NINTH REPORT OF THE COURT MONITOR

ON PROGRESS TOWARD COMPLIANCE

WITH THE AGREEMENT:

U.S. v. STATE OF DELAWARE

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

5/26/2016

I. Introduction:

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

a. Crisis Stabilization Services
b. Discharge Planning
c. Quality Assurance and Performance Improvement
d. Risk Management

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

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

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

[1] 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."

[2] The Eighth report of the Court Monitor was filed on 12/26/15.

II. Ratings of Compliance

A. Crisis Stabilization Services

Moving Towards Substantial Compliance

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

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

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[3] The Agreement defines "acute care" as hospitalizations lasting 14 days or fewer. Section II.C.2.d.i

[4] The Agreement's "base year" from which this is calculated is the fiscal year ending June 30, 2011.

[5] The Monitor's sixth report was filed with the Court on December 29, 2014.

[6] The Monitor's sixth report found that overall bed days in IMDs, where most of the acute care was being provided showed a reduction of 0.4% as of July, 2014 relative to the base year, and bed-days managed through DMMA showed an increase of 2.1%.

[7] These hospitals—Rockford Center, MeadowWood Behavioral Health, and Dover Behavioral Health—are commonly referred to, in federal terminology, as "IMDs" or Institutions of Mental Diseases.

[8] Delaware Psychiatric Center (DPC), the State-operated psychiatric hospital, has also increased its acute care bed-days relative to the base year, but this reflects an intentional transition of the facility from primarily being a long-term care setting to one providing acute psychiatric care. DPC's total number of civil beds (i.e, non-forensic) has actually been reduced during the course of the Agreement.

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

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

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

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

[9] Early in the process of implementing the Agreement, the State and the Monitor agreed on a set of diagnoses that are indicative of SPMI and would be used in identifying members of the Agreement's priority population.

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

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

[11] As agreed to by the parties on February 16, 2016.

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

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

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

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

Quantitative Measures:

A. Bed Days-

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

[12] The 2016 fiscal year runs from July 1, 2015 through June 30, 2016.

a. Sections III.D.3-4 relate specifically to reductions in "acute inpatient settings" which, as described above, were expected to be achieved through the establishment of the community alternatives that are required elsewhere in the Agreement. While these reductions are certainly central to the overall goals of the Agreement, so too are reductions in longer term hospitalizations, including for individuals who have had protracted stays at DPC. Past Monitor reports have included data about the State's success in reducing the number of days of long-term care at DPC and in shifting the facility's focus toward more acute care services. Yet, there is no section of the Agreement that specifically requires such reductions. Recognizing that the State's efforts to reduce long term hospitalizations is consistent with the ADA's requirements, the parties agreed that such data should be included in the revised measurement process.

b. Previously, data on hospitalizations had been reported in terms of Acute Care, which the Agreement defines as having a duration of 14 days or fewer; Intermediate Care, defined as 15-180 days; and Long Term Care, defined as 180 days or longer. Individuals receiving Long Term Care have complex clinical issues, and sometimes attendant legal barriers to discharge (e.g., sexual offenses). However, those in the Intermediate Care category reflect an array of issues, ranging from those who remain in the hospital slightly beyond 14 days as housing arrangements are made, to those who stay hospitalized for several months due to complicated clinical factors. For this reason, the parties agreed to a revised reporting structure to better differentiate among people with intermediate hospital stays. The State now categorizes stays in terms of Intermediate-I, which includes hospitalizations of 15-49 days, and Intermediate-II, which includes hospitalizations of 50-179 days. Acute and Long Term hospitalizations remain unchanged in terms of definitions.

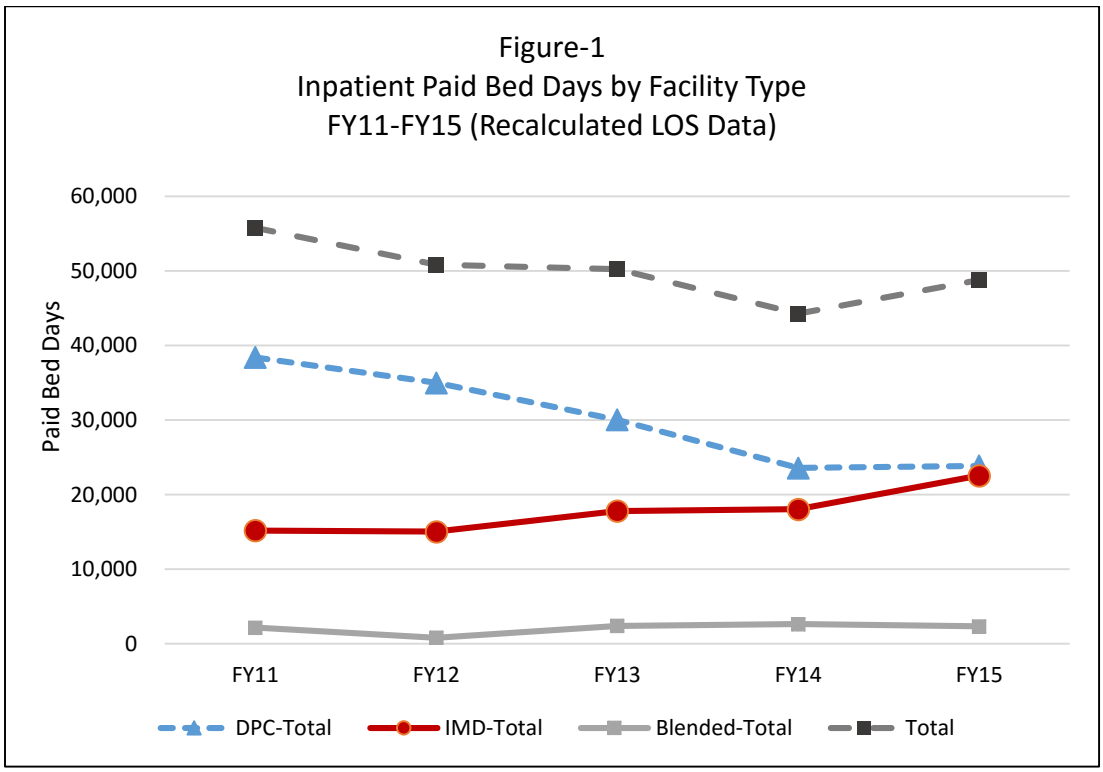
c. Admissions to DPC include some individuals coming directly from the community or hospital emergency departments, and some individuals who were admitted to an IMD and could not be stabilized through the acute care that those facilities provide. When individuals are transferred from IMDs to DPC for continuing care, the State now calculates the duration of the hospitalization as a single—or "blended"—episode that reflects the combined number of bed-days in the two facilities. Calculating bed days in this way more accurately reflects the duration of inpatient care for crises falling into this category.

