



STATE OF DELAWARE  
**STATE COUNCIL FOR PERSONS WITH DISABILITIES**  
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**MEMORANDUM**

DATE: May 25, 2016

TO: All Members of the Delaware State Senate  
and House of Representatives

FROM: Ms. Daniese McMullin-Powell, Chairperson  
State Council for Persons with Disabilities

RE: H.B. 311 (Mental Health Transition Plan)

The State Council for Persons with Disabilities (SCPD) has reviewed H.B. 311 which authorizes the Family Court to order the Department of Health and Social Services of Services (DHSS) to determine whether a child who is 17 years of age or older and in the custody of the Department of Services for Children, Youth and their Families (DSCYF) qualifies for adult mental or behavioral health services. If the child does qualify for adult mental or behavioral health services, this Act authorizes the Family Court to order that DHSS coordinate with DSCYF to develop and implement a transition plan for mental or behavioral health services for the child. The plan would include any adult mental health or behavioral health diagnosis, list the prospective adult services for which the child might qualify, and include other information or relief the Court determines relevant to the child's transition to adulthood. SCPD has the following observations.

First, the transition of minors served by the DSCYF's Division of Prevention and Behavioral Health Services (DPBHS) to DHSS's Division of Substance Abuse & Mental Health Services (DSAMH) has been a matter of concern for decades. The most significant "tension" between the juvenile and adult systems results from more restrictive eligibility standards in the adult system. For example, the DPBHS serves minors with a wide array of mental health diagnoses while DSAMH has traditionally focused eligibility on persons with severe and persistent mental illness (SPMI). Compare attached DPBHS eligibility standards with DSAMH LTC eligibility standards. DSAMH generally views SPMI to cover certain diagnoses, i.e., schizophrenia, depression, bipolar disorder, and personality disorder. Other DHSS mental health programs (e.g. PROMISE) also have rather prescriptive eligibility standards based on specific diagnoses. See attached excerpt from PROMISE Medicaid waiver standards (August 22, 2014).

Second, the current DPBHS Strategic Plan is published at <http://kids.delaware.gov/pdfs/pbh-StrategicPlanCY13-16-update-2016.01.05.pdf>. The attached excerpt identifies transition from the

juvenile to the adult mental health services system as a priority and describes the following initiatives addressing this priority:

- PBH is participating on a youth transition workgroup led by Judge Nicholas in Kent County.
- Project CORE was awarded to PBHS. This is a SAMSHA grant, in concert with DSAMH, to prevent psychosis in youth and young adults and to assist with the transition from youth BH services to the adult BH system.

If not already done, the sponsors of the legislation may wish to assess the status of the “youth transition workgroup” and SAMHSA-funded project addressing transition.

Third, H.B. 311 has the following positive features:

A. It would cover transition of youth not only in DPBHS custody, but also in DFS and YRS custody.

B. It provides a mechanism to ensure the collaboration of DSC&F and DHSS in developing a transition plan so transitioning youth do not “fall through the cracks”.

C. DHSS has been expanding its mental and behavioral health services support system in recent years. The system has become increasingly complicated and involves a wide array of programs and providers. For example, DMMA-regulated Medicaid MCOs provide mental health and behavioral health services. The federal Court Monitor has been critical of the lack of coordination among the MCOs, DMMA, and DSAMH while noting some recent improvement. See attached excerpt from Eighth Report of the Court Monitor (December 26, 2015). DMMA administers the Community Alternative Disability Program Medicaid program with eligibility up to age 19. See 16 DE Admin Code 25000. The PROMISE program is still in its early stages of implementation. Simply referring a 17 year old (with mental health limitations) to programs will result in a “bewildered” youth who may simply “give up” on trying to navigate the system. Development of a judicially-prompted plan should ensure a smooth transition for such youth.

Thank you for your consideration and please contact SCPD if you have any questions regarding our observations on the proposed legislation.

cc: The Honorable Rita Landgraf  
The Honorable Carla Benson-Green  
Ms. Deborah Gottschalk, DHSS  
Mr. Steve Yeatman, DSCYF  
Ms. Tania Culley, Office of the Child Advocate  
Mr. Brian Hartman, Esq.  
Governor’s Advisory Council for Exceptional Citizens  
Developmental Disabilities Council

HB 311 mental health transition plan 5-25-16

## Prevention and Behavioral Health Services

# Division of Prevention and Behavioral Health Services

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<b>Division of Prevention and Behavioral Health</b> (/pbhs/pbhs.shtml)
<b>Families</b> (/pbhs/pbhs_families.shtml)
<b>Providers</b> (/pbhs/pbhs_providers.shtml)
<b>Advocacy</b> (/pbhs/pbhs_advocacy.shtml)
<b>Kids Line Newsletters</b> (/pbhs/pbhs_newsletter.shtml)

### Who we are?

The Division of Prevention and Behavioral Health Services (DPBHS) is part of the Delaware Department of Services for Children, Youth and Their Families. On July 1, 2010, the Division of Child Mental Health and the Office of Prevention and Early Intervention blended to become the new Division. DPBHS provides a statewide continuum of prevention services, early intervention services, and mental health and substance abuse (behavioral health) treatment programs for children and youth. These services have graduated levels of intensity and restrictiveness that are child-centered and family focused.

DPBHS' prevention and early intervention services focus on promoting safe and healthy children, nurturing families and strong communities through community and school-based initiatives. DPBHS' treatment services are accredited under the Business and Services Management Standards of the Commission on Accreditation of Rehabilitation Facilities (CARF) (<http://www.carf.org/>). In addition, the contracted and/or state operated treatment providers within the DPBHS network are licensed where appropriate and most are accredited under one of the nationally recognized accrediting agencies such as CARF (<http://www.carf.org/>), JCAHO (<http://www.jointcommission.org/>), COA (<http://www.coanet.org/>) or CHAP (<http://www.chapinc.org/>).

### **Mission**

To develop and support a family-driven, youth-guided, trauma-informed prevention and behavioral health system of care.

### **Vision**

Resilient Children and Families Living in Supportive Communities

### **DPBHS Strategic Plan**

Strategic planning is a process of defining our direction, and making decisions on how to best pursue this strategy. Strategy generally involves setting goals and establishing smaller steps (objectives) that will lead to achieving the goals.

The DPBHS Strategic Plan (</pdfs/pbh-StrategicPlanCY13-16-update-2016.01.05.pdf>) was developed by the Division's leadership team.

*"...By definition, a real plan is never final; it is a living document. As we move forward to accomplish our goals, we will learn new information that may be incorporated into our process and change how we move forward."*

Susan Cczyk, Director

Questions regarding the strategic planning process should be addressed to Steve Perales at: [Stephen.perales@state.de.us](mailto:Stephen.perales@state.de.us) (<mailto:Stephen.perales@state.de.us>).

