**DISTRICT OF COLUMBIA**
*Department of Mental Health*

# REPORT ON GOVERNANCE OPTIONS FOR THE DISTRICT OF COLUMBIA COMMUNITY SERVICES AGENCY (DC CSA)

*September 18, 2008*

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# 1.0 EXECUTIVE SUMMARY

In January 2008, the Department of Mental Health (DMH) engaged KPMG LLP (KPMG) to conduct an analysis of options and alternatives for the governance and future operations of the District of Columbia Community Services Agency (DC CSA) consistent with the Dixon Court-Ordered Plan and DMH's 2001 enabling legislation.

**Background**

The DC CSA is DMH's budget-funded community-based provider of mental health services, designed to operate in parallel with contracted private providers. In 2001, the Dixon Court-Ordered Plan (the "Plan") "seriously considered" if DMH should render services directly. Ultimately, the Plan recommended that DMH continue to provide services directly until three tests could be passed by the private provider community. These tests are "*whether the private sector is willing and able to provide a given service, whether these services can be provided more efficiently through the private sector, and whether there is adequate capacity in the community to provide the necessary volume of quality services via the private sector.*[1]"

Per the Plan, the DC CSA was envisioned to "*exist with the same rules and conditions as any independent certified CSA … The Department-run CSA will have to meet the same standards as all other CSAs and will be subject to the same fee schedules for MRO services or any other contracted services. The intent is to create a choice-driven model, as required by Medicaid, with a "level playing field' for all CSAs.*" While the DC CSA does follow the same standards established by DMH for CSAs, the DC CSA has not been able to generate revenue to offset its expenditures within a Fee For Service (FFS) model. The DC CSA noted that this was partly due to the DC CSA functioning as a safety net for any consumers in the District, and offering other unique, non-reimbursable, but necessary services. The DC CSA's FY2007 expenditures were $33 million dollars, while it only has the claims records to generate a maximum of $10 million in FFS revenue. In addition, private providers claim that the DC CSA's subsidized funding creates difficulties hiring and retaining staff, resulting in adverse implications for continuity of care, and their capacity to serve additional consumers.

**Study/Project Approach and Outcomes**

KPMG analyzed a number of factors about the population served by the DC CSA in comparison to the private providers, defined the safety net functions performed by the DC CSA, identified services and functions that were unique to the DC CSA, and analyzed a number of organizational structure and governance options for the government operated services. This analysis was conducted with the goal of

[1] http://dmh.dc.gov/dmh/frames.asp?doc=/dmh/lib/dmh/pdf/final_court_ordered_plan_03-28-01.pdf

informing decision-making around options and alternatives, consistent with DMH's enabling legislation and the Court-Ordered Plan.

To conduct the analysis KPMG, under DMH's direction, performed the following tasks:

- Developed and implemented a communications plan for the dissemination of information regarding the project, with the DC CSA workgroup identifying relevant stakeholders and the preferred communication method(s);
- Conducted thirteen (13) focus groups with relevant stakeholders, including DC CSA Union representatives, DC CSA Staff, Community Stakeholders, Consumer Advocates, and Private Providers to document the current role(s) of the DC CSA and to assess the willingness of the community to take on those roles;
- Acquired and analyzed demographic, services, insurance, and claims data from DMH's eCura claims payment system, the DC CSA's Anasazi practice management system. Comparable data was also obtained from two private provider practice management systems;
- Acquired and analyzed staffing data from the DMH Schedule A and the DC CSA staffing rosters to determine expenditures to revenue ratios;
- Reviewed DC CSA staffing and team assignment plans for FY2007;
- Reviewed DC CSA productivity data for FY2007; and,
- Acquired and analyzed DC CSA budget and revenue data for FY2007.

Focus Groups

A key outcome of the focus groups was discussion around the definition of the safety net currently provided by the DC CSA. This resulted in identifying the following seven traits that should be incorporated into any consideration of the future operations of the DC CSA:

1. Services to consumers who are not eligible for Medicaid or other forms of insurance - The perception of a number of stakeholders, mainly DC CSA employees, is that the DC CSA predominantly serves consumers who are not eligible for Medicaid because the private provider network is unwilling to serve them and closes to their enrollment.
2. Service to consumers with the most difficult cases - A number of stakeholders suggested that the private provider community was often unwilling to take on those cases with the most difficult clinical diagnosis. Instead, those cases fall to the DC CSA who therefore deal with those consumers who are most deeply and persistently mentally ill.
3. Service to consumers in need of immediate or time delimited services – A number of stakeholders noted that the DC CSA acted as the safety net in providing access

to care when case circumstances required that a consumer be seen in an immediate timeframe. This was specifically noted with regard to the need to identify a placement under the direction of the Court.

4. Services to consumers when there is not capacity in other segments of the MHRS system – Some stakeholders noted that the DC CSA was available for enrollment regardless of capacity constraints when other providers may be closed to enrollment for various services or groups of consumers.
5. Specialized services - A number of stakeholders noted that the DC CSA provides a set of unique services that are not available from other components of the District's mental health system. Those services most typically noted were pharmacy, ACT services, and multi-cultural services. In addition, some stakeholders mentioned that the mix of services provided through the DC CSA was highly beneficial to a segment of consumers such as geriatric consumers.
6. Services at various sites around the District – Easy access to services a various locations around the District was mentioned by some stakeholders as an additional manner in which the DC CSA acted as a safety net in that its multiple locations made access to care more convenient and easy to obtain for consumers.
7. Safety net for community crisis situations – A number of stakeholders considered the work carried out by the DC CSA in both individual cases and public emergency situations to be an additional aspect of the safety net that it provides.

A common theme heard throughout the focus groups was that private providers select easy and/or profitable consumers while the DC CSA is left with the more difficult consumers. Examples provided of the more difficult consumers included non-Medicaid, multi-cultural, criminal justice, and co-occurring populations. Private providers were represented as focused on profit and revenue generation instead of consumer care. While private providers disagreed with this representation and believed they offered better services and increased outreach than the DC CSA, they did concede that they could better serve all consumers if adequate funding streams were in place, including ramp-up costs for new programs/buildings and higher MHRS rates (and/or case rates).

DC CSA employees and other stakeholders noted that it would be unfair to compare the DC CSA to the private providers as they are not on a level playing field due to governmental bureaucracies, employee regulations, IT infrastructure, procurement processes, and other management restrictions.

The DC CSA also has an older, more experienced workforce with higher levels of compensation and larger benefit packages compared to private providers. This leads to a much lower turnover rate for DC CSA employees, something touted as both a strength for continuity of care, and also as weakness as it tended to foster a support model of care rather than a rehabilitative model.

Most stakeholders were concerned how the analysis and any potential transitional process would affect the consumer population currently served by the DC CSA. Stakeholders also asked for a continuous flow of information as the results and decisions are made regarding implementation of any changes concerning future operations of the DC CSA.

Data Collection and Analysis

KPMG collected, analyzed, and presented data to compare the DC CSA to private providers. KPMG requested data to quantify the extent to which the DC CSA is serving in a safety net or other unique capacity. Data was primarily secured from DMH's eCura claims payment system, DC CSA's Anasazi practice management system, and private provider practice management systems in the following categories:

- Access to Care Considerations – This category included data with respect to Insurance Coverage per Enrolled Consumers, Insurance Coverage per Active Consumers, Location of Consumers throughout the District, and Timeliness of services rendered.
- Clinical Considerations - This category included data with respect to Global Assessment of Functioning (GAF) Score (DSM-IV-TR), Level of Care Utilized for Services (LOCUS), and CSR Outcome data.
- Programmatic Considerations - This category included data with respect to number of consumers served, breakdown of services rendered, and unique services offered by the DC CSA.
- Community/ population served - This category included data with respect to Age, Gender, Ethnicity, and Language spoken.
- Cost Considerations - This category included data with respect to the cost of the services provided by the DC CSA, and how much DMH would save by purchasing those services from the private community.

The available data was used to highlight the differences and similarities that exist between the DC CSA and the private providers, consistent with the criteria set out in the Dixon Court-Ordered Plan, in order to allow DMH to make the determination how and/or if the DC CSA should continue to function as a government-run direct service provider.

*Access to Care Considerations*

Based on the data obtained from DMH's claims payment system, the DC CSA serves a 10%-20% greater number of non-Medicaid consumers (partially caused by private provider closures due to DMH funding) than the private providers, serves consumers within similar zip codes, and provides first services more slowly and less consistently than private providers provide. Medicaid insurance related issues, consumer physical

addresses, and timeliness/lack of services do not appear to provide access issues for the private provider consumers of the District.

