

1 **SEVENTH REPORT OF THE COURT MONITOR**  
2 **ON PROGRESS TOWARD COMPLIANCE**  
3 **WITH THE AGREEMENT:**  
4 **U.S. v. STATE OF DELAWARE**

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

6 June 11, 2015

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9 **I. Introduction:**

10 This is the seventh report of the Court Monitor (Monitor) on the implementation by the State of  
11 Delaware (State) of the above-referenced Settlement Agreement (Agreement).<sup>1</sup> Prior reports of  
12 the Monitor have reviewed the State's progress with regard to each element of the Agreement, as  
13 well as related reforms it is making to support the Agreement's goals. With the concurrence of  
14 the parties, this is an abbreviated report. It focuses upon those provisions of the Agreement for  
15 which the Monitor has concluded that the State was not in Substantial Compliance per the  
16 Monitor's sixth report.<sup>2</sup> These provisions relate to:

- 17 a. Reducing the number of State-funded psychiatric inpatient bed-days used by the  
18 population of people with Serious and Persistent Mental Illness (SPMI) that the  
19 Agreement targets (Section III.D.3 of the Agreement),
- 20 b. Discharge planning for individuals who are hospitalized in Delaware Psychiatric  
21 Center (DPC) or one of the private psychiatric hospitals (IMDs<sup>3</sup>) that serve members  
22 of the target population through State funding (Section IV),
- 23 c. The State's Assertive Community Treatment programs (ACT) and their fidelity to the  
24 TMACT program standards (Section III.F<sup>4</sup>), and

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<sup>1</sup> This report generally covers the period from July 1, 2014 through February 28, 2015.

<sup>2</sup> Section VI.B.3.g presents criteria by which the Monitor is responsible for evaluating the State's performance with regard to the Agreement's provisions, through ratings of: Substantial Compliance, Partial Compliance, and Noncompliance. For the period ending July 15, 2014, the Monitor found the State to be in Substantial Compliance with the relevant provisions of the Agreement that are *not* discussed in this report. Although not reviewed here, the State is required to maintain Substantial Compliance for these provisions. Based upon the Monitor's ongoing evaluations, including the "dashboard" data provided by the State on a monthly basis, Delaware is, indeed, fulfilling its responsibility to sustain compliance with these provisions.

<sup>3</sup> IMD refers to the federal classification of such facilities under Medicaid as "Institutions for Mental Diseases." Three privately operated IMDs serve members of the target population.

<sup>4</sup> In 2012, the Monitor and the parties agreed that the TMACT model of fidelity would be substituted for the Dartmouth model, which is specified in the Agreement.

25 d. The State’s risk management program, which is intended to reduce the risk of harm to  
26 individuals covered by the Agreement (Section V.B).

27 In addition to these four provisions, this report also presents an update on the State’s efforts to  
28 increase the number of individuals who receive supported employment services (per Section  
29 III.J) and who ultimately secure jobs in the mainstream workforce. The State has been in  
30 Substantial Compliance with respect to providing the supported employment services required  
31 by this provision of the Agreement, however, the Agreement has no specific targets for the actual  
32 employment outcomes of these services. As was referenced in prior reports of the Monitor, the  
33 Governor has made employment of Delawareans with disabilities a priority of his administration.  
34 Furthermore, employment of people with disabilities in the mainstream of their communities is  
35 one essential goal of the Americans with Disabilities Act (ADA), upon which the Agreement is  
36 substantially based. For these reasons, an update on the State’s success in securing jobs for  
37 members of the target population is included in this report.

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40 **II. Review of Delaware’s Status with Respect to Specific Provisions of the Agreement:**

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42 **A. Annual Inpatient Bed-Days Used & Discharge Planning**

43 Reducing psychiatric hospitalizations among the target population is an important benchmark  
44 contained in the Agreement in that it reflects the collective impact of the various community-  
45 based services and supports that the Agreement requires. At the time the last Monitor’s report  
46 was written, the State had not demonstrated the overall reduction in annual state-funded bed-days  
47 as is required in Section III.D.3; it was found to be in Partial Compliance with this provision.  
48 Based upon data provided by the State at that time, Delaware had achieved significant reductions  
49 in bed-days for individuals receiving long-term care services at DPC, and more modest  
50 reductions in acute inpatient care—which is what this provision of the Agreement specifically  
51 references—for those individuals whose services were managed by the Division of Substance  
52 Abuse and Mental Health (DSAMH). However, for those individuals whose care was under  
53 management of the Division of Medicaid and Medical Assistance (DMMA)<sup>5</sup> and the private  
54 Managed Care Organizations (MCOs) with which it contracts, the number of acute bed-days  
55 used had actually increased, relative to the “base year” of 2011.<sup>6</sup>

56 Figure-1 presents updates on the cumulative number of state-funded hospital bed-days used by  
57 the target population this fiscal year with respect to the 30% and 50% reduction targets [relative  
58 to the baseline of the State’s fiscal year (FY) 2011] required by the Agreement.<sup>7</sup> The data

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<sup>5</sup> Both DSAMH and DMMA are divisions of the State’s Department of Health and Social Services (DHSS).

