

**EIGHTH REPORT OF THE COURT MONITOR  
ON PROGRESS TOWARD COMPLIANCE  
WITH THE AGREEMENT:  
U.S. v. STATE OF DELAWARE**

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

12/26/2015

1 **I. Introduction:**

2 This is the eighth report of the Court Monitor (Monitor) on the implementation by the  
3 State of Delaware (State) of the above-referenced Settlement Agreement (Agreement). Unless  
4 noted otherwise, it is based on compliance data through the State’s 2015 fiscal year<sup>1</sup> and is  
5 reflective of four years of implementation efforts by the State.

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

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

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<sup>1</sup> Delaware’s 2015 fiscal year runs from July 1, 2014 through June 30, 2015.

<sup>2</sup> Section VI.B.3.g of the Agreement defines the criteria on which the Monitor evaluates the State’s level of compliance as “Substantial Compliance,” “Partial Compliance,” or “Non-Compliance.”

<sup>3</sup> *Olmstead v. L.C.*, 527 U.S. 581 (1999)

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

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

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

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

<sup>5</sup> MCOs are Managed Care Organizations that, through contracts with DMMA, manage individuals’ Medicaid benefits.

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

55 **II. Ratings of Compliance with Specific Provisions of the Agreement**

56

**Summary of Compliance Ratings**

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

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59 **A. Crisis Hotline**

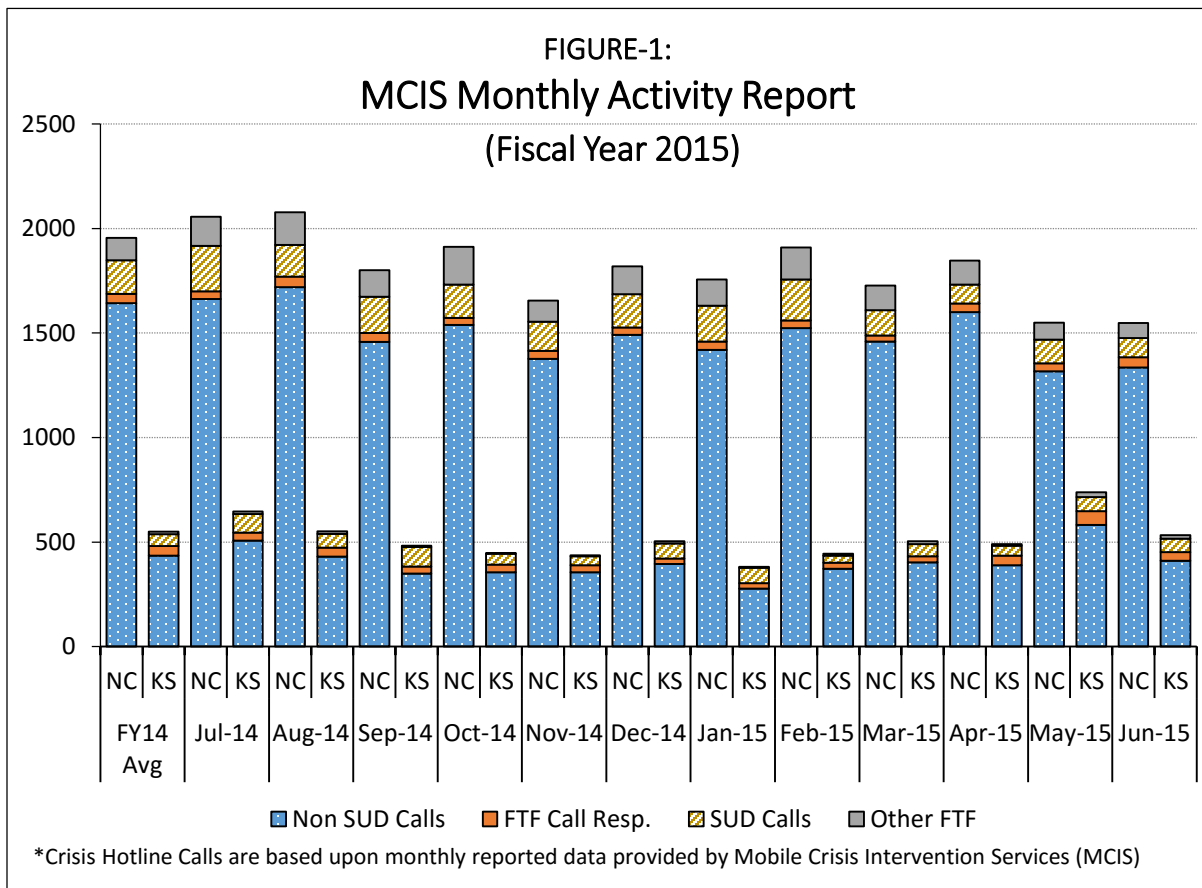
60 *Substantial Compliance.*

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

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

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

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

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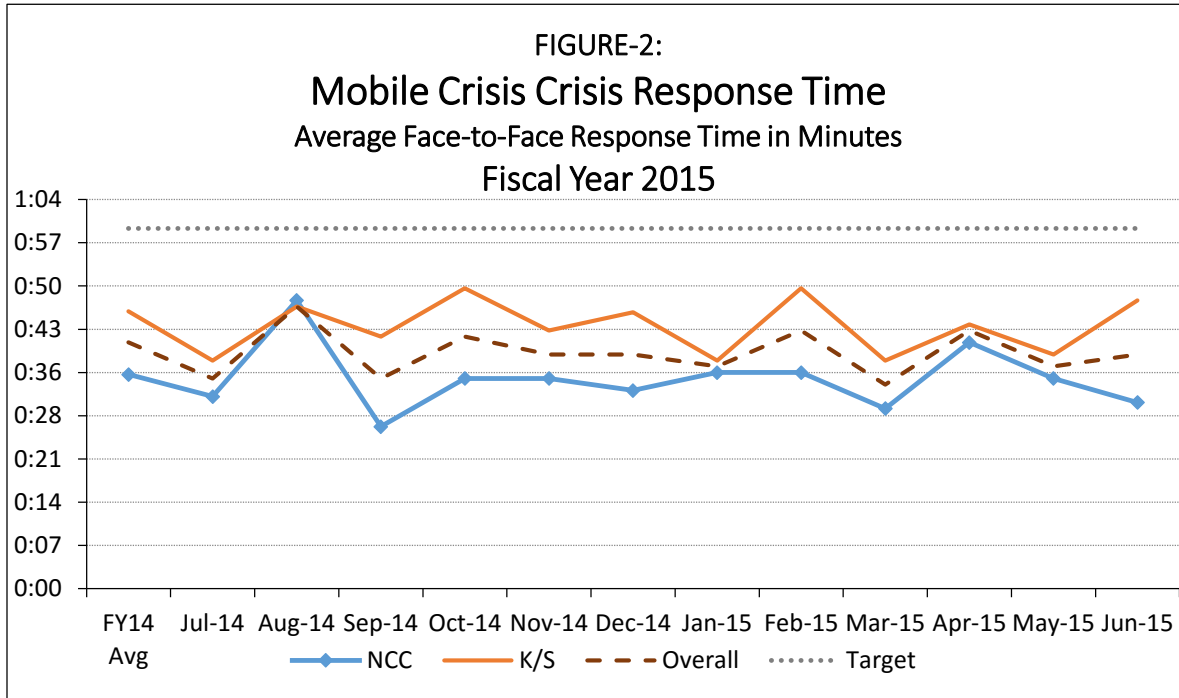
81 **B. Mobile Crisis Services**

82 *Substantial Compliance.*

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

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

92



93

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

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

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106 C. Crisis Walk-In Centers

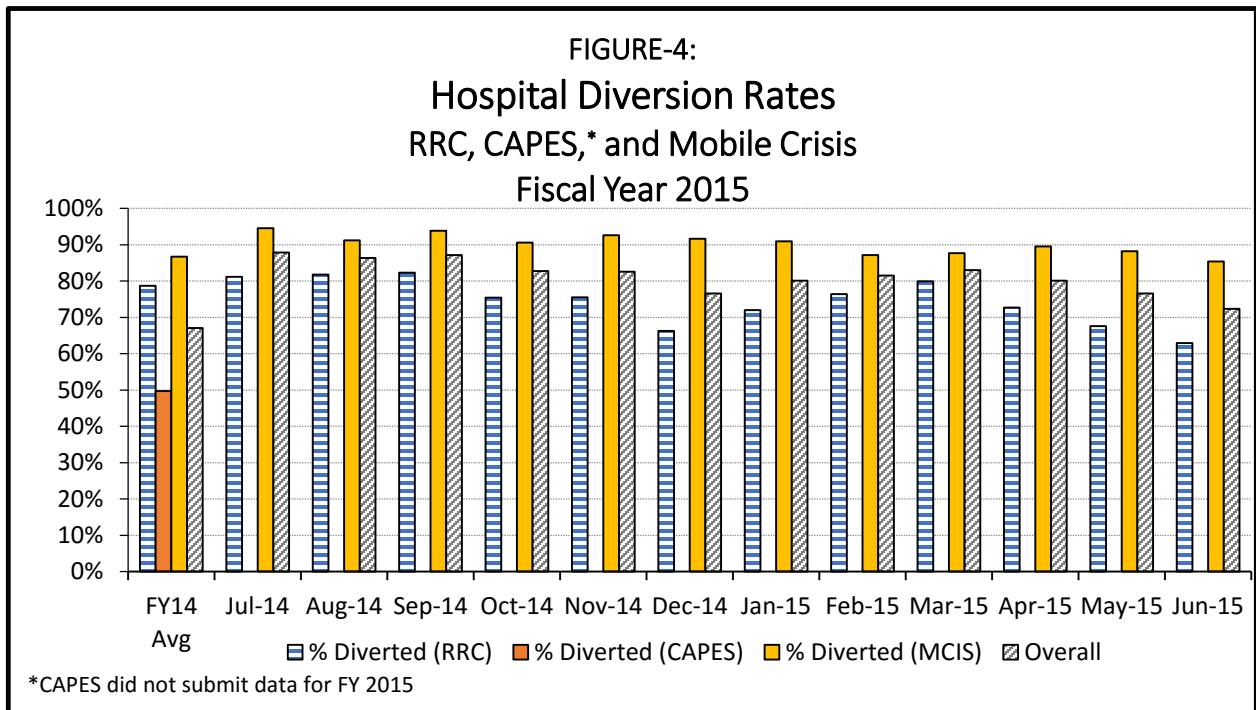
107 *Substantial Compliance.*

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

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

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

129



<sup>7</sup> 16 Del.C § 5004.

