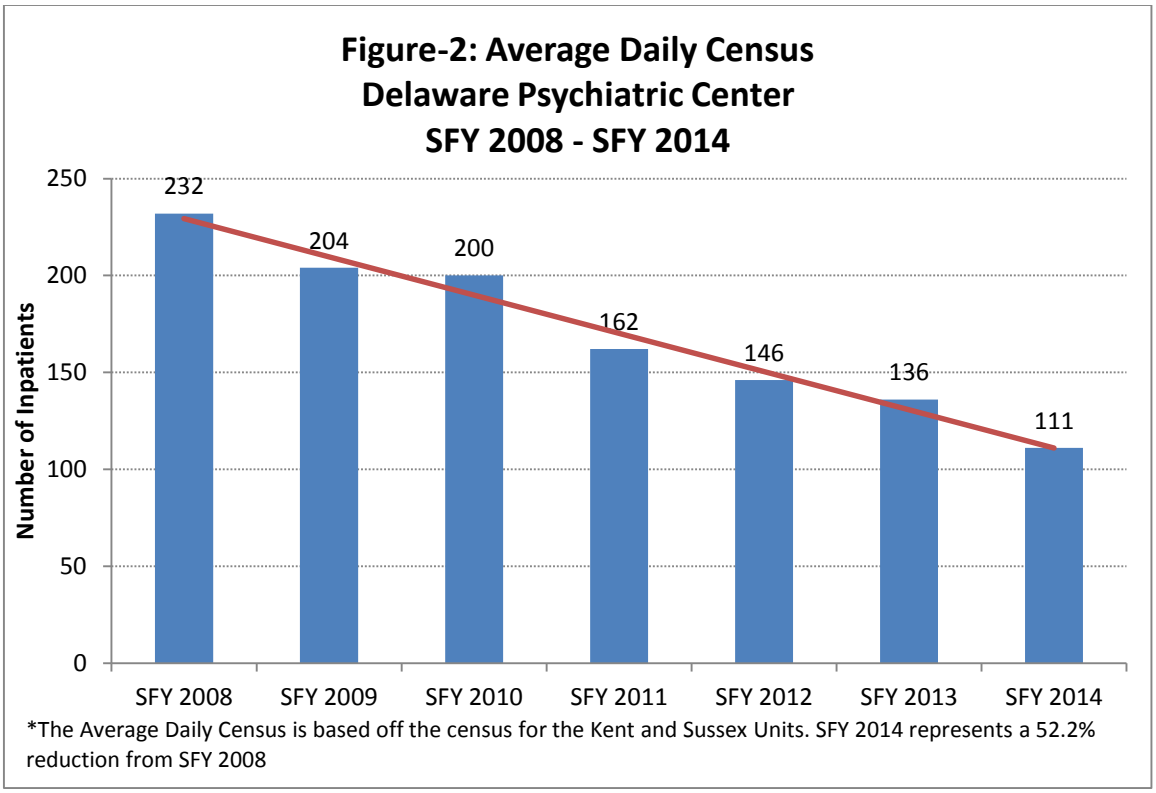
The much higher percentages of readmissions reflected in DPC's overall recidivism rates—16.0% within 30 days and 32.0% within 180 days—represent individuals who had been hospitalized for much shorter durations. While some of these individuals were served by ACT teams, as is described later in this report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

Facility Downsizing & Repurposing:

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

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

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



C. Reliance on Court-Ordered Treatment

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

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

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

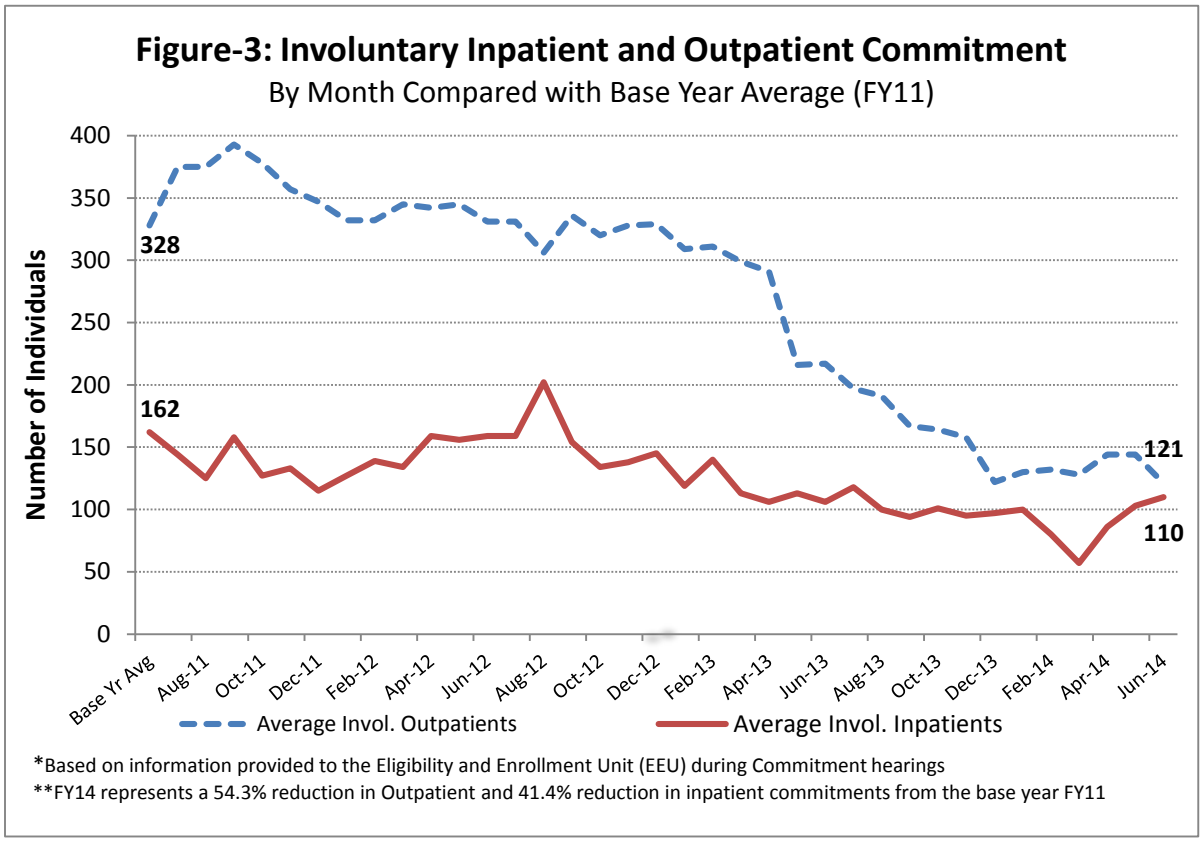
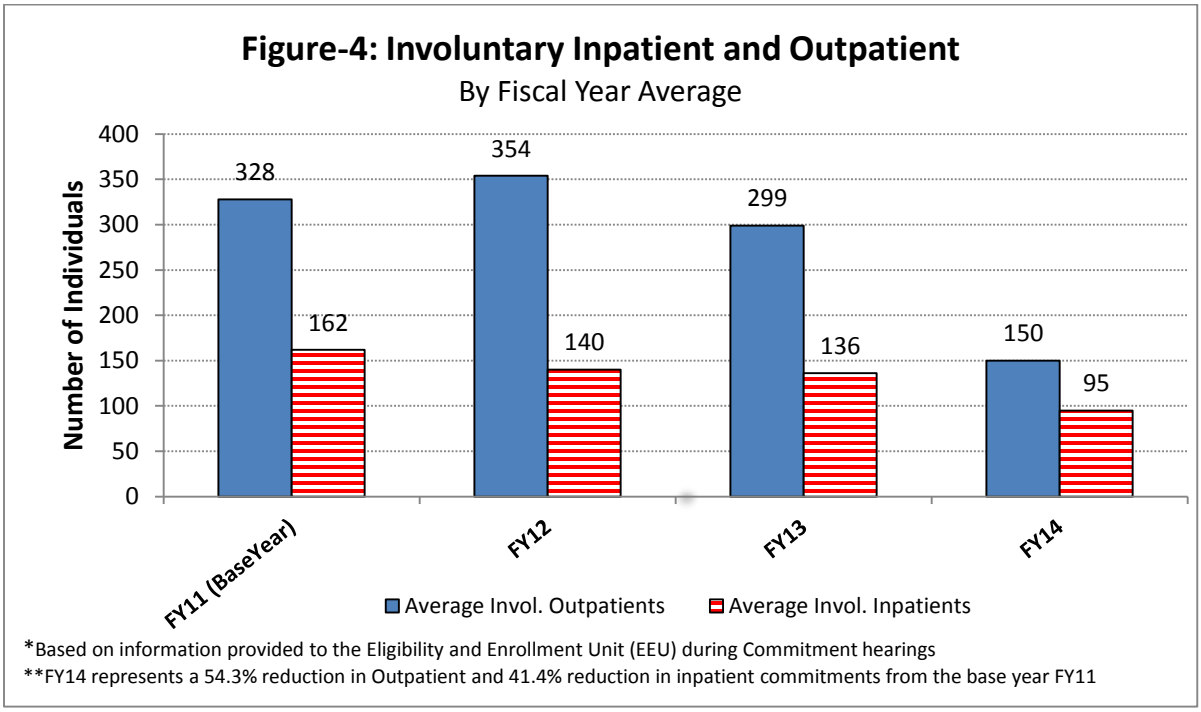


Figure-4 presents these data in a slightly different format, showing the average number of inpatient and outpatient commitments for each fiscal year since 2011.