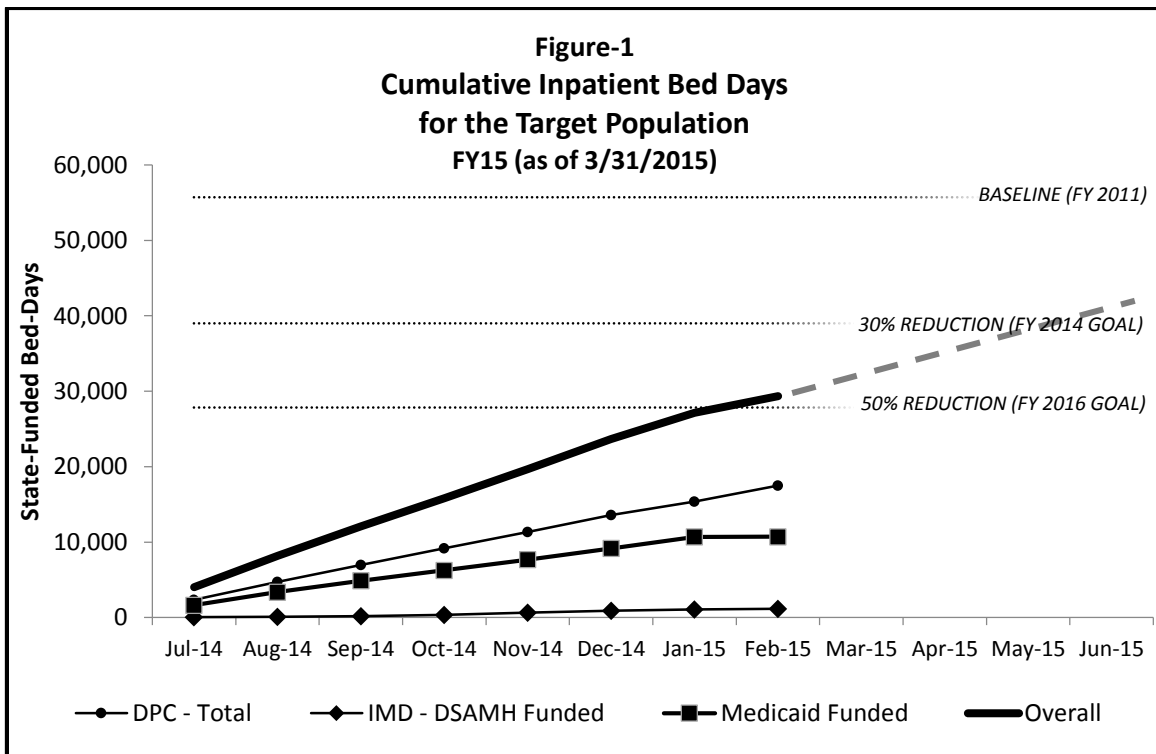
<sup>6</sup> It is noted that the State has improved its monthly reporting of Medicaid-funded bed-days since the Monitor’s last report. The State’s Bed-Day Reporting Memorandum, dated February 3, 2015, describes its corrective actions.

<sup>7</sup> Agreement, Sections III.D.3-4.

59 represent the period from July, 2014 through February, 2015, and the reduction targets represent  
 60 where the State’s overall bed-days are required to be as of June 30 in 2014 and 2016. Figure-1  
 61 includes the State’s total bed-day use for the target population (“Overall”), as well as cumulative  
 62 data for the three components that are comprised by the overall total. The DPC total reflects  
 63 bed-days for acute, intermediate, and long-term hospital care within that State-operated facility.  
 64 The IMD data for DSAMH and Medicaid are only for acute-care that is provided within those  
 65 privately-operated settings.

66 Relative to the base year, the State projects an overall reduction in hospital bed-days of 21.0% at  
 67 the end of this fiscal year (this projection is represented by the dashed portion of the “Overall”  
 68 line in the graph). In other words, its expected bed use for this fiscal year will exceed the 2014  
 69 reduction goal (Section III.D.3). This projection contemplates continued lower numbers of long-  
 70 term care days at DPC, as well as reductions in acute care managed through DSAMH at DPC  
 71 and the IMDs.

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75 Figure-2 presents the State’s projections of bed-day use for acute-care this fiscal year, based  
 76 upon current trends.<sup>8</sup> As is reflected in these data, overwhelmingly, the acute inpatient care  
 77 provided to the target population is managed through DMMA; the State projects a 25.9%

<sup>8</sup> Sections III.D.3-4 of the Agreement specifically reference acute inpatient settings.

78 increase in hospital bed days for this group relative to FY 2011, which is clearly inconsistent  
79 with the Agreement’s targets.

