SEVENTH 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

June 11, 2015

I. <u>Introduction</u>:

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

a. Reducing the number of State-funded psychiatric inpatient bed-days used by the population of people with Serious and Persistent Mental Illness (SPMI) that the Agreement targets (Section III.D.3 of the Agreement),

b. Discharge planning for individuals who are hospitalized in Delaware Psychiatric Center (DPC) or one of the private psychiatric hospitals (IMDs[3]) that serve members of the target population through State funding (Section IV),

c. The State's Assertive Community Treatment programs (ACT) and their fidelity to the TMACT program standards (Section III.F[4]), and

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[1] This report generally covers the period from July 1, 2014 through February 28, 2015.

[2] 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.

[3] 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.

[4] 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.

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

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

II. <u>Review of Delaware's Status with Respect to Specific Provisions of the Agreement</u>:

A. Annual Inpatient Bed-Days Used & Discharge Planning

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

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

[5] Both DSAMH and DMMA are divisions of the State's Department of Health and Social Services (DHSS).

[6] 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.

[7] Agreement, Sections III.D.3-4.

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

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

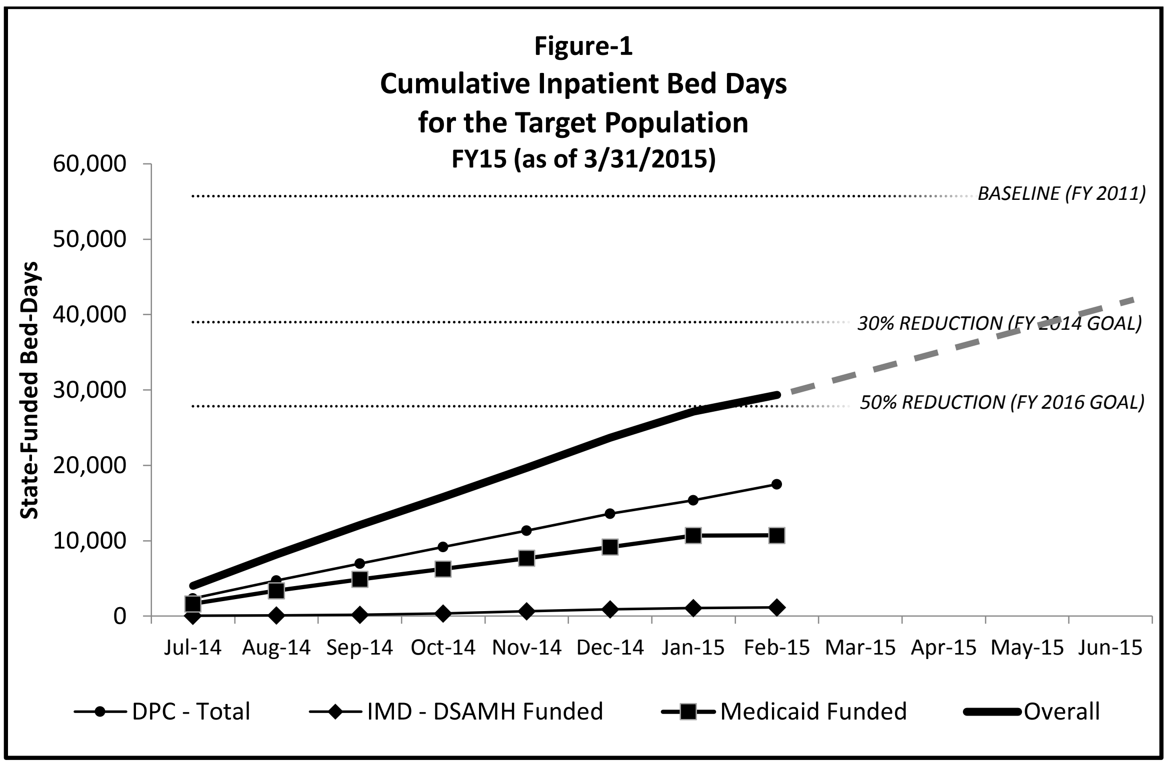


Figure-1
Cumulative Inpatient Bed Days for the Target Population
FY15 (as of 3/31/2015)

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

[8] Sections III.D.3-4 of the Agreement specifically reference acute inpatient settings.

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

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

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
DSAMH	142	254	412	650	984	1254	1439	2336	40.7% Red.
DMMA	1645	3374	4886	6268	7686	9172	10,700	16,086	25.9% Inc.

