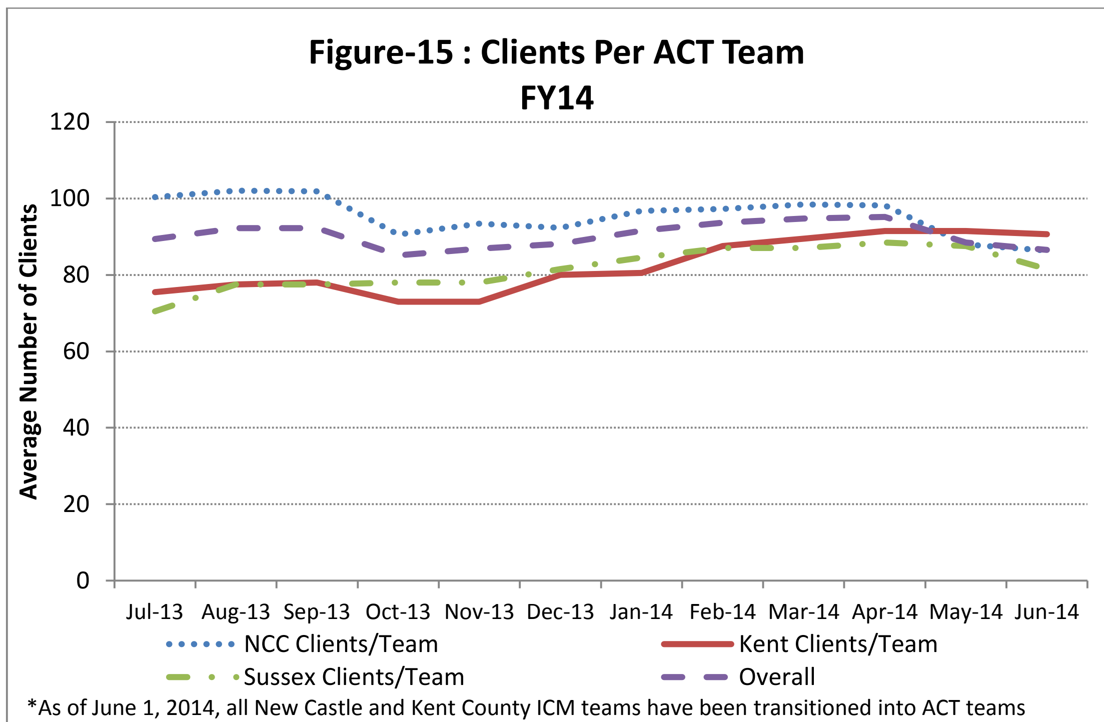
685 State has in place a working system aimed at monitoring fidelity and promoting continuous
686 improvement. The next round of data will give a clearer picture as to how the State is faring
687 in bringing all of its ACT teams into fidelity with TMACT standards, in keeping with Section
688 II.D.2.a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