80 In interpreting this projection, however, there are some important additional factors to consider.  
81 The data presented in Figure-2 from July through December, 2014 essentially represent  
82 management of inpatient care as it has taken place since the Agreement took effect. Beginning  
83 in January, 2015 some significant changes began to occur. Inpatient psychiatric care for  
84 DSAMH clients who have Medicaid coverage was no longer “carved out” of the State’s  
85 Medicaid managed care program and subject to approval (and reimbursement) through DSAMH.  
86 Instead, it came to be managed as for other Medicaid recipients, by DMMA through the  
87 contracted MCOs. For the Medicaid population of people with SPMI not served through  
88 DSAMH, there were changes as well; annual limits on psychiatric hospital care were no longer  
89 applied to these individuals.<sup>9</sup> And other changes in the State’s Medicaid program will shift  
90 further responsibility for the management of acute inpatient psychiatric care from DSAMH to  
91 DMMA.<sup>10</sup>

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**Figure-2**  
**Cumulative State-Funded Bed-Days for Acute Care**

	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	FY Projected Total	Change Relative to Base Year
<b>DSAMH</b>	142	254	412	650	984	1254	1439	2336	40.7% Red.
<b>DMMA</b>	1645	3374	4886	6268	7686	9172	10,700	16,086	25.9% Inc.

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94 These developments do not mean that management of inpatient psychiatric care for the  
95 Agreement’s target population became the sole responsibility of DMMA and the MCOs. As is  
96 explained in the next section, the State is in the process of implementing some significant  
97 reforms in how Medicaid-funded services for individuals with SPMI are managed. These  
98 measures should result in more consistent involvement of DSAMH in the coordination of care to  
99 individuals whose care is managed through DMMA, and they should improve the process for  
100 ensuring that individuals in need of specialized services and housing—both of which can reduce  
101 the risk of hospitalization—are appropriately referred to DSAMH. As a consequence of these  
102 multiple changes, there will likely be significant revisions in the number of bed-days used for  
103 acute care by the end of this fiscal year.

<sup>9</sup> Prior to this, DSAMH assumed responsibility for managing inpatient care when individuals’ annual Medicaid benefits for psychiatric hospitalization were exhausted.

<sup>10</sup> For instance, greater numbers of heretofore uninsured individuals will qualify for Medicaid and DSAMH will no longer be the funder and manager of their inpatient psychiatric care.

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## 1. The State's Measures to Reduce Inpatient Psychiatric Bed Days

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As a general matter, the parties agree that the bed-day reduction targets contained in the Agreement were intended as a proxy measure of the impact of the newly created array of community services upon the target population, particularly with respect to these individuals successfully living stably, integrated within their communities and outside of institutions. These goals are in keeping with the requirements of the ADA. Such a reduction may indicate that members of the target population are being appropriately served in the community in accordance with the ADA. Also important with regard to this provision are individuals' access to specialized services and supportive housing that allow them to live successfully in their communities, and the interrelated issue of discharge planning which should be a pivotal point in connecting people to these services (e.g., Section IV). The Monitor had in the past found that, for individuals whose care is managed through DMMA, the overall process of referring individuals for DSAMH's specialized services has been vague and not closely overseen by the State. In addition, discharge planning in the IMDs was found to be poorly coordinated with community providers.

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As was referenced in the last Monitor's report, DSAMH and DMMA have collaboratively developed a bed-day reduction plan that is intended to not only continue the trend toward decreased numbers of long-term care bed-days at DPC, but also impact the acute-care bed-days used. This plan incorporates a variety of approaches, including such elements as: PROMISE, an amendment to State's Medicaid waiver;<sup>11</sup> new collaborative agreements involving, variously, DMMA, DSAMH, the MCOs, and the IMDs; Medicaid funding for detoxification services in IMDs for individuals whose acute needs relate to substance use; and replication of the successful Recovery Resource Center (a crisis walk-in center serving southern Delaware) in New Castle County.

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Since the last report, progress has continued in this overall effort. The State has provided additional information about the new collaborative agreements, which include measures intended to address many of the problems cited in past Monitor reports that may underlie the increasing rates of hospital use. These measures should improve coordination among these entities prior to and following hospital admissions and improve discharge planning. In addition, they should help ensure that all members of the target population—particularly the sizable population of people with SPMI who are not served through DSAMH—are appropriately afforded access to the housing and specialized services that were created pursuant to the Agreement. This has been referenced in several previous Monitor reports. Some of the State's corrective measures have been implemented only recently, and others are still pending. Thus, their effects would not be expected to be fully seen in the bed-use data reported above. But, if implemented as planned, the

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<sup>11</sup> Through PROMISE, Medicaid now covers an array of new services relevant to the Agreement and its target population, including: Care Management, Individual Employment Supports, Short-Term Small Group Supported Employment, Financial Coaching, Benefits Counseling, Peer support, Non-Medical Transportation, Psychosocial Rehabilitation, Respite, Independent Activities of Daily Living/Chore Services, Personal Care, and Community Transition Services.

140 new agreements and revisions in operational protocols should have a favorable impact in  
141 reducing the annual bed-day numbers.