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

[9] Prior to this, DSAMH assumed responsibility for managing inpatient care when individuals' annual Medicaid benefits for psychiatric hospitalization were exhausted.

[10] 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.

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

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.

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;[11] 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.

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

[11] 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.

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

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

<u>Contracts between the State and the IMDs</u>:

- Embed principles of community integration, mainstream employment, informed personal choice, and involvement of peer supports—all of which reflect the requirements of the ADA and the Agreement.[12]

- Specifically reference the Agreement[13] and require IMDs to comply with its requirements relating to timely involvement by a community provider upon hospital admission (Section IV of the Agreement).[14]

<u>Contracts between the State and the MCOs:</u>

- Require a collaborative protocol involving the MCO and DSAMH to ensure that individuals are being appropriately referred to PROMISE (The PROMISE program comprises the array of specialized services provided through DSAMH, most of which are directly or indirectly required under the Agreement.).[15]

- Require that, with respect to involuntary inpatient or outpatient treatment, comprehensive discharge and crisis plans are developed including, as appropriate, referrals for PROMISE services.[16]

- Require MCOs to actively assist in discharge planning for individuals receiving institutional care.[17]

- Indicate that DSAMH has primary responsibility for developing and monitoring care provided under the PROMISE program and that MCOs have responsibility for service coordination,[18] and require DSAMH and the MCOs to devise protocols for collaboration to effectively carry out these functions.[19]

- Require MCOs to work with DSAMH to devise collaborative strategies to achieve the bed-use reductions required in the Agreement,[20] including in the process of

[12] Contract for Involuntary Patient Psychiatric Services between DHSS/DSAMH and IMDs, Appendix A-1 (e.g., Contract #j 021508).
[13] *Ibid*., Appendix B-4, p.1.
[14] *Ibid.*, Appendix B, p.2.
[15] MCO Final Contract, 2015, Section 3.8.4.1.
[16] *Ibid.,* Section 3.4.6.9.4.
[17] *Ibid.,* Section 3.8.4.2.3.
[18] *Ibid.,* Section 3.8.9.10.1.1.
[19] *Ibid.,* Section 3.8.9.10.3.
[20] *Ibid.,* Section 3.12.4.1.

admission to an IMD, in utilization review during the hospital stay, and in discharge planning.[21]

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

2. Referrals for Specialized Mental Health Services & Supported Housing

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

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

[21] *Ibid.,* Section 3.12.4.1.4, Section 3.10.2.1.58.

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

[23] Based upon the number of recent hospitalizations.

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

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

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

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

[24] 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.

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

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

Recommendation:

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

B. Assertive Community Treatment

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

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

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

[26] ICM teams are required in Section III.G of the Agreement.

number of individuals served by ACT and ICM following the conversion has increased by about 10%.[27]

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

	Dec, 2013		Sep, 2015	Mar, 2015
	Required	**Actual**	**Required**	**Actual**
ACT Teams	9[28]	11	11[29]	16
ICM Teams	4[30]	5	4[31]	1
Total Clients		1,587		1,751

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

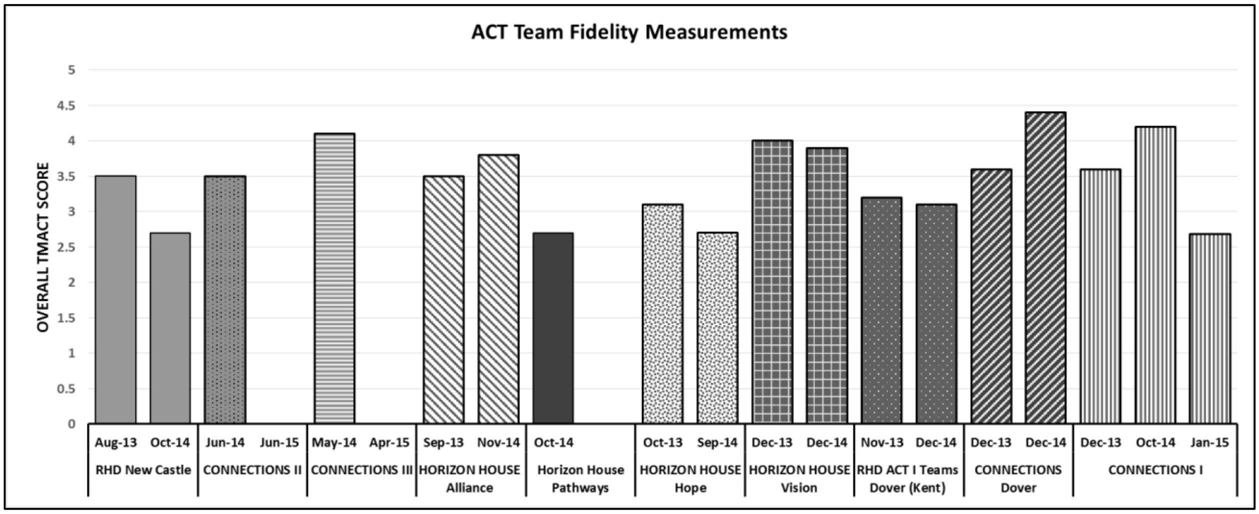
When teams are evaluated, DSAMH generates detailed reports of findings, including recommendations for improvement or requirements for corrective action plans. It subsequently monitors teams' efforts to comply with such plans and, as indicated, provides technical assistance in furtherance of these efforts.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