Questions regarding specific goals, objectives, etc. should be addressed to the person identified as the lead within the plan.

[Back to Top](#)

 Who we serve?

The Division provides voluntary behavioral health services to children up to the age of 18 and their families who:

- Could benefit from programming and services that promote health and well-being
- Do not have insurance to cover behavioral health services
- Have Medicaid and who require more than the basic Medicaid 30-hour annual outpatient benefit available through the [Diamond State Health Care Plan](#).  
(<http://www.dmap.state.de.us/home/index.html>)

[DPBHS Eligibility Policy \(/policies/pbh/cs001-Service-Eligibility-2015.pdf\)](#)

[Back to Top](#)

 How to obtain services

 Organizational Structure

 Commitment to Quality

 (/index.shtml)

Department of Services for Children, Youth and their Families (/index.shtml)  
Crisis Services (/services/crisis.shtml) | Child Abuse (/fs/fs\_iseethesigns.shtml) |  
Prevention (/fs/fs\_prevent.shtml) | Sitemap (/sitemap.shtml)

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**Division of Prevention and Behavioral Health Services**  
Department of Services for Children Youth and Their Families  
State of Delaware

CS 001	<b>DPBHS SERVICE ELIGIBILITY</b>		
Authored by:	<b>DPBHS Leadership Team</b>	Title:	
Approved by:	Susan Cycyk, M.Ed., C.R.C.	Title: Division Director	
Signature:	<i>Susan A Cycyk 4/5/16</i>	Revisions: 12/19/99; 11/19/03; 8/31/05; 11/29/06; 11/1/07; 12/17/08; 8/10/10, 7/11/11; 4/18/12; 4/15/13, 4/17/14; 9/8/15	Originated: 5/1/97

**PURPOSE:** To define eligibility criteria for services provided by the Division of Prevention and Behavioral Health Services ("DPBHS"), State of Delaware.

**DEFINITIONS:** Applicable definitions are given in the appendix to DPBHS policy "Development and Revision of Policies."

**POLICY:** Consistent with statutory authority (16 Del C. chapter 90), agreement with the State Medicaid Office under the Medicaid waiver, DPBHS hereby establishes eligibility criteria for mental health and substance abuse services for children and youth who are served by DPBHS. Eligibility for service is established when criteria 1., 2., 3., and 4. below are all met or when criteria 5. is met.

1. Age: Children and youth are eligible:
  - A. Up to Age 18 - Children and youth are eligible for services until their 18<sup>th</sup> birthday.
  - B. Over age 18 - For those youth active with DFS or DYRS and over the age of 18 and less than 19 years of age, DPBHS may provide consultation, monitoring, and or diagnostic services.
2. Residence: Delaware residents are eligible for services.
3. Medical Necessity: Medical necessity is established by the application of DPBHS "Level of Care Criteria." These criteria are available on the DPBHS website.
4. Categorical Eligibility:
  - A. Insurance and Medicaid Benefits: DPBHS services are intended as a primary resource for those who have
    - 1) Medicaid benefits, and who require more than the basic Medicaid 30-hour annual outpatient benefit; or
    - 2) Uninsured, or
    - 3) Exhausted all applicable private insurance mental health or substance abuse benefits. The absence of a specific level of care or specific provider in a mental health insurance package is not sufficient grounds for categorical eligibility.
  - B. Co-Insurance: DPBHS does not function as a secondary payor for the purpose of funding insurance co-payment or deductibles for the privately insured. There are two exceptions:
    - 1) If a youth is hospitalized in a DPBHS designated psychiatric hospital on an involuntary basis, or is hospitalized on an emergency basis with DPBHS authorization, and the hospital is unsuccessful in obtaining reimbursement for the private insurance, then DPBHS may reimburse the Provider up to the allowable Contract rate for up to 72 hours.
    - 2) If a youth has both private insurance and Medicaid, the private insurer is the primary payor and Medicaid is the secondary payor. However if the youth is treated by a participating Medicaid provider, then the parent, legal guardian or other legally liable individual is not responsible for any copay amount and, by federal regulation, private providers may not bill parents for that amount. In such a situation, Medicaid providers who have a contract with DPBHS may be reimbursed up to the Medicaid rate in cases pre-authorized by DPBHS. If the provider and Medicaid recipient wish to utilize any applicable Medicaid coverage to pay costs after the primary insurance has paid allowable

charges, the provider must obtain DPBHS authorization upon exhaustion of private insurance for the service, in addition to any other authorizations which may be required by other payors.

C. DPBHS does not provide services that substitute for services which are the responsibility of another agency. However, for clients meeting eligibility requirements for DPBHS services, and who also qualify for services from other state agencies, divisions within state agencies, school districts, physical/medical health care services, and/or other services, DPBHS will provide medically necessary mental health and substance abuse services arranged in concert with other involved agencies. For example, when eligibility criteria are met and the child has a moderate to severe mental health disorder that is not explained by an underlying developmental disorder, DPBHS may authorize or co-fund medically necessary care in concert with the education system and/or the Division of Developmental Disabilities Services. Also, DPBHS may provide or co-fund mental health and substance abuse treatment for children and youth active with another DSCYF division when the child meets DPBHS eligibility criteria.

5. Mental Health Crises – Crisis services may be provided to children and youth meeting criteria A. or B. below.

A. DPBHS crisis services and short-term emergency hospitalizations may be provided to non-resident youth under the age of 18 years of age who are in the State of Delaware and are at imminent danger to self or others arising from mental health or substance abuse disorders. DPBHS reserves the right to seek reimbursement for services provided to non-Delaware residents.

B. The DPBHS crisis service also may be utilized by privately insured persons if they meet criteria 1., 2., and 3. above for initial crisis response (excluding crisis bed) intervention, but subsequent treatment is the responsibility of the insurance carrier unless the youth otherwise meets eligibility criteria and is admitted to DPBHS services.

#### APPLICATION:

A. The application of this policy in a particular circumstance may be appealed by the affected parent or guardian, custodian or other legal caregiver if the parent is unavailable. (See also DPBHS Appeals Policy).

1) Providers and advocates may assist children and families with an appeal under this policy.

2) Families will be advised of their appeal rights whenever a client is determined to be ineligible for DPBHS services under this policy.

When DFS or DYRS has legal custody, staff in disagreement with DPBHS decisions should use the DSCYF case dispute resolution procedures instead of the appeal procedures.

B. DPBHS staff may request a review by the Division Director if application of the policy would yield a result substantially contrary to the combined interests of the State and the client. The decision of the Director will be documented in writing and signed by the Director, and kept on file by the DPBHS Quality Improvement unit.