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

<sup>9</sup> Prior reports of the Monitor have described this successful Crisis Walk-In program in Ellendale, Delaware.

<sup>10</sup> Examples of such reasons are that the RRC is full or that the individual presents an urgent danger of harm.

130 As is presented in Figure-4, RRC has demonstrated impressively high rates of diverting  
131 individuals from hospitalization, including those being evaluated under 24-hour detention orders.  
132 As has been discussed in previous Monitor reports, the State is developing a new Crisis Walk-In  
133 Center, patterned after the RRC and its “living room” model, to serve New Castle County. That  
134 facility is currently under construction. Once it is operational, EEU will direct individuals under  
135 24-Hour Detention orders to that facility as it currently does in the State’s southern counties.  
136 Until the new facility opens (likely early in 2016), CAPES—the Crisis Walk-In Center located in  
137 a general hospital—continues to provide services to the northern part of the state, including 24-  
138 Hour Detention evaluations for some individuals and a significant number of individuals  
139 continue to be evaluated at an IMD.

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

142

#### 143 D. Crisis Stabilization Services

##### 144 *Partial Compliance.*

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

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

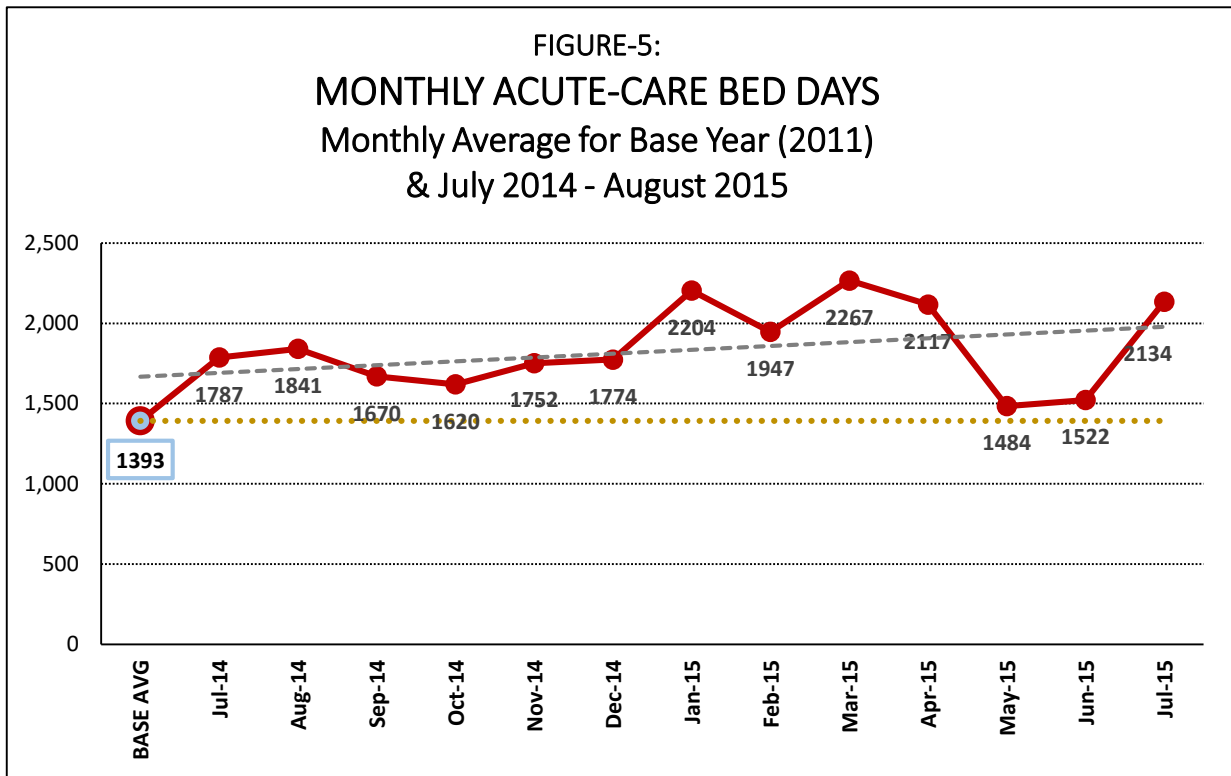
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<sup>11</sup> Delaware Psychiatric Center (DPC) is the state-operated psychiatric hospital located in New Castle, Delaware.

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

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

177



178

179 The increases in acute care bed-days are essentially attributable to hospital stays at the  
 180 IMDs. 87% of the bed-days categorized by the State as acute care occurred in the IMDs<sup>14</sup> and

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

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

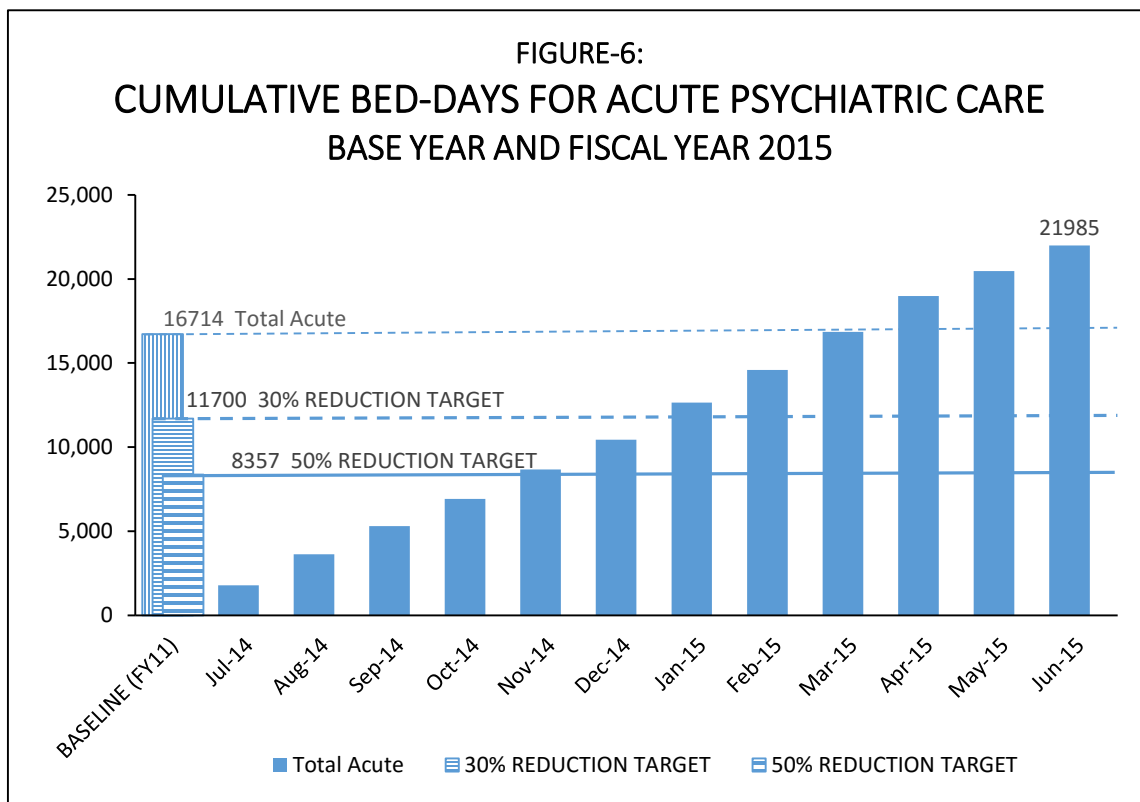
<sup>14</sup> It is noted that the State is now analyzing data with respect to individuals transferred to DPC from IMDs (e.g., because they could not be stabilized within a short period in those settings), and those moving from acute-care



181 were managed through DMMA (15,510 out of 17,771). As is explained later (and detailed in  
 182 prior Monitor reports), at least a part of these increases may have been due to the State’s lack of  
 183 appropriate controls over the process by which individuals whose behavioral healthcare was  
 184 managed through MCOs were referred to DSAMH for the specialized services and housing  
 185 required by the Agreement that can reduce the vulnerability for hospitalization. The protocols for  
 186 such referrals and lines of accountability have been significantly improved since January 1,  
 187 2015. However, acute bed-days have continued to rise this calendar year. Given this pattern of  
 188 increasing hospital use, plans that are now being discussed to further expand hospital capacity by  
 189 building a new IMD in southern Delaware<sup>15</sup> raise additional questions as to whether the State  
 190 will be able to curtail hospital rates for the target population.