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

[13] The State is reporting 2016 data but, because the fiscal year is not yet complete, this information does not appear on this chart.

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

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



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

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

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

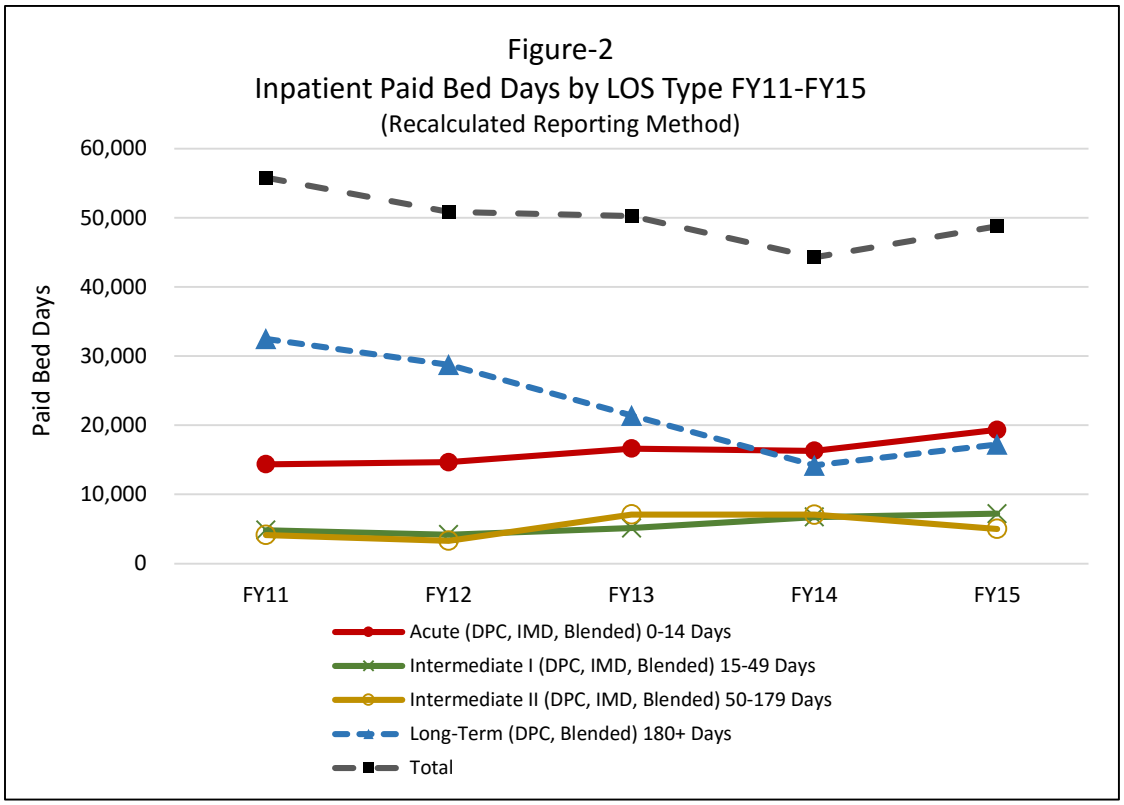
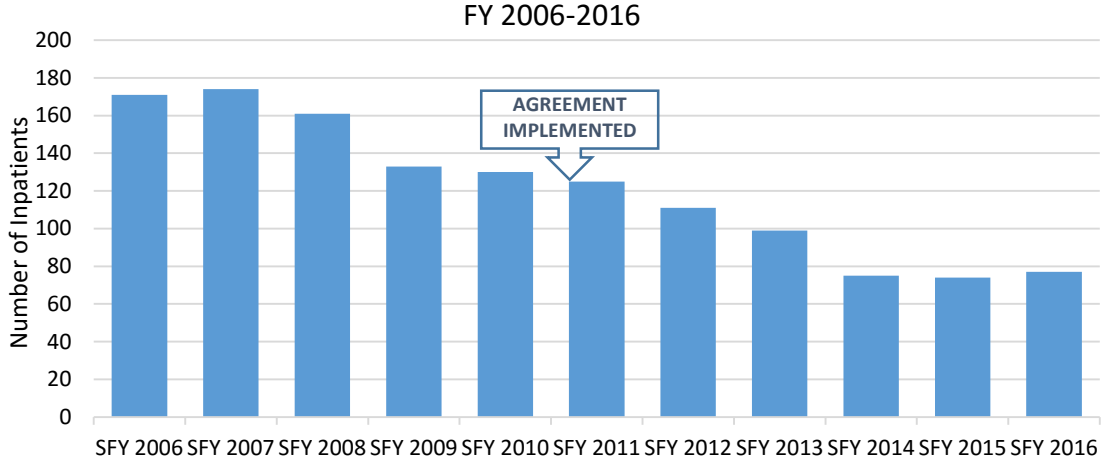