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Phone Numbers

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Delaware Health and Social Services » Division of Substance Abuse and Mental Health

**HOME**

**SERVICES**

**INFORMATION**

- Training
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- Mental Health Screener's Corner
- Recovery Resources
- Regulations
- Reports & Statistics
- Residency
- Publications & Forms
- Related Links

## I. Clinical Eligibility Determination

The Division of Substance Abuse and Mental Health (DSAMH) LTC system serves adults (age 18 years and older) with severe and persistent behavioral health disorders who meet disability, duration of illness and diagnostic criteria. The LTC System provides services for: individuals enrolled in Medicaid; individuals with dual eligibility of Medicaid and Medicare; individuals with Medicare only coverage; individuals without insurance coverage; and those with limited insurance coverage.

Clinical eligibility for and enrollment into the DSAMH Long Term Care (LTC) system will be determined by the DSAMH Eligibility and Enrollment Unit (EEU). The EEU will process all applications for enrollment into the DSAMH LTC System.

### Clinical Eligibility Criteria for Enrollment Into the DSAMH LTC System

- are age 18 years and older; and
- are U.S. citizens or have a legal resident alien status; and
- are residents of the State of Delaware; and
- are determined to have a specific primary DSM-IV diagnosis as listed below (Eligible Mental Illness Diagnoses and Eligible Substance Abuse Diagnoses) that has resulted in functional impairment which substantially interferes with or limits one or more major life activities [ as determined by a formal DSAMH EEU review of the clinical information submitted in a complete [Enrollment Application Form](#)]; and
- present a history of having received intensive behavioral health treatment in one or more community or institutional programs including: Delaware Psychiatric Center; DSAMH Continuous Treatment Team programs; group homes, and long-term residential substance abuse treatment facilities; and/or
- present a history of having had multiple alcohol and other drug detoxification admissions and/or multiple intensive substance abuse treatment episodes.

Special eligibility determinations will be made for adults with developmental disabilities/mental retardation who have a severe and persistent behavioral health disorder and are in the upper mild range of mental retardation (317.0).

All individuals meeting the clinical eligibility criteria will be enrolled in the DSAMH LTC system.

### Eligible Mental Illness Diagnoses

#### Schizophrenia and Other Psychotic Disorders

<b>Code</b>	<b>Diagnosis</b>
295.10	Disorganized Type
295.20	Catatonic Type
295.30	Paranoid Type
295.40	Schizophreniform Disorder
295.60	Residual Type
295.70	Schizoaffective Disorder
295.90	Undifferentiated Type
297.10	Delusional Disorder

#### Mood Disorders

##### Major Depressive Disorder, Recurrent

<b>Code</b>	<b>Diagnosis</b>
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296.30	Unspecified
296.32	Moderate
296.33	Severe Without Psychotic Features
296.34	Severe With Psychotic Features

**Bipolar Disorders****Code    Diagnosis**

296.40	Bipolar I Disorder, Most Recent Episode Hypomanic
296.50	Bipolar I Disorder, Most Recent Episode Manic
296.60	Bipolar I Disorder, Most Recent Episode Mixed, Unspecified
296.70	Bipolar I Disorder, Most Recent Episode Unspecified
296.80	Bipolar Disorder NOS
296.89	Bipolar Disorder II

**Personality Disorders****Code    Diagnosis**

301.00	Paranoid Personality Disorder
301.22	Schizotypal Personality Disorder
301.83	Borderline Personality Disorder

**Eligible Substance Dependence Diagnosis****Substance Dependence Diagnosis****Code    Diagnosis**

303.90	Alcohol Dependence
304.00	Opioid Dependence
304.10	Sedative, Hypnotic or Anxiolytic Dependence
304.20	Cocaine Dependence
304.80	Polysubstance Dependence
304.90	Other (or unknown) Substance Dependence; Phencyclidine Dependence

***Clinical Eligibility Exclusions***

DSAMH LTC services will not be available for:

- Adults with DSM-IV diagnoses not listed as eligible. Adults with the following DSM-IV developmental disabilities/mental retardation diagnoses: 318.0 (Moderate Mental Retardation); 318.1 (Severe Mental Retardation); 318.2 (Profound Mental Retardation); and 319.0 (Mental Retardation, Severity Unspecified); and
- Adults with DSM-IV diagnoses not listed as eligible.

Requests for a clinical eligibility determination should be submitted on a consumer's/client's behalf by any Managed Care Organization (MCO) participating in the Diamond State Health Plan (DSHP) or by a behavioral health provider currently treating the consumer/client. The referral process will remain the same for all organizations submitting a request for a clinical eligibility determination and enrollment. The documentation for a clinical eligibility determination is independent from the financial eligibility determination for Medicaid, Medicare and other third party insurance liability. Financial eligibility determination for Medicaid will be performed by the DHSS/Division of Social Services (DSS).

The requesting MCO or behavioral health organization must provide full documentation regarding medical necessity when applying for a consumer's/client's clinical eligibility determination for and enrollment in the DSAMH LTC system. This will include full documentation regarding the consumer's/client's utilization of behavioral health services prior to the request for clinical eligibility determination.

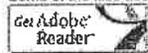
The requesting organization must complete the Enrollment Application Form and submit it to the Director of the EEU. The requesting organization will ensure that all information needed to make a timely decision for a clinical eligibility determination will be provided to the EEU. In addition to submitting the Enrollment Application Form, the requesting organization must designate a Clinical Liaison to serve as a point of contact regarding issues of referral.

The EEU will review the referral packet for completeness and quality. Incomplete packets will be returned to the referring organization for completion within one (1) working day of DSAMH's receipt of the incomplete application.

Upon receipt of a complete referral packet, the EEU will evaluate the clinical documentation provided, complete an **Eligibility Determination Review** and make a determination as to the consumer's/client's eligibility for the DSAMH LTC system within one (1) working days of receipt of the complete application.

The EEU will provide written notification to the referring organization and the consumer/client of the results of its eligibility determination within one (1) working days of the review's completion. Notification to the referring organization will include a copy of the **Eligibility Determination Summary**.

Some of the files above are in Adobe Acrobat format. You can view them with Adobe Acrobat Reader. For your free copy please visit [Acrobat](#)



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Last Updated: Friday January 10 2014

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## 1115 Demonstration Amendment for State of Delaware PROMISE (Promoting Optimal Mental Health for Individuals through Supports and Empowerment) Program Changes

August 22, 2014

### Introduction

The State of Delaware (State) is seeking an amendment to their existing 1115 demonstration waiver to comprehensively meet the needs of individuals with behavioral health (BH) needs, including individuals identified under the State's Olmstead settlement with the United States Department of Justice. The 1115 demonstration amendment is being submitted following submission of a State Plan Amendment (SPA) for crisis intervention, substance use disorder (SUD) treatment, and treatment by other licensed practitioners.