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

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



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

III. Ratings of Compliance with Specific Provisions of the Agreement

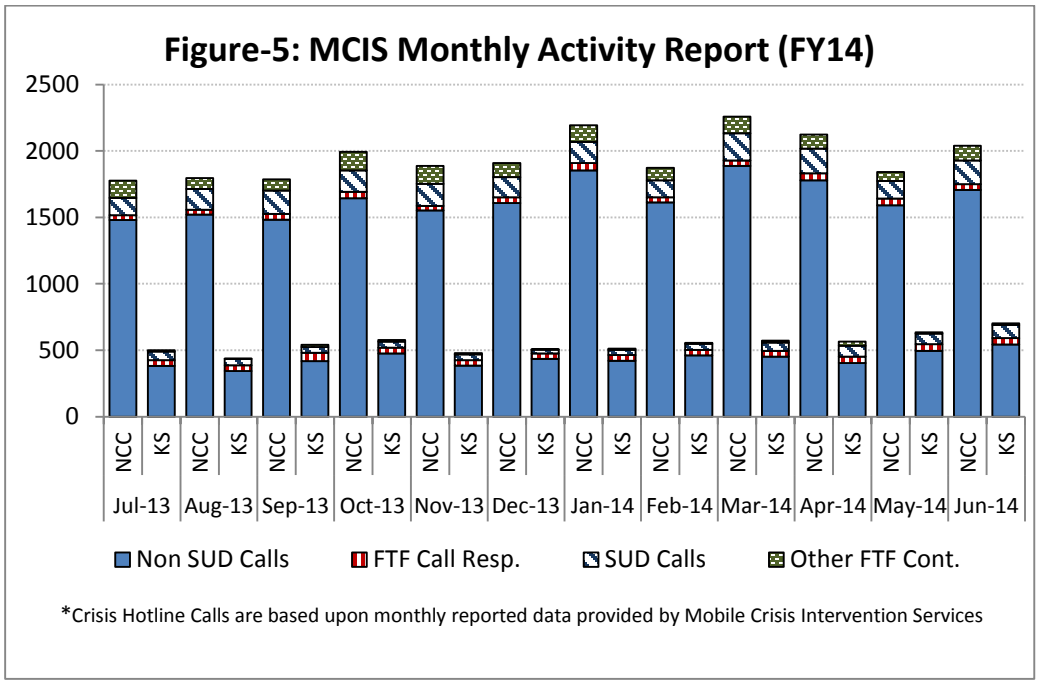
The following sections present ratings of the State's compliance with respect to provisions comprised by Sections II-V of the Agreement, including those with specific numerical targets. As of July, 2014 and based upon available information (i.e., given the limitations in information about people served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

A. Crisis Services

Substantial Compliance.

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

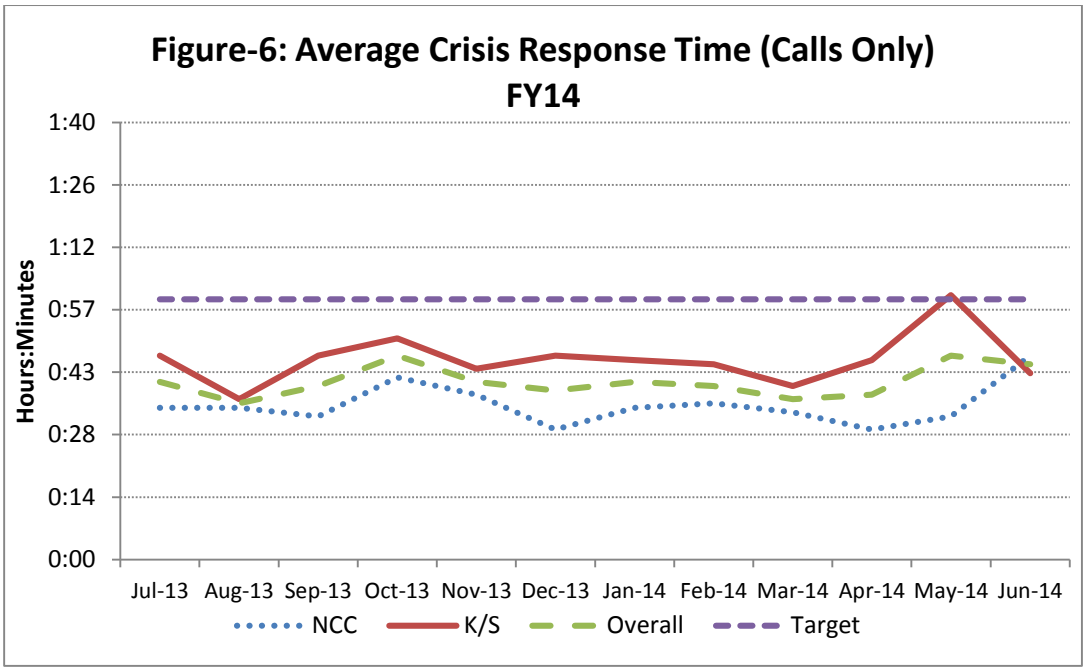
As would be expected based upon the population distribution in Delaware, the bulk of the calls come from New Castle County, where the State's residents are most concentrated. However, staff reports indicate that calls emanating from Kent and Sussex Counties, which are more rural, tend to be more acute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



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

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

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

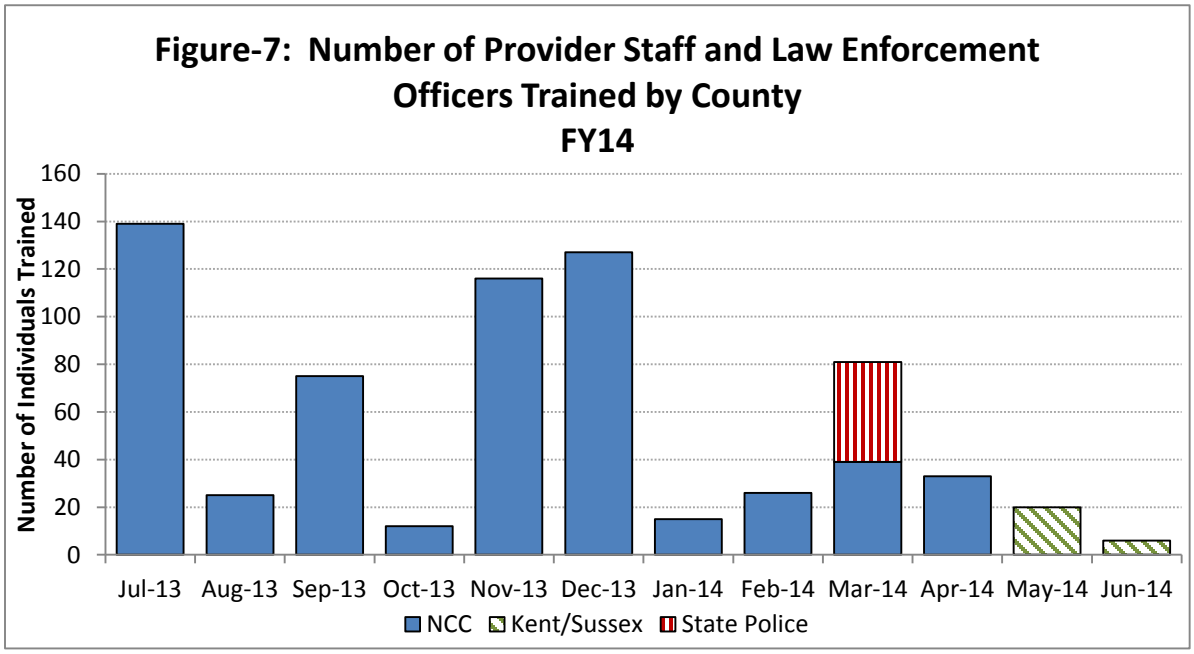


The State's Mobile Crisis program is not limited to one-time emergency interventions. Mobile Crisis responders routinely reconnect with at-risk individuals, either in person or by telephone, for follow up activities such as wellness checks or to deliver medication. In addition, the program is well integrated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

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

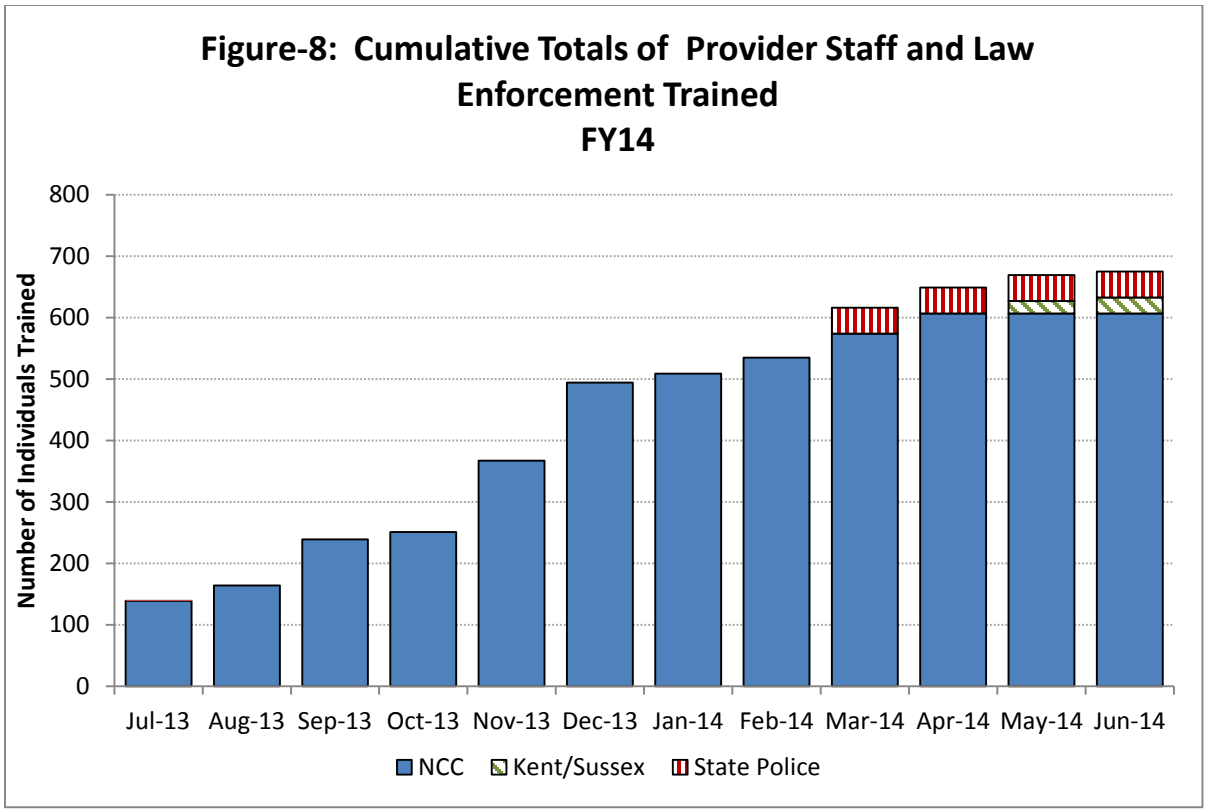
Recovery Response Center ("RRC," the Crisis Walk-In Center in Ellendale) to address thoughts of suicide and Mr. E, who was under a 24-Hour Detention to and from a medical consultation that had been requested by the RRC. These functions are not only far less costly to the State, but also are likely far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

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



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

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



B. Crisis Walk-in Centers

Substantial Compliance.