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

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

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

698

699 

700

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

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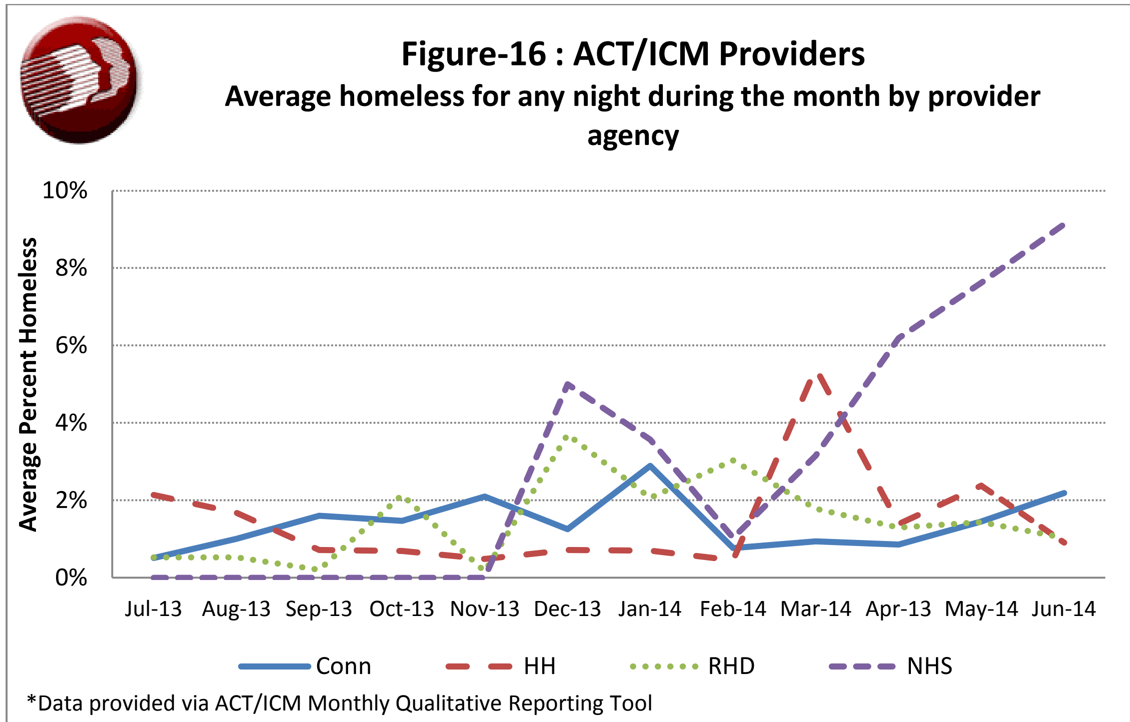
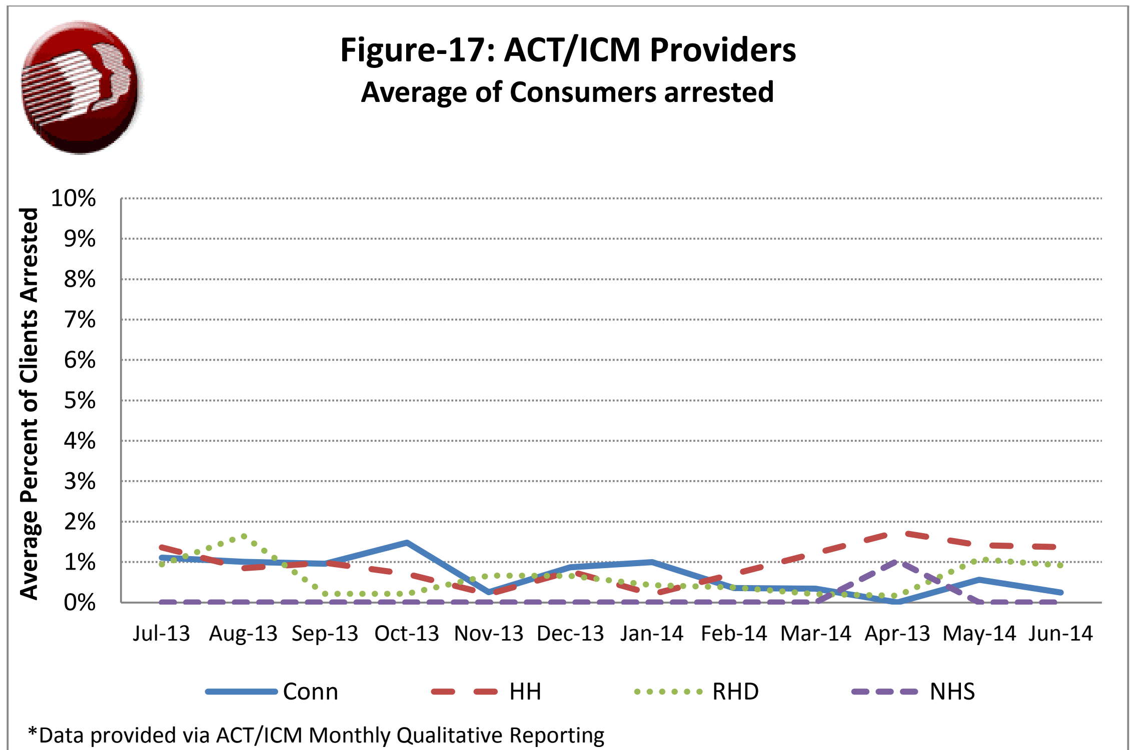