Figure-3 summarizes the State's success over the past decade in downsizing DPC. Since 2014, the average daily census for "civil" (i.e., non-forensic) patients has been less than 80 patients. This represents about a 35% reduction of the facility's census from when implementation of the Agreement began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

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

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

Figure-3
Average DPC Daily Census
(Non-Forensic Inpatient Care)
FY 2006-2016



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

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

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

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

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

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

B. Timeliness of Discharge-

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

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

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

[14] That hospitalization lasted 59 days, which is at the low end of the Intermediate-II category.

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

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

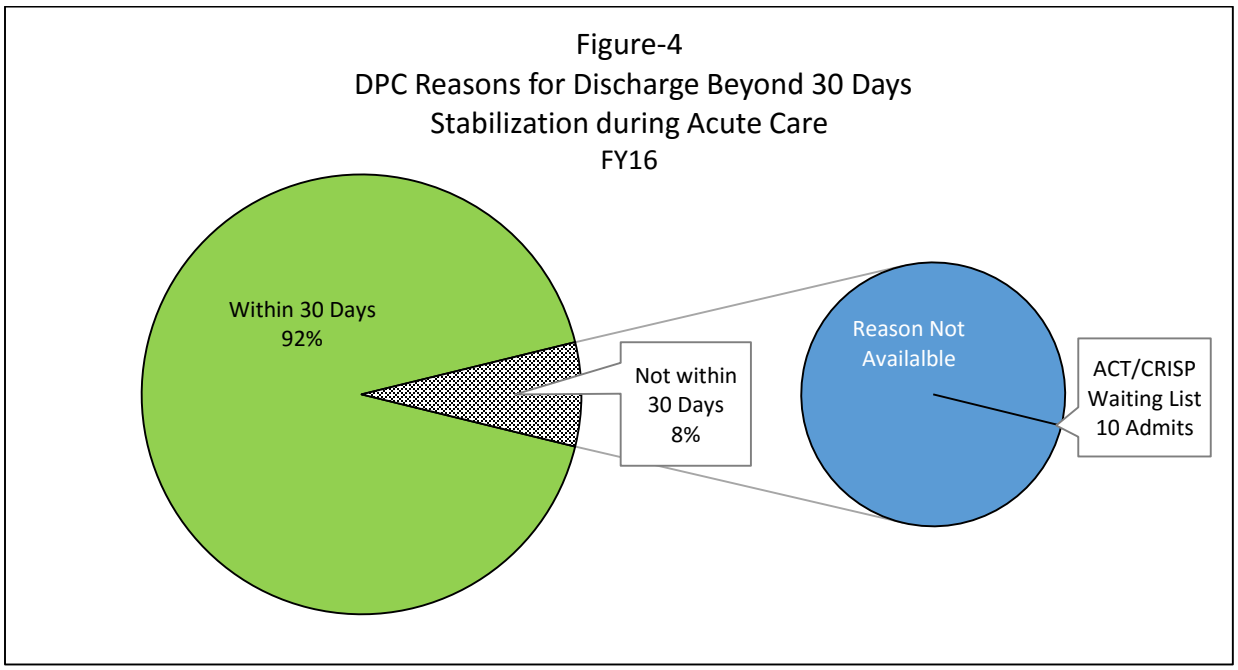


Figure-5 presents similar data for individuals at DPC who were determined to be discharge ready during the Intermediate-I period. Of the 19% of these discharges that did not occur within 30 days, eleven individuals were awaiting ACT or CRISP services, and one individual was awaiting a bed in a group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

[15] ACT and CRISP have been described more fully in past Monitor reports.