The PROMISE program seeks authority to target individuals with behavioral health needs and functional limitations in a manner similar to an Home and Community-Based Services (HCBS) 1915(i) State Plan authority. The HCBS authority under an 1115 amendment is sought, instead of a 1915(j) State Plan Amendment, to ensure coordination with the Diamond State Health Plan (DSHP) Plus program, to allow the State to include State Plan BH services in the managed care organization (MCO) benefit package, and to allow the State to competitively procure vendors under its new HCBS BH program, identified as PROMISE (*Promoting Optimal Mental Health for Individuals through Supports and Empowerment*). The demonstration amendment ensures that the freedom of choice waiver required for the procurement under this new HCBS program is granted under the State's current 1115 demonstration waiver and includes all affected individuals' costs under a single Centers for Medicare and Medicaid Services (CMS) authority. In particular, because of the small size of the State and low volume of services needed, the State will be competitively procuring contractors under the demonstration to meet the high quality and fidelity standards required under the Olmstead ADA settlement.

- For adult Medicaid populations meeting targeting and functional limitations statewide, the State will offer an enhanced benefit package of HCBS using HCBS authority in the 1115 demonstration. Generally, this includes individuals meeting the Olmstead settlement BH target population as well as other Medicaid-eligible adults with serious mental illness and/or substance use disorder needs requiring HCBS to live and work in the most integrated setting. These services are provided in addition to the State Plan services to help maintain individuals in home and community-based settings. The enhanced Medicaid benefit package will be coordinated by the Division of Substance Abuse and Mental Health (DSAMH) through the fee-for-service (FFS) program in compliance with home and community-based standards and assurances and the signed Olmstead agreement. *This population will continue to receive non-BH and most non-enhanced BH Medicaid State Plan services through the MCO benefit. See the benefit sections below for a description of the covered services.* The State is also considering including non-medical transportation services in the State's existing transportation broker contract and this amendment would provide the freedom of choice authority necessary for that contract amendment.
- For adults served in MCOs throughout the State who are not in the PROMISE target populations, the MCOs will integrate all covered services for mental illness, SUDs, and physical health (PH) conditions under this demonstration.

The goals of the two delivery system models are to improve clinical and recovery outcomes for individuals with BH needs and reduce the growth in costs through a reduction in unnecessary

institutional care through care coordination, including initiatives to increase network capacity to deliver community-based recovery-oriented services and supports. This structure will also ensure care continuity for individuals depending on their levels of need.

## **Background**

Many individuals who are not currently eligible for Medicaid receive critical BH services through State-only funds, federal block grant dollars, or other resources. Although the State already has expanded Medicaid eligibility, many of the individuals served in the BH system who have not historically been eligible for Medicaid become eligible for Medicaid under health care reform in 2014. Under this proposed demonstration amendment, the State plans to develop access to additional supports and services to better meet the BH needs of the Medicaid expansion population in 2014 and to better serve the target populations under the Olmstead settlement. These efforts are aimed at modernizing and improving the delivery of mental health and substance use services in Delaware to better meet the needs of those currently eligible, but also to build the foundation to ensure that there is a robust continuum of supports and evidenced-based options available in the future. It is the State's intention to offer the expansion population the same benefit package as the rest of Medicaid with any necessary wraps to ensure essential health benefits.

The management of severe and persistent mental illness (SPMI) and chronic and disabling SUD require specialized expertise, tools, and protocols which are not consistently found within most medical plans. As a result, for adult populations meeting the SPMI and SUD targeting and functional criteria statewide, specialty BH care within the State will be care managed by DSAMH on a FFS basis with MCO care managers participating in person-centered planning with DSAMH and the participants to fully integrate PH needs with BH needs.

The demonstration amendment seeks to address the issues arising from special needs populations with SPMI and/or SUD through a comprehensive, interconnected approach to providing services to all individuals with BH needs in Delaware, ensuring that the individuals served are receiving the most appropriate services to meet their needs in the most integrated settings possible.

## **PROMISE Program**

In order to better treat individuals meeting SPMI and SUD targeting and functional needs criteria, Delaware will be providing an enhanced benefit package of HCBS services to adults (ages 18 and older) meeting the targeting and functional needs criteria for SPMI and SUD under the PROMISE program. All individuals who meet the targeting and functional needs criteria will receive specialized care management and care coordination consistent with established protocols for managing care for adults with SPMI and/or SUD. This includes providing for behavioral supports in community-based settings (individuals' own homes), as well as residential, employment, and day settings to help individuals live in the most integrated setting possible. DSAMH, through its network of care managers and providers, will ensure that all HCBS requirements and assurances are met. This initiative is intended to fundamentally meet the requirements of the Olmstead agreement signed with the United States Department of Justice, and to build a sustainable behavioral health system for Delaware.

## **PROMISE Eligibility Requirements**

Demonstration enrollees applying for services must be screened by DSAMH using a standardized clinical and functional assessment developed for Delaware and based on national standards.

Individuals in PROMISE will not be eligible for the State's new Pathways 1915(j) State Plan Amendment Program because the PROMISE program is a more comprehensive program that includes all Pathways services as well as other services necessary for individuals with behavioral health needs to be supported in their homes. The Delaware-specific American Society for Addiction Medicine (ASAM) tool integrates the assessment and evaluation of both mental health and SUD conditions into a single document with an algorithm that can be used to determine functional eligibility and is designed to ensure appropriate treatment of individuals based on their medical and functional needs. State Medicaid eligibility staff will review financial criteria to ensure that applicants meet the community financial eligibility criteria. Individuals eligible for and enrolled in PROMISE may also be enrolled in the PLUS program if meeting the criteria for both programs unless the PROMISE individual has been identified as a CRISP individual under the ADA settlement. If the individual is identified as a CRISP individual, the individual will be enrolled in the PROMISE program only and will receive all services necessary for community living from the PROMISE program through CRISP. The CRISP program will not provide any services under the acute care MCO benefit. The PROMISE program will ensure that Medicaid payments are backed out of any state-only capitated payments made for the CRISP program thus ensuring no duplicate payment between CRISP/PROMISE and Plus. For individuals in PROMISE and PLUS, medically necessary PROMISE services will be provided in addition to any services that the individual is otherwise eligible for in PLUS if the individual is assessed as needing additional services and the services are outlined on the individuals Recovery Plan. The PROMISE care manager will coordinate with the Plus case manager, who will lead the individual's care team. To be eligible under the PROMISE HCBS program, individuals must meet one of the targeting criteria and the corresponding functional criteria under the Delaware-specific tool. The following are acceptable combinations for individuals eligible under the demonstration:

- Target criteria A and functional criteria A or C.
- Target criteria B and functional criteria B or C.