708

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

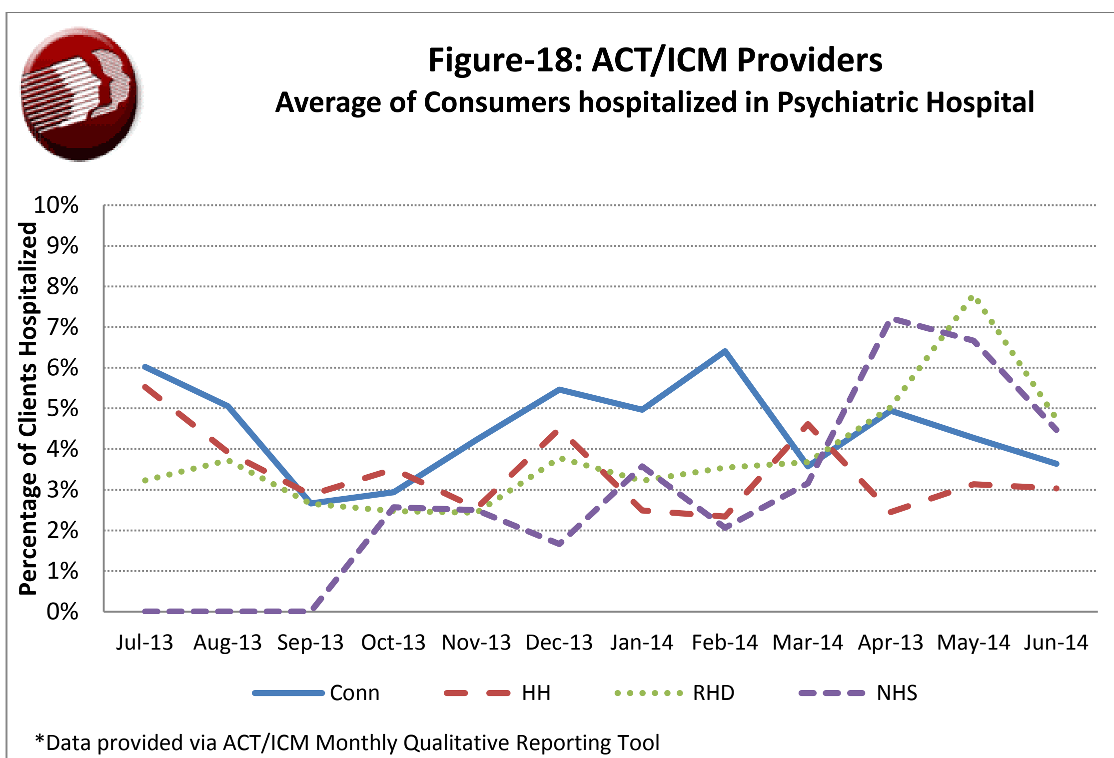


712

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

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

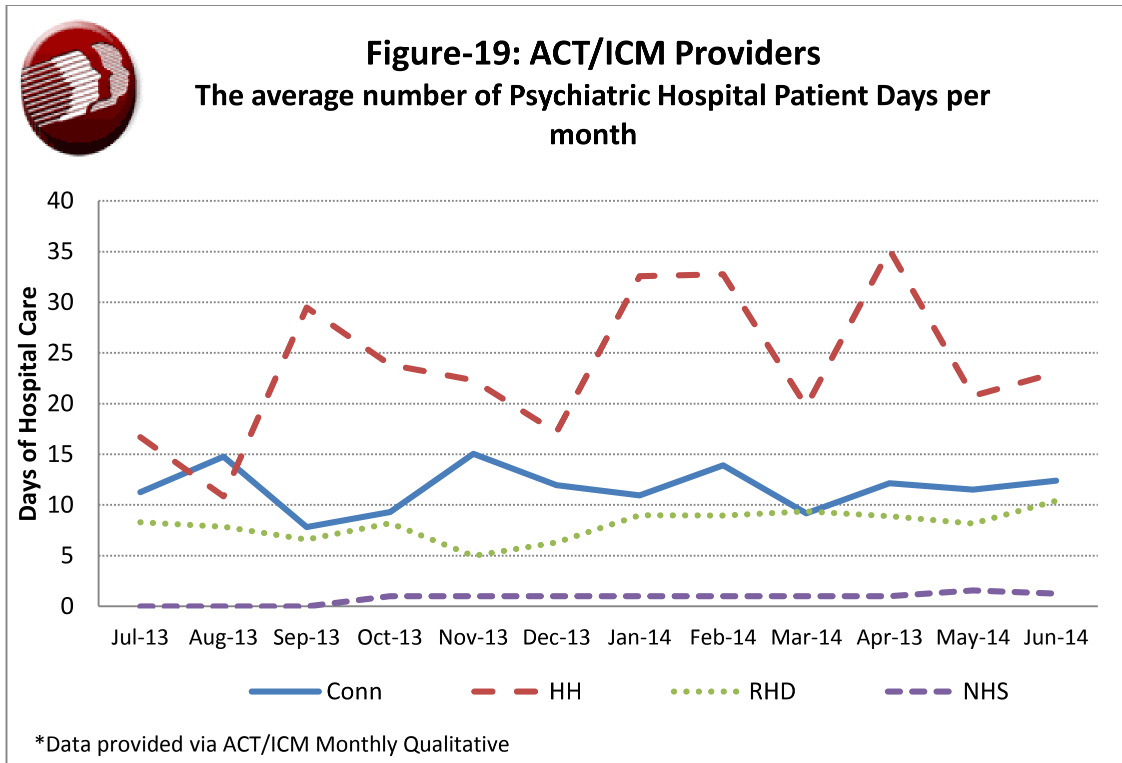
723



724

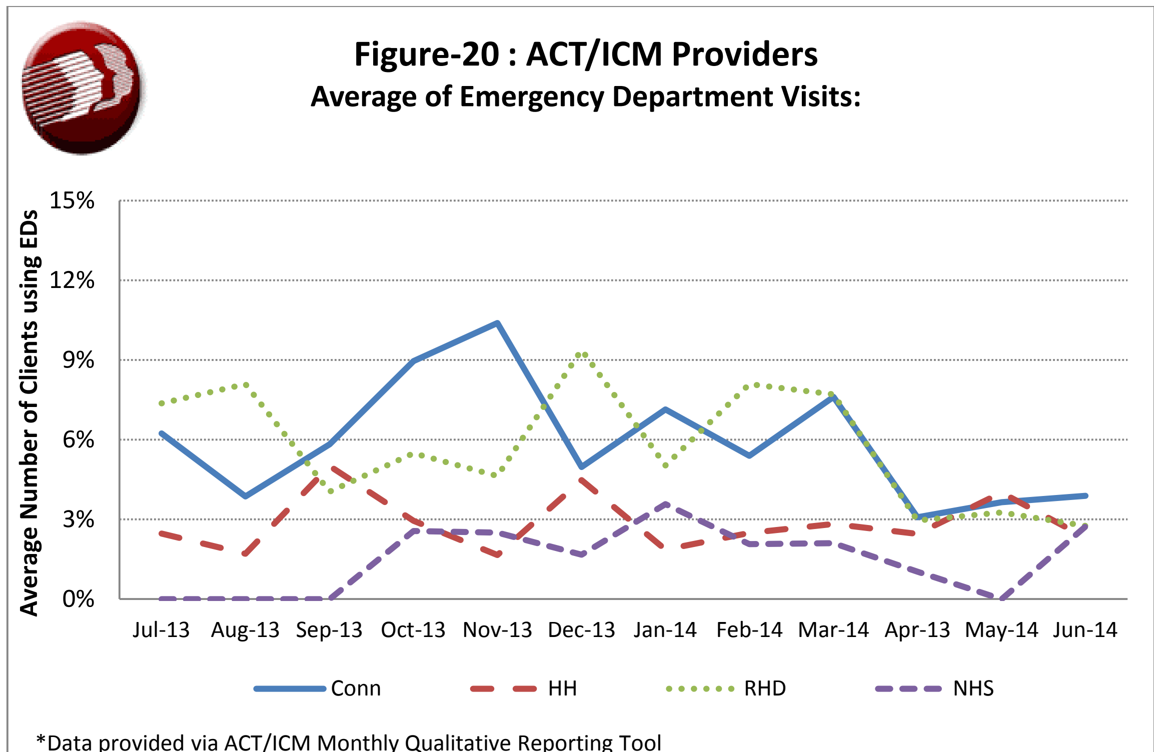
725