142 The new contracts and collaborative agreements with the MCOs and with the IMDs provide a  
143 structure to significantly improve matters. For instance:

144 Contracts between the State and the IMDs:

- 145 • Embed principles of community integration, mainstream employment, informed  
146 personal choice, and involvement of peer supports—all of which reflect the  
147 requirements of the ADA and the Agreement.<sup>12</sup>
- 148 • Specifically reference the Agreement<sup>13</sup> and require IMDs to comply with its  
149 requirements relating to timely involvement by a community provider upon  
150 hospital admission (Section IV of the Agreement).<sup>14</sup>

151 Contracts between the State and the MCOs:

- 152 • Require a collaborative protocol involving the MCO and DSAMH to ensure that  
153 individuals are being appropriately referred to PROMISE (The PROMISE  
154 program comprises the array of specialized services provided through DSAMH,  
155 most of which are directly or indirectly required under the Agreement).<sup>15</sup>
- 156 • Require that, with respect to involuntary inpatient or outpatient treatment,  
157 comprehensive discharge and crisis plans are developed including, as appropriate,  
158 referrals for PROMISE services.<sup>16</sup>
- 159 • Require MCOs to actively assist in discharge planning for individuals receiving  
160 institutional care.<sup>17</sup>
- 161 • Indicate that DSAMH has primary responsibility for developing and monitoring  
162 care provided under the PROMISE program and that MCOs have responsibility  
163 for service coordination,<sup>18</sup> and require DSAMH and the MCOs to devise protocols  
164 for collaboration to effectively carry out these functions.<sup>19</sup>
- 165 • Require MCOs to work with DSAMH to devise collaborative strategies to achieve  
166 the bed-use reductions required in the Agreement,<sup>20</sup> including in the process of

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<sup>12</sup> Contract for Involuntary Patient Psychiatric Services between DHSS/DSAMH and IMDs, Appendix A-1 (e.g., Contract #j 021508).

<sup>13</sup> *Ibid.*, Appendix B-4, p.1.

<sup>14</sup> *Ibid.*, Appendix B, p.2.

<sup>15</sup> MCO Final Contract, 2015, Section 3.8.4.1.

<sup>16</sup> *Ibid.*, Section 3.4.6.9.4.

<sup>17</sup> *Ibid.*, Section 3.8.4.2.3.

<sup>18</sup> *Ibid.*, Section 3.8.9.10.1.1.

<sup>19</sup> *Ibid.*, Section 3.8.9.10.3.

<sup>20</sup> *Ibid.*, Section 3.12.4.1.

167 admission to an IMD, in utilization review during the hospital stay, and in  
168 discharge planning.<sup>21</sup>

169 At this juncture, the State’s contracts with the IMDs are in effect and operational. DSAMH,  
170 DMMA and the MCOs are having regular meetings to discuss implementation of the State’s  
171 contracts with the MCOs, and DSAMH and DMMA are having regular interdivisional  
172 agreements to discuss related matters. The State is finalizing the specifics about procedures  
173 relating the new agreements, how it will oversee these processes, and how it will report progress  
174 relevant to the Agreement as a part of the Monitor’s monthly dashboard. As was explained  
175 earlier, elements such as these are critical in augmenting the inpatient bed-use numbers to  
176 demonstrate the State’s status with respect to Section III.D and other provisions of the  
177 Agreement.

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## 179 **2. Referrals for Specialized Mental Health Services & Supported Housing**

180 As was referenced earlier, the Monitor has found significant problems in the State’s processes to  
181 ensure that individuals covered by the Agreement are being appropriately referred to DSAMH  
182 for the specialized services and housing that are not otherwise available to them.<sup>22</sup> While such  
183 referrals may be made at any time, they are particularly relevant as a part of discharge planning  
184 following an acute hospitalization, and they should be part of a seamless transition from the  
185 hospital to the community service system. The Monitor’s last report noted that the State has  
186 identified 454 individuals whose care is managed through DMMA and who, based upon their  
187 psychiatric diagnoses and a history of repeated hospitalizations in IMDs, likely should have been  
188 referred for intensive services such as ACT, Peer Services, and Supported Housing. Because  
189 these referrals were not made in a timely way (i.e., at the point of hospital discharge), beginning  
190 in September, 2014, the State launched an intensive effort to connect with these individuals and  
191 to work through this backlog of referrals. Unfortunately, due to the time that elapsed between the  
192 hospitalizations and this referral initiative, significant numbers of these individuals cannot now  
193 be located. As of the beginning of March 2015, the State attempted to connect—by phone or in  
194 person—to 185 people on the list of 454, beginning with those who ostensibly have the greatest  
195 need.<sup>23</sup> Notwithstanding DSAMH’s intensive outreach efforts, the State has not been able to  
196 locate 44.3% of this group due to inaccurate contact information. An additional 13% refused the  
197 offer of services. And only 22 of the 185 (11.8%) are being successfully engaged in services.