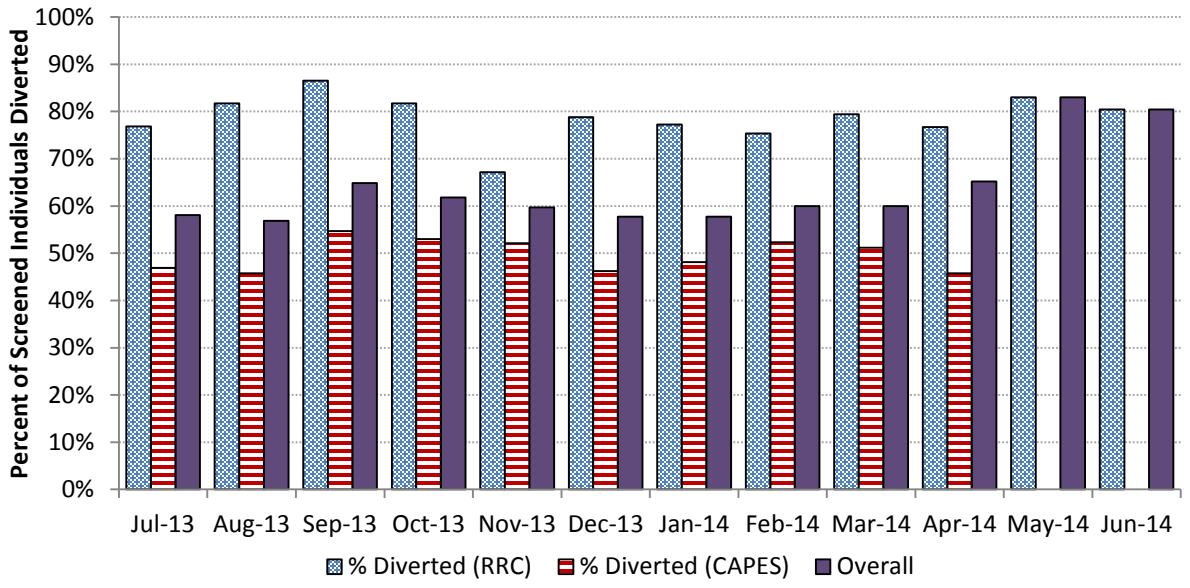
Crisis Walk-In Centers are another critical element of the State's service system. Their goal is to provide intensive, short-term assessments of individuals who are in crisis and whose issues cannot be resolved at home (e.g., through Mobile Crisis), and to implement intervention plans that represent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

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

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

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

Figure-9: RRC and CAPES Hospital Diversion Rates FY14



CAPES data not reported for May and June, 2014

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

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

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

Recommendation-

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

C. Crisis Stabilization Services

1. Reduction in Inpatient Bed Days:

Partial Compliance.

Issues in Measuring Compliance

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

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

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

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

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

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

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

[8] This was described in the Monitor's last report.

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

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

Later in October, the State agreed to set aside its challenges to the diagnostic criteria used to identify the population being monitored and to revert to the original approach. Accordingly, IMD bed-days would once again be counted for individuals whose care is managed through DMMA when one or more of their discharge diagnoses appear on a diagnostic list that the Monitor constructed in 2011 in collaboration with DSAMH, DMMA, and the MCOs. These data are presented in Figure-10.[12] As has been the case throughout the Agreement, all

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

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

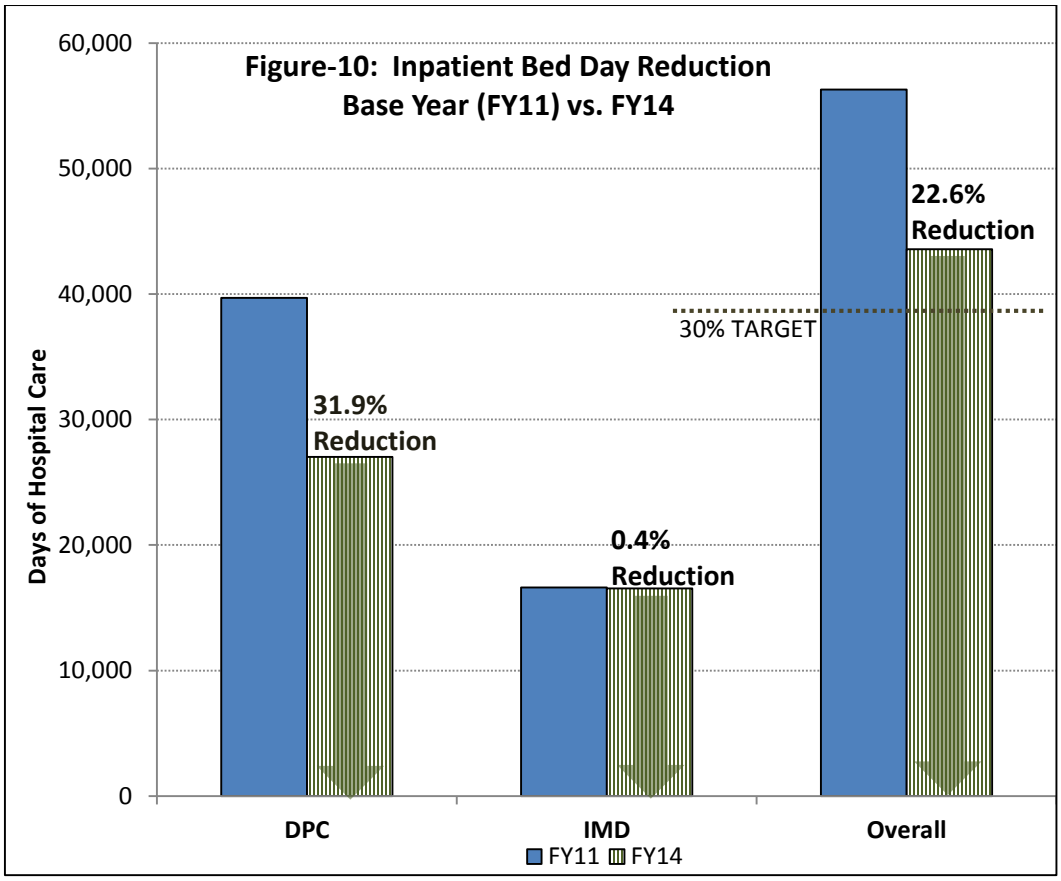
[11] The MCO explained that hospitals have up to 90-days to bill for care, but that claims are overwhelmingly settled much sooner, within 30 days.

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

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

Bed-Use Data

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

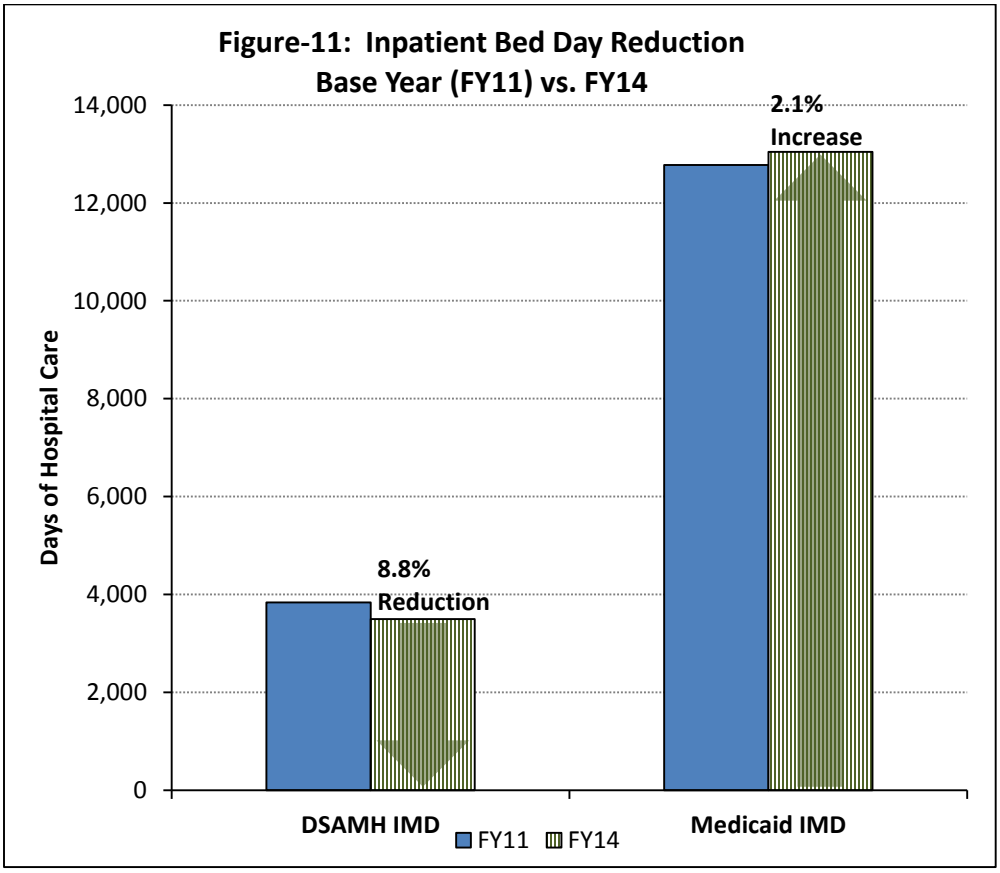


Because of its relevance to the Agreement and the ADA, with concurrence of the parties, the Monitor has been including the long-term care population at DPC in calculations of hospital

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

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

Figure-11 presents data about the first of these factors, demonstrating that there are significant differences in bed-use managed through DSAMH, compared with that managed through DMMA. Clinically, these populations are similar. And to the extent that differences do exist, DSAMH is managing hospital care for a generally more complex group of individuals (e.g., people who have been referred for its specialized services or DMMA-managed individuals whose needs are such that they had exhausted their Medicaid inpatient benefit[13]). As is depicted in Figure-11, relative to the base year, DSAMH-managed acute hospital days have decreased by 8.8%—a divergence from the 30% target of 21.2%—while DMMA-managed hospital days have *increased* by 2.1%—a divergence from the July target by 32.1%.