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

195



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

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

196 This chart shows that last fiscal year the State’s total overall bed-day use met and  
 197 exceeded the 50% reduction level (which is to be met by July 1, 2016 per Section III.D.4 of the  
 198 Agreement) in November 2014, with seven months still remaining in the fiscal year. By January  
 199 2015—with five months remaining in the fiscal year—it had already exceeded the 30% reduction  
 200 level which was to have been met in July 2014 (Section III.D.3). And in March 2015 it had  
 201 almost reached the point of utilizing the full Baseline bed-use from which these reduction targets  
 202 are calculated. By the end of the 2015 fiscal year, the State reported 21,985 acute care bed days,  
 203 which is greater than a 30% increase in acute care bed use by the target population, relative to  
 204 the Baseline year. These increases not only run counter to the requirements of the Agreement,  
 205 but they raise systemic issues of quality and performance. As is discussed in the section of this  
 206 report relating to Quality Assurance and Performance Improvement, the State is not taking  
 207 appropriate advantage of data that could clarify the characteristics of the population responsible  
 208 for bed-use increases, as well as their utilization of services earlier on that could reduce their  
 209 hospitalization rates.

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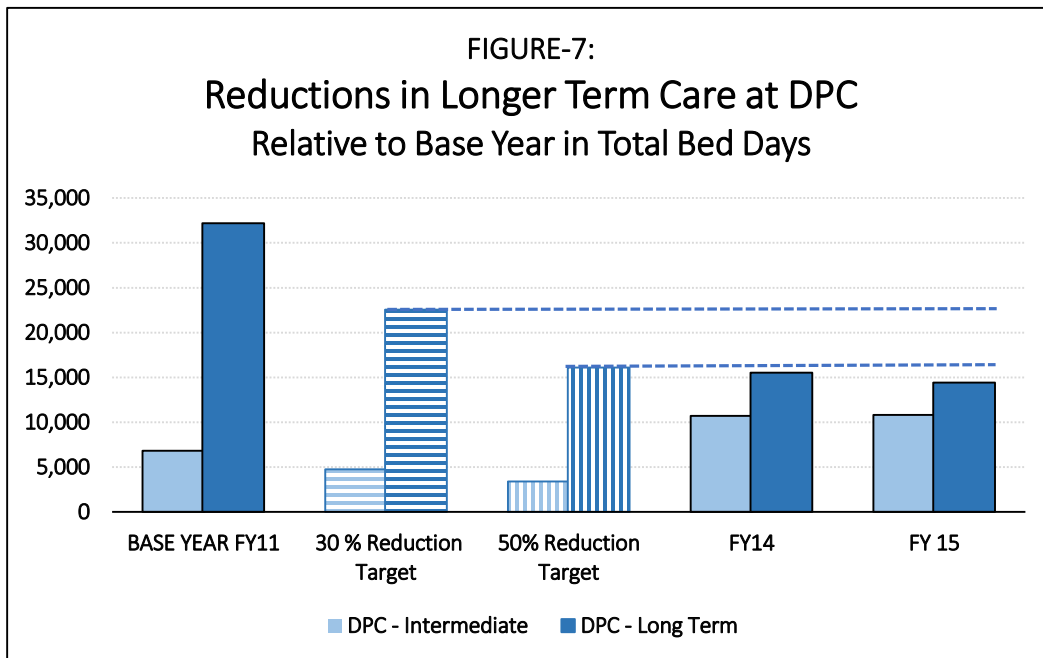
211 Additional Factors

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

214

215 *Reductions in Longer-Term Care at DPC*

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217

218 Figure-7 presents data demonstrating the State’s success in reducing reliance on long  
219 term care at DPC. Applying the 30% and 50% reduction targets which the Agreement contains  
220 with respect to acute care to longer term care at DPC, the State is performing much better.<sup>16</sup> The  
221 State defines “acute care” as hospitalization lasting 14 days or fewer. “Intermediate” term care at  
222 DPC is defined as lasting 15 to 179 days and “long term” hospital care is defined as longer than  
223 179 days. As is reflected in this chart, the State has dramatically reduced bed-days in long term  
224 care, meeting a 50% reduction target in both fiscal years 2014 and 2015. These rates have  
225 remained stable for some time. Whereas DPC used approximately 40,000 bed days for  
226 intermediate- and long-term care in the base year, as of fiscal year 2015 the combined total for  
227 these categories of care was only about 25,000 bed days—a reduction of about 38%.

228

### 229 *Referrals for Specialized Mental Health Services*

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

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

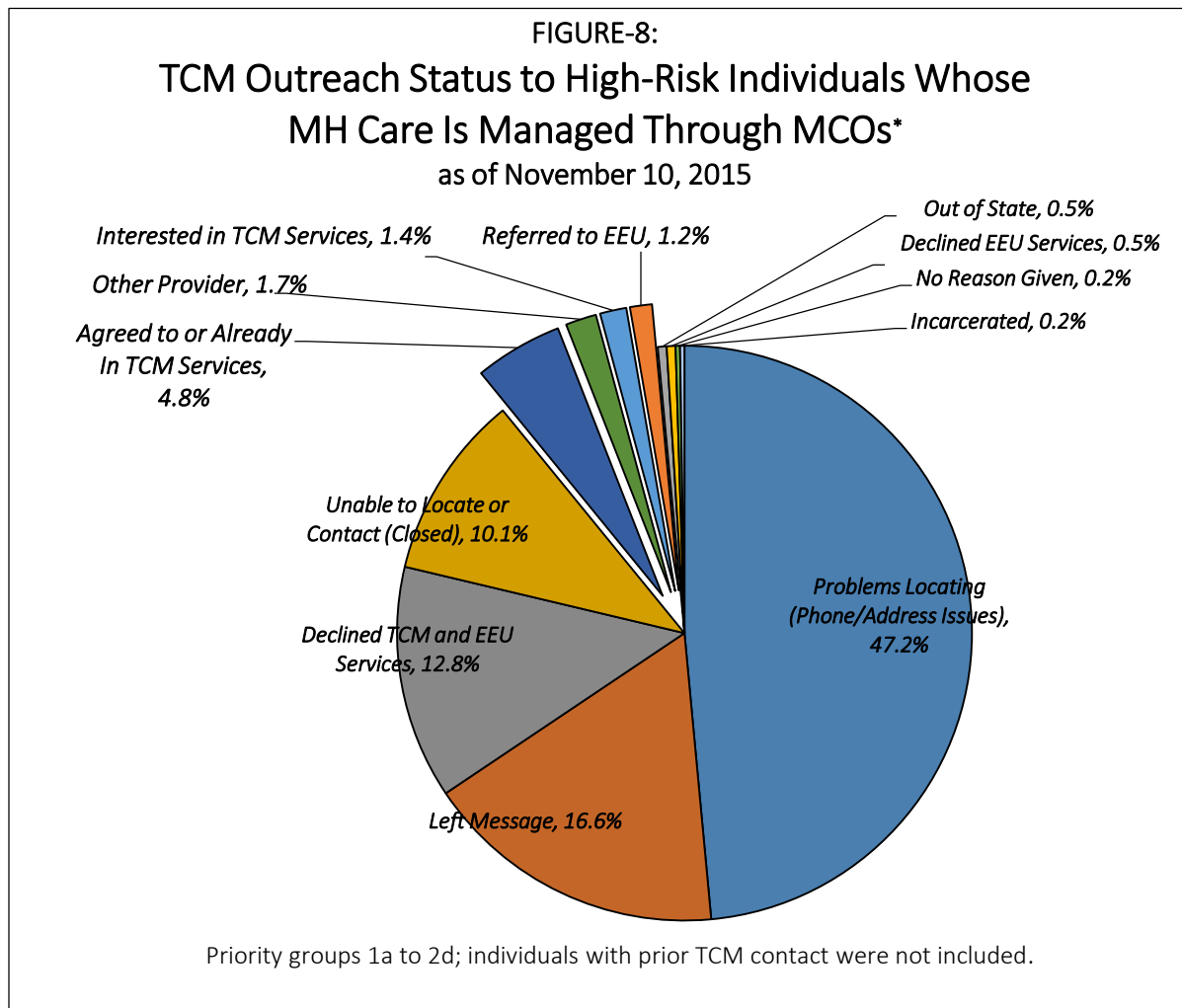
250 Figure-8 summarizes the outcomes of this effort, as well as the detailed data the State  
251 maintained to track its progress. Notwithstanding their intensive efforts, the TCM staff were able  
252 to make contact with only about 23% of the group; they were unable make contact with about  
253 77% of this group. With respect to those actually contacted, about 13% of the group of 454  
254 declined the offer of services and just under 10% were brought to some level of either receiving  
255 services or enrollment in services. For those individuals not among those on track to be served  
256 (and who are still in the State’s Medicaid program), the applicable MCOs have been notified of

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<sup>16</sup> Such targets for long-term care, however, are not a part of the Agreement.

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

259



260

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

270

271 *Referrals of Homeless Individuals for Housing*

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

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

287

**FIGURE-9:  
 Outcomes of Housing Assessments by IMDs  
 March-April 2015**

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

288

<sup>17</sup> The Monitor had not found this to be an issue at DPC.

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

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

303 ###

304  
305 In summary, with respect to the Agreement’s requirements relating to Crisis Stabilization  
306 Services, the State has not met the bed-use reduction targets of Section III.D.3 of the Agreement  
307 and it is very unlikely that it will meet the further reductions specified in Section III.D.4 to be in  
308 effect by July 1, 2016. It has made—and maintained—its progress in reducing long-term care at  
309 DPC, where some individuals had been consigned for decades. Particularly since the beginning  
310 of this calendar year, the State has begun to take important steps in linking individuals who are at  
311 elevated risk of hospitalization to the services and housing they need to be successful in the  
312 community. As is discussed in the Quality Assurance and Performance Improvement section of  
313 this report, there are steps that the State can take to better understand factors underlying the  
314 increasing number of bed-days used by the target population and to devise interventions  
315 accordingly.