*Clinical Considerations*

Based on the data from the Community Service Reviews (CSRs), the DC CSA's adult consumers are not clinically lower functioning, or do they require higher levels of care than private providers. The DC CSA is able to obtain better outcomes for those consumers served. Although the data is limited, there does not appear to be significant variation in children's outcomes, but more attention should be focused on children's services since children served by the DC CSA appear to be slightly lower functioning that those served by private providers.

*Programmatic Considerations*

The DC CSA serves a significant volume of the District's mental health consumers, but does not generate the same potential revenue that the private providers have generated. Additionally, the DC CSA does offer a different service mix than private providers, which may be partially based on the reimbursement and/or qualifications required to render those services. The DC CSA also has a number of unique factors and/or programs that DMH may benefit from maintaining. DMH will have an opportunity to gradually ramp-up the capacity of the private providers as part of the redesign of the public mental health system.

*Community/ Population Served*

The populations served by the DC CSA do not vary a great deal from those served by private providers based on age, gender, ethnicity and language spoken. There do not appear to be any factors present in the data that would show that the DC CSA is serving a different population than the private providers.

*Cost Considerations*

The DC CSA is generating FFS revenue of less than half per consumer per month as private providers. If DMH were to purchase the same set of services as recorded (but not necessarily billed) in Anasazi by the DC CSA, DMH would pay out approximately $10.5 million dollars, a savings of approximately $14.2 million dollars by providing those same services at the DC CSA. If private providers were to render the same level of services to the DC CSA population as they are rendering to their current consumers, the savings to DMH may decrease to approximately $11 million based on current claims per consumer per month.

**Observations**

KPMG made the following observations based on the analysis of data:

- From a demographic perspective, the populations served by the DC CSA do not vary significantly from those served by private providers based on age, gender, ethnicity and language spoken.

- The services delivered by the DC CSA are similar to the services delivered by the private provider network.
- While the capacity of the provider network is enhanced by the DC CSA, the current fee-for-service payment structure and funding mechanism of the DC CSA were reported to create an impediment to private providers creating additional service capacity.
- The source of funding for DC CSA services is not as predominantly non-Medicaid consumers as presumed by most stakeholders.

  Closures of private providers to non-Medicaid enrollment is more an unintended consequence of the contracting processes and task order limitations imposed on private providers than a reflection of the willingness of private providers to serve non-Medicaid clients.
- The timeliness of service provision by the DC CSA is similar to the private provider network.
- The DC CSA and the private provider network served clients who's location, based on address zip code, were similarly distributed across the District.
- The DC CSA tended to deliver more services in an office-based setting.
- The DC CSA provides a set of services that is unique when compared to those delivered through the private provider network. These include:
  - Pharmacy;
  - ACT to the extent that they are the predominant ACT provider;
  - Multi-cultural services; and,
  - Psycho-education in school based settings.
  - Outpatient competency restoration
  - Residents clinic
- The current DC CSA funding model has a negative impact on the functioning of the overall provider network.
- Services are being delivered by the DC CSA at significantly greater cost to the District. The same services delivered in FY 2007 by the DC CSA could be purchased through current fee-for-service arrangements with the private provider network for approximately $11-$14 million less.

**Recommendations**

Based on the observations above, the following are recommended actions for consideration:

- Continue direct government provision of a limited number of specialized services currently provided by the DC CSA. The following specialized services should be provided as direct government provided services: the Pharmacy, the Psycho-Ed Program, Multicultural coordination, outpatient competency restoration program and the 35 K Street Residents' Clinic.

  The preceding programs should be linked to, and incorporated into new a direct services entity under the direction of the DMH Authority that could also include current Authority functions/programs such as CPEP and school-based services.

  The following should be considered for inclusions in specific requirements that must be provided by the provider network:

  - Capacity to provide walk-in unscheduled visits similar to the SURE Program.
  - Provision of after hours child psychiatric coverage for the DC courts and DC child and youth serving agencies.
  - Emergency Mental Health Response Teams – This is already addressed by the soon to start mobile crisis services for youth and adults.
- Discontinue the delivery of the remainder of direct services by the DC CSA by transferring consumers receiving services otherwise provided by the private provider network on a phased basis to that network. This includes the following:
  - Adult Services
    - Assertive Community Treatment
    - Rehabilitation Day Services
    - Housing
    - Supportive Employment
    - Community Support
  - Child and Youth Services
    - Intake
    - Community Support
    - Community-based Intervention
- Broaden the provision of multicultural services across the private provider network.
- Develop increased capacity to deliver ACT services to adults.
- Utilize resources that become available from the DC CSA transition to fund aspects of a mental health system redesign.

- Implement a detailed transition plan.
- Establish enhanced accountability mechanisms.
- Establish Contractual mechanisms and obligations to solidify the public mental health safety net. These should include:
    - Compliance with DMH requirements for hours of operation, including evenings, holidays and weekends;
    - A provision prohibiting discrimination on the bases of health insurance coverage; and,
    - Offering same day services or urgent care.

**Future Actions**

DMH should take the following steps to manage the implementation of recommendations proactively. These actions would utilize the plan/act model that DMH has successfully utilized for other major organizational initiatives. Specific implementation management actions include:

- Define the future structure of the mental health system and vet with stakeholders.
- Create a structure to manage the DC CSA change headed by an individual charged with the overall responsibility for its execution.
- Develop a detailed work plan and milestones that would be used to stage individual work tasks and frequently assess and report progress.
- Develop subsidiary plans including, but not limited to a Communications Plan, an Organizational Change Management Plan, a Risk Management Plan, and a Financial Plan.
- Develop and document processes and protocols for implementing the detailed work plan and the subsidiary plans.
- Develop key performance indicators to be assessed as the change process progresses.

# 2.0 BACKGROUND

The District of Columbia Department of Mental Health (DMH) engaged KPMG LLP (KPMG) to assist in conducting an analysis of options for the future operation and governance of the District of Columbia Community Services Agency (DC CSA). This section provides background on the DC CSA and KPMG's analysis.

## 2.1 BACKGROUND ON DMH AND THE DC CSA

DMH was established as a Cabinet-level department reporting directly to the Mayor through the enactment of the Mental Health Establishment Amendment Act of 2001 consistent with the Dixon Court-Ordered Plan. DMH provides comprehensive mental health services to adults, children, youth, and their families. DMH also evaluates and treats individuals referred through the criminal justice system. The Department is comprised of three main organizational components:

1. The Mental Health Authority (MHA) – Responsible for the infrastructure and program development capabilities of the entire District of Columbia public mental health system. This includes the Office of the Mental Health Director, the Office of the Chief of Administrative Services (including budget and finance, contracting, information technology, and human resources) the Office of Accountability, the Office of Strategic Planning, Policy and Evaluation, and the Office of Programs and Policy.
2. St. Elizabeths Hospital – Provides services to both voluntary and non-voluntary consumers requiring inpatient treatment.
3. The DC CSA – Provides community-based mental health rehabilitation services to adults and children in parallel to those provided by private providers. The DC CSA is intended to function as a "safety net" for the provision of community based mental health services to District residents.

The Dixon Court-Ordered Plan established the DC CSA to operate as a comprehensive mental health services provider directly serving adults, children, youth, and their families in a community-based setting. The goals of the DC CSA were to develop, support, and oversee a comprehensive, community-based, consumer-driven, culturally competent, quality mental health program. The DC CSA was to act as the public, community-based provider of mental health services offering a range of services that parallels those offered by private providers, as well as functioning in a mental health "safety net" capacity. The mandate for DMH to deliver direct government-provided services through a single Core Services Agency was included in

the Court-Ordered Plan largely based on the perception at that time that there was a lack of capacity in the community or viable alternatives to contract through the private sector to meet the array of needs.

The DC CSA was to be responsible for a range of adult and child and youth services based on a unified service delivery and administrative infrastructure and provision of services at sites that would serve as models for providing both adult and child and youth services. The government–run DC CSA was to exist under the same rules and conditions as other certified private providers.

## 2.2 CURRENT DC CSA OPERATIONS

The DC CSA continues to offer a range of services to community-based consumers today. The following summarizes the operational components of the DC CSA:

**Adult Services**

Adult Services teams are comprised of six to ten members, including psychiatrists, nurses, licensed social workers, mental health specialists, vocational rehabilitation staff, a recovery specialist and a case manager. Mental health services provided by the Adult teams include:

**Assertive Community Treatment Teams –** There are three multidisciplinary Assertive Community Treatment (ACT) teams focused on providing mental health services to consumers who require an intensive level of assistance, with the objective of keeping the consumers out of the hospital. Consumers are referred to the ACT teams by case managers upon determination that specialized intensive treatment is required for rehabilitation, recovery and independence. Services provided by the ACT teams are available 24 hours per day, seven days a week. As a result, the majority of the services provided by the ACT teams are in consumers' homes, community residential facilities or hospitals. The ACT teams complete comprehensive or supplemental assessments and develop self care-oriented Individualized Specific Service Plans (ISSP) for each consumer assigned to their team. Services offered by the ACT teams include:

- Medication prescription, administration and monitoring, crisis assessment, and intervention;
- Symptom assessment, management and individual supportive therapy;
- Substance abuse referral for consumers with a co-occurring addictive disorder;
- Psychosocial rehabilitation and skills development;
- Interpersonal training and social skills training; and,

- Education, support and consultation to consumers' families and/or their support system, which is directed exclusively to the well-being and benefit of the consumer.