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



734

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



739

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

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

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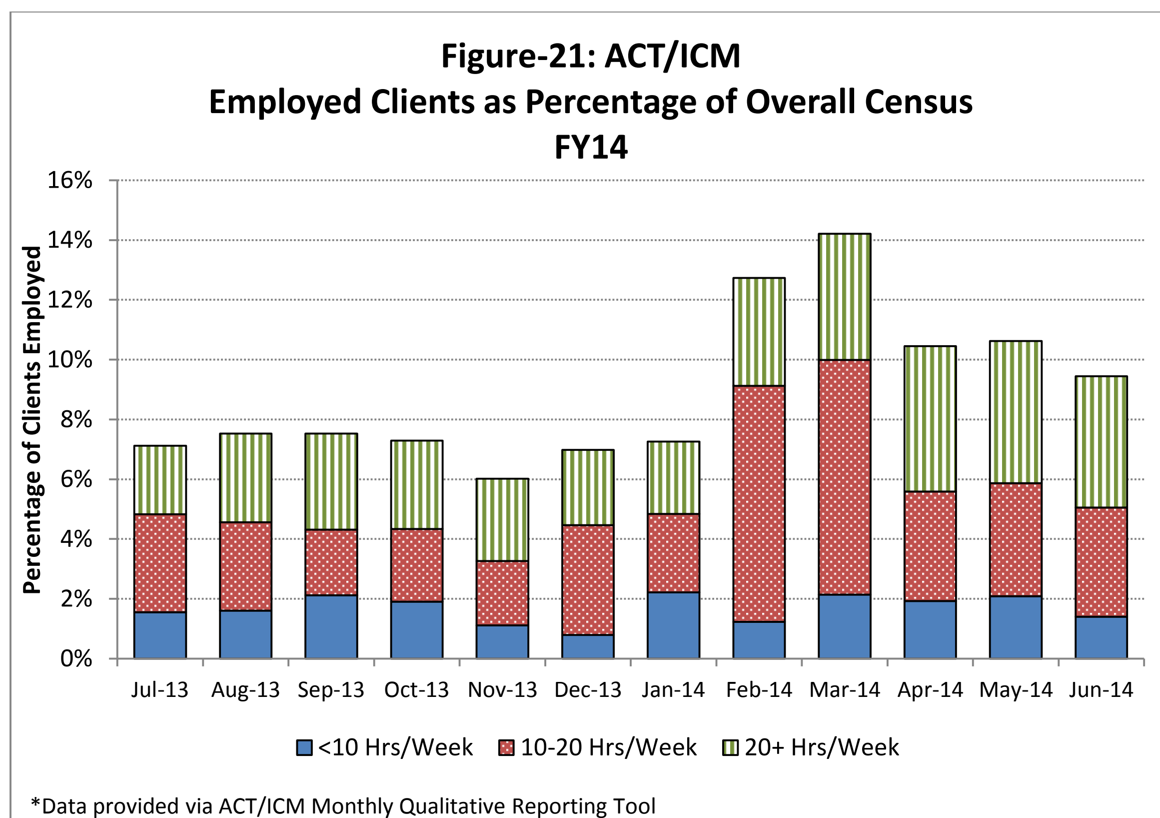