316 The State is in Partial Compliance with the Agreement’s Crisis Stabilization  
317 requirements.

318

#### 319 E. Training Relating To Crisis Diversion Services

##### 320 *Substantial Compliance.*

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

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

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

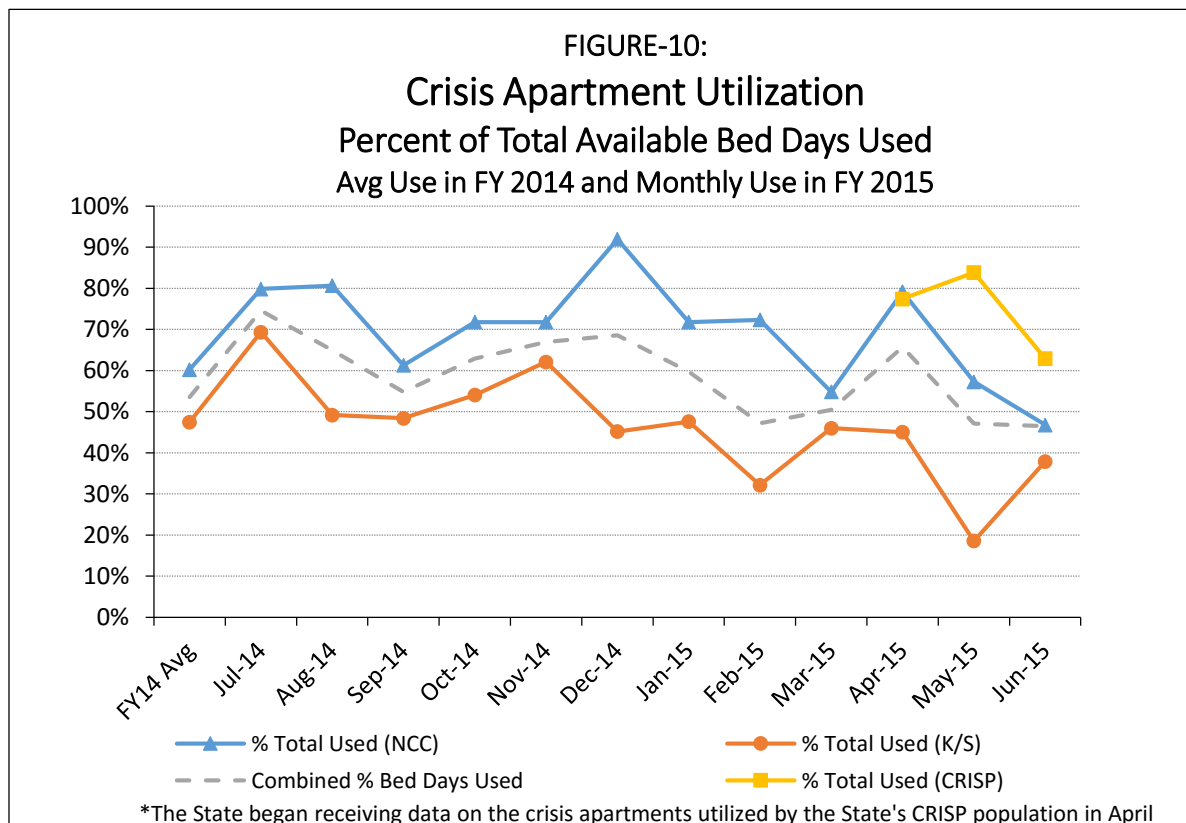
331

### 332 E. Crisis Apartments

#### 333 *Substantial Compliance.*

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

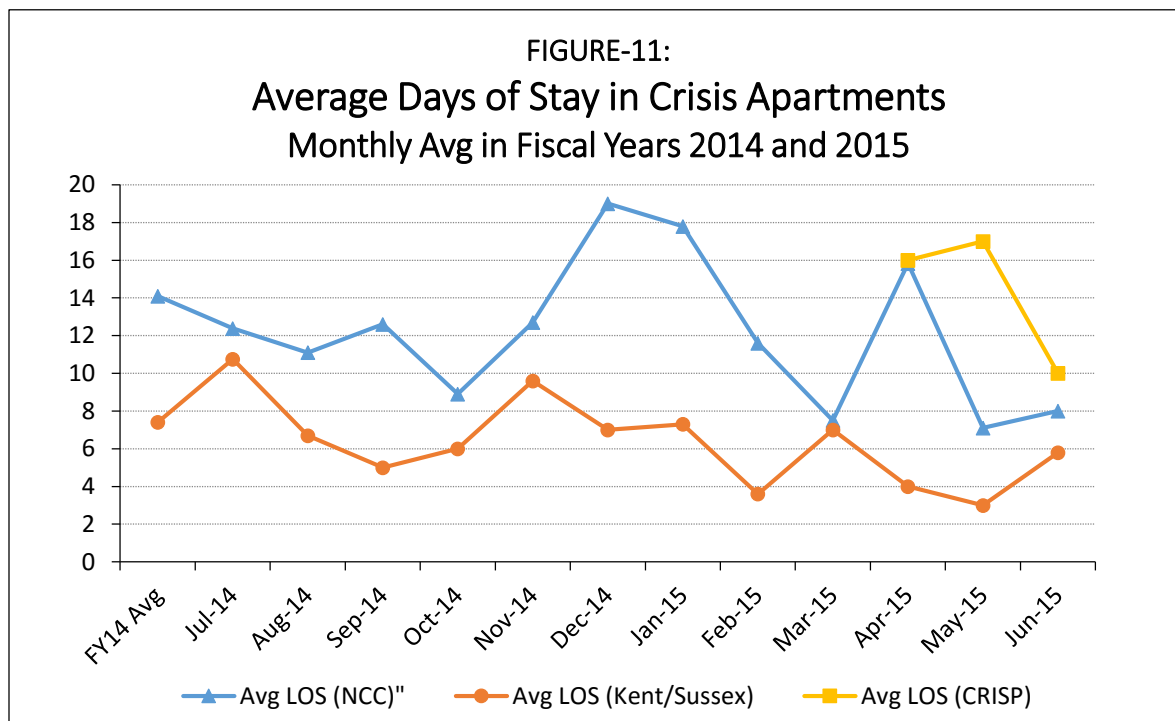
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345

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

356



357

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

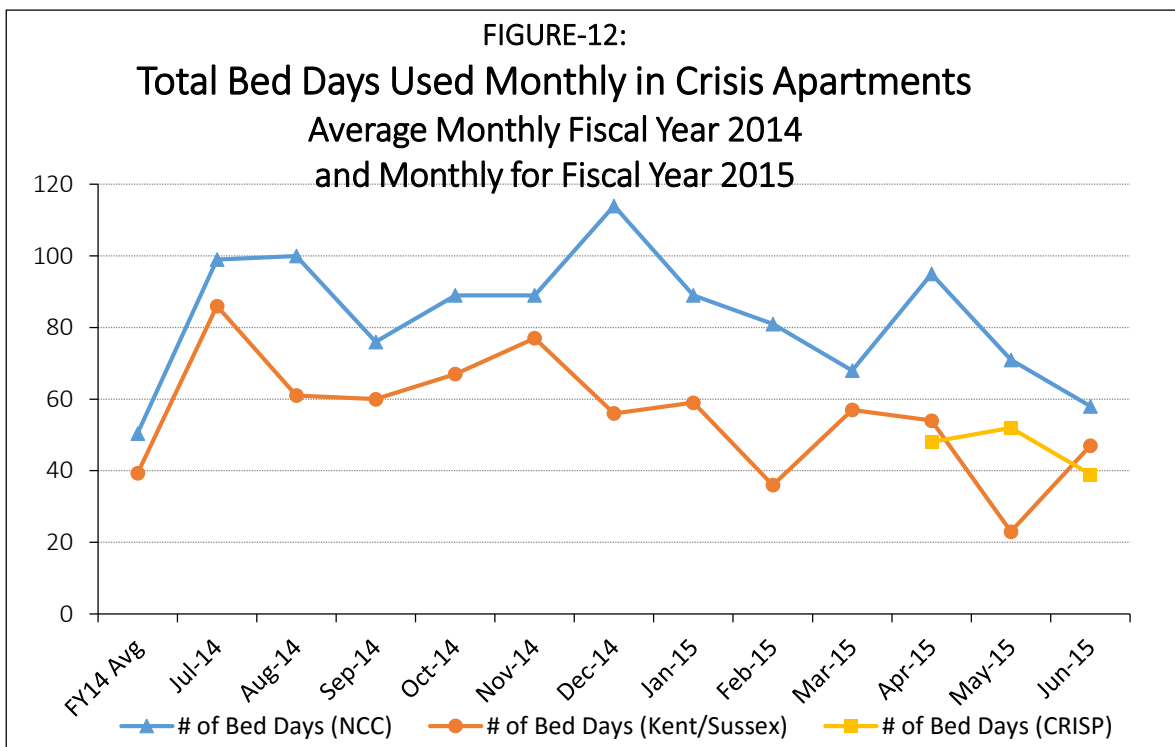
<sup>18</sup> CRISP has been described in detail in prior Monitor reports; it is an ACT-like program that serves high-need individuals and that enables providers to flexibly use capitated funds to address their clients' needs, including for crisis apartments.