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

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

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

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

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

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

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

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

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

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

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

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

Recommendations:

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

2. Discharge Planning:

Partial Compliance.

Sections II.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. The Monitor's last report 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.

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

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

D. Crisis Apartments

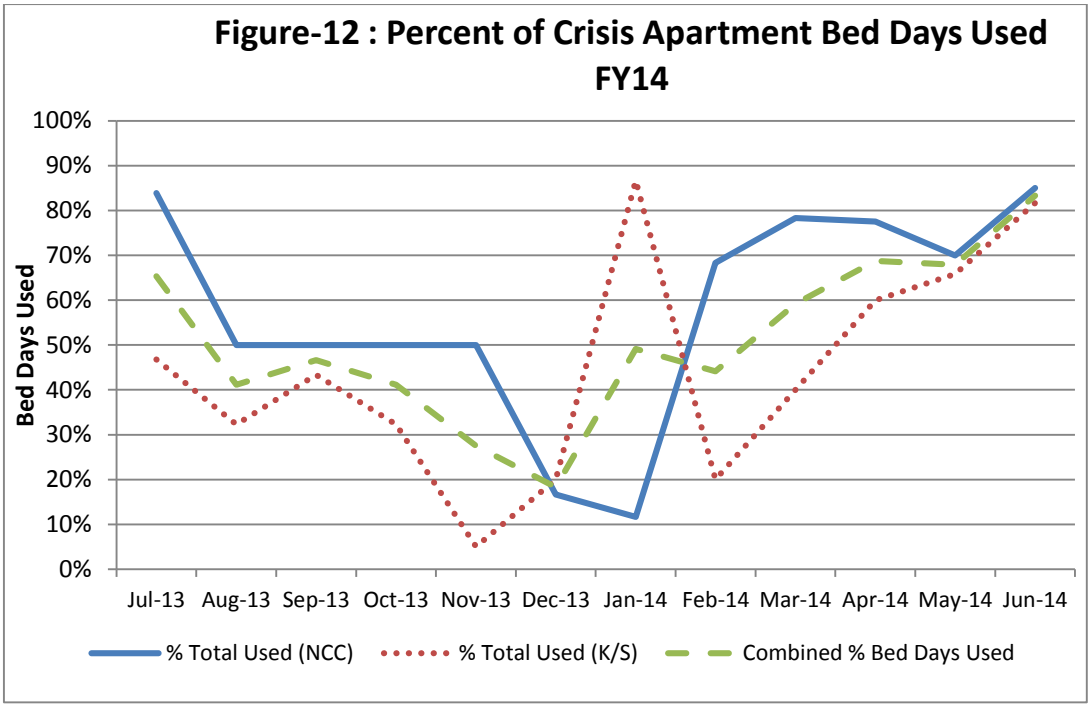
Substantial Compliance.

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

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

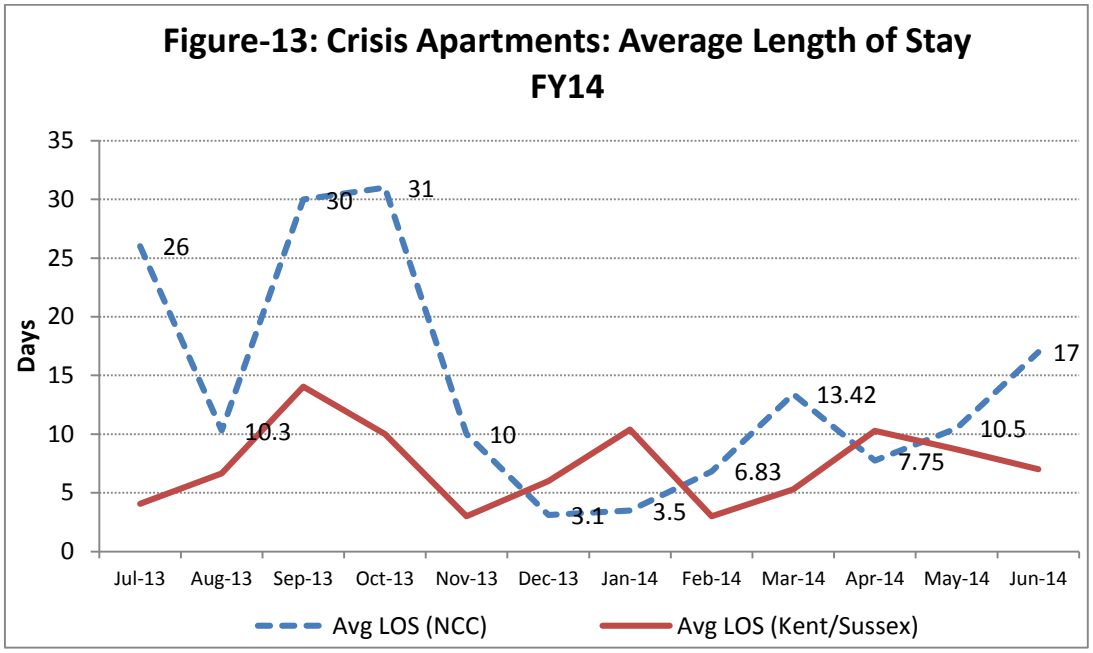
Landlords that had been leasing units to house this program became concerned about their use by transient residents who were not only unknown to them but, by program design, were experiencing psychiatric emergencies. Accordingly, during the 2014 fiscal year, the State relocated its crisis apartment programs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

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



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

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



E. Assertive Community Treatment

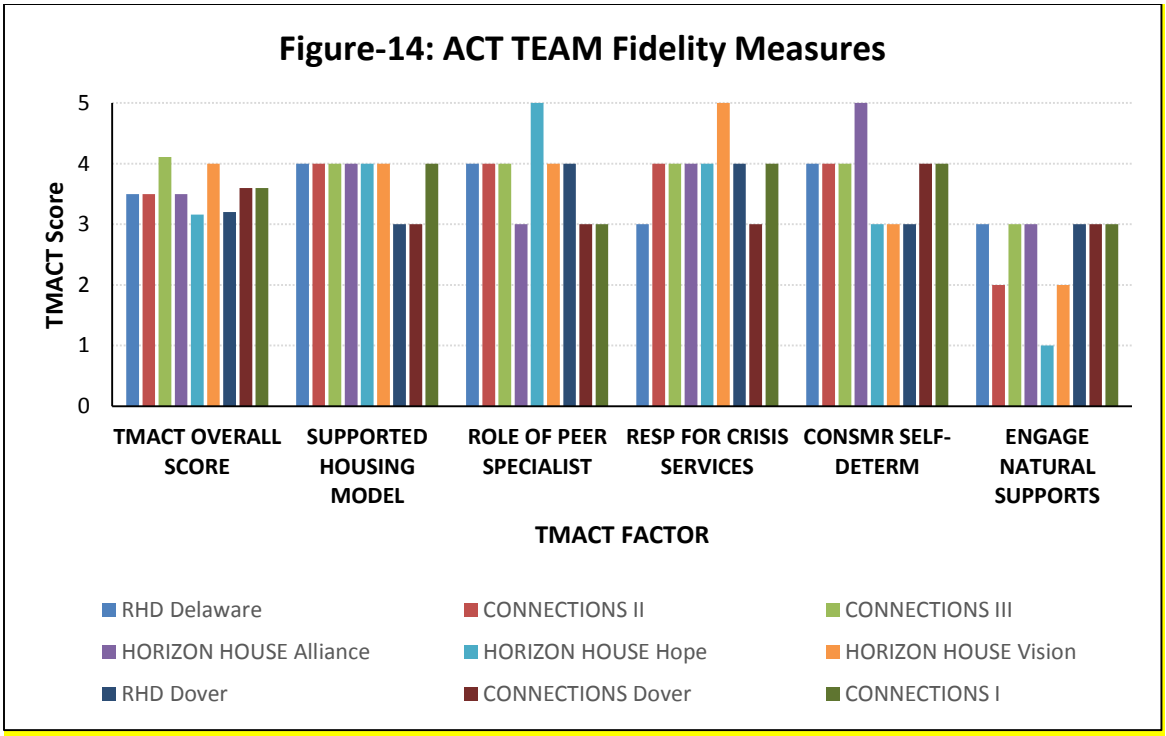
Partial Compliance.

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

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

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

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



.