**Rehabilitation Day Services Team -** The Rehabilitation Day Services team is focused on providing adult consumers with onsite (clinic) curriculum-driven mental health services for developing skills that foster social role integration for successful community living through a range of social, psycho-educational, behavioral, and cognitive mental health interventions. The team is located at 3849 Alabama Avenue SE.

**Housing Team –** The Housing team facilitates consumers' access to all types of housing arrangements including placement of adult consumers into Community Residence Facilities (CRF), subsidized housing, and other available programs to provide shelter to consumers and maintain stability in the community. As a significant number of consumers are unemployed, the Housing team is responsible for assisting consumers apply for federal and local housing programs and funds. The team is located at 1125 Spring Road NW.

**Care Coordination Team –** The Care Coordination team coordinates the psychiatric/medical evaluations and assessments for Adult consumers. The team members are responsible for facilitating adult consumers' intake processing and obtaining authorizations for services on consumers' treatment plans. Team members also provide administrative support and other front desk duties. Team members are located at the following locations: 35 K Street NE, 1125 Spring Road, NW, 3849 Alabama Avenue SE, and 3861 Alabama Avenue, SE.

**Supportive Employment Team –** The Supportive Employment team is responsible for assisting unemployed adult consumers with obtaining and maintaining employment. Team members are located at 1125 Spring Road, NW.

**Community Support Teams –** There are 14 Community Support teams, including specialized services to a geriatric population, people with developmental disabilities and hearing impairment. These teams provide adult consumers with mental health services designed to reduce psychiatric symptoms and develop optimal living skills. Services offered by the Community Support teams include:

- Medication prescription, administration and monitoring, crisis assessment and intervention;
- Symptom assessment, management, and individual supportive therapy;
- Substance abuse referral for consumers with a co-occurring addictive disorder;
- Psychosocial rehabilitation and skills development;
- Interpersonal and social skills training; and,

- Education, support, and consultation to consumers' families and/or their support system, which is directed exclusively to the well-being and benefit of the consumer.

Team members are located at: 35 K Street, NE; 1125 Spring Road, NW; and 3861 Alabama Avenue, SE.

**Child and Youth Services**

Children and youth between the ages of 5 and 18 are referred to the DC CSA Child and Youth Services division from the DC Child and Family Services Agency (CFSA), DC Department of Youth Rehabilitation Services, District of Columbia Public Schools (DCPS), parents and primary care givers. The Child and Youth Services division provides or facilitates treatment interventions to these consumers and their families. Treatment interventions, which are provided at community-based locations include: diagnostic assessment, medication and somatic treatment, counseling, and community support services. In addition, the department provides crisis stabilization, community-based intervention, mobile crisis emergency outreach services, and special education services for children and adolescents. Child and Youth services provided include:

**Intake Coordination –** The Intake Coordination team coordinates the psychiatric/medical evaluations and assessments for children and youth consumers. Team members are responsible for facilitating the consumers' intake process and obtaining authorizations for services on consumers' treatment plans. Team members also serve as administrative support, including answering phones and other front desk duties. Team members are located at the following locations: 821 Howard Road, SE and 1250 U Street, NW.

**Community Support –** Five Community Support teams provide mental health rehabilitation and environmental support to assist consumers in achieving rehabilitation and recovery goals. The teams focus on building and maintaining a therapeutic relationship with the consumer. The teams are located at the following locations: 1250 U Street, NW and 821 Howard Road, SE.

**Community Based Intervention/Mobile Urgent Stabilization –** The Community-Based Intervention (CBI) and Mobile Urgent Stabilization teams (MUST) provide time-limited intensive mental health services to children and youth. The CBI team is focused on providing services intended to prevent the utilization of an out-of-home therapeutic resource by the consumer (i.e., psychiatric hospital, residential treatment facility, juvenile justice facility).

The MUST team provides CBI services and serves as psychiatric emergency services responders 24 hours per day, seven days a week. In addition, MUST services include urgent and emergency evaluations for consumers of all ages, who:

- Are in a crisis;

- Need safe, structured, therapeutic support;
- Need continuous support; or,
- Require specific psychiatric intervention.

For FY 2009, DMH has developed new mobile crisis services for adults and children. The adult services will be a component of CPEP and the child crisis services will be operated through a contract with Anchor Mental Health. Therefore, except for rare situations, the MUST service will primarily provide CBI services in the future.

**Psycho-Educational Programs –** The Psycho-Educational team provides mental health services to children and youth enrolled (up to 120) in the District of Columbia Public Schools (DCPS) Psycho-Educational program. DCPS and DMH work collaboratively to provide a comprehensive education and mental health treatment program. The program is designed to promote growth in the emotional, behavioral and academic areas through the following:

- A academic curriculum focused on enhancing the student's ability to compete with peers in general education settings;
- A clearly defined system of behavioral expectations and incentives designed to enhance school performance;
- Specific social skills instructions, which enable students to learn problem solving, decision-making, coping and reliance skills;
- Address psychological and psychiatric barriers to the student's academic achievement, safety, and well-being; and
- Collaborate with other systems to address unmet family/caregiver psychiatric/psychological needs that are barriers to the student's academic achievement, safety, and well-being.

**Office of the Chief Clinical Officer**

The Chief Clinical Officer is responsible for implementing measures that address and monitor the mental health needs of DC CSA adult, children and youth consumers. The Chief Clinical officer has oversight of the following services:

**Pharmacy Services –** The DC CSA operates two pharmacies to adhere to the policy of serving as a safety net provider of pharmaceuticals for consumers who do not have prescription drug coverage through Medicaid or a third party payor, and who are unable to pay for medication. Consumers who are eligible for Medicaid, or who have prescription drug coverage are not serviced by Pharmacy Services, but are referred to outside pharmacies that accept Medicaid. DC CSA pharmacies are currently staffed with one supervisory pharmacist, three pharmacists and six pharmacy technicians. Detail on the pharmacy utilization is addressed in the programmatic implications section of this report.

**Psychiatrist Services -** Psychiatrists are core members of the interdisciplinary teams, which also include psychologists, social workers, mental health specialists, counselors, nurses, and other staff. Psychiatrists contribute to the treatment plan of a consumer by providing specialized clinical skills and perspectives to help the consumer achieve optimal psychological, behavioral, social, educational, and vocational functioning. There are approximately 20 psychiatrists employed with the DC CSA, of which approximately 12 are full time.

**Nursing Services –** The DC CSA currently employs a supervisory nurse and staff nurses to provide physical and mental health care services to consumers. The nurses assist interdisciplinary teams by providing the following services:

- Nursing/medical assessments on new consumers;
- Obtain weights and vital signs of consumers; and
- Ensure that medication prescriptions are current.

**Organizational Support Units**

**Office of Quality Improvement -** This office is staffed with a Quality Improvement Specialist, Practice Enhancement Specialist, Medical Records Administrator and six Medical Record technicians. The Director establishes objectives that relate to the mission of the DC CSA to provide quality recovery/rehabilitation based mental health services. The objectives established are derived from DMH requirements, MHRS standards, and DC CSA priorities. The following are current quality improvement objectives:

- Establish Quality Council Structures and Committees;
- Develop Quality Indicators/ Measures of Performance and Track Outcomes;
- Provide Staff Training regarding Compliance Requirements/Performance Measures;
- Develop a Compliance Plan and Perform Clinical Record Audits;
- Implement the Clinical Records Office Plan; and
- Oversee Activities Pertaining to Agency Review and Certification.

**Office of Consumer Advocacy** - The Consumer Affairs Liaison establishes guidelines for the complaint and grievance process. In addition, the liaison facilitates the resolution of issues relating to consumers receiving unfair treatment or having their rights violated.

**Office of the Director of Operations**

Operations is a core department in the DC CSA's organizational structure. The department is overseen by a Director who also is responsible for oversight and direction of Child and Youth Services. The department is responsible for ensuring the

DC CSA's long-term strategic objectives and short-term tactical plans are being met. The Operations department manages the agencies revenues and expenditures, and provides administrative and operational support through the following components:

**Patient Accounts –** For consumers receiving in-patient care at St. Elizabeths Hospital and in the community, Patient Accounts maintains records pertaining to costs, payments received and made, and services provided to consumers.