<sup>19</sup> Agreement, Section II.C.2.e



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

370



371

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

374

375 F. Assertive Community Treatment

376 *Substantial Compliance.*

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

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

<sup>21</sup> One team, Connections ACT-IV, is new and has not yet had its full TMACT evaluation.

383 TMACT standards, provides similarly intense mobile services to individuals who have service  
384 needs that are at least as significant as those served through ACT.<sup>22</sup>

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

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

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

407 Figure-13 presents TMACT "overall" scores for the State's ACT teams, reflecting  
408 evaluations conducted in Fiscal Year 2015 and, where they exist, comparative evaluations for  
409 Fiscal Year 2014.<sup>23,24</sup> These overall scores are composite measures reflecting six subscales that  
410 comprise 47 measures. Some teams' overall scores reflect consistency among the subscales,  
411 while in other instances, there may be considerable internal variance. As is indicated in this  
412 chart, eleven out of the fourteen ACT teams that were scored obtained overall TMACT scores of  
413 3.0 or higher; even within these teams, there may be deficiencies identified through the subscales  
414 for which the State is requiring corrective measures. The three ACT teams with overall scores

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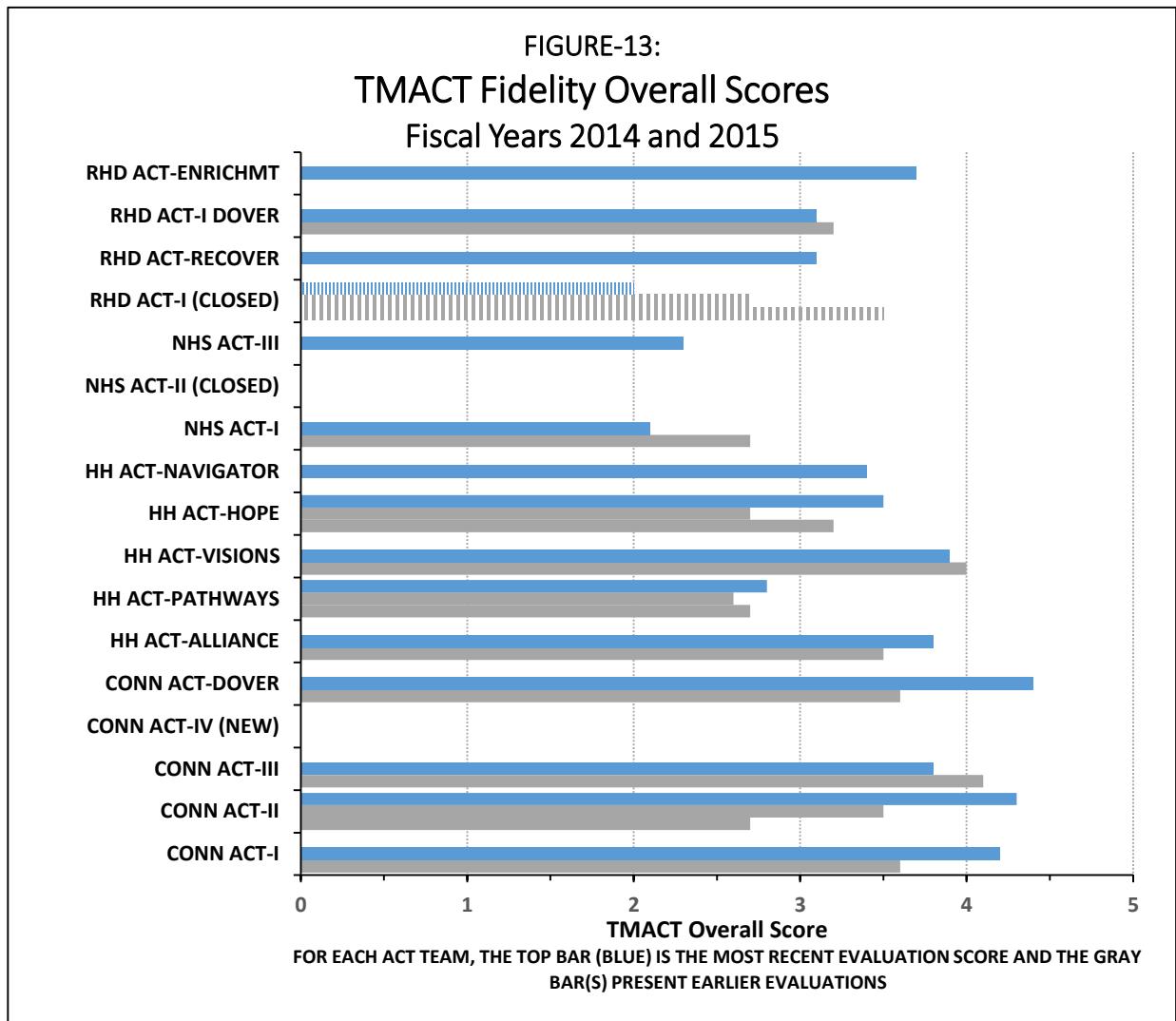
<sup>22</sup> Reconciling the State's compliance with the numerical targets of Section III.F (ACT) and III.G (Intensive Case Management, or ICM) has been a bit challenging because, with the concurrence of the parties and the Monitor, the State converted some of its ICM teams to ACT. Furthermore, the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