198 In order to get a sense of the individuals who were not being successfully engaged, the Monitor  
199 reviewed records at one of the IMDs of 11 individuals whom the State had not been able to  
200 locate. Each these individuals had in excess of 3 psychiatric hospitalizations during a two-year  
201 period ending in July, 2014. All told, they accounted for at least 45 admissions to this one

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<sup>21</sup> *Ibid.*, Section 3.12.4.1.4, Section 3.10.2.1.58.

<sup>22</sup> Most of these services, other than housing, will be covered through the new PROMISE program, which also entails referral to DSAMH.

<sup>23</sup> Based upon the number of recent hospitalizations.

202 hospital alone during this period. Their records indicated significant problems that strongly  
203 suggest a need for ACT or other intensive services provided through DSAMH. Most were  
204 repeatedly admitted due to suicidality. At least 6 of the 11 individuals were repeatedly admitted  
205 and identified as homeless, without being referred for the supported housing available through  
206 DSAMH. At least one individual was repeatedly admitted and discharged back to a living  
207 arrangement that was reported to be exploitive.

208 As the State continues its efforts to reconnect with such high-risk individuals, moving forward,  
209 its new collaborative arrangements involving the MCOs, DSAMH, and the IMDs should ensure  
210 a much more systematic approach to referring at-risk individuals with SPMI to ACT, supportive  
211 housing, and other specialized services. Nevertheless, the intensity of the issues identified in the  
212 records review speaks to the importance of the State vigorously continuing its efforts to  
213 reconnect with them and offer needed services. DMMA has indicated that, by the end of April, it  
214 will provide the MCOs with the names of their beneficiaries who are among the 454 prioritized  
215 for review by DSAMH.<sup>24</sup>

216 The State is now working with the Monitor to establish monthly dashboard measures relating to  
217 the new agreements discussed above, including their impact in ensuring that individuals are  
218 appropriately connected with the services and housing required by the Agreement. One such  
219 measure will be the number of individuals newly referred to DSAMH for services (this number  
220 will ultimately include referrals for the new PROMISE program). To this end, the State has  
221 compiled baseline data reflecting new referrals to DSAMH's Eligibility and Enrollment Unit  
222 (EEU) since January, 2014; these data can be compared with referral patterns after the new  
223 initiatives are operational. For the calendar year 2014, the monthly average number of such  
224 referrals was 19.1. January, 2015, when several new components of the State's collaborative  
225 agreements began to go into effect, already showed an increase, with 29 new referrals for that  
226 month. The State will continue to provide monthly data relating to EEU referrals, as well as  
227 other new dashboard indicators in order to monitor progress relating to this important measure  
228 and to help detect problems in implementation as they may arise.

229 In addition, to better identify members of the target population who are homeless or are living in  
230 unstable or inappropriate housing, the State is now requiring that IMDs complete a housing  
231 assessment form for all admitted Medicaid clients with SPMI; heretofore, this form had been  
232 used only for DSAMH-funded clients and there was no systematic means of evaluating the  
233 housing status of other members of the target population.<sup>25</sup> This measure should significantly  
234 assist the State in capturing housing information relevant to members of the target population  
235 served through MCOs who, as exemplified in the cases referenced above, may be appropriate for  
236 the supported housing created pursuant to the Agreement. The State is taking additional steps to

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<sup>24</sup> This process was delayed somewhat because, as of January 1, 2015, there were changes among the MCOs working under contract with the State and not all individuals affected had yet expressed their choices as to which MCO they preferred to manage their Medicaid benefit.

<sup>25</sup> This form was developed to facilitate the State's compliance with Sections II.B.2.f, II.E, and III.I.



237 identify members of the target population who are homeless through consultation with  
238 Delaware’s Homeless Planning Council.

239 Recommendation:

- 240 • The State’s list of individuals whose care is managed through MCOs and who are  
241 considered to be at elevated risk of hospitalization or other adverse outcomes has  
242 not been updated since July, 2014. Although there are measures in various phases  
243 of implementation that should improve the referral of such individuals to  
244 DSAMH (or the new PROMISE program), it is recommended that the State  
245 update this list and include newly identified individuals in its outreach efforts  
246 until the improved processes for collaboration and coordination are fully  
247 functional.

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250 **B. Assertive Community Treatment**

251 ACT is an essential community-based service for many individuals who have SPMI—  
252 particularly those who have histories of adverse outcomes such as repeated hospitalizations,  
253 criminal justice contact, and homelessness. Properly implemented, ACT programs provide  
254 flexible clinical and psychosocial services outside of office settings and, instead, in the home,  
255 work, and other community environments where individuals spend their days. In this way, ACT  
256 teams gain a first-hand understanding of the individual’s success and challenges in meeting the  
257 demands of community life, and when issues arise, they can tailor interventions accordingly.