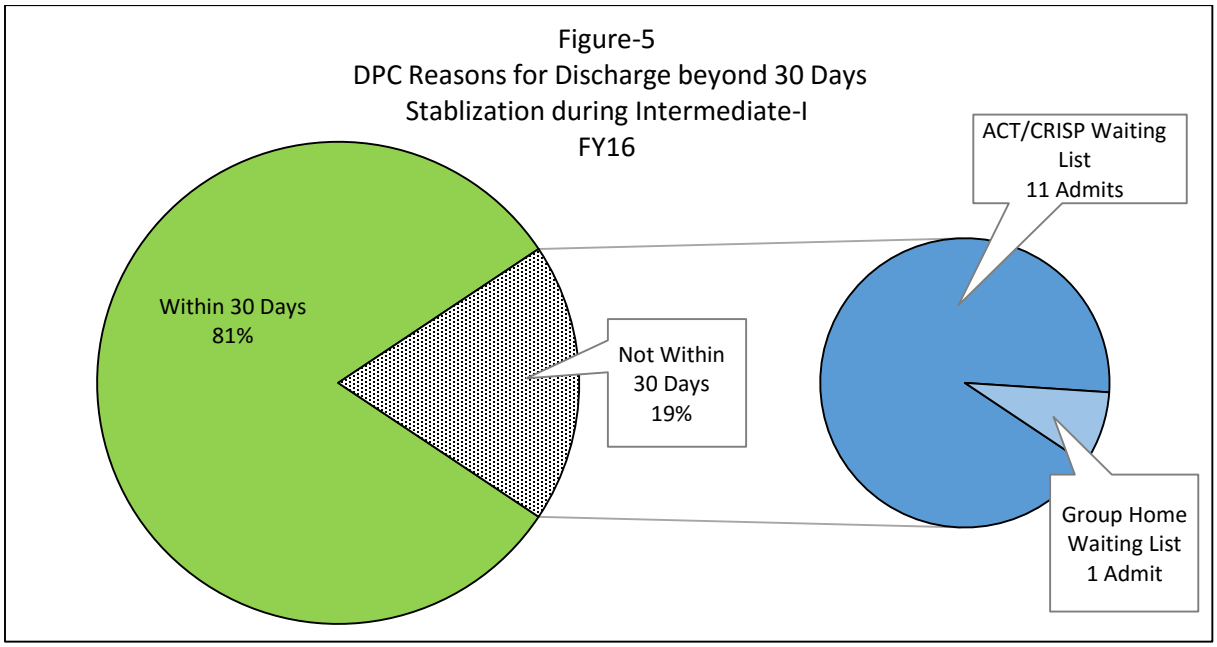


Figure-6 presents the data for individuals at DPC who were determined to be discharge-ready during the Intermediate-II period. Although the proportion of Intermediate-II discharges is large, the actual number of individuals included in this group is small—12 people. The issues delaying their discharges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

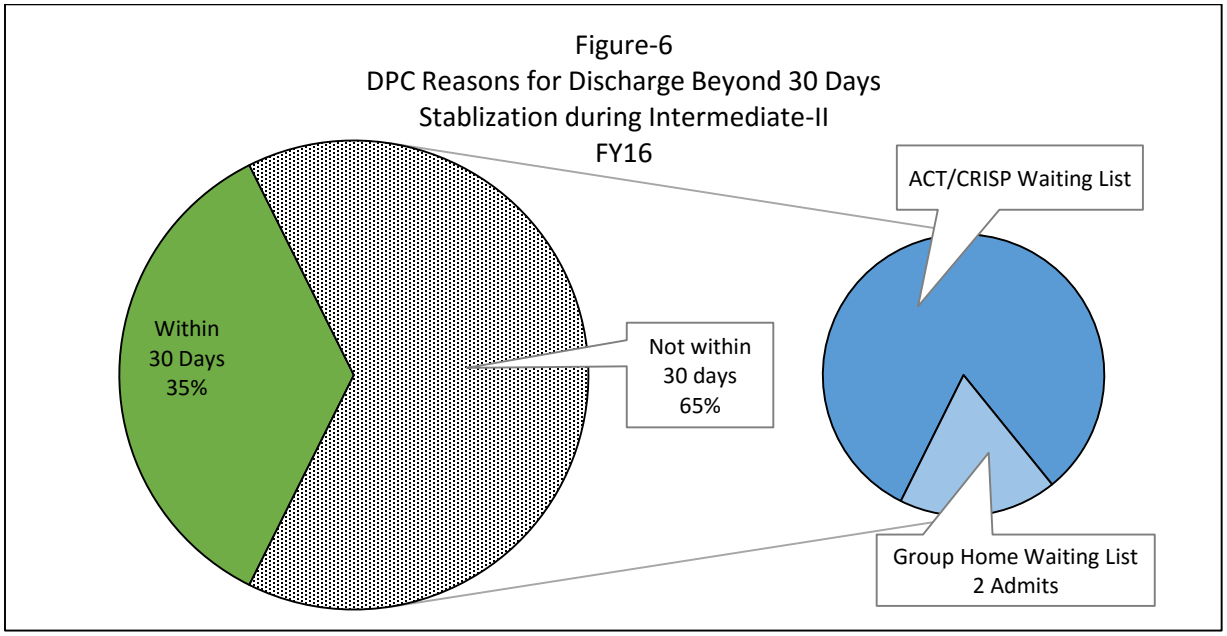
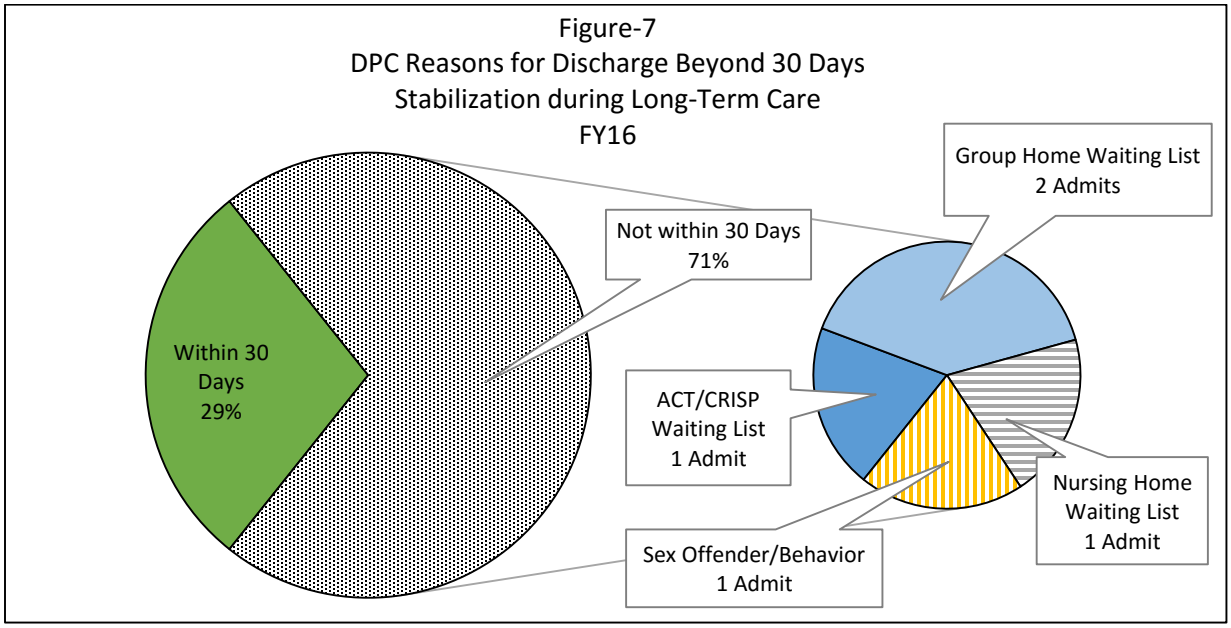