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

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

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

423



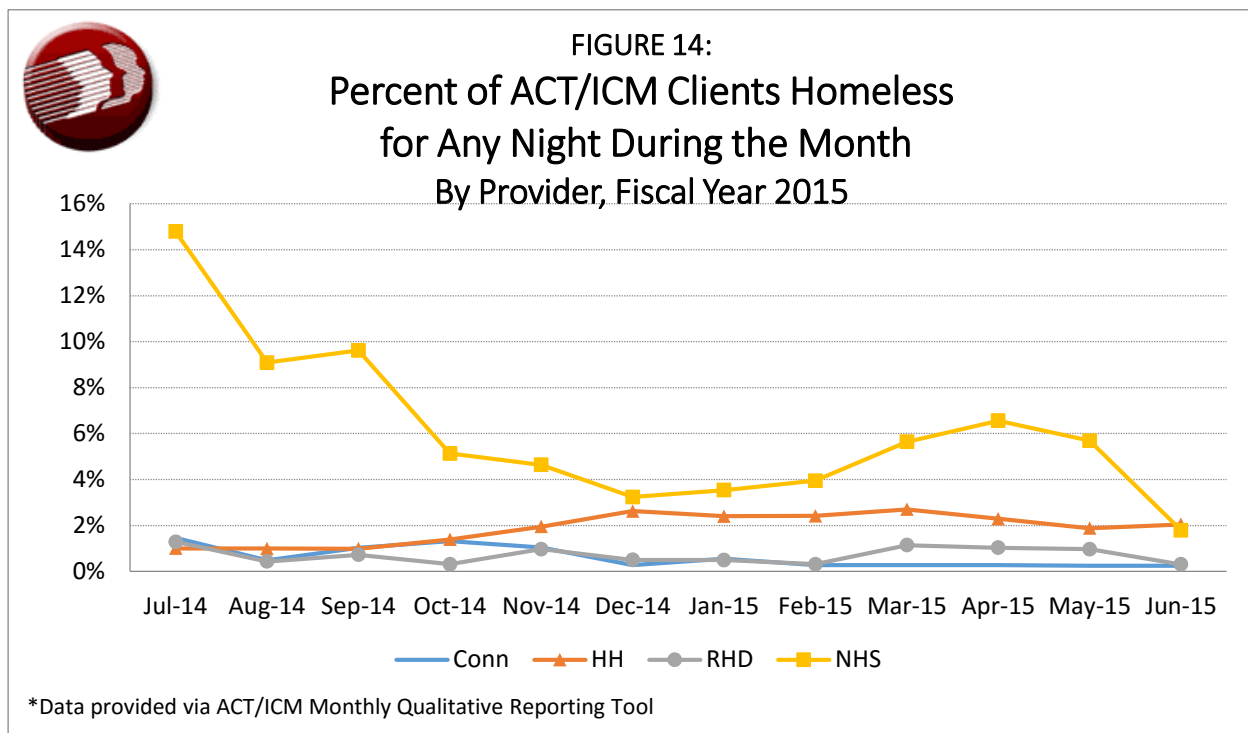
424

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

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

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

434



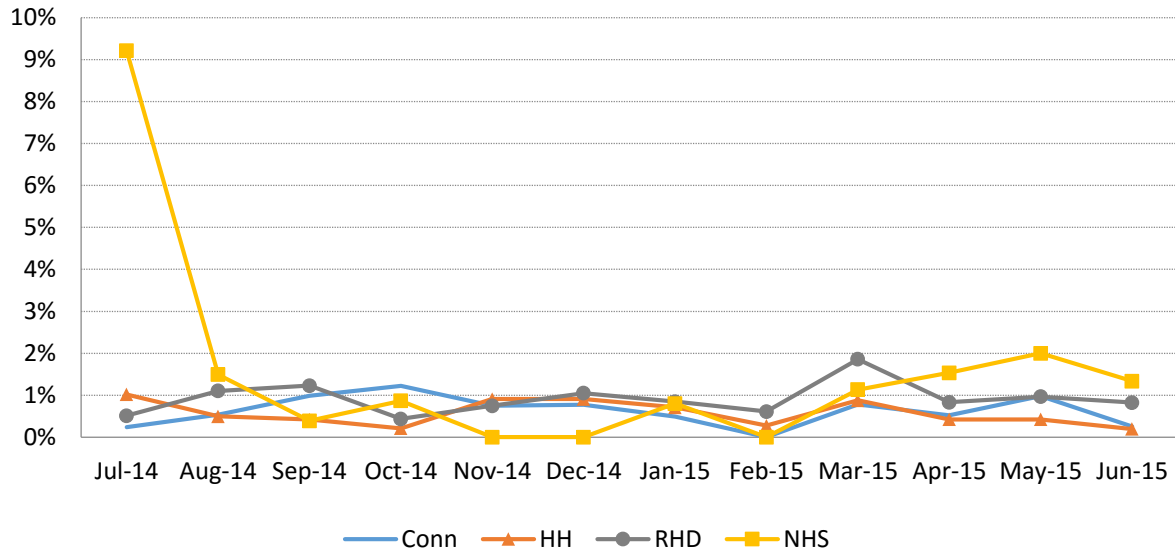
435

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

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



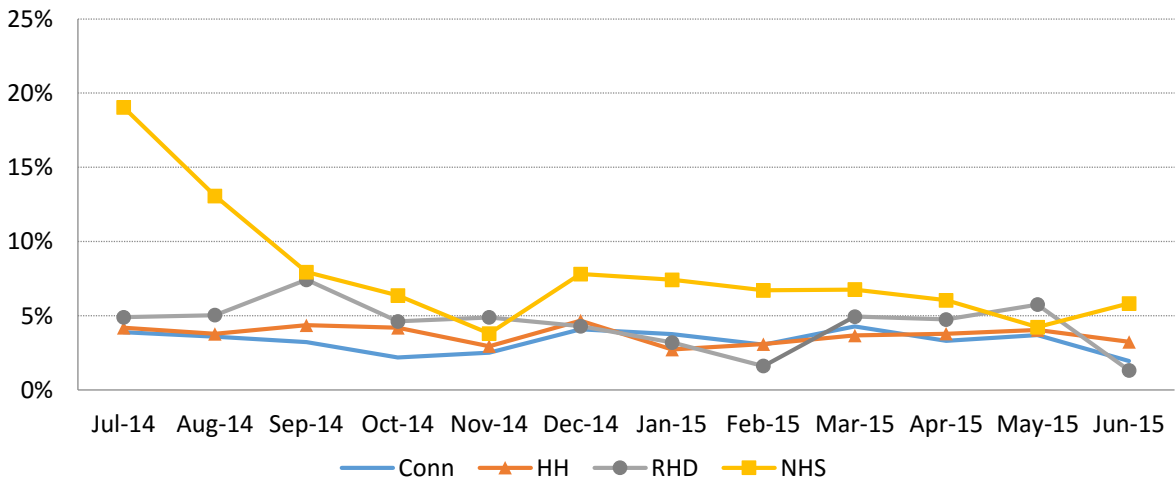
**FIGURE-15:**  
**Percent of ACT/ICM Clients Arrested**  
**By Provider, Fiscal Year 2015**



\*Data provided via ACT/ICM Monthly Qualitative Reporting Tool



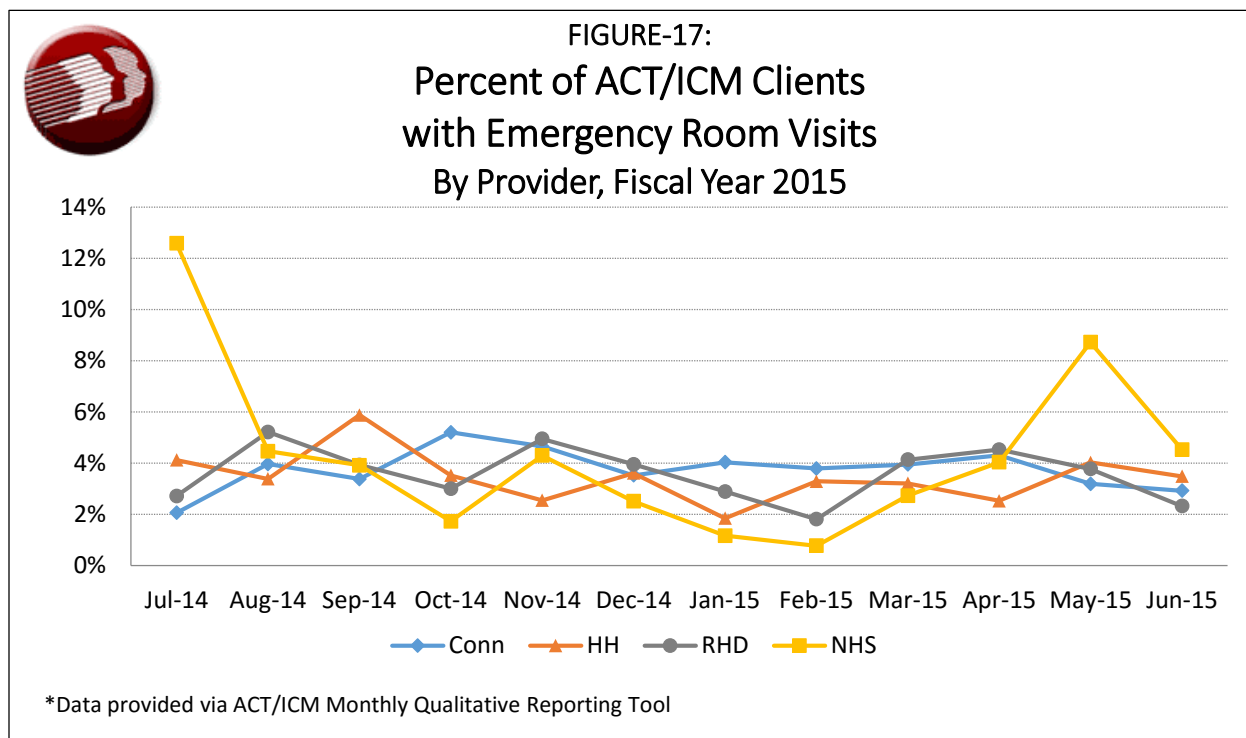
**FIGURE-16:**  
**Percent of ACT/ICM Clients Psychiatrically Hospitalized**  
**By Provider, Fiscal Year 2015**



\*Data provided via ACT/ICM Monthly Qualitative Reporting Tool

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

457



458

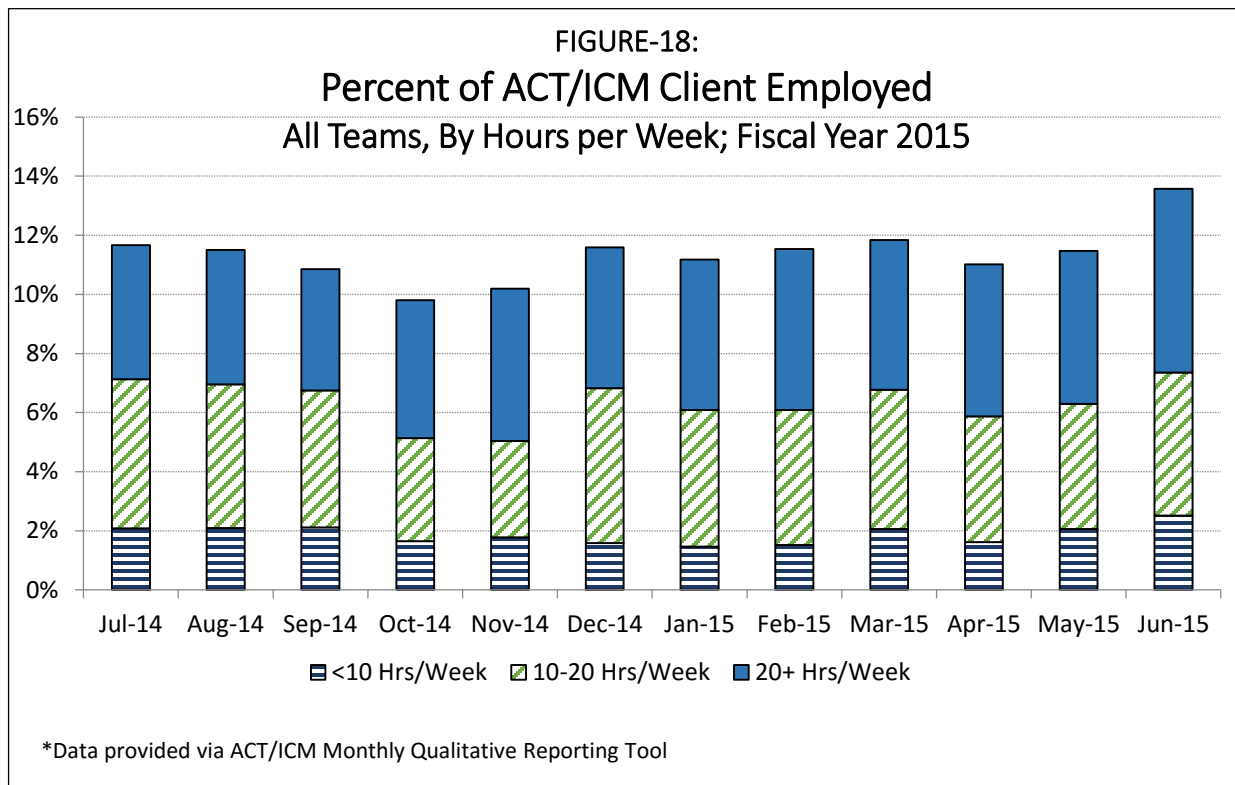
459 As is explained later (with regard to Quality Assurance and Performance Improvement),  
 460 an ongoing study through the University of Pennsylvania is looking at how different cohorts of  
 461 the target population are faring as new services and refinements in processes roll out through the  
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