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

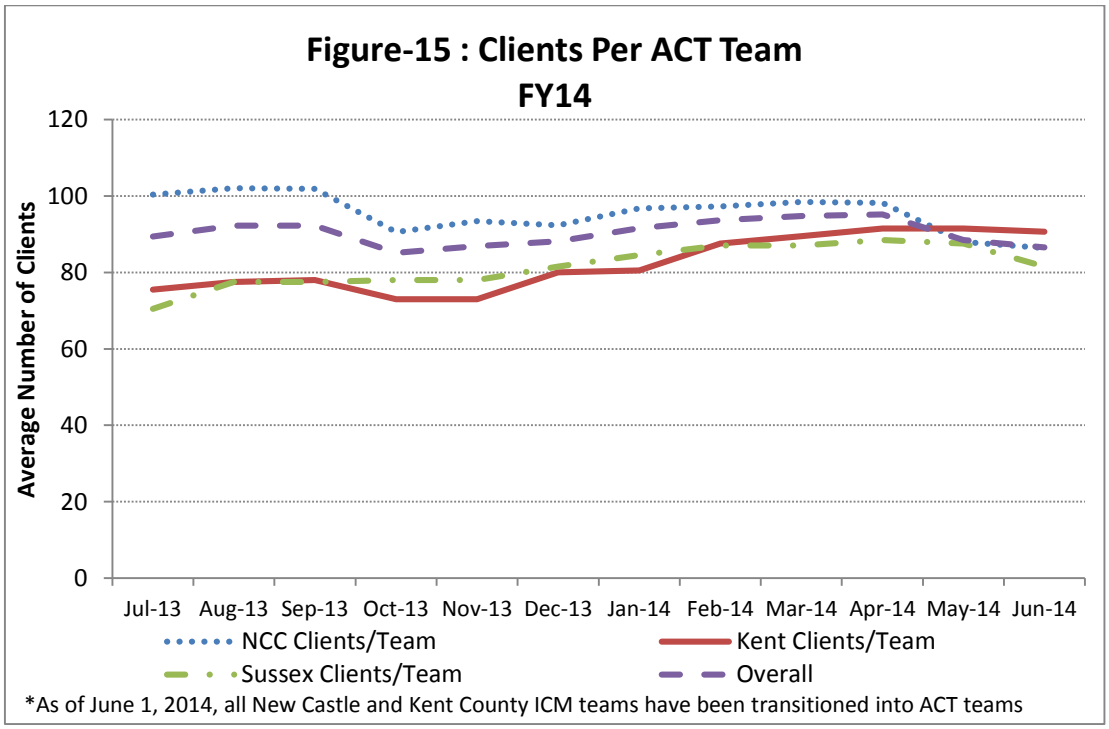
[18] Two of the teams had not yet reached the point where a formal review is conducted. A number of teams were about to have their annual reviews, so more current data are forthcoming.

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

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

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

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



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

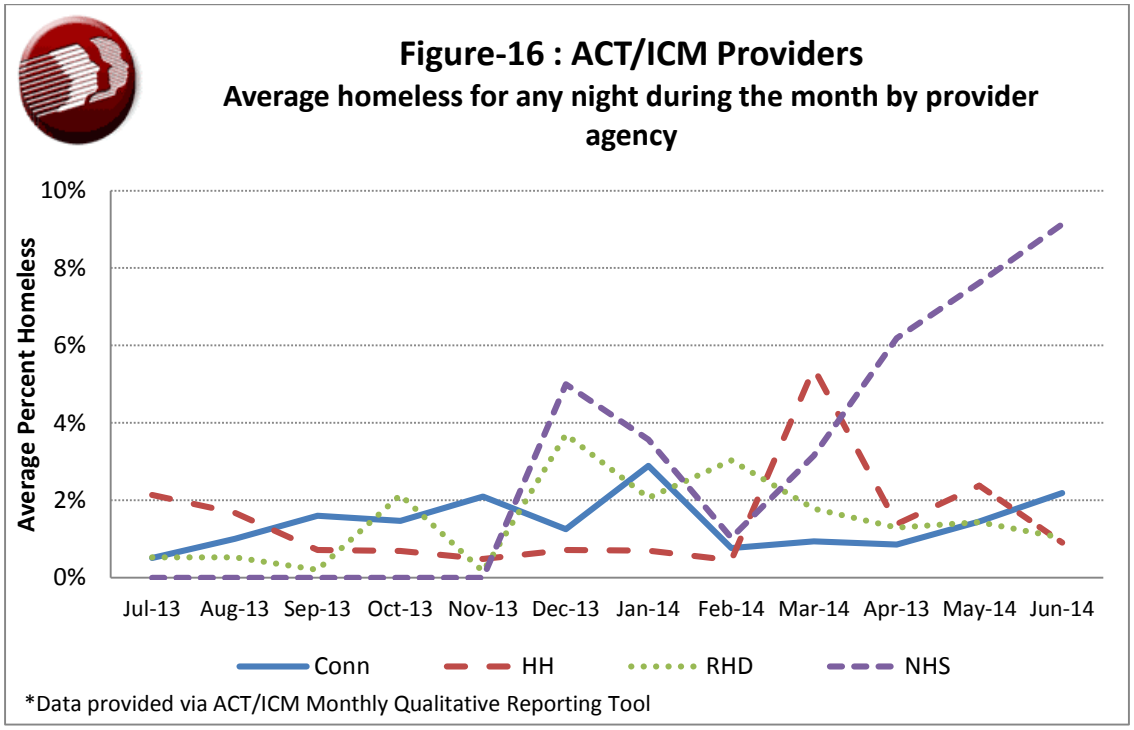
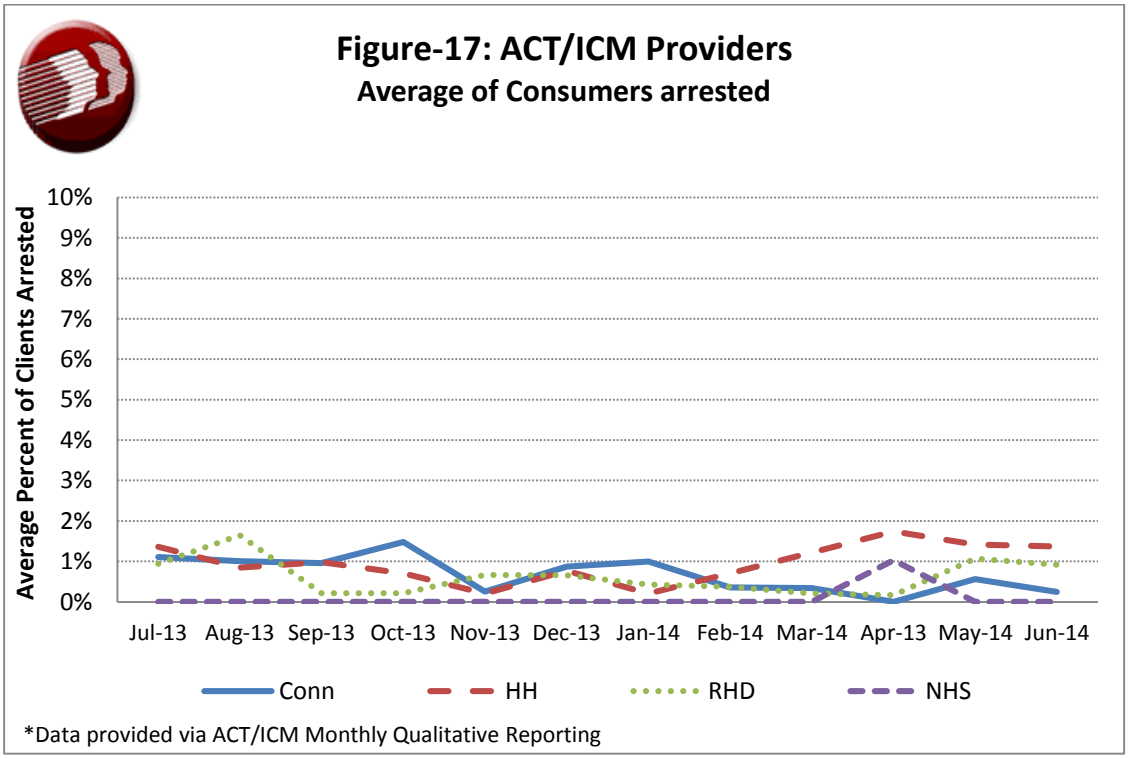


Figure-17 presents the State's tracking of the number of ACT clients who were arrested each month, a risk factor specifically referenced in the Agreement. A substantial number of individuals served by ACT have histories of contact with the criminal justice system,



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

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

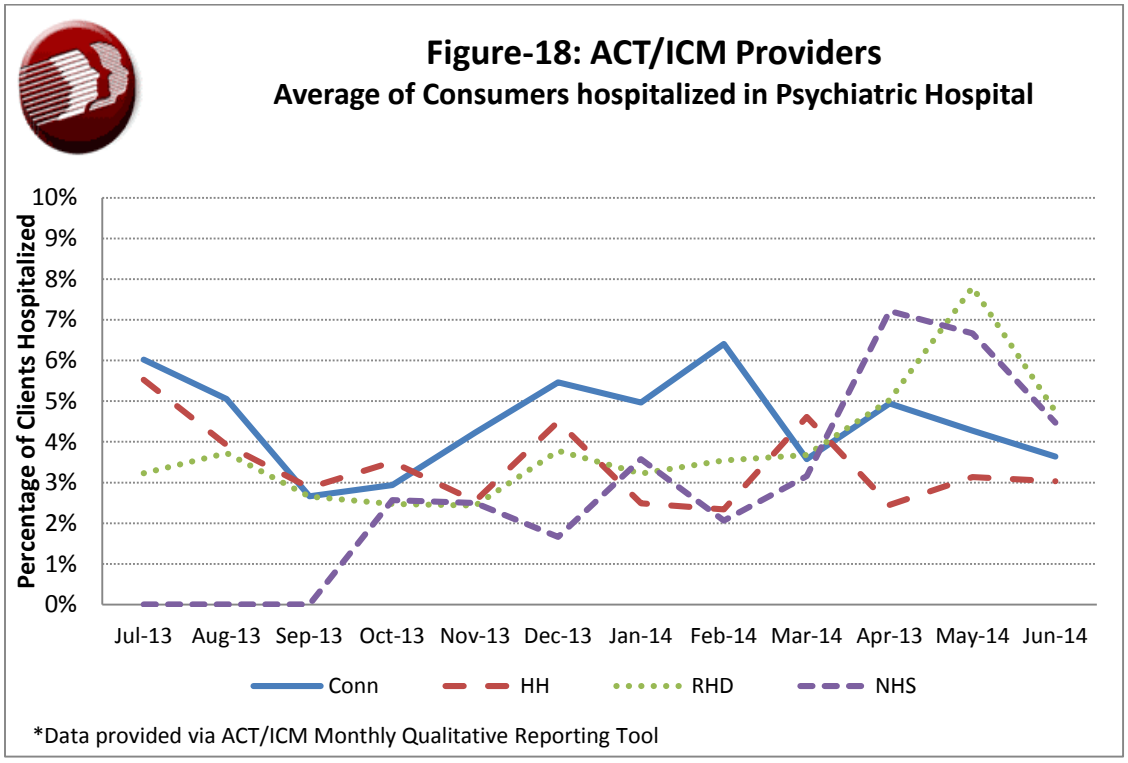


Figure-19 presents data on the average number of days individuals being served by ACT spent in psychiatric inpatient care for each month of the fiscal year. Interestingly, NHS, which showed relatively high rates of hospitalization in Figure-18, showed low numbers of days clients spent in the hospital;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