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751

752 F. Intensive Care Management

753 <u>Substantial Compliance.</u>

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

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

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

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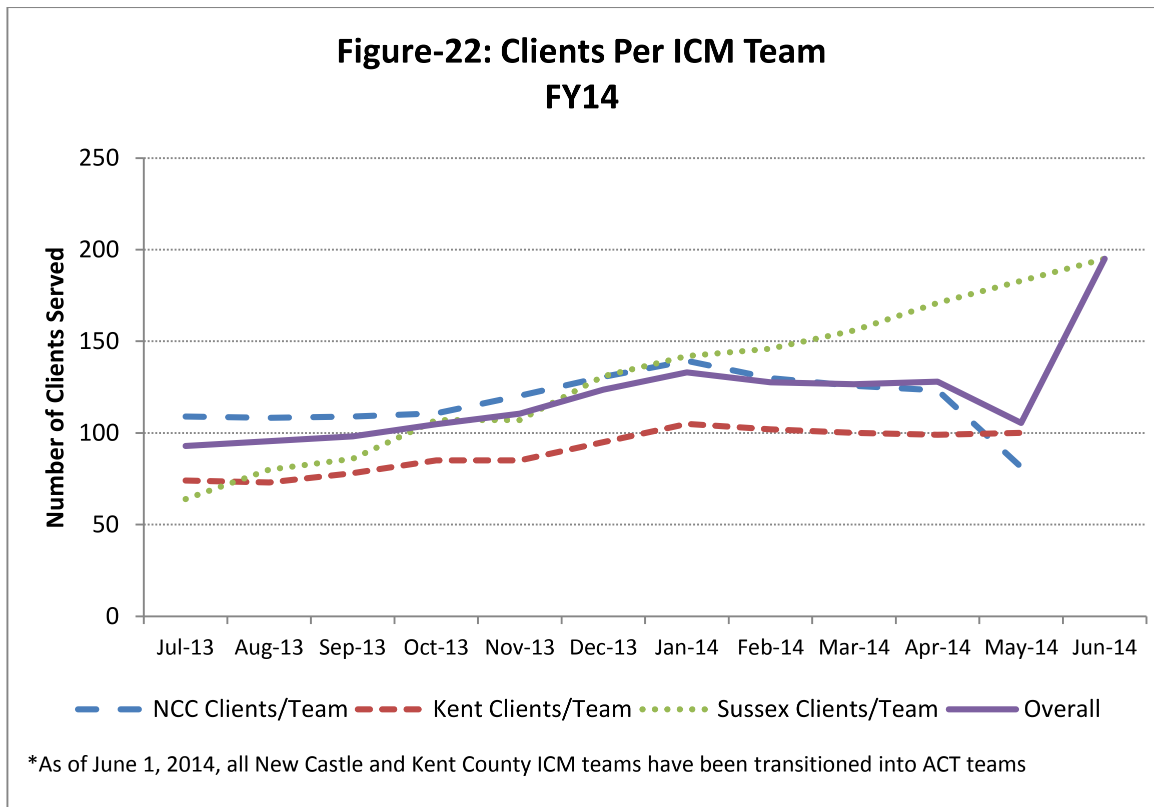


771

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

776

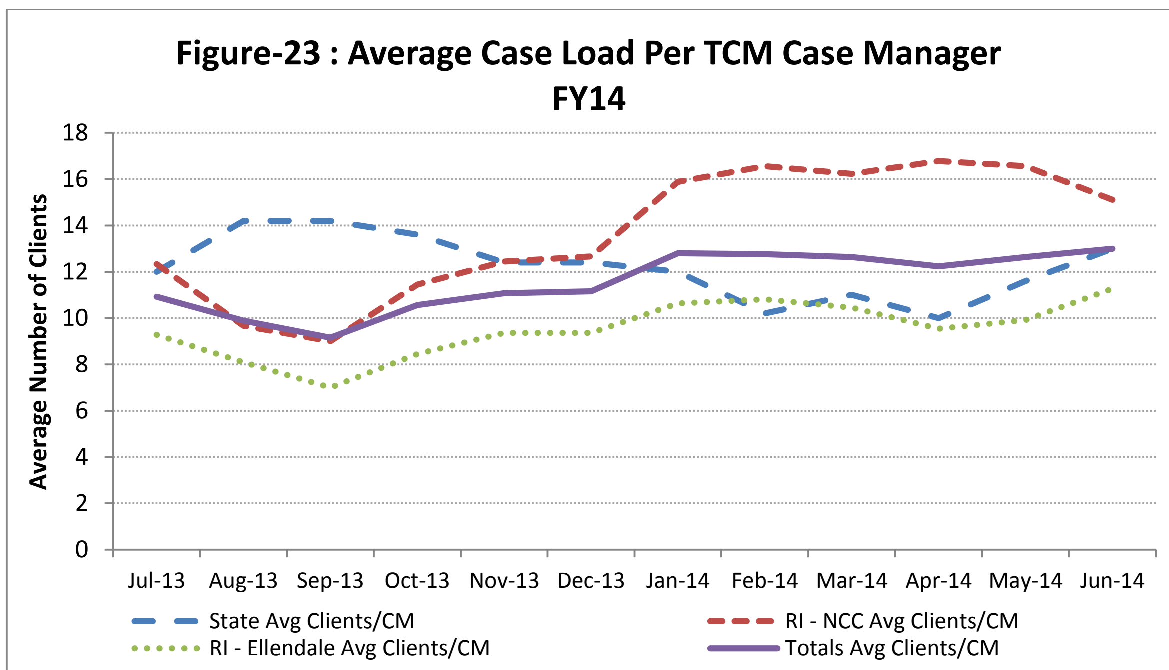
[19] Because these ACT teams are new, they are not included in the data presented in the previous section, including the data relating to fidelity. They will be incorporated in these measures in the 2015 fiscal year.