**Budget –** This office coordinates the budgeting process related to the DC CSA component of the overall DMH budget**.** In conjunction with the DMH OCFO and the DMH Office of Fiscal and Administrative Services, the Budget office assists in developing and monitoring the DC CSA budget.

**Reimbursement Services –** This office reviews claims for accuracy prior to submission to DMH, submits claims, and tracks payments received. This operational capacity includes the ability to:

- Verify eligibility for Medicaid and other third party payors;
- Work claims suspended within the Anasazi system in conjunction with service teams;
- Submit claims and related documentation to DMH; and
- Track payments for services.

**Facilities Management –** This office is responsible for providing healthy, safe, accessible environments for staff, consumers, and family members within the DC CSA locations.

**Staff Development/Training –** This office/function creates training and development programs for DC CSA staff that reflect the standards established by the MHRS program. Its purpose is to enhance the quality of employee core competencies and to improve the climate and quality of the DC CSA work environment.

By offering this wide range of direct and support services, the DC CSA was intended to compete in the marketplace in which consumers would pick the CSA of their choice. The government-run CSA was to meet the same standards as all other CSAs and be subject to the same fee schedule for MHRS services. The intent was to create a choice-driven model, as required by Medicaid, with a "level playing field" for all CSAs. The one notable exception in this regard was that the funding for operation of the DC CSA became, in reality, budget driven as a set of line items within the overall DMH budget. For FY 2007, DC CSA expenditures were $33MM. MHRS fee-for-services payments became recoveries against the budgeted expenditure that, at $6MM, did not equal the budgeted expenditures. Thus, the DC CSA has become a direct services operation funded by DMH.

## 2.3 EVENTS LEADING TO THIS ANALYSIS

The Dixon Court-Ordered Plan recognized that it might take several years for the DC CSA to achieve the proper level of stabilization and development, even with strong leadership. In designating the DC CSA as a primary direct service provider, the Dixon Final Court-Ordered Plan stated that the Department of Mental Health should "explore appropriate legal options to enable the DC CSA to operate as an independent non-profit organization. This would enable the Department to focus its leadership efforts on its authority functions, avoid perceptions of favoritism, and provide the DC CSA greater flexibility to operate with an independent Board, budget, and personnel system, etc." (Court-Ordered Plan, page 25). Furthermore, the Court-Ordered Plan requires the District to assess continuation of direct provision of services based on the ability of the community to provide all needed community-based services through analysis of the following factors:

- Whether there is adequate capacity in the community to provide the necessary volume of quality services through the private sector,
- Whether the private sector is willing and able to provide a given service, and
- Whether these services can be provided more efficiently through the private sector.

More recently, the Dixon Court Monitor indicated in various Reports to the Court his strong view that the issue of the future of the DC CSA needs to be brought to a resolution. Such resolution should maximize the community focus of the MHRS program and enhance the level of services provided with program budget dollars.

Finally, the District of Columbia City Council has included language in the FY 2009 Budget Support Act requiring DMH to report to the Council on recommendations for a new governance structure for the DC CSA by October 1, 2008, and present a plan for implementation of any recommendations by December 31, 2008.

In January 2008, KPMG was engaged by DMH to conduct an analysis of options and alternatives for governance and future operations of the DC CSA. As part of this engagement, KPMG was tasked to analyze a number of factors about the population served by the DC CSA in comparison to the private providers, to delineate the safety net functions performed by the DC CSA, to identify services and functions that were unique to the DC CSA, and to assess various organizational options for the government operated services with the goal of informing decision-making around options and alternatives, consistent with DMH's enabling legislation.

# 3.0 APPROACH TO THE ASSESSMENT OF DC CSA OPTIONS

In order to develop an analysis to serve as the basis for evaluating options for the future operations for the DC CSA, DMH contracted with KPMG to provide support for analyzing DC CSA governance and operation options and alternatives. In carrying out our analysis, KPMG performed the following tasks:

- Conducted thirteen (13) focus groups with relevant stakeholders;
- Acquired and analyzed demographic, services, insurance, and claims data from DMH's eCura claims payment system, the DC CSA's Anasazi practice management system. Comparable data was also obtained from two private provider practice management systems;
- Acquired and analyzed staffing data from the DMH Schedule A and the DC CSA staffing rosters;
- Reviewed DC CSA staffing and team assignment plans;
- Reviewed DC CSA productivity data; and,
- Acquired and analyzed DC CSA budget and revenue data.

Data was collected to address several considerations that were deemed relevant to the consideration of options for DC CSA operations. These included:

- Access to care;
- Clinical implications;
- Programmatic implications;
- Community/population needs; and
- Cost implications.

## 3.1 COMMUNICATION WITH STAKEHOLDERS

KPMG recommended and implemented a communications plan for the dissemination of information regarding the analysis, with the DC CSA workgroup identifying all stakeholders and the preferred communication method. DMH established multiple communications channels to inform stakeholders about the analysis, including:

- Briefings and question and answer sessions at scheduled DC CSA all-staff meetings and other team meetings;

- A direct e-mail address available for DC CSA employees, consumers and relevant stakeholders for questions and feedback regarding progress of the analysis;
- An article in the DC CSA consumer newsletter to inform consumers of the status of the project and the timeline for completion;
- Employee-focused Frequently Asked Questions (FAQs) document;
- Feedback mechanism for anonymous comments, questions, and suggestions, through drop boxes that were placed in each DC CSA site and at the Authority, as requested by labor union management;
- Direct communications through team leads regarding individual employee concerns;
- Briefings for other stakeholders and interest groups (i.e., the DC CSA Roundtable); and
- Meetings with the labor union management group.

## 3.2 DATA ANALYSIS

KPMG requested documentation related to the current operations of the DC CSA and the private providers network. Data was primarily obtained from DMH's eCura claims payment system, DC CSA's Anasazi practice management system, and private provider practice management systems in the following areas:

- Access to Care Considerations
- Clinical Considerations
- Programmatic Considerations
- Community/ population served
- Cost Considerations

## 3.3 IDENTIFICATION OF OPTIONS

At the outset of the analysis, a number of potential options for DC CSA governance and operations were identified by the DC CSA Workgroup. They were:

- **Continue the Current State** – Continue to operate the DC CSA or parts of it as a DMH Core Service Agency providing adult, child and youth services. DC CSA management would be responsible for determining operational improvements.
- **Create a New Not-for-Profit Organization** – Transforming the DC CSA into a not-for-profit corporation. Not-for-profit corporation formed under a policy where no individual (e.g., stockholder, trustee) will share in any profits or losses of the organization. To be a Section 501 (c) (3) organization, the entity must be

organized as a corporation, trust, or unincorporated association. The organizing documents must limit the organization's purposes and permanently dedicate its assets to its exempt purposes. The organization must be operated to further one or more exempt purposes stated in its organizing document. The governance of the not-for-profit corporation operated through a Board of Directors. The governance function is responsible for providing overall strategic direction, guidance and controls. The Board is comprised of individuals from the community and, ideally, is representative of the organizations clients. The Board can configure the nonprofit in whatever structure it prefers to meet the organization's mission and usually does so via specifications in its bylaws. Members of nonprofit Boards are generally motivated by a desire to serve the community and the personal satisfaction of volunteering. Non-profit Board members may not receive monetary compensation for serving on the Board.

- **Evolve the DC CSA into a Public Benefit Corporation** – Transforming the DC CSA into a public benefit corporation. Public Benefit Corporation refers to a non-profit organization owned by the government which carries out the services or functions for the benefit of the public.
- **Expand Services Currently Purchased through the Existing Provider Network** – Transferring the delivery of components of the current DC CSA services to provider providers through the transfer of clients in a coordinated manner. The outsourcing of services would dissolve DC CSA under DMH governance. Special attention would be given to the services not available in the private provider network.
- **Privatize the DC CSA Operations** – Acquisition of the DC CSA by an external private entity. The process would result in transferring the ownership from the government to the private sector.

These options/alternatives formed a backdrop for the analysis of services and costs, and provided a potential framework around which various recommendations could be considered.

# 4.0 ANALYSIS OF OPTIONS

DC Official Code 7-1131.04(6) required that DMH directly operate a Core Service Agency for three years from December 18, 2001 to address the mental health needs of the residents of the District of Columbia. The DC CSA was created to meet this requirement in large measure to provide a safety net to ensure that sufficient capacity to provide required mental health services was in place as a network of private providers implemented the MHRS program. From a historical perspective, creation of a public agency to directly deliver mental health services also provided an appropriate transition from the community-based services then being predominately provided by several out-patient clinics of Saint Elizabeths Hospital.

In the data analysis section of this report we used available data to identify the differences and similarities between the DC CSA and the private providers, based on the criteria defined in the Dixon Court-Ordered Plan. The results of this analysis will be used by DMH in its evaluation of the options and alternatives for the future operations of the DC CSA.