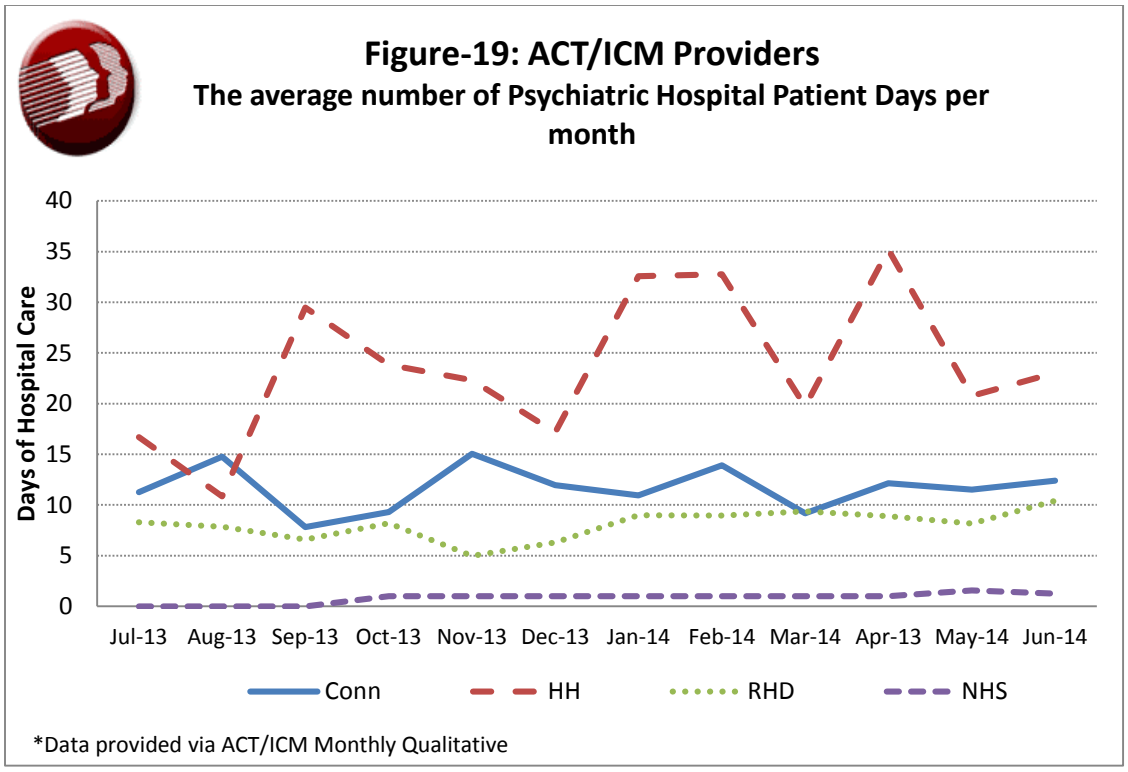
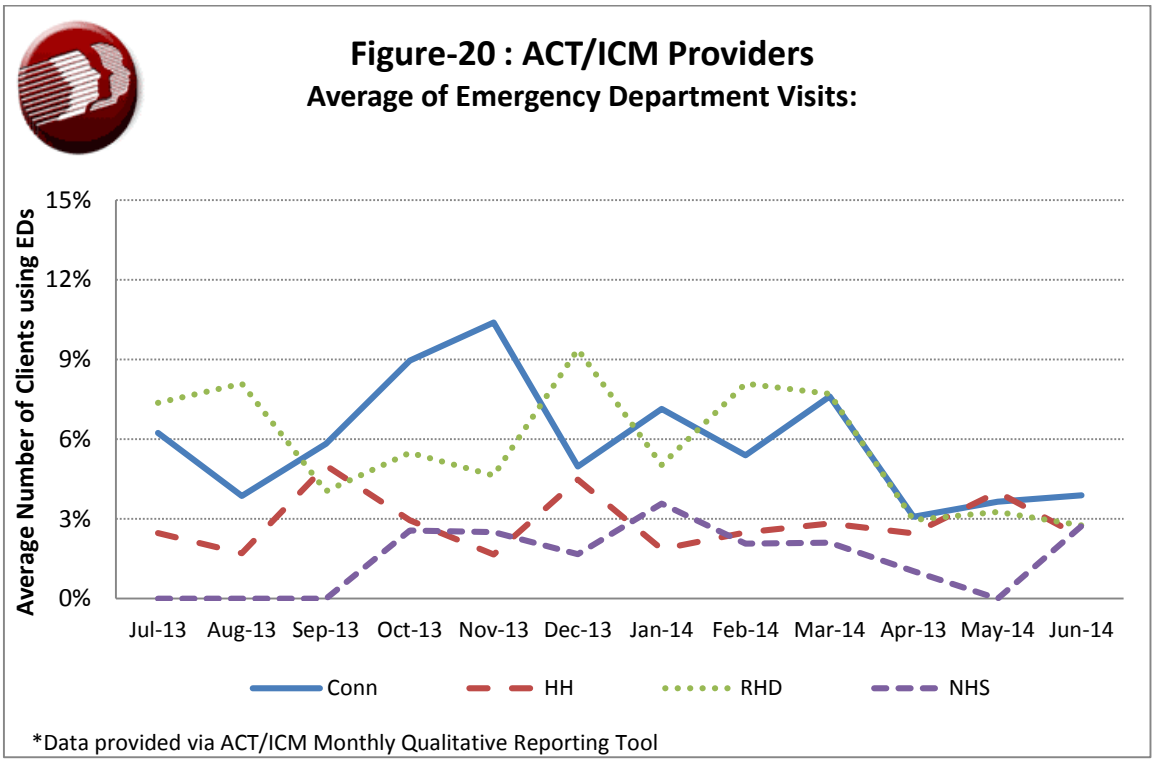
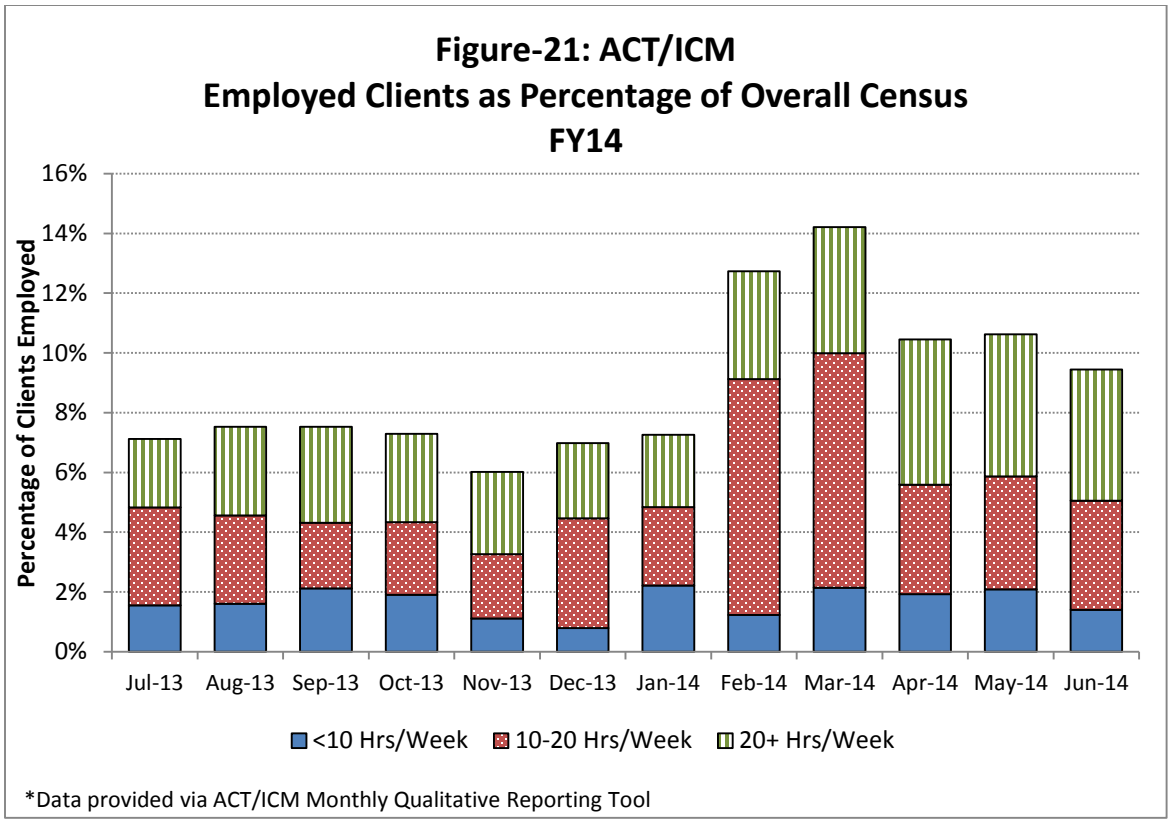


Figure-20 shows the average percentages of ACT clients who utilized emergency rooms of general hospitals each month, another risk indicator that is specifically referenced in the Agreement. Although clients may go to emergency rooms for a variety of reasons, as the State accumulates more performance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