[27] 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.

[28] Agreement, Section III.F.3
[29] Agreement, Section III.F.4
[30] Agreement, Section III.G.2
[31] *Ibid.*
[32] The maximum score that can be achieved is 5.

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

Figure-4



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

C. Risk Management

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

[33] 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.

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

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

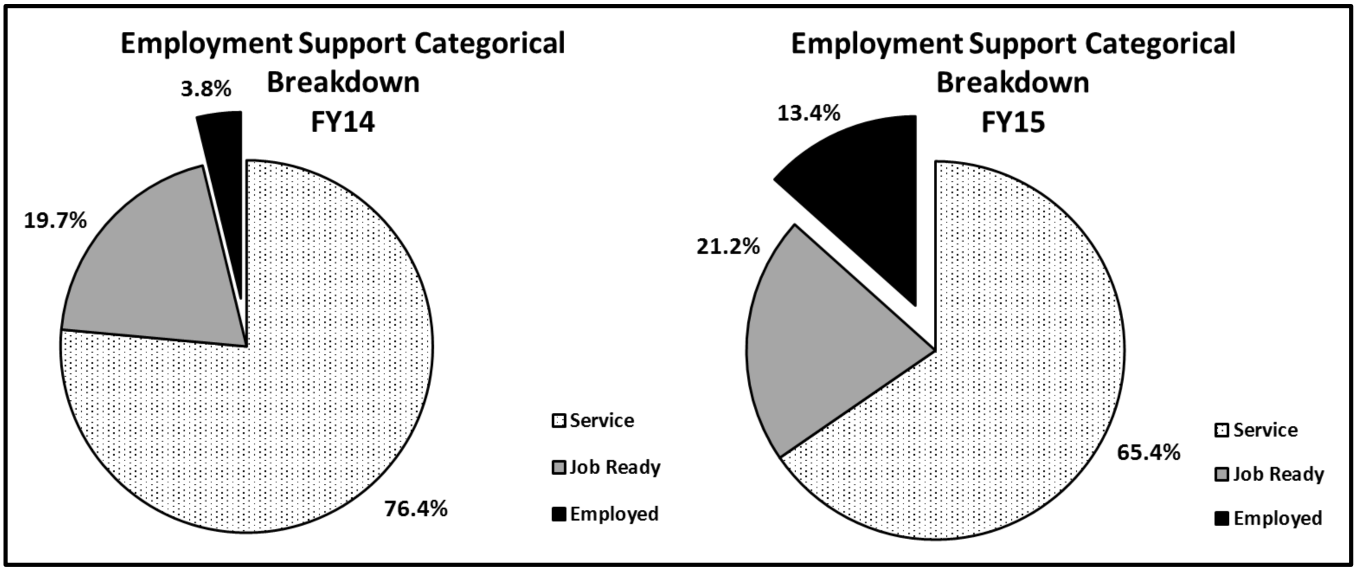
If this effort continues as anticipated, the State is positioned to vastly improve its risk management of services to the target population. In the interim, the State is providing the Monitor with monthly updates, as well as critical incident reports and investigations.

D. Supported Employment

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

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

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



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

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

<u>Recommendation</u>:

- As is reflected above, the State is making some significant improvement in moving people with SPMI through the supported employment process and into jobs in the mainstream workforce. While the job market remains competitive, the State has indicated that it could likely achieve even further improvements if additional trained employment specialists were available to work with the targeted population and prospective employers. While the State is in Substantial Compliance with the numerical requirements relating to supported employment servicers, mainstream employment (like mainstream housing) is an outcome that 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 disabilities, it is recommended that the State carefully consider an expansion in the number of trained employment specialists working with the target population.

III. **Summary**:

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

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