## 4.1 SAFETY NET CONSIDERATIONS

Today, the DC CSA is still viewed by many stakeholders within the public mental health system as the safety net for the delivery of mental health services across the District. During the focus groups, conducted as part of this analysis process, we received a number of comments on the safety net issue. These various perspectives are summarized as follows:

- The DC CSA provides the safety net for services to consumers who are not eligible for Medicaid or other forms of insurance - The perception of a number of stakeholders, mainly DC CSA employees, is that the DC CSA predominantly serves consumers who are not eligible for Medicaid because the private provider network is unwilling to serve them and closes to their enrollment. For additional discussion and analysis, see section 4.2, Access to Care Considerations.
- The DC CSA provides the safety net for services to consumers with the most difficult cases – A number of stakeholders suggested that the private provider community was often unwilling to take on those cases with the most difficult clinical diagnosis. Instead, those cases fall to the DC CSA who therefore deal with those consumers who are most deeply and persistently mentally ill. For additional discussion and analysis, see section 4.3, Clinical Considerations.

- The DC CSA provides the safety net for those consumers who need to be seen in a timely manner – A number of stakeholders noted that the DC CSA acted as the safety net in providing access to care when case circumstances required that a consumer be seen in an immediate timeframe. This was specifically noted with regard to the need to identify a placement under the direction of the Court. For additional discussion and analysis, see section 4.2, Access to Care Considerations.
- The DC CSA provides a safety net when there is not capacity in other segments of the MHRS system – Some stakeholders noted that the DC CSA was available for enrollment regardless of capacity constraints when other providers may be closed to enrollment for various services or groups of consumers. For additional discussion and analysis see section 4.2, Access to Care Considerations and section 4.5, Programmatic Considerations.
- The DC CSA provides a safety net for specialized services – A number of stakeholders noted that the DC CSA provides a set of unique services that are not available from other components of the District's mental health system. Those services most typically noted were pharmacy, ACT services, and multi-cultural services. In addition, some stakeholders mentioned that the mix of services provided through the DC CSA was highly beneficial to a segment of consumers such as geriatric consumers. For additional discussion and analysis, see section 4.5, Programmatic Considerations.
- The DC CSA provides a safety net by virtue of its location at various sites around the District – Easy access to services at various locations around the District was mentioned by some stakeholders as an additional manner in which the DC CSA acted as a safety net. Its multiple locations made access to care more convenient and easy to obtain for consumers. For additional discussion and analysis, see section 4.2, Access to Care Considerations.
- The DC CSA provides a safety net for crisis situations – A number of stakeholders considered the services provided by the DC CSA in both individual cases and public emergency situations to be an additional aspect of the safety net that it provides. For additional discussion and analysis, see section 4.5, Programmatic Considerations.

The various aspects of the safety net provided by the DC CSA that were identified by stakeholders form a core consideration that must be addressed in determining the future operations of the DC CSA. In the remaining sections of this report the extent to which the DC CSA actually provides such safety net capacity, and the opportunities and options available for other approaches to providing a safety net are discussed.

Specifically KPMG, at the request of DMH, collected and analyzed data across the following areas to evaluate the statements and commonly held beliefs listed above as they relate to:

- Access to Care Considerations
- Clinical Considerations
- Programmatic Considerations
- Community/ population served
- Cost Considerations

## 4.2 ACCESS TO CARE CONSIDERATIONS

A number of key factors were considered with respect to access to care, including the following:

- Insurance Coverage per Enrolled Consumers;
- Insurance Coverage per Active Consumers;
- Location of Consumers throughout the District; and
- Timeliness of services.

**Insurance Coverage per Enrolled Consumers**

One of the most common statements heard at all the focus groups, and most notably at DC CSA employee focus groups, was that the DC CSA serves the majority of non-Medicaid consumers in the District. This statement was substantiated with respect to enrollments and active consumers, but not to the extent purported by stakeholders.

The DC CSA enrolled 2,330 consumers in FY 2007 – 55% (1,278) already had Medicaid upon enrollment, 4% (88) were converted to Medicaid within three months, and 41% (964) remained as non-Medicaid consumers. Private providers enrolled 4,822 in FY 2007 – 76% already had Medicaid (3,660), 3% (132) were converted to Medicaid within three months, and the remaining 21% (1,030) remained as non-Medicaid consumers. This data shows a ~20% discrepancy between the enrollment of Medicaid vs. non-Medicaid consumers. It was noted however, that several barriers to serving non-Medicaid consumers exist for private providers that do not exist for the DC CSA - specifically their capped funding streams for non-Medicaid consumers, and unknown yearly funding amounts to allow for proper resource planning. Further analysis into the active consumers (or those with at least one service in the last 12 months) shows less of a discrepancy.

**Insurance Coverage per Active Consumers**

Upon review of data for active consumers (including those enrolled in FY 2007 and prior years still receiving services), only a 10% difference in coverage is shown. Per a rolling monthly average, the DC CSA had 4647 consumers enrolled with at

| | Private | | DC CSA | | Variance |
|---|---|---|---|---|---|
| MCO | 1,348.17 | 19.5% | 635.83 | 13.7% | 5.8% |
| Medicaid | 4,639.83 | 67.0% | 2,917.00 | 62.8% | 4.2% |
| Non-Medicaid | 941.42 | 13.6% | 1,093.83 | 23.5% | -10.0% |
| Total | 6,929.42 | | 4,646.67 | | |

least one service in the past 12 months, of which 77% had Medicaid coverage (either MCO or FFS), and 24% had non-Medicaid coverage. Private providers saw 6,929 consumers based on a rolling monthly average with at least one service in the previous 12 months, with 86% of those consumers eligible for Medicaid, and 14% with non-Medicaid coverage. It should be noted that the consumer counts are not unduplicated in that if a consumer transferred from a CSA to another CSA, they would be counted as served at both CSAs.

The enrollment data is also skewed toward less Medicaid due to private provider closures for non-Medicaid consumers. An example of the status can be seen in DMH suspended referral report which can be found in Appendix 3. This is a result of several reasons, but primarily due to funding sources. The private providers are required to operate in an FFS environment, where the management of utilization of staff is a priority to remain a viable business. This includes keeping current staff utilization as high as possible, while managing multi-threaded funding sources to optimize services to consumers. Many providers remain open to Medicaid consumers at all times because they know that they will be paid for all MHRS services offered, while funding for non-Medicaid consumers is contingent upon DMH funding availability and also DC contracting regulations (e.g., Council approval of contracts over one million dollars). Other funding streams, such as specific evidence-based grants, affect closures to special populations.

**Location of Consumers throughout the District**

Another consideration raised was that the DC CSA serves individuals in different areas of the city. However, the distribution of enrolled consumers across the private providers and the DC CSA does not appear to be significantly different, with only six zip codes having a variance larger than 1% (Detailed data can be found in Appendix 4). This analysis was not able to obtain enough data to determine how far the consumers were traveling for services, due partially to the nature of community-based services.

**Timeliness of services**

Additional access concerns were centered on the ability for private providers and the DC CSA to provide timely services and conduct outreach to connect with consumers that are more difficult. While no data was accessible for the system specifically on "no show" consumers, data was available on the timeliness of services after a consumer was enrolled with a CSA, including how long it took to receive their first service, and if they ever received a service at all. This data provides some insight into the level of outreach a provider is conducting to serve consumers, and how fast a consumer can be seen after enrollment with a provider.

While detailed data can be found in Appendix 5, we noted that the DC CSA served 22%, and private providers served 26% of newly enrolled consumers within 30 days after their enrollment. The DC CSA also saw slightly less percentages of consumers in each of the categories analyzed including: 0-7 days, 8-30 days, 31-60 days, 61-90 days and 91+. Additionally, the DC CSA did not see 14% of consumers enrolled at all, while the private providers did not see 7% percent of enrolled consumers.

| | Days to First Service | | | | | |
|---|---|---|---|---|---|---|
| **Clinical Home** | **0-7** | **8-30** | **31-60** | **61-90** | **91+** | **No service** |
| DC CSA | 10% | 12% | 11% | 10% | 43% | 14% |
| Private Providers | 11% | 15% | 13% | 13% | 41% | 7% |

This data shows that the DC CSA is slightly slower, on average, to serve consumers than the private provider network, and that the DC CSA did not ever serve a significantly higher percentage of the consumers which are enrolled to the DC CSA.