### **Targeting Criteria**

**Target Criteria A:** An individual must have formally received one of the included Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnoses that constitute the targeted portion of the State's definition of SPMI, or a diagnosis of post-traumatic stress disorder (PTSD) by a qualified clinician. Diagnoses include the following:

<b>DSAMH Current SPMI Diagnosis Codes (updated 7/1/2012)</b>			
<b>DSM IV Code</b>	<b>DSM 5 Code</b>	<b>Disorder</b>	<b>DSM IV Category</b>
295.10	295.90	Schizophrenia, Disorganized Type <i>(In DSM 5 Disorganized subtype no longer used)</i>	Psychotic Disorders <sup>1</sup>
295.20	295.90	Schizophrenia, Catatonic Type <i>(In DSM 5 Catatonic subtype no longer used)</i>	Psychotic Disorders
295.30	295.90	Schizophrenia, Paranoid Type <i>(In DSM 5 Paranoid subtype no longer used)</i>	Psychotic Disorders
295.40	295.40	Schizophreniform Disorder	Psychotic Disorders
295.60	295.90	Schizophrenia, Residual Type <i>(In DSM 5 Residual subtype no longer used)</i>	Psychotic Disorders
295.70	295.70	Schizoaffective Disorder	Psychotic Disorders

<sup>1</sup> In DSM 5, the associated diagnostic category is labeled, "Schizophrenia Spectrum and Other Psychotic Disorders".

DSAMH Current SPMI Diagnosis Codes (updated 7/1/2012)			
DSM IV Code	DSM 5 Code	Disorder	DSM IV Category
295.90	295.90	Schizophrenia, Undifferentiated Type ( <i>In DSM 5 Undifferentiated subtype no longer used</i> )	Psychotic Disorders
296.30	296.30	Major Depressive Disorder, Recurrent, Unspecified	Mood Disorders <sup>2</sup>
296.32	296.32	Major Depressive Disorder, Recurrent, Moderate	Mood Disorders
296.33	296.33	Major Depressive Disorder, Recurrent, Severe Without Psychotic Features ( <i>In DSM 5, "Without Psychotic Features" is not a further specifier</i> )	Mood Disorders
296.34	296.34	Major Depressive Disorder, Recurrent, Severe With Psychotic Features ( <i>In DSM 5, "With psychotic features" is its own specifier, and, when present, is used instead of Mild, Moderate, or Severe, not in addition to Severe</i> ) <sup>3</sup>	Mood Disorders
296.40	296.40	Bipolar I Disorder, Most Recent Episode Hypomanic <sup>4</sup>	Mood Disorders
296.42	296.42	Bipolar I Disorder, Most Recent Episode Manic, Moderate	Mood Disorders
296.43	296.43	Bipolar I Disorder, Most Recent Episode Manic, Severe Without Psychotic Features ( <i>In DSM 5, "Without Psychotic Features" is not a further specifier</i> )	Mood Disorders
296.44	296.44	Bipolar I Disorder, Most Recent Episode Manic, Severe With Psychotic Features ( <i>In DSM 5, "With psychotic features" is its own specifier, and, when present, is used instead of Mild, Moderate, or Severe, not in addition to Severe</i> ) <sup>5</sup>	Mood Disorders
296.50	296.50	Bipolar I Disorder, Most Recent Episode Depressed, Unspecified	Mood Disorders
296.52	296.52	Bipolar I Disorder, Most Recent Episode Depressed, Moderate	Mood Disorders
296.53	296.53	Bipolar I Disorder, Most Recent Episode Depressed, Severe w/o Psychotic Features ( <i>In DSM 5, "Without Psychotic Features" is not a further specified</i> )	Mood Disorders
296.54	296.54	Bipolar I Disorder, Most Recent Episode Depressed, Severe w/ Psychotic Features ( <i>In DSM 5, "With psychotic features" is its own specifier, and, when present, is used instead of Mild, Moderate, or Severe, not in addition to Severe</i> ) <sup>6</sup>	Mood Disorders
296.60		Bipolar I Disorder, Most Recent Episode Mixed, Unspecified ( <i>This Bipolar 1 sub-type was removed from DSM 5</i> )	Mood Disorders
296.62		Bipolar I Disorder, Most Recent Episode Mixed, Moderate ( <i>This Bipolar 1 sub-type was removed from DSM 5</i> )	Mood Disorders
296.63		Bipolar I Disorder, Most Recent Episode Mixed, Severe Without Psychotic Features ( <i>This Bipolar 1 sub-type was removed from DSM 5</i> )	Mood Disorders

<sup>2</sup> In DSM 5, mood disorders are broken out into "Depressive Disorders" and "Bipolar and Related Disorders".

<sup>3</sup> The DSM 5 code for Major Depressive Disorder, Recurrent, with Psychotic Features is 296.34.

<sup>4</sup> In DSM 5 code 296.40 is also used for "Bipolar I Disorder, Current or Most Recent Episode Manic, Unspecified".

<sup>5</sup> The DSM 5 code for "Bipolar I Disorder, Current or Most Recent Episode Manic, with Psychotic Features" is 296.44.

<sup>6</sup> The DSM 5 code for "Bipolar I Disorder, Current or Most Recent Episode Depressed, with Psychotic Features" is 296.54.

DSAMH Current SPMI Diagnosis Codes (updated 7/1/2012)			
DSM IV Code	DSM 5 Code	Disorder	DSM IV Category
296.64		Bipolar I Disorder, Most Recent Episode Mixed, Severe With Psychotic Features ( <i>This Bipolar 1 sub-type was removed from DSM 5</i> )	Mood Disorders
296.70	296.70	Bipolar Disorder, Most Recent Episode Unspecified	Mood Disorders
296.89	296.89	Bipolar II Disorder	Mood Disorders
297.1	297.1	Delusional Disorder	Psychotic Disorders
301.0	301.0	Paranoid Personality Disorder	Personality Disorders
301.20	301.20	Schizoid Personality Disorder	Personality Disorders
301.22	301.22	Schizotypal Personality Disorder	Personality Disorders
301.83	301.83	Borderline Personality Disorder	Personality Disorders
309.81	309.81	Posttraumatic Stress Disorder (PTSD)	Anxiety Disorders <sup>7</sup>

**Target Criteria B:** Individuals may also meet other targeted DSM diagnoses. The DSM diagnosis must be among those that are included in the following larger DSM categories (excluding pervasive developmental disorders):

- Mood Disorders:
  - *In DSM 5 "Depressive Disorders" and "Bipolar and Related Disorders" are separated out as diagnostic groupings.*
- Anxiety Disorders:
  - *DSM 5 includes a separate category, "Obsessive-Compulsive and Related Disorders".*
  - *DSM 5 includes a separate category, "Trauma- and Stressor-Related Disorders",*
- Schizophrenia and Other Psychotic Disorders:
  - *In DSM 5 this category is labeled, "Schizophrenia Spectrum and Other Psychotic Disorders".*
- Dissociative Disorders
- Personality Disorders
- Substance-Related Disorders:
  - *In DSM 5 this category is labeled, "Substance-Related and Addictive Disorders".*

**Functioning Criteria**

Each person who is screened and thought to be eligible for PROMISE must receive the State-required diagnostic and functional assessment using the Delaware-specific ASAM tool.