Figure-7 presents data on individuals whose readiness for discharge was determined during periods of long-term care, that is, hospitalizations lasting 180 days or longer.Thus far this fiscal year, five individuals fell into this category. In addition to ACT/CRISP and group home availability being factors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

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



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

C. Crisis Walk-In Centers

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

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

Table-5
RRC Crisis Walk-In Center
Referral and Diversion Breakdown
(All figures relate to individuals with SPMI who are a part of the Agreement's Target Population)
FY 2014-2015

	FY14	FY15
Number of Individuals Evaluated at RRC (Total)	1760	2183
Number Diverted from Hospitalizations	1386	1627
% Diverted	78.75%	74.53%
Number Admitted to IMD [Dover Behavioral Health (DBH)]	476	658
Number of DBH Admissions Evaluated by RRC	374	556
% of DBH Admissions Evaluated by RRC	78.57%	84.50%
Number of DBH Admissions Not Evaluated by RRC	102	102
% of DBH Admissions Not Evaluated by RRC	21.43%	15.50%

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

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

D. Engagement in Community Services Comprised by the Agreement

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

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

[16] Referrals to PROMISE are essentially referrals for DSAMH services.

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

Table-6
Breakdown of Psychiatric Hospitalizations by PROMISE Status
FY 2015-2016 (partial data for both years)

	FY15 (Jan thru Jun)		FY16 (Jul thru Dec)	
	Number	%	Number	%
Total Hospital Admissions	**1813**		**1661**	
DSAMH/PROMISE Clients*	245	13.5%	189	11.4%
Others w/ SPMI and Medicaid Coverage	1568	86.5%	1472	88.6%
Unduplicated Hospital Admissions	**1369**		**1243**	
DSAMH/PROMISE Clients	161	11.8%	130	10.5%
Others w/ SPMI and Medicaid Coverage	1199	87.6%	1109	89.2%
Admissions of the same individual with and without PROMISE	9	0.7%	4	0.3%

*These individuals have been presumptively determined to be eligible for PROMISE because they are being served by ACT, Intensive Care Management, or in a group home.

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

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

[18] Two MCOs operate under contract with DMMA as part of the administration of the State's Medicaid program.

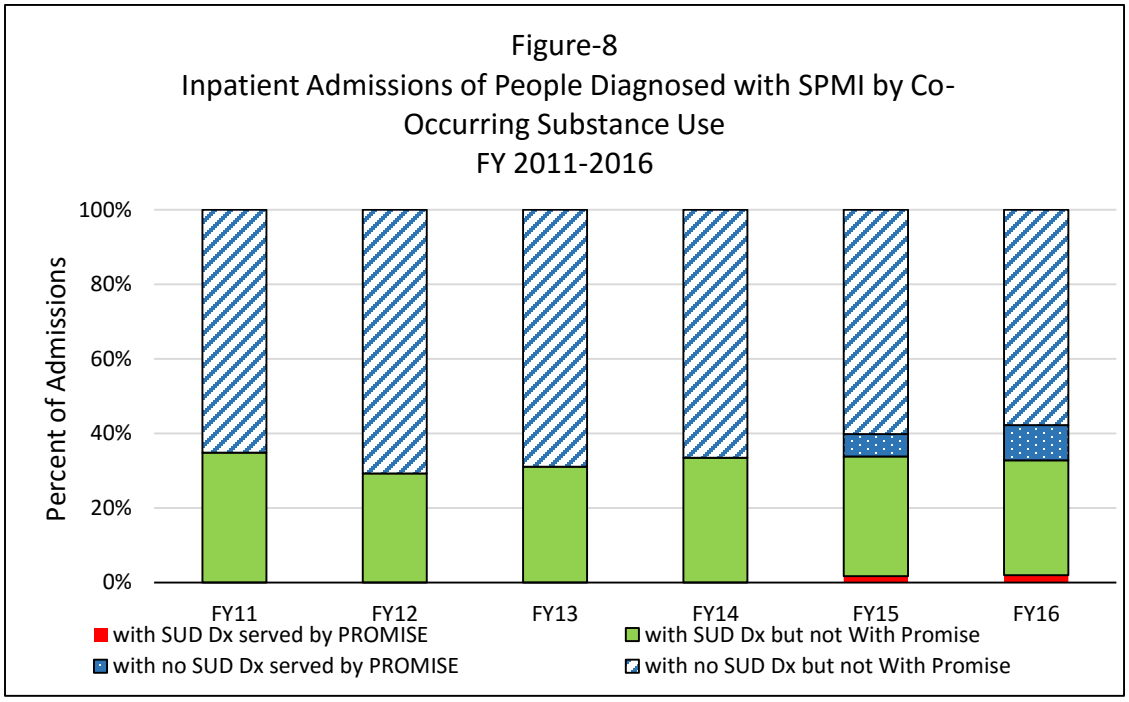
population in PROMISE, thereby affording them access to the array of services required by the Agreement as well as other community supports.