**Based on the data presented above, the DC CSA serves a 10%-20% greater number of non-Medicaid consumers (partially caused by private provider closures due to DMH funding) than the private providers, serves consumers within similar zip codes, and provides first services more slowly and less consistently than private providers. Medicaid insurance related issues, consumer physical addresses, and timeliness/lack of services do not appear to provide access issues for the private provider consumers of the District.**

## 4.3 CLINICAL CONSIDERATIONS

While comprehensive clinical outcome data to evaluate the services rendered by the DC CSA and those rendered by the private providers is not available, the Community Services Reviews (CSRs) provide insights into consumer functioning and clinical outcomes for comparative purposes. Paid claims data also provides a picture of the services that are rendered to the consumers to allow for the outcomes determined through the CSRs. Data was utilized which represented those cases which were selected for CSR review from the years 2004-2008 - 184 adult and 204 child cases for private providers and 102 adult and 66 child cases for the DC CSA. This data is only valid across the consumers sampled, and should not be projected across the entire DC CSA population.

The following clinical indicators were considered:

- Global Assessment of Functioning (GAF) Score (DSM-IV-TR)
- Level of Care Utilized for Services (LOCUS)
- CSR Outcome data

**Global Assessment of Functioning (GAF) Score (DSM-IV-TR)**

The GAF score is defined by the Diagnostics and Statistical Manual of Mental Disorders (DSM) as a standardized measure to determine the level of functioning of a consumer. The higher the GAF score, the higher functioning the consumer is perceived to be. A score of 100 would be a highly functioning individual, while a consumer with a score of five would be very low functioning. The data in Appendix 6 details the level of functioning of the consumer's cases surveyed by the CSRs for the total population of private providers and those surveyed at the DC CSA.

A comparison of adult consumers with a GAF score of greater than or equal to 61 is 28% with private providers, while the DC CSA is 46% (a summation of the percentages of GAF ≥ 71, GAF 61-70, and GAF ≥ 61). Of the surveys conducted, the DC CSA consumers are higher functioning than those of the private providers. This could be interpreted two ways – either the DC CSA's practices lead to consumers with a higher level of functioning, or the DC CSA serves higher functioning consumers. However, both of these conclusions are contrary to the belief that the DC CSA serves consumers that are more difficult. The children's GAF score comparison is very similar between the DC CSA and private providers, with variances less than 5%.

**LOCUS**

The second data set collected from the CSR data is the standardized assessment of Level of Care Utilized for Services (LOCUS) score and the Child and Adolescent Level of Care Utilization System (CALOCUS). The LOCUS and CALOCUS provide a structure for assigning the appropriate level of care, first developed by the American Association of Community Psychiatrists. The system evaluates the consumers across a number of dimensions to establish a standardized level (score of 1-6) of services required to address the needs of the consumer.[2]

Comparison of the private provider network to the DC CSA shows that the DC CSA has 7% less of the selected cases with a LOCUS score of zero or one, which includes prevention and maintenance services. These consumers are considered stable and do not require intensive services. While the occurrence of level 2 or low-intensity cases in the sample are similar in percent of total cases reviewed, the DC CSA cases show a sharp decrease of 11% in the more difficult, less stable consumers requiring high intensity community-based services compared to the private providers.

For the sample size taken, it would appear that the DC CSA's Adult population requires less intensive services when compared to the private providers.

The CALOCUS scores for children are less clearly defined, due to the smaller sample size at the DC CSA. However, given the available data, the private providers serve 4% more level 0 and level 1 consumers, and 8.6% less level 2 and 3 consumers and roughly equal for levels 4-6. The remaining differences are a result of data anomalies present for the private providers such as missing, blank, or not available.

[2] CALOUS, Version 1.5

For the sample size taken, it would appear that the DC CSA's Child and Adolescent population requires more intensive services when compared to the private providers.

**Outcomes**

CSR outcome data was used to compare MHRS private providers to the DC CSA. Outcomes are based on three dimensions: person overall status, overall progress, and practice performance. Appendices 7 and 8 detail the outcomes for Adult and Child cases, respectively.

*Overall status* of the consumer is based on the current state of the consumers functioning. For the cases selected, 16% more of the DC CSA's consumers were rated with a 4-6 or that the reviewer believed their status should be maintained. This could be interpreted in two ways, first being that the DC CSA rehabilitates there consumers better than private providers; or second, that they serve consumers that are more stable and easier to serve.

The *overall progress* of the consumer takes into account the historic goals of the consumer and their treatment plan towards rehabilitation. The DC CSA again has a 10% higher number of cases that were rated in the 4-6 range of maintain for overall progress for the consumer. This data represents that for the sample taken, the DC CSA outperformed the private providers in terms of consumer progress.

*Practice performance* is rated based on the actions of the team serving the consumer, and if the actions allowed for the greatest opportunities for the consumer to be rehabilitated. Again, the DC CSA performed 8% higher on the selected cases to maintain its current practice performance.

The status and practice performance are then combined to a two dimensional rating with the best rating being maintain/maintain; two mid ratings of either maintain/improve, or improve/maintain, and a final rating of improve/improve. The comparison of the review outcomes introduces another aspect to the analysis, comparing both the practices of the provider against the status of the consumer. The most straightforward comparison is between the review outcome 1 (most desirable), and status 4 (least desirable). For these two categories, the DC CSA performs better than the providers on both accounts (more status 1, and less status 4).

*Outcomes* 2 and 3 are less clearly defined. Outcome 2 would represent a lower status person receiving services from a high performing practice, which the DC CSA has 3% less, while status 3 is a high status person served by a low performance practice, for which the DC CSA have a greater amount. One possible interpretation of this data is that the DC CSA serves consumers which are already in a maintain status, or are easier to serve, while the private providers are serving the more difficult consumers with good practices, but the consumers have not reached a stable status.

**Based on the data presented above, the DC CSA's adult consumers are not clinically lower functioning, nor do they require higher levels of care than private providers.**

**The DC CSA is able to obtain better outcomes for those consumers served. Although the data is limited, there does not appear to be significant variation in children's services scores, but more attention should be focused on the children's services because the children served by the DC CSA appear to be slightly lower functioning than those served by private providers.**

## 4.4 PROGRAMMATIC CONSIDERATIONS

### Number of Consumers Served

The DC CSA serves a significant percentage of the consumers in the District of Columbia, however; their claims paid generation based on those services rendered do not appear to be as high as reported in their practice management system. The DC CSA serves ~2,000 consumers each month, while the private providers serve ~5,000 consumers a month. A rolling monthly average of active consumers for the previous year shows that the DC CSA serves ~4,600 consumers and the private providers serve ~7,000 consumers (See insurance coverage in Appendix 2). On average, the DC CSA rendered at least one service a month to ~2,000 consumers, with the private providers rendering services to ~5,000 consumers per month, a ratio of 4/10. A view of active consumers over the past 12 months shows that the DC CSA served ~4600 consumers compared to the private providers ~7,000, or a ratio of 6.6/10. This data shows that the DC CSA serves fewer consumers on a monthly basis than private providers, potentially a result of either the consumer's lack of clinical need, consistent with the adults GAF and LOCUS scores, or that the private provider's practices result in additional contacts per month. This may have transitional impact and should be factored into consideration in the net difference in cost between provision of services by the DC CSA versus the private provider network.

### Service Breakdown

Private providers were paid ~$34.0 million in claims; while the DC CSA would have only been paid ~$6.3, million. Appendix 10 details ~$10 million in services that were recorded in Anasazi, but for some reason did not post to bill or were denied by DMH. Given this discrepancy, it is difficult to directly compare the breakdown of services, but several data points did stand out. The DC CSA submits significantly higher percentages of claims for Medication/Somatic (Med/Som) services, Assertive Community Treatment (ACT), and Counseling than the private provider network. The ACT services provided by the DC CSA alone represent 56% of all ACT services paid by eCura; development of ACT capacity represents a challenge for DMH moving forward. Other than these services, and community support, the make-up for variances, the remainder of MHRS services rendered do not vary greatly from the private provider network.