<sup>7</sup> In DSM 5, PTSD is moved to another diagnostic category, called "Trauma- and Stressor-Related Disorders".

Functional Criteria A: If the individual meets Targeting Criteria A, the individual must be assessed with a rating of moderate on at least one of the six Delaware-specific ASAM dimensions. The six dimensions include the following<sup>8</sup>:

1. Acute intoxication and/or withdrawal potential — substance use.
2. Biomedical conditions/complications.
3. Emotional/behavioral/cognitive conditions or complications (with five sub-dimensions, including suicidality, self-control/impulsivity, dangerousness, self-care, and psychiatric/emotional health).
4. Readiness to change (with two sub-dimensions, including understanding of illness and recovery, and desire to change).
5. Relapse, continued use, continued problem potential.
6. Recovery environment (with two sub-dimensions, including recovery environment and interpersonal/social functioning).

Functional Criteria B: If the individual does not meet Targeting Criteria A, but does meet Targeting Criteria B, the individual must be assessed with a rating of severe on at least one of the above six Delaware-specific ASAM dimensions.

Functional Criteria C: An adult who has previously met the above targeting and functional criteria and needs subsequent medical necessary services for stabilization and maintenance. The individual continues to need at least one HCBS service for stabilization and maintenance (i.e., at least one PROMISE service described below in Table 3).

#### **PROMISE Benefits and Cost-Sharing**

Effective with MCO re-procurement, adults under PROMISE will receive through MCOs all non-BH Medicaid State Plan services, as well as the following State Plan non-enhanced BH services:

- Hospital (inpatient general hospitals including BH stays in psychiatric units<sup>9</sup>; emergency room (ER); outpatient; inpatient psychiatric care the age 21<sup>10</sup>).
- Physician — all types except for psychiatric providers employed by and providing supervision to the PROMISE program services of assertive community treatment (ACT), intensive case management (ICM), and residential supports.
- Pharmacy — all excluding medication assisted treatment.
- Crisis intervention.

The following BH State Plan services will be provided FFS with care coordination through DSAMH for adults receiving services under PROMISE:

- SUD services including medication assisted treatment.
- Services by licensed BH practitioners.

<sup>8</sup> 2nd edition ASAM by Dr. David Mee-Lee et al. at <http://www.asam.org/publications/patient-placement-criteria/ppc-2r>.

<sup>9</sup> 42 CFR 440.10.

<sup>10</sup> 42 CFR 440.160. Note: because this program is for individuals ages 18 and over, this reference to adults in inpatient psychiatric care under age 21 refers to individuals ages 18-21 as indicated under the approved Delaware State Plan.

Division of Prevention and Behavioral Health Services (DPBHS)  
Strategic Plan for Calendar Year 13-16

Goals	Objectives	How to measure	Lead	Status
<p>Goal Three: Enhance access to services through multiple pathways</p>	<p>3.1 Work on transition services and service coordination for transition to age 21</p>	<ul style="list-style-type: none"> <li>Work with DHSS &amp; other partners towards policy and budget development</li> </ul>	Webb	<ul style="list-style-type: none"> <li>PBH is participating on a youth transition workgroup led by Judge Nicholas in Kent County.</li> <li>Project CORE was awarded to PBHS. This is a SAMHSA grant, in concert with DSAMH, to prevent psychosis in youth and young adults and to assist with the transition from youth BH services to the adult BH system.</li> </ul>
	<p>3.2 Work on services and service coordination for children and youth who have developmental disabilities in addition to mental health/substance abuse disorders</p>	<ul style="list-style-type: none"> <li>Work with DDDS and other partners towards policy and budget development</li> <li>Seek opportunities to implement the PIER Model in collaboration with DSAMH</li> </ul>	Leadership Team	<ul style="list-style-type: none"> <li>Susan Cycyk has met with Jane Gallivan, Director, Division of Developmental Disabilities Services on multiple occasions to discuss deeper collaboration with DDDS. Follow up meeting set for January 2016.</li> <li>Project CORE was awarded to PBHS. This is a SAMHSA grant allows that provides resources for PBHS, in concert with DSAMH, to implement the PIER Model</li> </ul>
	<p>3.3 Increase access to Psychiatric and Advance Practice Nurse Care</p> <ul style="list-style-type: none"> <li>Recruit child psychiatrists willing to consult with Primary Care Physicians</li> <li>Investigate Tele-Health</li> <li>Participate in Statewide access efforts</li> <li>Assure capacity for medication evaluation and management services</li> </ul>	<ul style="list-style-type: none"> <li>Reclassify Division child psychiatry position to a level that offers increased wages (Refers to state employment positions)</li> <li>Re-bid PBH contracted psychiatric services</li> <li>Develop a budget projection based on regional fair market value for psychiatric services.</li> <li>Tele-Health implemented</li> </ul>	Margolis	<ul style="list-style-type: none"> <li>Reclassification completed.</li> <li>Re-bid for contracted psychiatric services successfully completed</li> <li>Revised rates for psychiatric services are in place.</li> <li>Contracts were finalized with 4 providers to participate in the Primary Care Physician-Psychiatrist Consultation Project pilot program: Two Psychiatrists, one Primary Care site in Kent County, and one primary care site in Sussex County. Following initial implementation of services, La Red has elected to discontinue participating.</li> <li>Telepsychiatry is available at Stevenson House, People's Place in Milford and at the La Red locations in Seaford and Georgetown.</li> </ul>

Division of Prevention and Behavioral Health Services (DPBHS)  
Strategic Plan for Calendar Year 13-16