258 Section III.F of the Agreement requires the State to have a total of 11 ACT teams operational by  
259 September 1, 2015. As has been discussed in prior reports by the Monitor, the State has  
260 exceeded the number of ACT teams required and, in fact, at the end of 2013 it had already met  
261 its 2015 goal. It also upgraded most of its Intensive Case Management teams (ICM)<sup>26</sup> to the  
262 ACT model in order to more appropriately meet the needs of the individuals who were being  
263 served through those teams. The parties have recognized that the conversion of ICM teams to  
264 ACT teams actually represents more intensive community services than are required by Section  
265 III.G for ICM clients. Thus they agreed that, as long as the number of individuals being served  
266 was not reduced as a result of this upgrade and as long as the ACT fidelity standards were met,  
267 the State’s compliance with the Agreement’s requirements regarding ICM teams would not be  
268 negatively affected.

269 Figure-3 reconciles the numbers of teams and individuals being served before the conversion  
270 (December, 2013) with current data from March, 2015 (following the conversion). It shows that  
271 the State continues to exceed the upcoming September, 2015 requirements and that the total

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<sup>26</sup> ICM teams are required in Section III.G of the Agreement.

272 number of individuals served by ACT and ICM following the conversion has increased by about  
 273 10%.<sup>27</sup>

**Figure-3**  
**ACT and ICM Services**  
**Prior-To and Following ICM Conversions**

	Dec, 2013		Sep, 2015	Mar, 2015
	Required	Actual	Required	Actual
<b>ACT Teams</b>	9 <sup>28</sup>	11	11 <sup>29</sup>	16
<b>ICM Teams</b>	4 <sup>30</sup>	5	4 <sup>31</sup>	1
<b>Total Clients</b>		1,587		1,751

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275 The Agreement specifically requires the State to operate its ACT programs in conformance to  
 276 standardized fidelity measures. Figure-4 presents comparisons of ten of the ACT teams’ overall  
 277 scores according to the TMACT model which the State uses.<sup>32</sup> The remaining teams which are  
 278 not represented in Figure-4 are in various stages of preliminary assessment, so scores were not  
 279 yet available. Following a start-up period when preliminary assessments and consultations by  
 280 the State’s experts are provided, ACT teams are evaluated at least annually. For teams that have  
 281 been operational long enough to have more than annual assessment, trending of their  
 282 performance according to TMACT is included in Figure-4.

283 When teams are evaluated, DSAMH generates detailed reports of findings, including  
 284 recommendations for improvement or requirements for corrective action plans. It subsequently  
 285 monitors teams’ efforts to comply with such plans and, as indicated, provides technical  
 286 assistance in furtherance of these efforts. As is reflected in the above chart, some ACT teams  
 287 have improved in their scores over time, others have scored more poorly, and some have stayed  
 288 fairly consistent. Such variance is common within State systems, influenced in part by factors  
 289 including staff turnover, vacancies, level of experience and provider management.  
 290 Notwithstanding the State’s assistance, some teams have not performed adequately during the  
 291 course of the Agreement’s implementation; there have been instances where DSAMH has  
 292 terminated ACT contracts and reformulated teams under the auspices of different provider  
 293 organizations. While such events are unfortunate (and certainly not reflective of most ACT  
 294 teams that were developed pursuant to the Agreement), they do demonstrate that DSAMH is  
 295 actively monitoring and holding providers accountable for the quality of services being provided.

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<sup>27</sup> It is standard that ACT teams each serve about 100 individuals, so the required 11 teams should serve a total of 1,100 people. There are no such general standards for ICM; the Agreement specifies minimum staff-to-client ratios for ICM, but not a specific number of clients to be served.