The claims values/service make-up from eCura for FY 2007 is as follows:

| | Private Providers | | DC CSA | | |
|---|---|---|---|---|---|
| Service | FY2007 $ Value | Service Mix | FY2007 $ Value | Service Mix | Percent of System by $ |
| CBI MST DMH21 | $804,195.00 | 2.36% | | 0.00% | 0.00% |
| CJS DMH22 | $92,587.50 | 0.27% | | 0.00% | 0.00% |
| Crisis Stabilization | $236,756.00 | 0.70% | | 0.00% | 0.00% |
| H - ACT - H0039 | $1,469,608.08 | 4.32% | $1,876,096.14 | 29.65% | 56.07% |
| H - CBI - H2022 | $2,133,104.21 | 6.27% | $52,392.12 | 0.83% | 2.40% |
| H - Comm Supp Group – H0036HQ | $80.40 | 0.00% | | 0.00% | 0.00% |
| H - Comm Supp Indiv - H0036 | $25,658,566.76 | 75.37% | $2,575,279.95 | 40.70% | 9.12% |
| H - Counseling Onsite Indiv - H0004 | $941,799.44 | 2.77% | $470,026.21 | 7.43% | 33.29% |
| H - Day Services - H0025 | $500,469.89 | 1.47% | $59,210.93 | 0.94% | 10.58% |
| H - Med Som Tx Indiv - T1502 | $1,407,115.37 | 4.13% | $1,287,307.80 | 20.34% | 47.78% |
| H-Diagnostic /assessment | $258,498.00 | 0.76% | $240.00 | 0.00% | 0.09% |
| H - Crisis/Emerg - H2011 | | | $7,150.41 | 0.11% | 100.00% |
| Options Jail Diversion Services | $456,720.00 | 1.34% | | 0.00% | 0.00% |
| Grand Total | $34,041,768.65 | | $6,327,703.56 | | |

The explanation for as to why the DC CSA provides the Med/Som and counseling services has not been quantitatively detailed, but is believed to be related to cost of employing and rendering the services. These services require more expensive and credentialed staff than staff delivering community support (the highest utilized service by private providers). For ACT services , DMH is currently in the process of increasing the associated rates, as it has been evidenced that ACT is under funded compared to its costs as well as proposing rate increases for counseling, CBI and Med/Som services.

**Unique Services**

Pharmacy - The DC CSA operates a pharmacy for all non-Medicaid insured MHRS consumers of DMH, serving 4,224 consumers in 2007. The most frequently prescribed drugs are Zyprexa, Risperdal, Abilify, Geodon, Klonopin, Depakote, Metformin, and Prozac. This service is not currently replicated by any private provider and was transferred to the DC CSA as part of the separation from St. Elizabeths Hospital. As St. Elizabeths was a Federal Institution, they were able to use Department of Defense wholesale rates to purchase pharmaceuticals. This agreement remains in effect today at a great savings to the District. Due to this sizable discount on the purchase of over

~$3 million in pharmaceuticals, it would be difficult to create a cost-effective solution in the private provider network.

The Multicultural Services Division (MSD) – The DC CSA has taken a leadership role in the development and rendering of multi-lingual and multi-ethnic mental health services for the District's Limited English and No English Populations (LEP/NEP). These efforts are inline with required legal and regulatory compliance aspects of both federal and DC law requiring access to federally funded programs for all persons. In addition, a DC CSA employee has been functioning as DMH's Language Access Coordinator since required by the DC Language Access Act of 2004. A number of stakeholders also noted that private organizations would refer consumers to the MSD if they were not able serve the consumer due to a language barrier.

Psycho-educational (PsychoEd) services – The Psycho-Educational team provides mental health services to children and youth enrolled (up to 120) in the District of Columbia Public Schools (DCPS) Psycho-Educational program. DCPS and DMH work collaboratively to provide a comprehensive education and mental health treatment program, and are not replicated by any private provider.

In addition, the DC CSA self-identified the following services to the District that may have unique attributes that warrant further consideration:

- SURE Program (the only citywide mental health program offering same day assured access to outpatient services).
- 35 K Street Residents' Clinic (the primary outpatient placement for psychiatric residents for the DMH/St. Elizabeths Psychiatric Residency Training Program - an ACGME accredited training program for over 30 psychiatric residents).
- Provision of after hours child psychiatric coverage for the DC courts and DC child and youth serving agencies.
- Emergency Mental Health Response Teams (the only on call city wide mental health response teams - providing significant contributions to Anthrax, Katrina, Unifest, Columbia Heights city declared emergencies).

The DC CSA also performs a number of practice leadership and/or system-wide development activities that are beneficial to not only DMH, but also the private network. DMH will need to consider the manner in which such development functions can continue to be facilitated. The following list was complied by DC CSA staff to highlight such areas:

- Mortality Review Process (provided the standard form that was adopted by DMH for agency-wide use for community providers)
- Credentialing Process for Unlicensed Staff (became a model for use by other providers)

- Medicaid Compliance Plan (DMH has borrowed extensively from the plan developed by DC CSA)
- Development / Implementation of Supervision Standards for Psychiatric Residents in Outpatient Settings Consistent with Medicaid Requirements
- Development / Implementation of Psychiatric Encounter/Progress Note (became a model for use by other providers)
- Achievement of designation of 35 K Street / Southeast locations as federally designated underserved areas for purposes of recruitment / retention of providers in hard to fill locations
- Achievement of designation of all DCCSA sites as participants in DC Professional Health Loan Repayment Program
- Development and routine implementation of interventions for mental health consumers during heat emergencies
- Provision of physical health screening clinics for consumers with severe / persistent mental illness (one model for co-location / integration of mental health and primary care services)
- Development and utilization of pharmacy report on "two or more atypicals" to mirror Medicaid variance report
- Development / implementation of inter-agency reimbursement agreement with Medicaid for the provision of Risperdal Consta (a costly atypical antipsychotic medication) to Medicaid recipients
- Development of the requirements for authorization of med/somatic services now used by the Mental Health Authority
- Primary referral resource for DC agencies needing access to mental health outpatient services - DC Family Court and CSOSA
- Identification of the necessary components for the revised rules re FD-12 officer agents
- Development of the guidelines for compliance with language access requirements used by DMH
- Development / Implementation of processes for CSR review preparations and incorporation of CSR principles into clinical practice

**In summary, the DC CSA serves a significant volume of the District's mental health consumers, but does not generate the same potential revenue that the private providers have proven to generate per consumer. The service mix provided by the DC CSA is somewhat different than that provided by private providers, which may be partially based on the reimbursement and/or qualifications required to render**

**those services. The DC CSA also has a number of unique factors and/or programs that DMH may benefit from maintaining. These include the Pharmacy, the Psycho-Ed Program, Multicultural coordination, outpatient competency restoration program and the 35 K Street Residents' Clinic.**

## 4.5 COMMUNITY/POPULATIONS SERVED

The following demographic comparisons between DC CSA consumers and private provider's consumers were made.

**Demographics**

- Age
- Gender
- Ethnicity
- Language spoken

**Age**

To determine the number of consumers served by the DC CSA and their respective age ranges, we first established the ranges of ages to compare. The ranges used are the same as used for a number of other data collection initiatives in DMH and correspond to types of services/providers that would serve the consumers and the payor eligibility that are available to that group (e.g., Medicare for Geriatric, and Medicaid for children). The age groups used consist of children (0-12), teenagers (13-17), Transitional adults (18-22), adults (23-64), and geriatric (65+). A consumer was counted as in an age group if their age was within that range on September 30, 2007, and with at least one claim in FY 2007.

In summary, the data contained in Appendix 11 shows that the DC CSA serves an older population, with 84% of DC CSA consumers over the age of 23 compared to the private providers 66%. This is contradictory to the commonly held belief that the DC CSA served more children because they were able to support the increased salaries demanded by the higher certification requirements to serve children.

**Gender**

The difference in gender distribution between the DC CSA and Private Providers is less than 2% between male, female, and other. Further analysis may be needed around special populations and/or the need for development of specialized programs to address the "other" population; however, this was not within the scope of our analysis. See Appendix 11 for additional detail regarding the gender distribution.

**Ethnicity**

While a significant portion of consumers are unspecified in both the provider network and at the DC CSA, similar trends can be seen across the agencies in Appendix 12. The largest percentage of consumers is identified as Black/African American, and the next two highest percentages are White and Hispanic, respectively, at both private providers and the DC CSA. The DC CSA does have a significantly more developed multicultural component that serves the entire network in a language capacity.

**Language**

Similarly, for language spoken, a significant majority of consumer languages spoken were "unspecified" in eCura making any language analysis difficult. One of the language data points to note is that the DC CSA does serve a majority of the Amharic and sign language consumers and is the sole entity serving Vietnamese-speaking consumers. Detailed language data can be found in Appendix 13.

**In summary, the populations served by the DC CSA do not vary a great deal from those served by private providers based on age, gender, and ethnicity. There do not appear to be any factors present in the data that would show that the DC CSA is serving a different population than the private providers.**

## 4.6 Cost of provision of Services by the DC CSA

While the consumers may not be more difficult by the clinical and demographic definitions, the DC CSA may serve consumers that are more difficult from a business perspective. Due to the administrative burdens associated with the MHRS program ,(e.g., eCura issues, need to pre-authorize services, etc.) a consumer receiving intensive services may have a similar overhead cost to a consumer receiving fewer services. MHRS are required to be pre-authorized, requiring the provider to enter an authorization plan every 90 days, which matches with that consumer's treatment plan. The administrative time to enter this plan is the same whether the consumer requires 1 unit of service or 200. As such, a private provider may not choose to serve a consumer that requires very low frequency services to make up for the administrative burden associated.