<p>3.6 Prevention as access (if needed) to more intense treatment</p> <ul style="list-style-type: none"> <li>Well informed providers and Partners who know how to access services.</li> </ul>	<ul style="list-style-type: none"> <li>Implement Block Grant recommendations</li> <li>Train Prevention providers and partners in obtaining outpatient services for their participants (Track the training)</li> <li>Track source of referrals for outpatient</li> </ul>	<p>Warner</p>	<ul style="list-style-type: none"> <li>Guide to Prevention Services disseminated to all staff, including presentation at PBH Managers meeting, division-wide email distribution and posting full document on PBH Extranet</li> <li>Working to implement quarterly Prevention provider training to increase knowledge of available treatment services and how to access</li> <li>FCTs and BHCs have been trained and updated on current prevention services and referral process.</li> </ul>
<p>3.7 Review Crisis System</p> <ul style="list-style-type: none"> <li>As recommended via system review</li> </ul>	<ul style="list-style-type: none"> <li>Review completed and accepted by Leadership</li> <li>Recommendations on process</li> <li>Consider opportunities to work more closely with DSAMH's adult mobile crisis and address transitional age students</li> </ul>	<p>Perales/ Doppelt</p>	<ul style="list-style-type: none"> <li>The Child Priority Response Review Committee convened from April 2013 through June 30, 2013. Several stakeholders including Acute Care Team, DGS, DFS, family members, Education and the Courts participated in the discussions. On June 29, 2013, the committee delivered its recommendations.</li> <li>Received permission from SAMHSA to use part of our SOC grant to fund an expansion of our Crisis Services.</li> <li>RFP for Crisis Services expected in FY '17.</li> </ul>
<p>3.8 Increase Assessments within natural environment and enhance family engagement</p>	<ul style="list-style-type: none"> <li>Increase numbers of assessments completed</li> <li>Track and report on timeliness</li> <li>Track and report on family engagement, satisfaction, practical applicability of assessments</li> </ul>	<p>Giddens/ Leusner  Doppelt</p>	<ul style="list-style-type: none"> <li>Currently tracking assessment numbers, timeliness and satisfaction surveys.</li> <li>CAS is meeting demand with reduced staff. Meeting court requirements.</li> </ul>

EXCERPT  
EIGHTH REPORT OF THE COURT MONITOR  
ON PROGRESS TOWARD COMPLIANCE

WITH THE AGREEMENT:

U.S. v. STATE OF DELAWARE

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

12/26/2015

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

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

142

143 D. Crisis Stabilization Services

144 *Partial Compliance.*

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

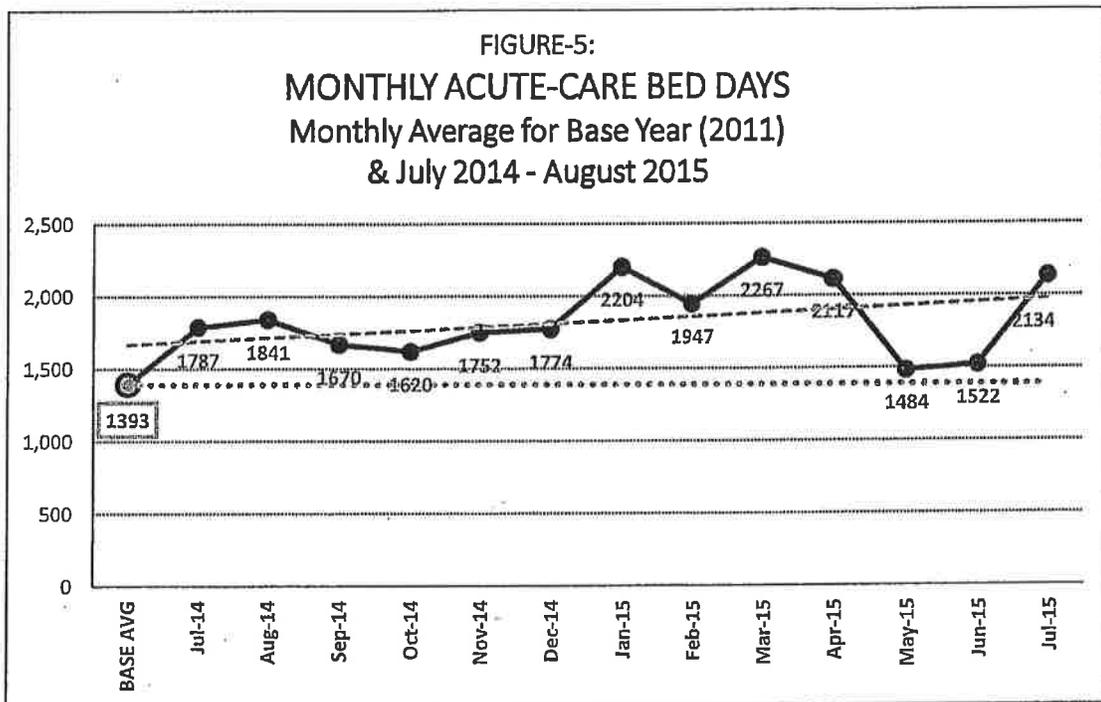
157 Inpatient psychiatric care is sometimes warranted, but it is also intrusive, it can be  
158 coercive or traumatic, and it is an expensive service that drains resources that could be used  
159 otherwise. The Agreement anticipates that the array of community program alternatives required  
160 in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

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

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

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

177



178

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

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

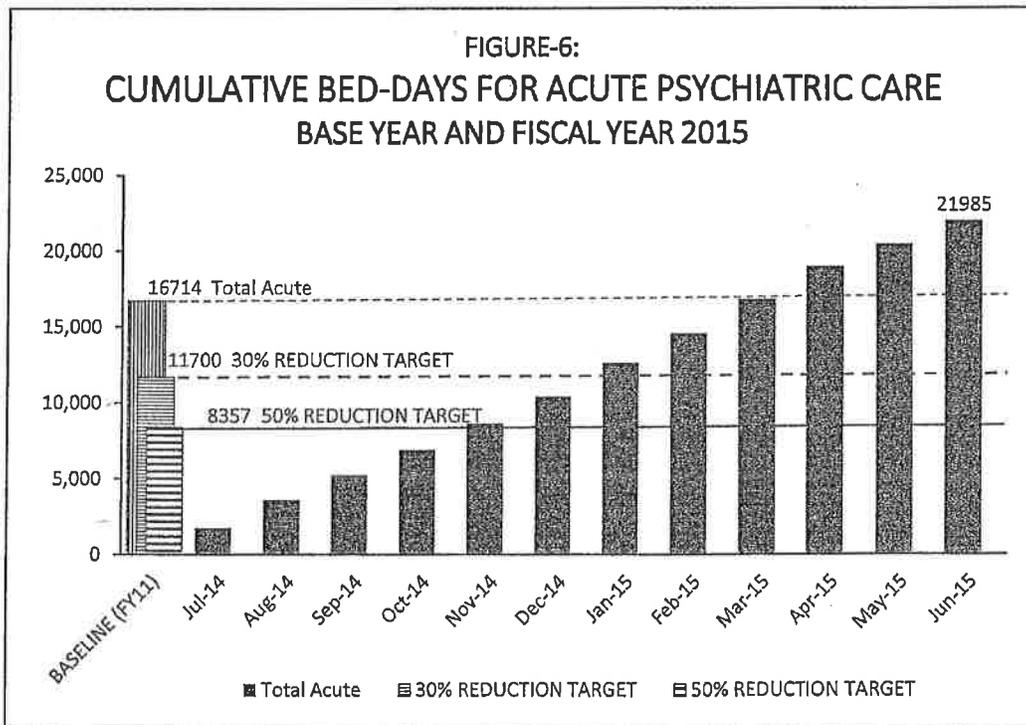
<sup>13</sup> In the past, these data have been broken out by the State division responsible for oversight (DSAMH and DMMA); given the changes since January 1, 2015, this differentiation is no longer relevant.