<sup>28</sup> Agreement, Section III.F.3

<sup>29</sup> Agreement, Section III.F.4

<sup>30</sup> Agreement, Section III.G.2

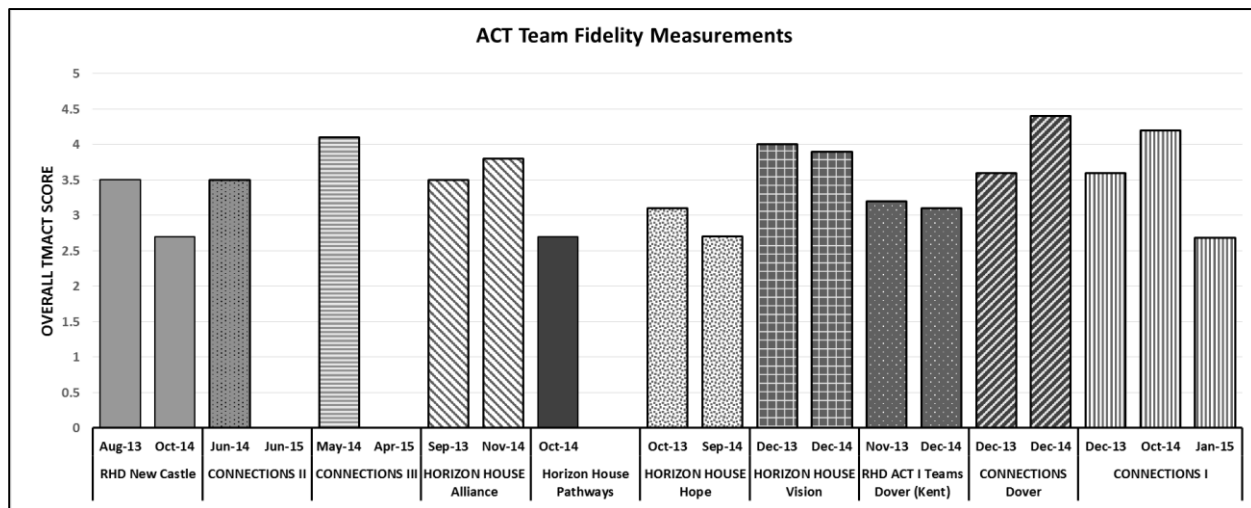
<sup>31</sup> *Ibid.*

<sup>32</sup> The maximum score that can be achieved is 5.

296 As the State compiles TMACT data on the ACT teams that are not included in Figure-4, it is  
 297 expected that it will be able to demonstrate Substantial Compliance with the Agreement's Sections  
 298 III.F-G.

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**Figure-4**



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301 Complementing the above fidelity data, prior reports by the Monitor have presented the  
 302 impressive array of trending data that the State collects to measure positive outcomes (such as  
 303 employment) and adverse events (such as hospitalizations) among individuals served by ACT  
 304 teams. In addition, in concert with the University of Pennsylvania, the State is carrying out  
 305 ongoing comprehensive qualitative assessments of how ACT clients are faring.<sup>33</sup> The State  
 306 regularly presents these data and consults with the Monitor about its quality control and  
 307 performance improvement measures relating to ACT.

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### C. Risk Management

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311 The State continues to make progress in its efforts to reduce the risk of harm to members of the  
 312 target population, both within institutional settings and within the community programs that are  
 313 required under the Agreement. As has been described in prior reports of the Monitor, the relevant  
 314 risk management systems within DHSS had been disjointed and significantly defined by where  
 315 an incident involving harm occurred (for instance, a state-operated facility as opposed to a  
 316 community setting). It did not promote the identification and remediation of issues that cut  
 317 across various settings and bureaucratic divisions. The State is moving forward with a major  
 318 restructuring of its system, with the goals of unifying its reporting and investigations, individual  
 319 and aggregate reviews of adverse events, and corrective actions—both on a case-level and

<sup>33</sup> This quality of care research also includes the State's CRISP program, which provides ACT-like services through a capitated funding mechanism designed to encourage flexible use of resources to address clients' needs.

320 systemically. Based upon these plans, the State has been evaluated as being in Partial  
321 Compliance with respect to the requirements of Section V.B of the Agreement.

322 Revision of the risk-reduction processes affecting the target population is a complex endeavor,  
323 involving multiple levels of staff and provider entities. As such, system redesign, training, and  
324 the development of data systems are involving a significant staff effort. This body of work is  
325 proceeding according to timeframes established last year; the State is anticipating rolling out  
326 major changes in risk management this spring. DSAMH is already conducting intensive  
327 training, both internally and with its contractual providers, relating to its refined risk-reduction  
328 program. This training includes comprehensive sections on the identification of adverse  
329 incidents (such as abuse, neglect, and inappropriate restraint practices); mandatory reporting  
330 requirements for state employees and employees of contractual providers; uniform protocols for  
331 reporting and investigations; staff background checks; and the State's structures for oversight  
332 and review. The risk-reduction requirements covered by the training apply not only to services  
333 currently managed by DSAMH, but to the new PROMISE program, as well.

334 If this effort continues as anticipated, the State is positioned to vastly improve its risk  
335 management of services to the target population. In the interim, the State is providing the  
336 Monitor with monthly updates, as well as critical incident reports and investigations.