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

E. Co-Occurring Substance Use

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

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



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

F. Homelessness

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

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

Table-8
Target Population IMD Homelessness Initiative Outcomes
March, 2015 Through November, 2015

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

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

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

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

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

G. Readmissions

Representing another measure of the State's effectiveness in linking members of the target population with needed services and reducing unnecessary hospitalizations, the State is now reporting readmission rates associated with each of the categories reflecting the duration of hospitalizations. Table-9 present readmission data for individuals who were hospitalized in fiscal year 2014, the most recent year for which it compiled data in reporting this new measure. The Acute Care data relate to individuals with hospital episodes lasting 14 days or fewer; most of these were in the IMDs, but some also occurred among individuals treated at DPC. In the Intermediate categories and in Long Term care, overwhelmingly, the discharges relate to individuals who were treated at DPC. From a clinical perspective, as the hospitalization classifications proceed from Acute Care to Long Term care, individuals are presenting increasingly complex issues that necessitate extended inpatient stays. Nevertheless, with only a couple of exceptions, the readmission rates are successively lower as the clinical complexity increases, to the point that *none* of the 27 individuals who were discharged to the community following long-term stays at DPC were readmitted within a year.

Table-9
Hospital Readmission Rates by Duration of Hospitalization
for Individuals Discharged in FY 2014

Duration of Hospitalization	Number of Discharges	1-30 Days		31-90 Days		91-180 Days		181-365 Days	
		n	%	n	%	n	%	n	%
Acute Care	2042	349	17.09%	231	11.31%	204	9.99%	236	11.56%
Intermediate-I	238	44	18.49%	25	10.50%	20	8.40%	31	13.03%
Intermediate-II	90	8	8.89%	6	6.67%	5	5.56%	8	8.89%
Long Term	27	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Total	2397	401	16.73%	262	10.93%	229	9.55%	275	11.47%

H. Quality Assurance Initiatives relating to Inpatient Bed Use

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

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

1. A study of high-end users (at DPC and/or an IMD), as defined by: four or more hospitalizations, 30 days of inpatient care within a one-year period, or three hospital admissions within any 90-day period. A scan of various data sources revealed that 41 individuals met one or more of these criteria within the 2015 calendar year. DSAMH established a High-End User Review Committee which is monitoring the status of and treatment afforded to these individuals, and is guiding actions to reduce their use of inpatient care.

2. A study of homeless individuals being admitted to IMDs, aimed at identifying this population and ensuring referrals to supportive housing or other housing services. This initiative, which is ongoing, produced the data presented in Table-8.

3. A study of Single-Episode Hospital Utilization, now underway, which is examining case records of a sample of individuals who have diagnoses of SPMI upon discharge from an IMD, but who have no further encounters with the system for extended periods of time, thus raising questions about their diagnoses and possibly skewing data relating to inpatient bed use of the target population. This study was referenced above in Section D.

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

Summary

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

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

a. It has significantly reduced the census at DPC, particularly with respect to long-term institutionalization.

b. While acute psychiatric hospitalizations have increased, these are of short duration (averaging 6.4 days).

c. Only a small number of hospitalizations exceed the acute care period of 14 days; out of 3,267 admissions in fiscal year 2015, 2,790—or 85%—lasted 14 days or fewer and only 15% exceeded 14 days.

d. Of those hospitalizations extending beyond 14 days, 70% (334 admissions out of 477 in fiscal year 2015) were classified as Intermediate-I, with an average length of stay of 21.6 days.

e. Only a small number of people who remain hospitalized longer than 14 days are not discharged within 30 days of a determination that they no longer need hospital care. The State is examining systemic barriers to their timely discharge, for instance, whether ACT teams and other high-end services are appropriately moving clients through their programs, thereby creating vacancies to accommodate hospitalized individuals.

f. People who are receiving the services required under the Agreement account for only 10.5% of hospital admissions.

g. The State is actively enrolling individuals in PROMISE services.

h. The State has working plan in place to identify homeless individuals and to link them with housing and other services.