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

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

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

195



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

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

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

210

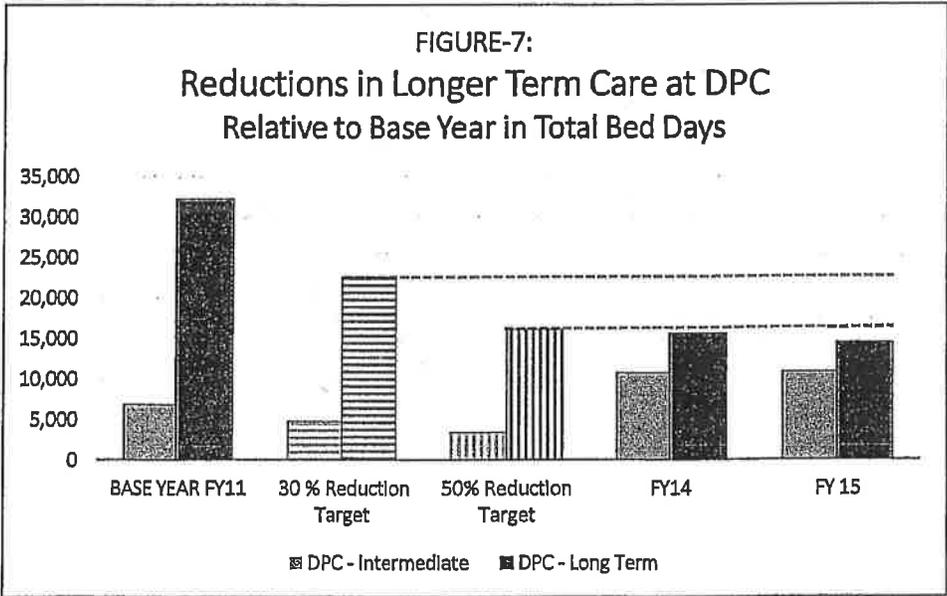
211 Additional Factors

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

214

215 *Reductions in Longer-Term Care at DPC*

216



217

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

228

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

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

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

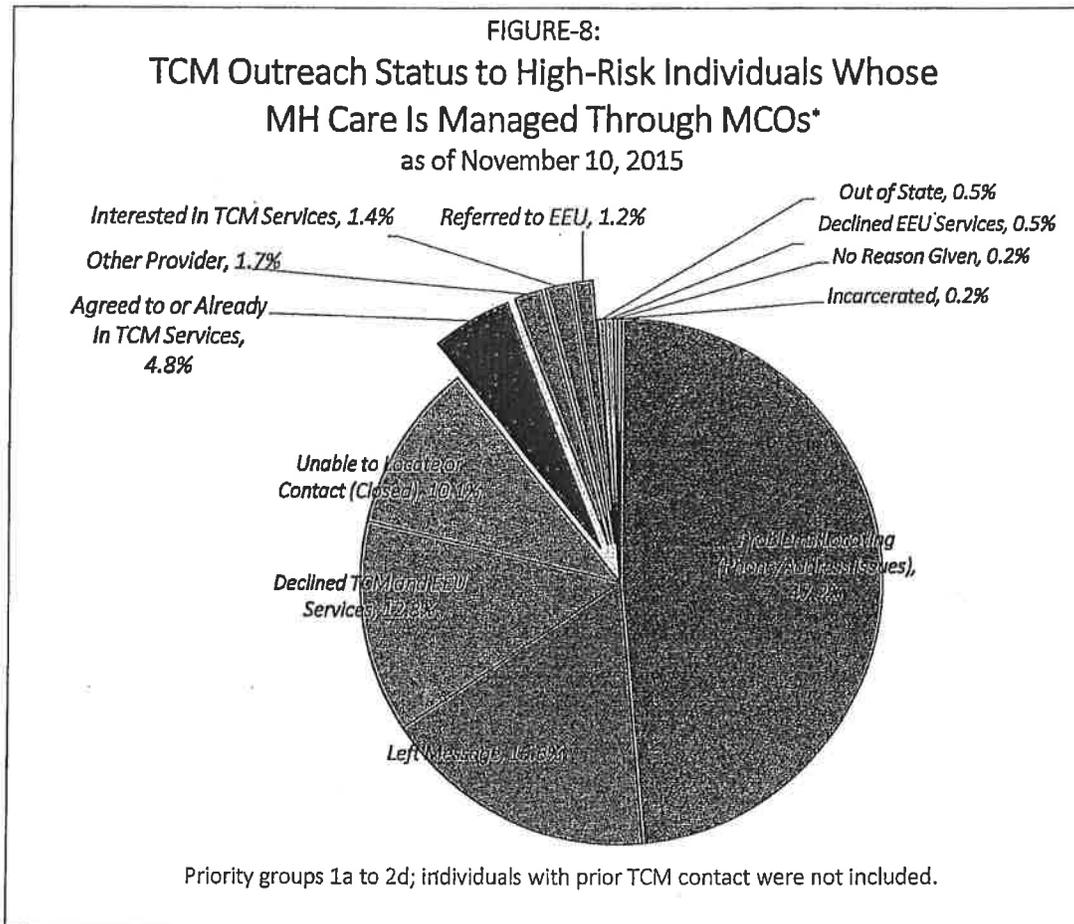
250 Figure-8 summarizes the outcomes of this effort, as well as the detailed data the State  
251 maintained to track its progress. Notwithstanding their intensive efforts, the TCM staff were able  
252 to make contact with only about 23% of the group; they were unable make contact with about  
253 77%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

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

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

259



260

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

270

# DPC report critical of state

## Monitor questions court commitments

By Beth Miller  
The News Journal

Delaware courts are ordering too many people with mental illness to outpatient commitment – an involuntary treatment status – and the rate of such orders increased in 2012, according to the court-appointed monitor of the state's progress in revamping its mental health services.

The practice – which dates back more than half a century – is vague, not covered by Delaware law and largely unsupervised, state officials acknowledged Tuesday. And its continuing use points to underlying problems in the system, according to Robert Bernstein, an expert in civil rights issues for those with disabilities who was appointed by U.S. District Court to evaluate Delaware's reforms.

Delaware has until 2016 to meet terms of a sweeping settlement with the U.S. Department of Justice, which sued the state after finding violations of civil rights at the Delaware Psychiatric Center. The DOJ's investigation was prompted by a series of reports in The News Journal about conditions at the

See REPORT, Page A2