777 **G. Case Management**

778 Substantial Compliance.

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

787



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789

790 **H. Supported Housing**

791 Substantial Compliance.

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

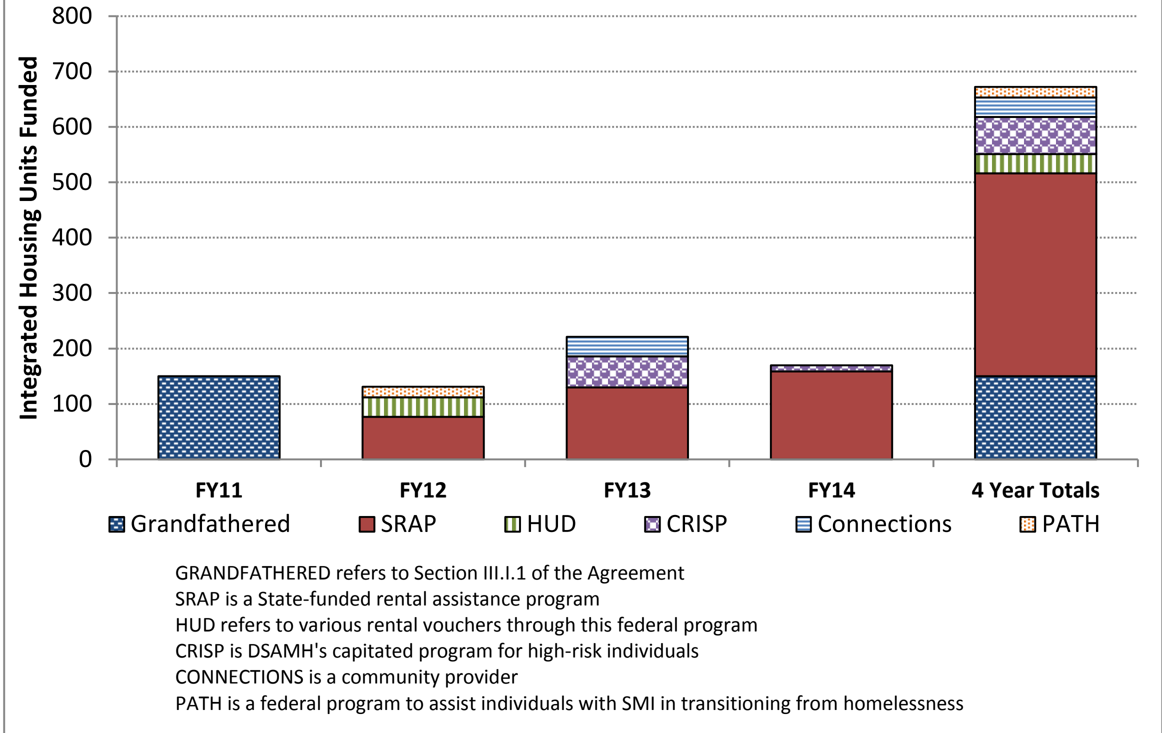
800 palpable moves to increase access to scattered-site supported housing (as defined in the
801 Agreement). Only about 2% of individuals on the TPPL live in state-funded group homes,
802 increasingly due to medical care needs that co-occur with SPMI.