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

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

1. Continue its collection of data, as delineated in Table-1;

2. Provide the Monitor with findings, action steps, and outcome measures associated with QA activities, including those referenced above;

3. Evaluate and address the factors that are creating delays in discharging individuals from DPC when they need ACT or CRISP services, including whether individuals currently served through those programs could be more appropriately served elsewhere in the system, thereby creating vacancies for people at DPC; and

4. Provide the Monitor with documentation of how the agreed upon data sets and QA findings are being used to better understand hospital use by the Agreement's targeted priority population and to drive activities aimed at reducing hospitalizations among this group.

B. Discharge Planning

Substantial Compliance

The Monitor's eighth report found that the State was making progress with respect to the Agreement's discharge planning provisions II.C.2.d.iii-iv, but that additional documentation was required to demonstrate that it is meeting its obligations. Notably, it was missing tracking data relating to the timely engagement of community providers at DPC. It has since provided the necessary data to demonstrate Substantial Compliance.

Figure-9
Average Provider Response Time (Days) to Inpatient Admission
FY 2016 by Month, Compared with FY 2015 Average

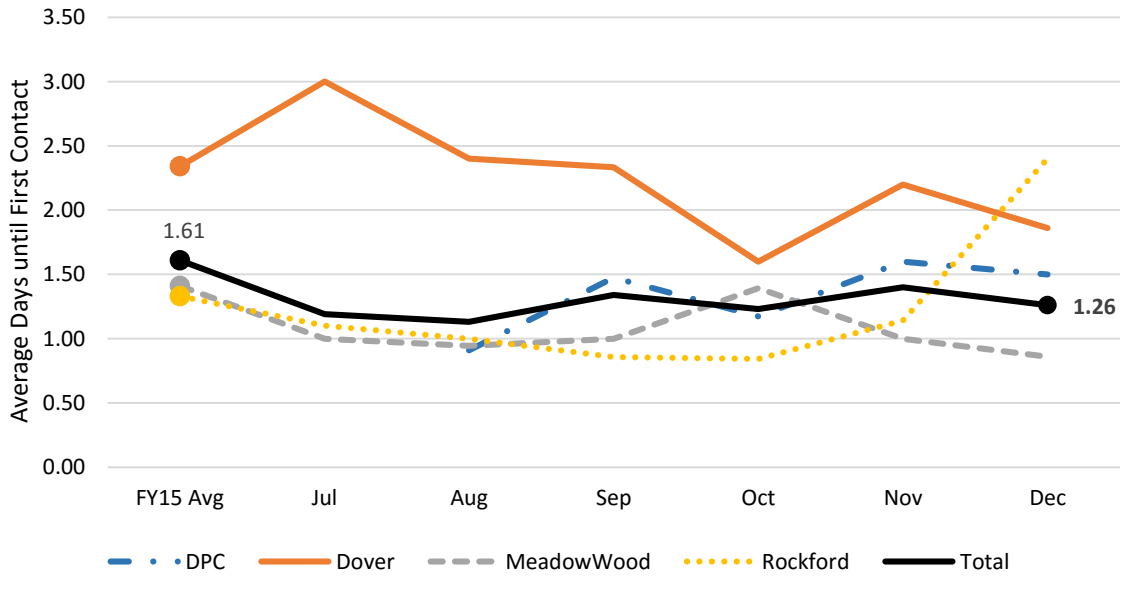


Figure-9 presents response time tracking for community providers in each inpatient setting. This information is a part of the State's monthly data dashboard and trends are being monitored accordingly. Figure-9 also shows that the average length of time between an individual's hospital admission and contact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

C. Quality Assurance and Performance Improvement

Substantial Compliance

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

1. A Quality Process Review of Assertive Community Treatment (ACT) and Intensive Care Management (ICM)[21] that has been ongoing since 2015.

2. An investigation of how homelessness affected lengths of stay among members of the target population who were hospitalized at DPC, which was initiated in 2015.

3. A study of rates of court commitment for inpatient or outpatient treatment (initiated in 2014 and referenced in past Monitor reports), which shows the systems impressive move toward voluntary treatment.[22]

4. Monthly QA meetings between DSAMH and the IMDs to resolve problems in care, including coordination and information sharing between hospital and community providers; this initiative was launched early in 2016.

5. An initiative to incorporate into practice data from the evaluation of DSAMH's CRISP program that has been a product of the ongoing partnership between the State

[21] ACT and ICM are programs required by the Agreement.
[22] The State's new data dashboard includes related data (see Table-1, items 7a and 7b).

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

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

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

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

D. Risk Management

Partial Compliance

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

The Monitor's December, 2015, report noted a key, longstanding issue with respect to evaluating the State's compliance with the Agreement:[23] "[the State] 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."[24] An effective Risk Management program that includes the IMDs is highly relevant to the Agreement. As a general matter, Risk Management deals with abuse, neglect and serious issues up to and including deaths, so it plays a very important role with respect to reducing the possibility of physical and psychological harm. Secondly, the IMDs play a very significant role in serving the target population; in 2015, they accounted for 89% of the hospitalizations covered by the Agreement (2,926 out of a total of 3,267 admissions). Thirdly, by virtue of the fact that these admissions involve individuals in acute mental health crises—including situations where there is an immediate danger to self or others—and sometimes involuntary treatment orders, IMD hospitalizations may entail an elevated risk of adverse events, allegations of abuse, and so on. Finally, IMDs

[23] The risk management provisions of the Agreement pertain to individuals with SPMI who receive mental health services (whether in the community, DCP or IMDs) paid for by the State (i.e., DSAMH or DMMA).
[24] Monitor's Eighth Report, line 788.