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

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

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

484



485

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

489

490 G. Intensive Case Management

491 *Substantial Compliance.*

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

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

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

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

506

## 507 H. Case Management

### 508 *Substantial Compliance.*

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

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

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

530

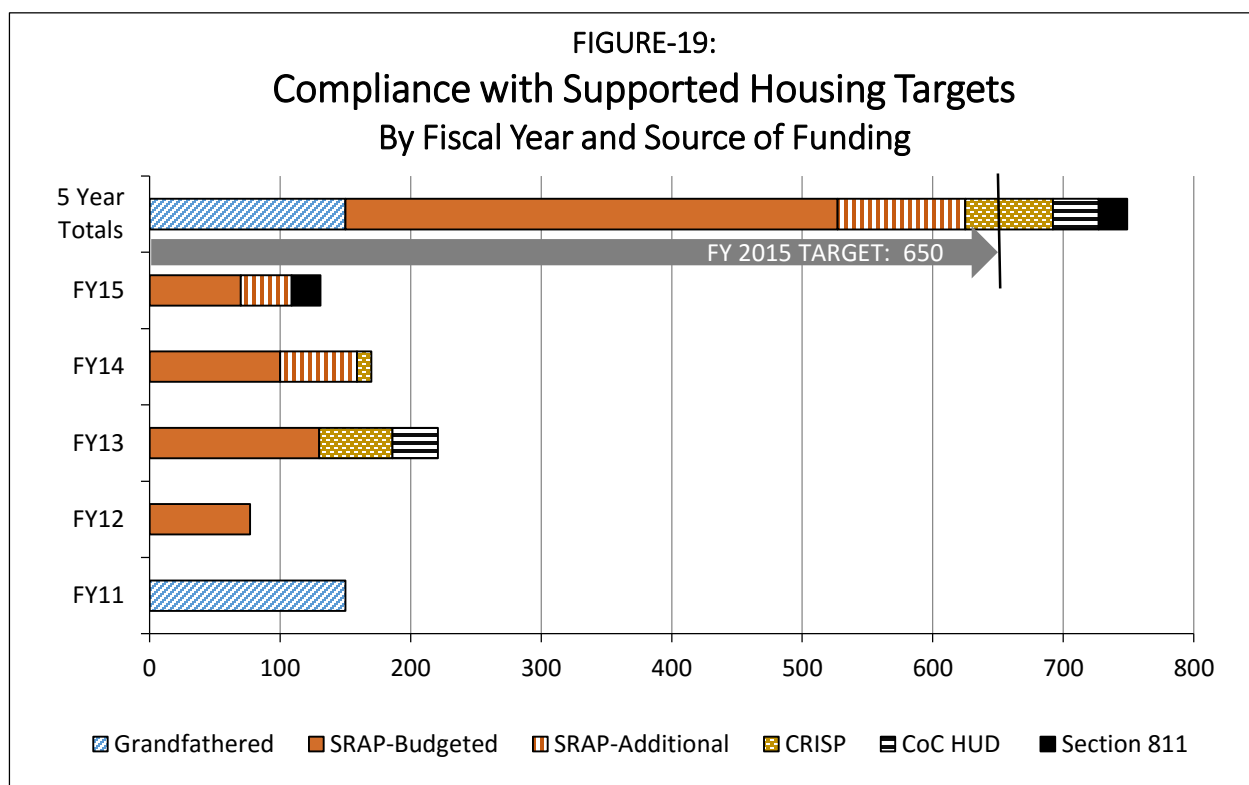


531 I. Supported Housing

532 *Substantial Compliance.*

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

541



542

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

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

<sup>26</sup> Agreement, Section II.2.E1.a

550 support. Particularly relevant here will be whether or not existing resources are sufficient to  
551 address the ongoing and already known housing needs of the target population, as well as those  
552 of homeless individuals with SPMI who are identified when admitted to an IMD (this was  
553 discussed above in the section “Referrals of Homeless Individuals for Housing”) and newly  
554 identified individuals arising from DSAMH’s interactions with the State’s Homeless Planning  
555 Council.<sup>27</sup>

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

558

## 559 J. Supported Employment

### 560 *Substantial Compliance.*

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

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

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

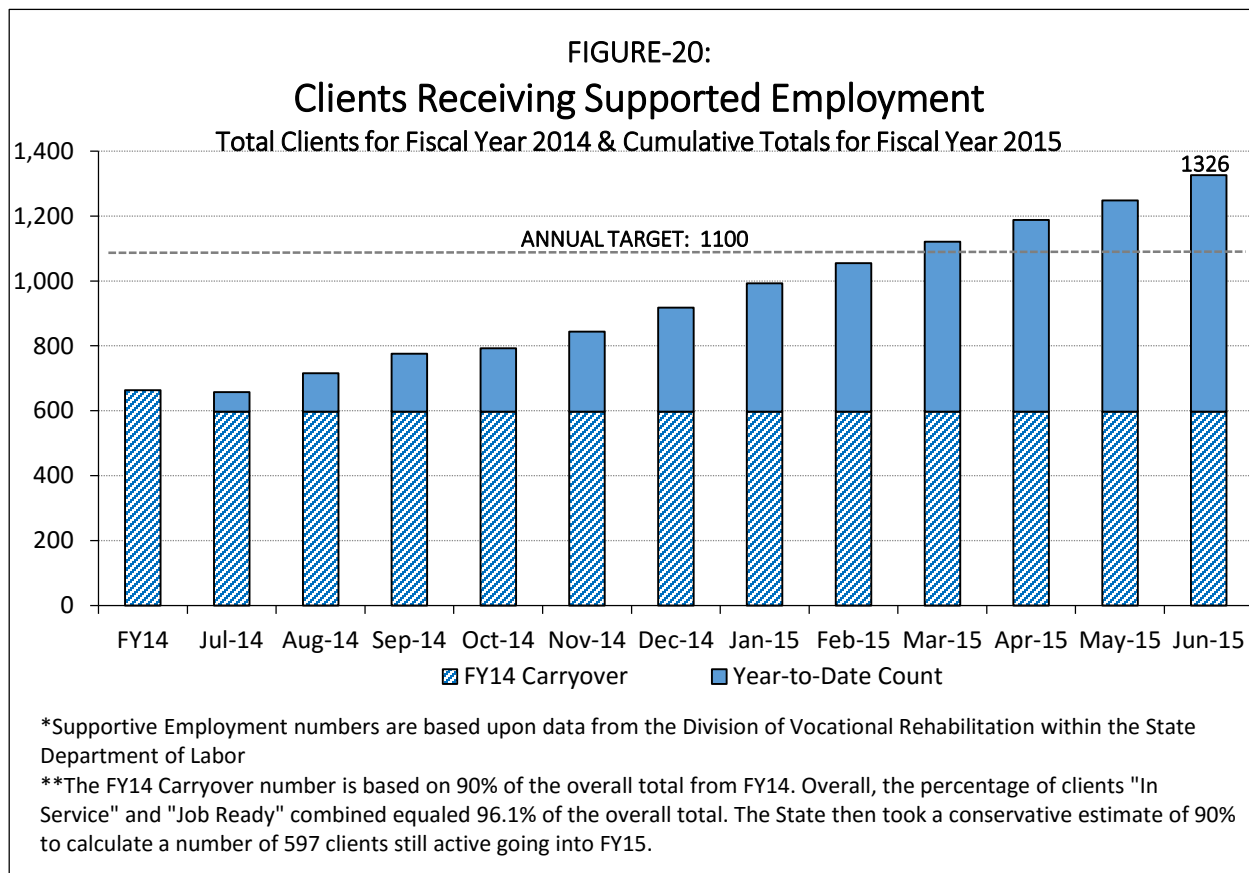
575 There are some factors in the federal program that is administered by DVR that present  
576 challenges to individuals with SPMI. Generally, DVR supported employment services terminate  
577 after an individual is employed in a job for 90 days, a federal limitation that was not designed  
578 with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

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<sup>27</sup> The 2016 Delaware Homeless Planning Council Point in Time count is specifically referenced in Section III.I.6.