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

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

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

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



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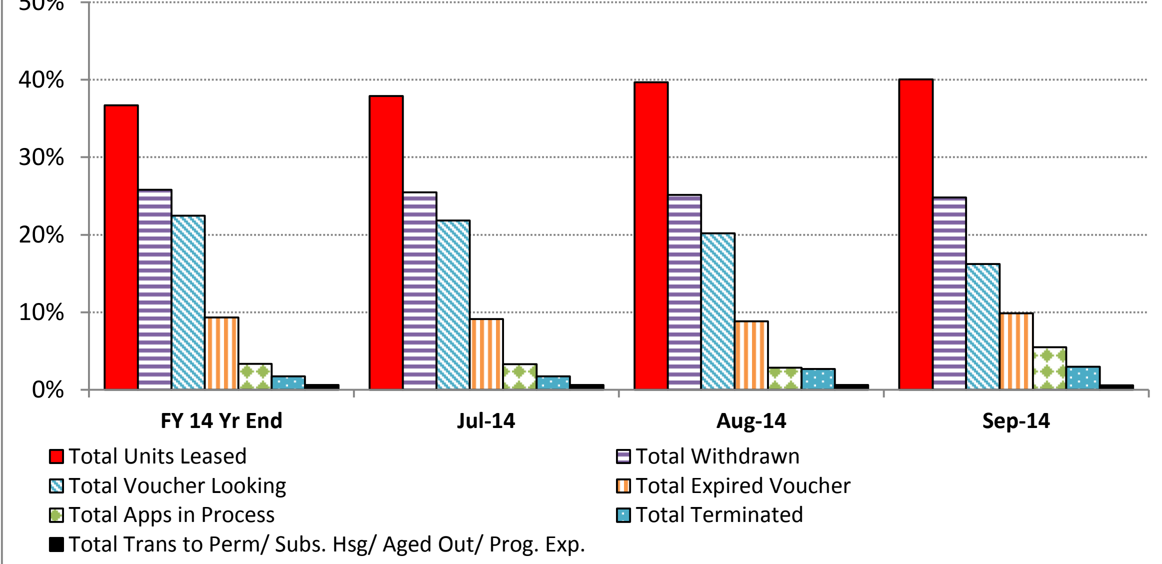


834

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

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

848

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

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

849

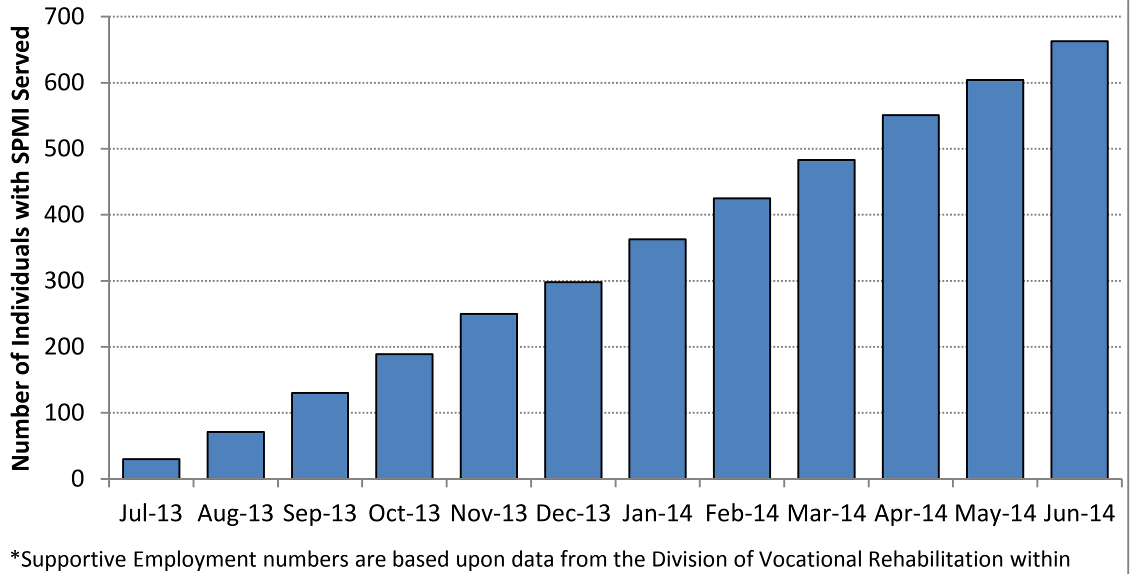
850 **I. Supported Employment**

851 <u>Substantial Compliance</u>.

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

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

864



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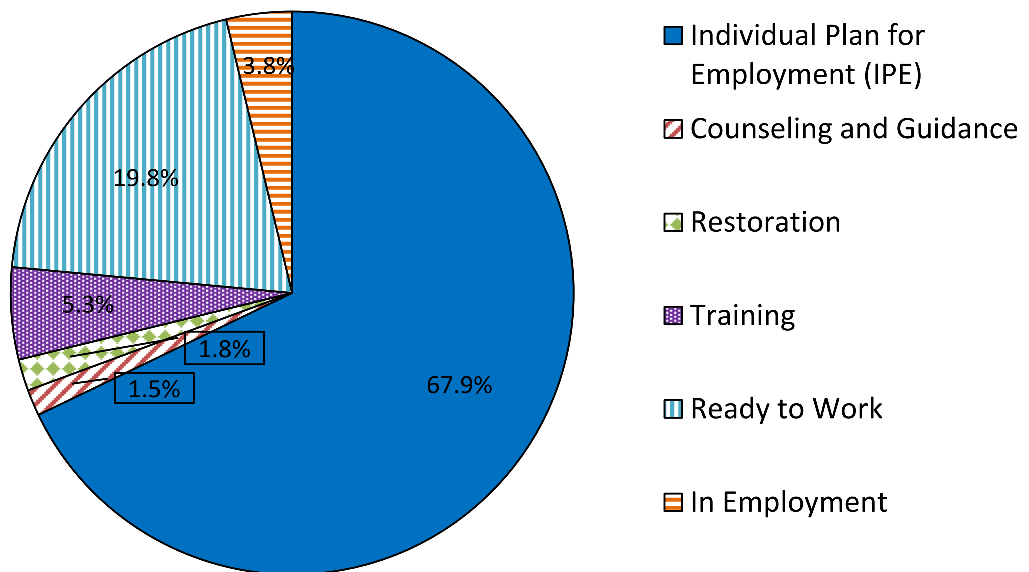

866 process; although the numbers are not large, other individuals in the targeted group have
867 received supported employment in earlier years and are no longer counted in this data set.