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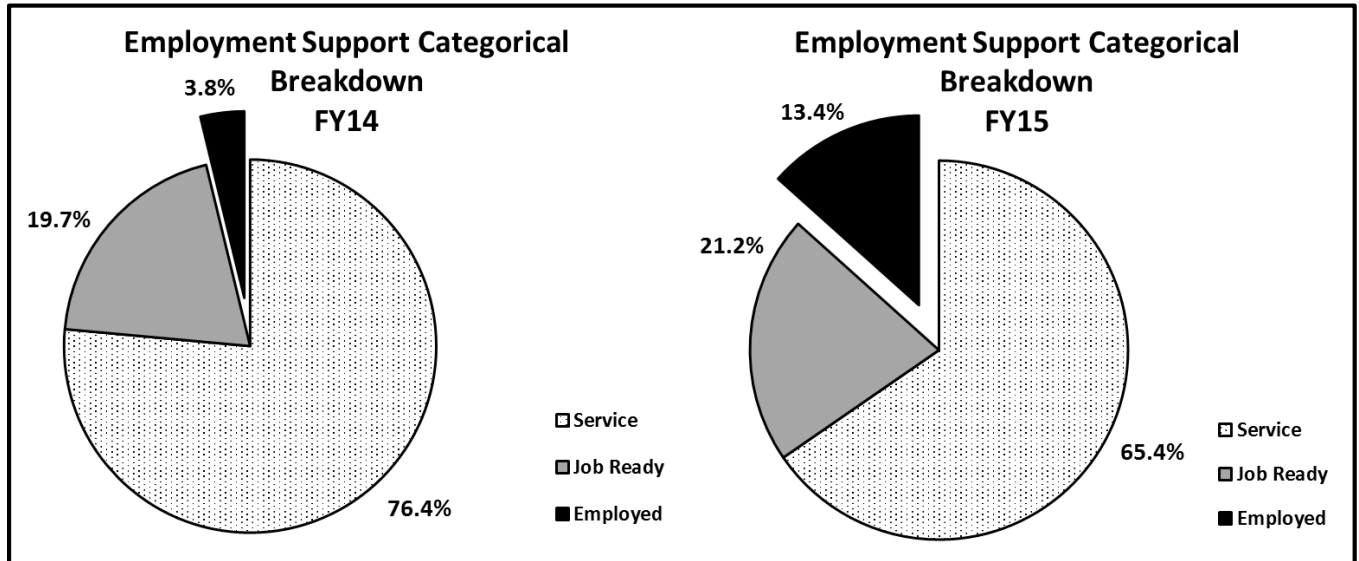
#### 338 **D. Supported Employment**

339 The requirements of the Agreement harmonize with Governor Markell's priority to promote the  
340 employment of Delawareans who have disabilities. This priority has been embraced by DHSS  
341 and the State's Department of Labor (DOL). As has been previously reported by the Monitor,  
342 the State has consistently met or surpassed its annual numeric goals for supported employment,  
343 per Section III.J of the Agreement. These goals relate to the number of individuals within the  
344 target population who receive supported employment services.

345 DOL's Division of Vocational Rehabilitation (DVR) has a longstanding, close working  
346 relationship with DSAMH. It maintains detailed data about services provided to its clients—  
347 including the substantial proportion who are members of the target population. Because  
348 supported employment entails several levels of service (from application through actual  
349 engagement on a job), for purposes of evaluating the State's compliance with Section III.J, the  
350 parties have agreed to count only those members of the target population who are at least at the  
351 point of having active individualized employment plans in place. The Monitor's last report  
352 noted that the State was meeting its requirements under the Agreement with respect to the  
353 number of people receiving such services, but that about 20% of these individuals were job-  
354 ready but unemployed, and only about 4% were actually employed. Figure-5 presents an update  
355 for the current fiscal year. Whereas the proportion of people served who are considered job-  
356 ready has remained about the same (21.2%) there has been an approximate 400% increase in the  
357 proportion of individuals who are now employed (3.9% in FY 14, as compared with 13.4% in  
358 FY 15).

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**Figure-5**  
**Status of Members of the Target Population**  
**Who Are Receiving Supported Employment Services**  
**FY 14 and FY 15 (YTD)**



364  
365

366 To further understand the employment status of members of the target population, DSAMH has  
367 developed a detailed spreadsheet through which its contractual providers will report such factors  
368 as where individuals are employed, at what hourly rate, and for what duration. These data will  
369 be incorporated in its monthly dashboard of compliance indicators.

370 In addition, the State has been receiving expert technical assistance and the Monitor has  
371 discussed providing additional technical assistance resources should the State request them.

372

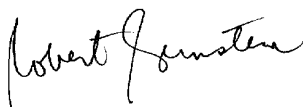
373 Recommendation:

- 374
- 375 • As is reflected above, the State is making some significant improvement in  
376 moving people with SPMI through the supported employment process and into  
377 jobs in the mainstream workforce. While the job market remains competitive, the  
378 State has indicated that it could likely achieve even further improvements if  
379 additional trained employment specialists were available to work with the targeted  
380 population and prospective employers. While the State is in Substantial  
381 Compliance with the numerical requirements relating to supported employment  
382 servicers, mainstream employment (like mainstream housing) is an outcome that  
383 goes to the core of the Agreement’s intent. Accordingly, and consistent with the  
State’s priority of promoting the employment of Delawareans who have

384 disabilities, it is recommended that the State carefully consider an expansion in  
385 the number of trained employment specialists working with the target population.  
386

387 **III. Summary:**

388 This abbreviated report documents that Delaware is making progress in addressing issues raised  
389 in prior Monitor's reports and toward fulfilling its requirements under the Agreement. As has  
390 been explained above, several key measures have not yet been fully implemented, but systems  
391 and processes that support the goals of the Agreement are now being developed. Data over the  
392 coming months should begin to demonstrate the impact of the State's new processes and, as has  
393 been reflected in the State's approach throughout implementation of the Agreement, should  
394 inform further ongoing system refinements.

395 

396 Robert Bernstein, Ph.D.  
397 Court Monitor