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

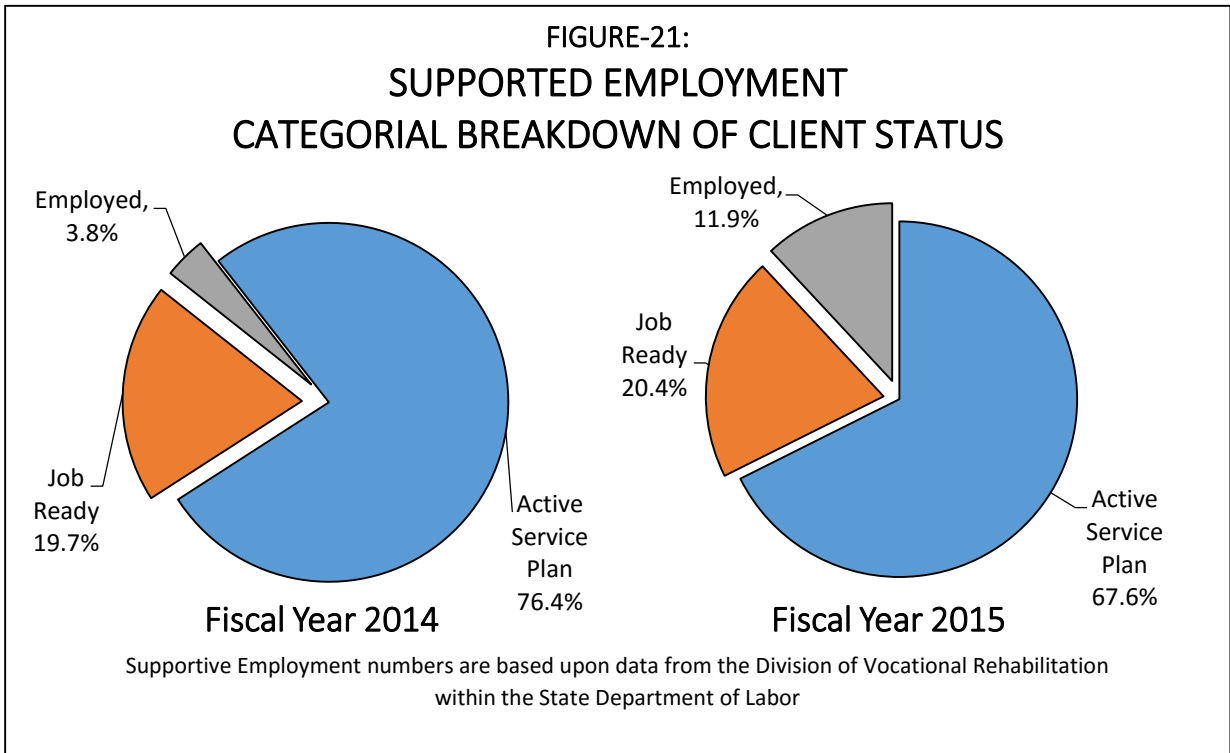
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591

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

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



605

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

608

609 **K. Rehabilitation Services**

610 *Substantial Compliance.*

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

617	Psychosocial Rehab Services, Psychosocial Group Services, or Family Psychosocial	
618	Education —at least twice/month for at least 6 months .....	517 individuals
619	Some level of Substance Abuse Treatment for a	
620	co-occurring disorder.....	1,593 individuals
621		
622	Total.....	2,110 individuals <sup>29</sup>

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

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

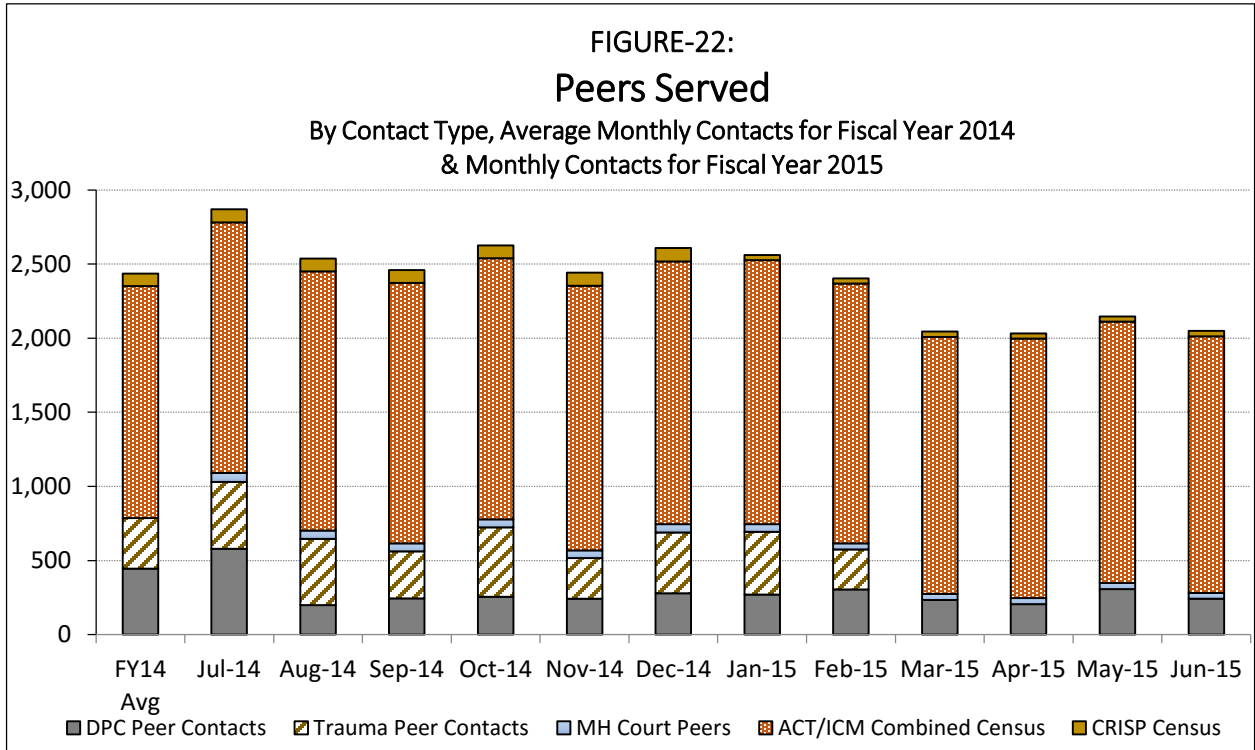
625

626 L. Family and Peer Supports

627 *Substantial Compliance.*

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

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



642

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

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

658

#### 659 M. Community Involvement in Discharge Planning

##### 660           *Partial Compliance.*

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

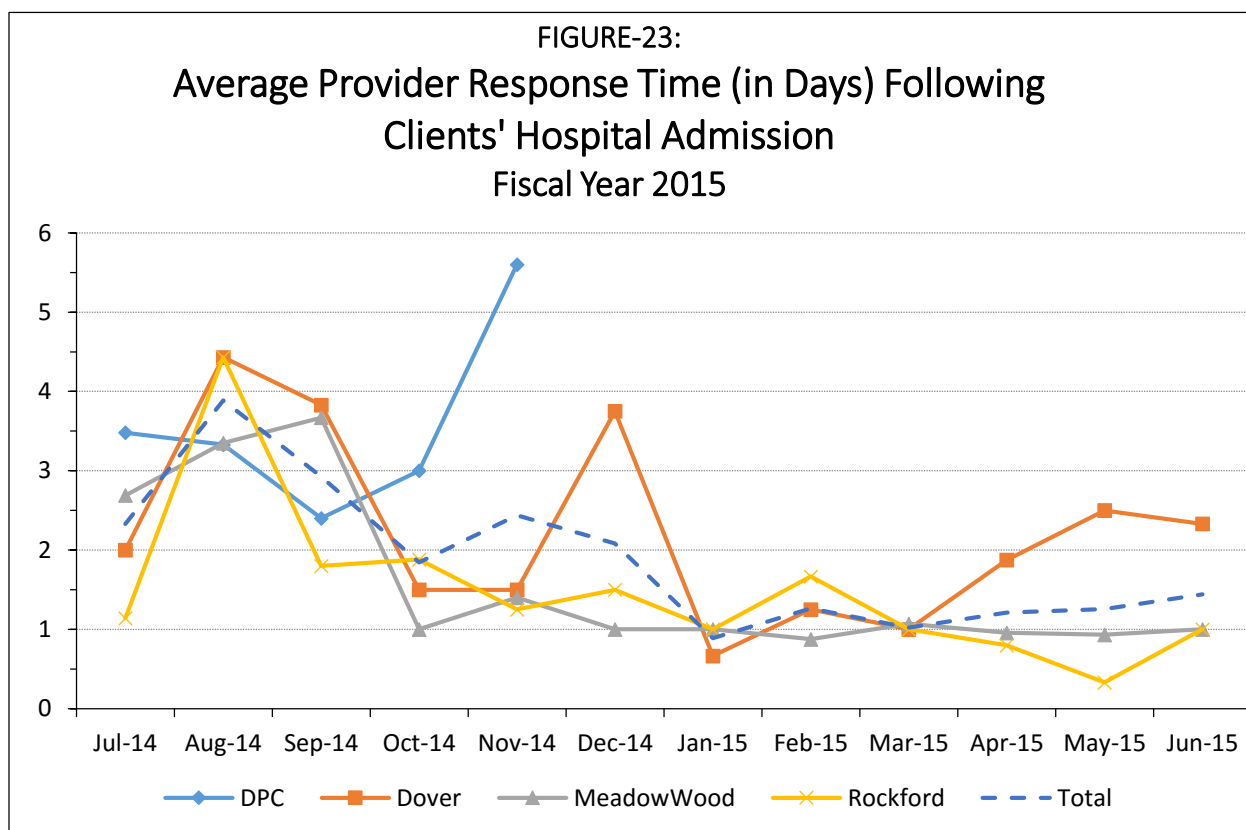
672           To briefly summarize these requirements and related discussions, the Agreement  
673 specifies that community providers become involved with an individual within 24 hours of  
674 admission to an IMD or DPC for acute care, with the goal of coordinating treatment and ensuring  
675 timely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

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

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

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

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

704

## 705 N. Quality Assurance and Performance Improvement

### 706 *Partial Compliance.*

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

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

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



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

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

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<sup>31</sup> This was discussed in the section of this report relating to Crisis Stabilization.

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

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

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

<sup>35</sup> Agreement, Section V.A. Emphasis added.

771 O. Risk Management

772 *Partial Compliance.*

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

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

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

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

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<sup>36</sup> Agreement, Section V.B.1.

<sup>37</sup> See "Sixth Report of the Monitor," December 29, 2014, p. 41.

809 putting in place. The State is rated as being in Partial Compliance with regard to the provisions  
810 contained in Section V.B, although in some important respects it is only “slightly above a non-  
811 compliance rating.”<sup>38</sup>

812

### 813 **III. Conclusion**

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

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836 Robert Bernstein, Ph.D.

837 Court Monitor

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