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

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



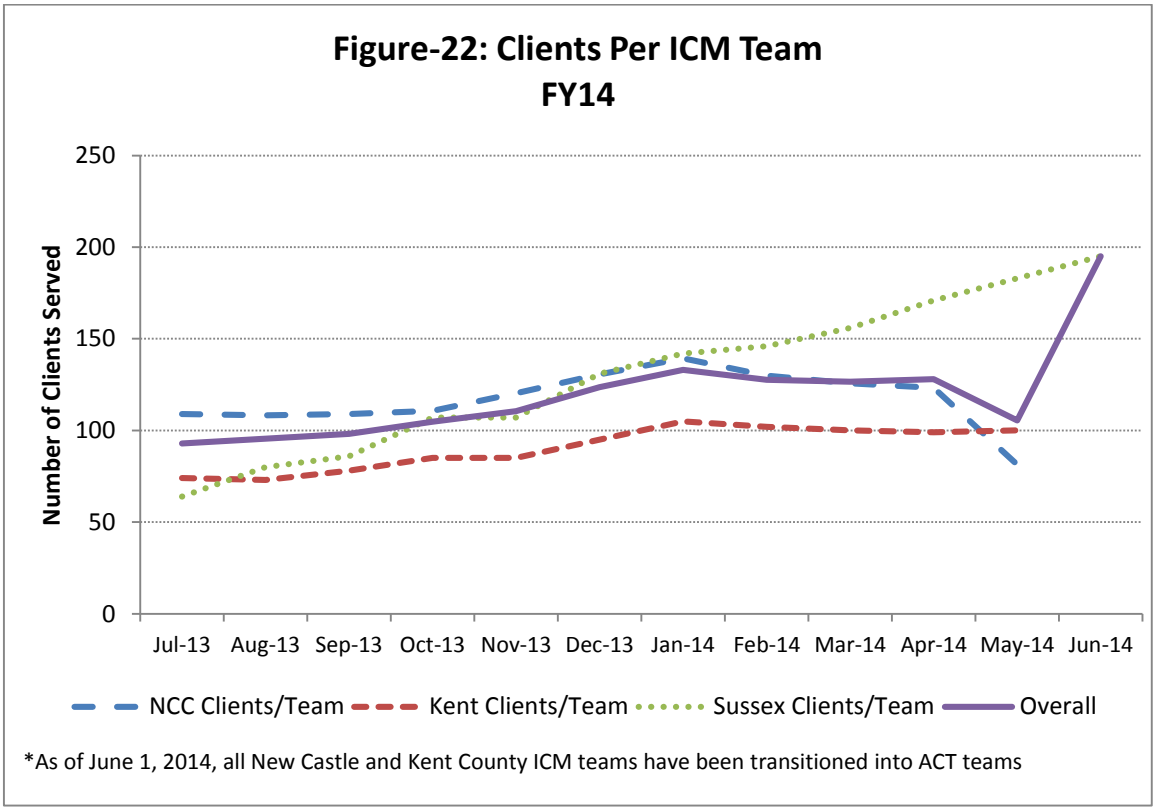
F. Intensive Care Management

Substantial Compliance.

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

people being served by ACT teams. In consultation with the Monitor, DOJ supported the State's plan to convert all but one of its ICM teams to ACT, serving the same number of individuals, but having the capacity to provide supports that exceed what could be provided through ICM. Accordingly, as of June 1, 2014, the ICM teams serving New Castle and Kent Counties converted to ACT[19] and there is now one ICM team in the State that serves Sussex County (DSAMH has indicated that it will convert that team to ACT, as well, if warranted).

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



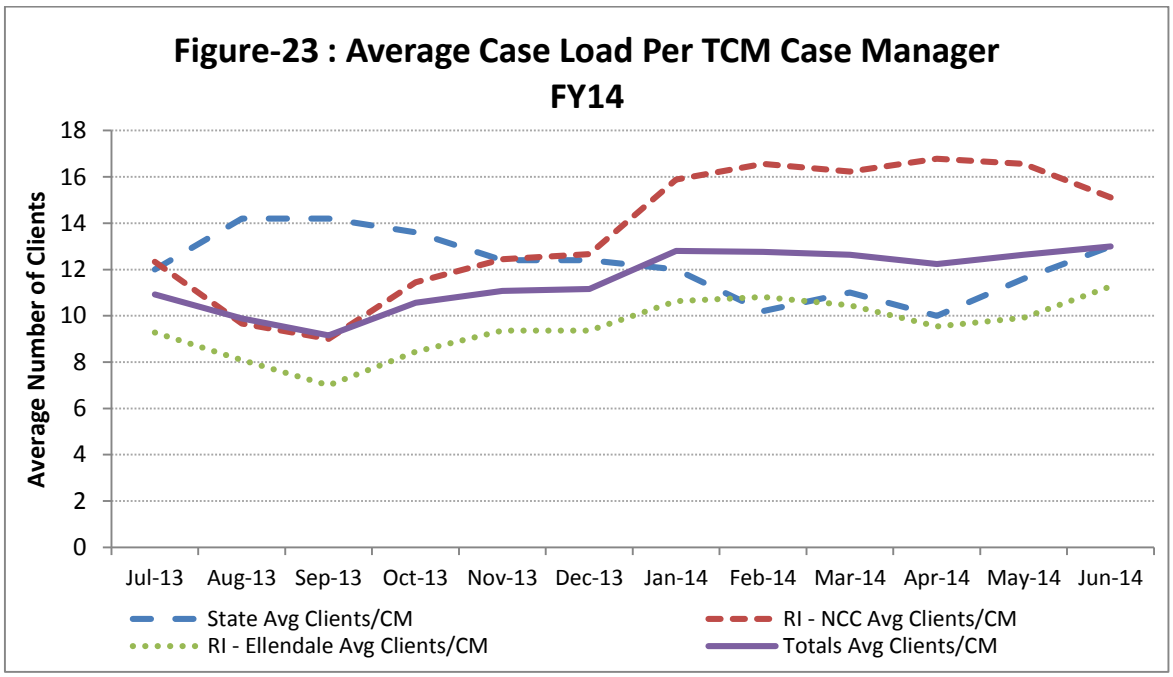
The State is rated as being in Substantial Compliance with Section III.G.2 of the Agreement in that it developed—and even surpassed—the number of ICM teams required and then, with the concurrence of the parties, is now providing services that exceed this requirement in keeping with the needs of the individuals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

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

G. Case Management

Substantial Compliance.

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



H. Supported Housing

Substantial Compliance.

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

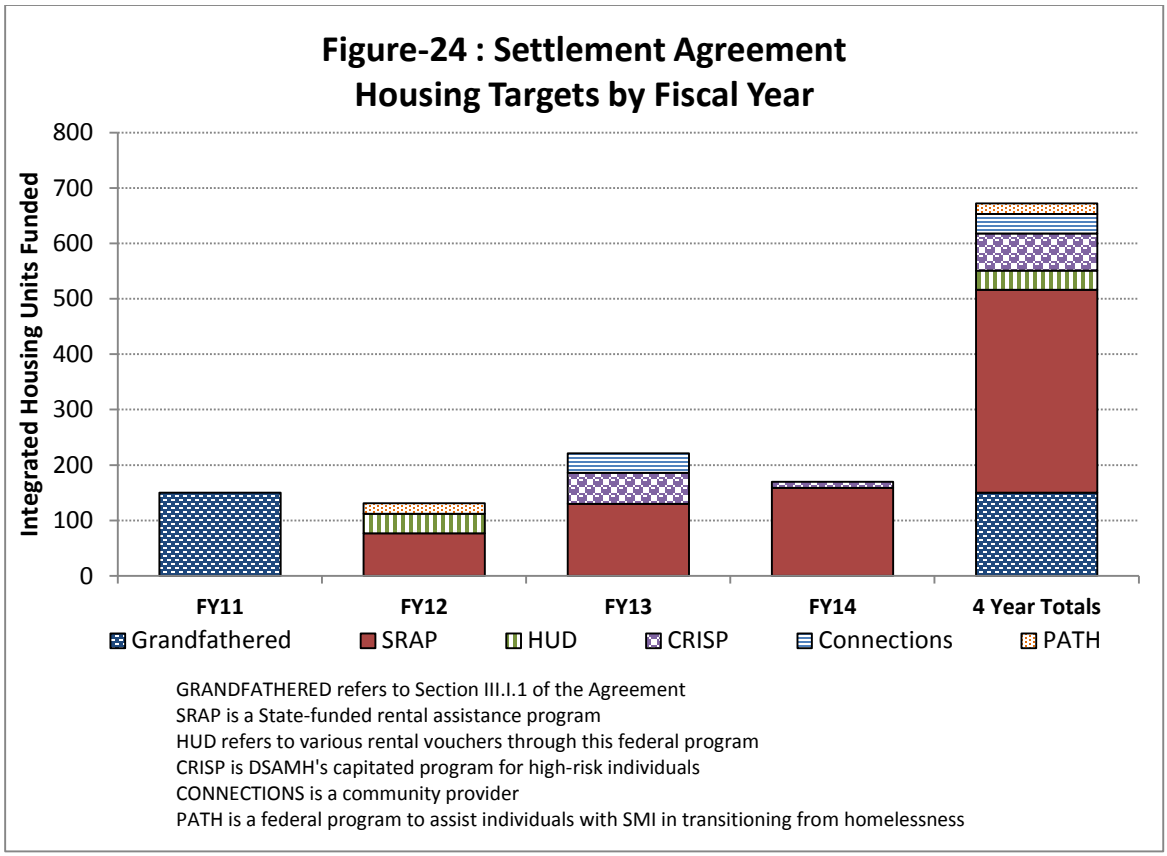
palpable moves to increase access to scattered-site supported housing (as defined in the Agreement). Only about 2% of individuals on the TPPL live in state-funded group homes, increasingly due to medical care needs that co-occur with SPMI.