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

870

871 ***Recommendations:***

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

876

877 **J. Rehabilitation Services**

878 Substantial Compliance.

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

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

894

895 The State is in Substantial Compliance with this provision.

896

897 **K. Family and Peer Supports**

898 Substantial Compliance.

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

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

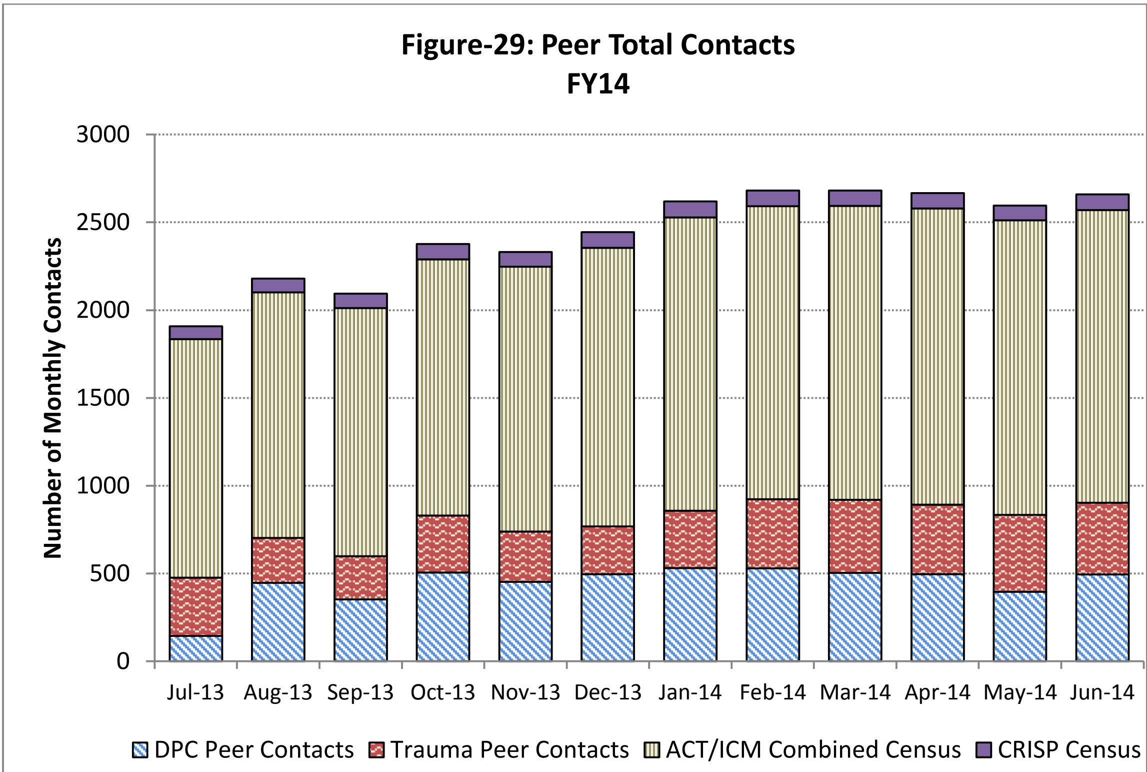

Figure-29 presents only a portion of the picture of the role of peer services in DSAMH programs. It shows the number of peer contacts with individuals who are hospitalized at DPC, as well as those served through ACT Teams or DSAMH's CRISP program, which focuses mostly on individuals with histories of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

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

929

930 **L. Quality Assurance and Performance Improvement**

931 Substantial Compliance.

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

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

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

954

955 **M. Risk Management**

956 Partial Compliance.

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

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

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

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

IV. Summary

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

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

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

997 into effect on January 1, 2015. These initiatives are positive steps but, setting aside the
998 human impact of the State's foregoing interim measures to comply with the Agreement with
999 regard to the DMMA-managed population, these programs will likely be fully operational for
1000 only a little over one year at the point the State is aiming to be able to demonstrate full
1001 compliance with the Agreement, in July of 2016. Accordingly, it is critical that the State
1002 redouble its efforts to ensure that all populations covered by the Agreement are appropriately
1003 served and that it be able to provide meaningful, comprehensive, and timely data to
1004 document that this is the case. The Monitor remains available to assist the State in this effort.

1005

1006

1007

1008 Robert Bernstein, Ph.D.

1009 Court Monitor