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

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

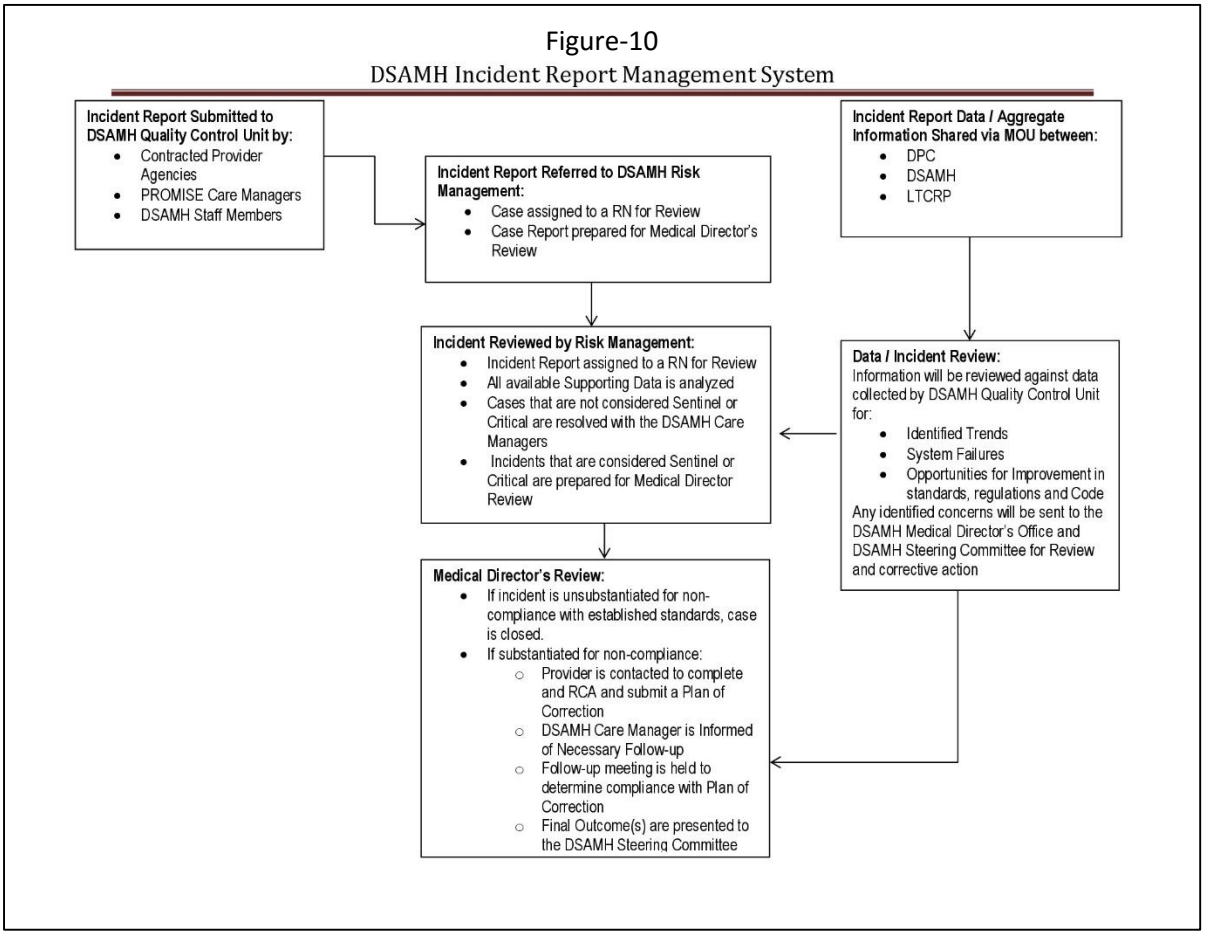
In response to a request for examples of recent investigations in IMDs, the State provided documents that do not allow a meaningful assessment of how risk management processes now being carried out through other DHSS divisions align with the requirements of the Agreement. These examples of recent investigations—some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

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

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

Figure-10

DSAMH Incident Report Management System



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

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

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

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

1. Continue its progress in improving Risk Management for events occurring at DPC or in community programs operating under contract with DSAMH;

2. Meaningfully integrate reporting, investigations, and corrective actions associated with events occurring within IMDs relating to the target population, including all events relating to serious injury or deaths in IMDs involving members of the target population;

3. Provide documentation to the Monitor on how events relating to care in IMDs are reported, including legal or regulatory requirements for such reporting; how consumers or other stakeholders can file complaints and how they are apprised of this process; and what actions ensue once a report of an incident is received;

4. Collect and analyze monthly information relating to the number of incidents, categories of incidents (e.g., death, serious injury, abuse), actions taken (investigations, root cause analyses, corrective plans), and resolutions with respect to members of the target population, beginning in fiscal year 2015;

5. Provide to the Monitor unredacted documentation relating to each incident of death or serious injury occurring in an IMD (including any incidents of death or serious injury proximate to care an IMD) with respect to members of the target population, beginning in fiscal year 2013 forward, including investigations and all actions taken;

6. Provide to the Monitor documentation of how events and findings associated with the care of the target population in IMDs is incorporated in the Quality Control Steering Committee; and

7. Otherwise demonstrate that the system is fully in conformance with each of the provisions of section V.B

III. Summary:

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

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

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Court Monitor