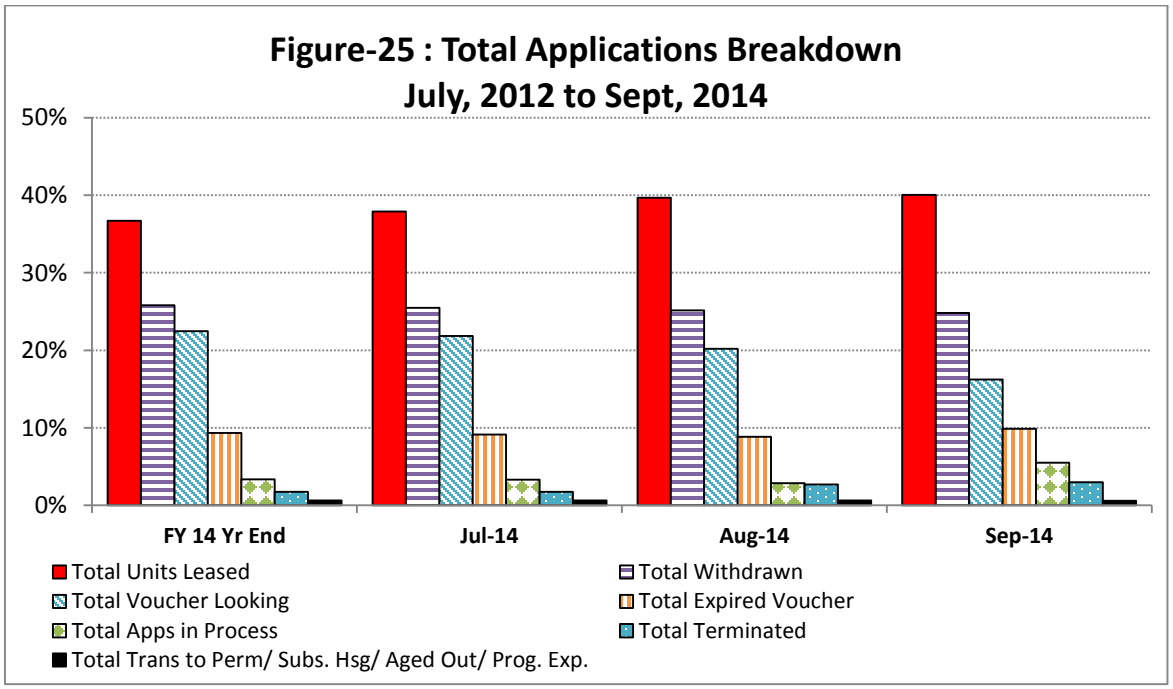
Developing supported housing in keeping with the requirements of the Agreement is a complicated endeavor. It requires a comprehensive assessment of individual's preferences and needs—sometimes not an easy task to accomplish given that many do not have histories of stable housing and have difficulties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

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

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

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





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

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

Figure-26: Status of Housing Vouchers as of September, 2014

	Vouchers	Percent of Target
Supported Housing Units Required (Target)	400	
Vouchers Issued: Units Rented	284	71.0%
Vouchers Issued: Housing Being Arranged	115	28.8%
Applications Submitted: Vouchers Pending	39	9.8%
Total Vouchers Issued and Pending	438	109.5%

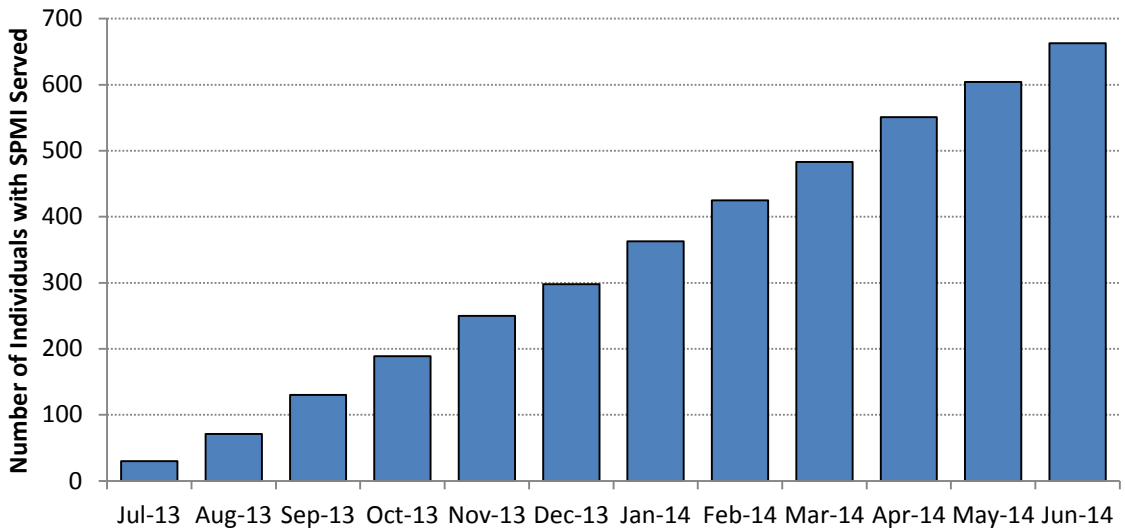
I. Supported Employment

Substantial Compliance.

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

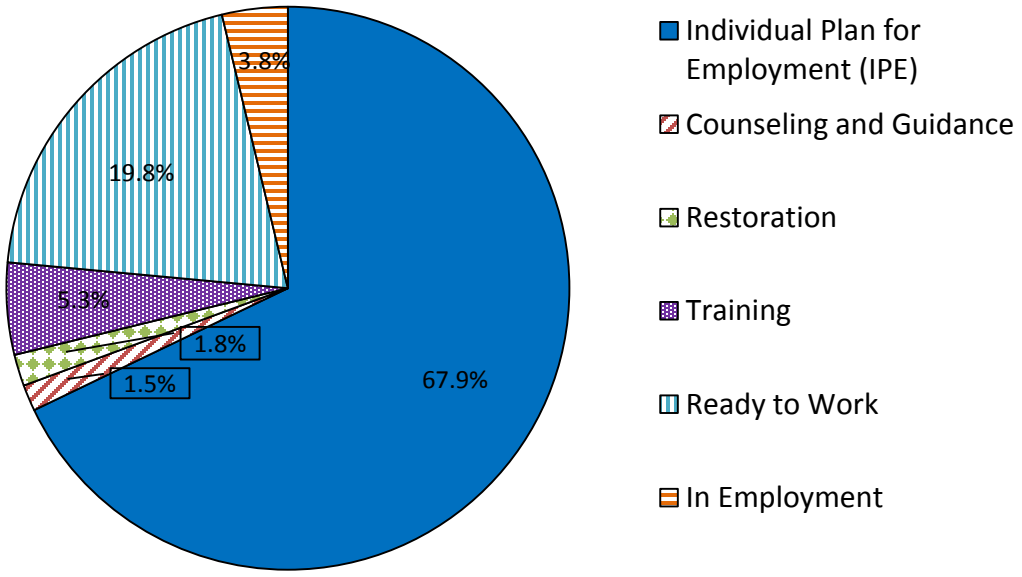
Figure-28 summarizes the status of these individuals. The data presented below represent the status of the 663 individuals served last fiscal year in the supported employment

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



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

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



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

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

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

Recommendations:

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

J. Rehabilitation Services

Substantial Compliance.

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

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

The State is in Substantial Compliance with this provision.

K. Family and Peer Supports

Substantial Compliance.

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

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

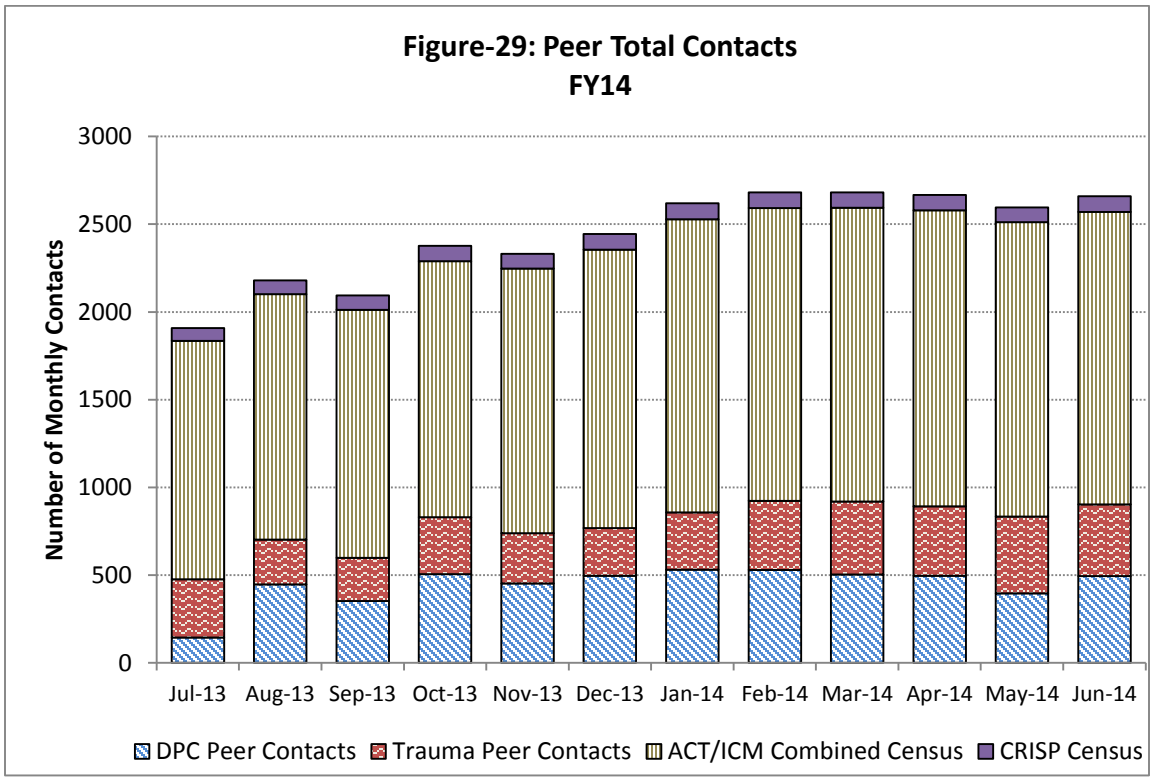


Figure-29 presents only a portion of the picture of the role of peer services in DSAMH programs. It shows the number of peer contacts with individuals who are hospitalized at DPC, as well as those served through ACT Teams or DSAMH's CRISP program, which focuses mostly on individuals with histories of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

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

L. Quality Assurance and Performance Improvement

Substantial Compliance.

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

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

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

M. Risk Management

Partial Compliance.

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

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

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

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

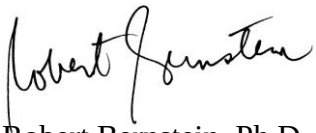
IV. Summary

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

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

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

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



Robert Bernstein, Ph.D.

Court Monitor