Additionally, the District government salary and fringe benefit structure were purported to be higher than the private market for similar positions. The average DC CSA staff's salaries range from $41,653 to $82,556 (not including Nurses, Psychologists, or Doctors) while a major private provider's salary ranges are $32,000 for case managers to $52,000 for supervisors. This creates multiple issues for private providers, one being that they compete for the same limited resources for clinical positions as the DC CSA, but with decreased job security and more stringent utilization requirements.

At a gross level, the DC CSA does not generate enough claims revenue to cover its expenditures. In FY 2007 $6 million in claims were paid versus the $26 million of

expenditures allocated to direct service teams rendering MHRS services (excluding other expenditures discussed later in this section). Upon comparison of active consumers served by the DC CSA (~2,000/month) to the cost to operate the DC CSA MHRS program (~$2MM/month), the DC CSA is incurring $1,029 per consumer, per month. The private providers, on the other hand, cost DMH ~$560 per consumer, per month (~5,000 consumers at $2.8M/month) for services rendered.

The DC CSA claims that a number of issues outside of their control, (e.g., eCura claims processing issues, IT infrastructure, etc.) result in a significant under reporting of revenue generated. To remove this issue from the analysis, KPMG allocated all of the expenditures incurred by the DC CSA to service records entered in Anasazi. This method would give the DC CSA credit for services that did not post to bill in Anasazi, services excepted out of eCura, services that were denied out of eCura, and services that were denied by Medicaid. All categories that a private provider has to rework and resubmit.

The objective of our cost analysis was to determine how much it costs the DC CSA to render a service compared with how much it cost DMH to purchase that same service from private providers. Our cost comparison began with the allocation of DC CSA overhead functions to each service team based on the number of FTE's in those teams. The cost per team was then divided by the number of service hours per team to calculate cost per hour of service rendered.

To compare costs rendered per service, per team, KPMG requested data related to the FY 2007 operations of the DC CSA as follows:

- FY 2007 expenditures data from SOAR
- Schedule A by Team for FY 2007
- Organizational Charts for FY 2008
- Services Rendered in FY 2007, by Team from Anasazi
- FY 2007 Total Revenue per Team
- FY 2007 Consumer Hours per Team

**Cost Allocation Process**

The FY 2007 Schedule A was broken into two main categories – service team staff and administrative staff. The service team staff was further separated by the program/fund code assigned to each individual in the Schedule A and then segregated further based on the organizational charts provided by the DC CSA.

Teams were broken into the two main categories - Adult and Family Services and Child and Youth Family Services.

The FTE's of the teams totaled 207.4. Administrative staff, agency management, Office of the CEO, clinical support, consumer advocacy, intake and continuity of care,

quality improvement and security staff totaled 82 FTE's. For the analysis, only filled positions were allocated (289.4), an additional 31 positions were vacant in FY2007 for a total of 320.4 budgeted positions.

To allocate cost per team, total service FTE's were broken into 23 individual teams based on their designations in the Schedule A and the provided tables of organization. Several of the teams were combined for cost allocation purposes due to FTE's being assigned to both teams and/or changes in naming convention across the documents. The allocations above resulted in a total expenditure per each service team.

**Exclusions from Cost Allocation**

The teams that provided services not provided by private providers were excluded from the cost allocation. Such services include:

- Psycho Ed program ($944,999.36) - as DC CSA is the only provider of those services.
- Pharmacy ($4,953,309.00) - employees and associated expenditures were excluded from calculation per DMH request (As discussed in section 4.5 programmatic considerations).

These exclusions led to a final MHRS value of **$ 25,813,484.52** allocated to Service teams.

**Cost Comparison**

The total expenditures per team were divided by the number of hours for which that team created service records in Anasazi. The total cost per team was divided by the service hours per team to determine the cost of an hour of rendered service.

These rates per hour were then compared to the MHRS FFS rates to obtain the net difference between what it cost the DC CSA team to deliver those services and what it would cost to pay a private provider to deliver those same services.

**Results of the Cost Comparison**

The table below summarizes the difference between the total cost per service per team and cost savings that DMH would receive if paying private provider to render the same set of services. For a detailed table by team see Appendix 14.

| DC CSA Team | Allocated Cost | Service Hours Recordeed | Net Difference DC CSA vs FFS |
|---|---|---|---|
| **ALL TEAM TOTAL** | **$ 25,956,481.93** | **120759.29** | **$ (14,772,443.38)** |

The above calculation assumes that the private providers will render the same services as present in Anasazi (~$10.5MM) to the average of 2,000 consumers per month resulting in a rate of $437 per consumer per month. It should be noted that this is significantly less than the consumers currently being served by private provider's average of $560 dollars per month. The reasoning behind the difference may be

driven by the consumer's clinical needs or by provider practices, but either way, DMH should consider the possibility that these 2,000 monthly consumers may be rendered services at rates between the $440 and $560 reducing the possible savings to $11.3 million dollars or further. The potential implications of these private provider practices could be mitigated by decreasing the unmanaged care limits currently in place as DMH is currently exploring. Additionally, the impending Public Mental Health System (PMHS) redesign that DMH is undertaking as part of this process, may also have an unknown affect on the estimated savings and/or penetration rates calculated in this section.

**In summary, the DC CSA is generating FFS revenue of less than half per consumer per month as private providers. If DMH were to purchase the same set of services as recorded (but not necessarily billed) in Anasazi by the DC CSA, DMH would pay out approximately $10.5 million dollars, a savings of approximately $14.2 million by providing those same services at the DC CSA. If private providers were to render the same level of services to the DC CSA population as they are rendering to their current consumers, the savings to DMH may decrease to approximately $11 million based on current claims per consumer, per month.**

# 5.0 OBSERVATIONS, RECOMMENDATIONS AND FUTURE ACTIONS

## 5.1 OBSERVATIONS

Based on information received through the focus groups and data collected from DMH, DC CSA and other private provider sources, the following are observations regarding the provision of services currently provided by the DC CSA that are relevant for consideration of future alternatives:

- **The consumer population served by the DC CSA is similar to the consumer population served by the private provider network** – The DC CSA serves consumers who essentially mirror the overall mental health system - demographically and clinically they are not appreciably different from those served by the private provider network. A number of stakeholders stated their belief that the DC CSA served clients who were more severely and persistently mentally ill. Comparison of data extracted from the CSR process performed by DMH over the past five years indicates that this is not the case. For adults, both GAF and LOCUS scores indicate that the DC CSA consumers are higher functioning and, if anything, require less intensive services. Although the children's data is very limited, there does not appear to be significant variation, but more attention should be focused on the children's services because the children served by the DC CSA appear to be slightly lower functioning that those served by private providers.

  From a demographic perspective, the populations served by the DC CSA do not vary a great deal from those served by private providers based on age, gender, ethnicity and language spoken. There do not appear to be any factors present in the data that would show that the DC CSA is serving a different population than the private providers.

- **The mix of services delivered by the DC CSA is similar to the mix of services delivered by the private provider network** – A review of services delivered based on data from eCura and Anasazi shows that the overall breakdown of services at the DC CSA is less focused on community support than private providers. The largest differences are in ACT services, counseling, and med/Som services that are believed to be a result of a rate deficiency that DMH has begun to address.

- **While the capacity of the provider network is enhanced by the DC CSA, the current fee-for-service payment structure and funding mechanism of the DC CSA were reported to create an impediment to private providers creating additional service capacity -** Due to differences in salary ranges, fringe benefit

structures, as well as increased stresses on utilization, private providers have a difficult time competing with the DC CSA to retain clinicians.

- **The source of funding for DC CSA services is not as predominantly non-Medicaid as presumed by most stakeholders–** The percent of non-Medicaid consumers served is not as disproportionately tilted toward the DC CSA as commonly believed. The payor mix supported by active consumers of the DC CSA is not prohibitively different (10%) from that supported by the private provider network.

  Closures of private providers to non-Medicaid enrollment is more an unintended consequence of the contracting processes and task order limitations imposed on private providers than a reflection of the willingness of private providers to serve non-Medicaid clients.

- **The timeliness of service provision by the DC CSA is similar to the timeliness of service provision by the private provider network –** There is not an appreciable difference in the timeliness of service provision between the DC CSA and the private providers.

- **The DC CSA and the private provider network served clients whose location, based on address zip code, and were similarly distributed across the District -** The location of clients served as indicated by the zip code of their address of record is not appreciably different between the DC CSA and the private provider network.

- **The DC CSA tended to deliver more services in an office based setting -** The purported reliance on office-based services by the DC CSA may limit the District-wide reach of some of their service delivery efforts.

- **The DC CSA provides a set of service that is unique when compared to those delivered through the private provider network –** There are a number of unique services that are delivered by the DC CSA. These include:

  - Pharmacy
  - ACT to the extent that they are the predominant act provider
  - Multi-cultural services
  - Psycho-education in school based settings
  - Outpatient Competency Restoration
  - Residents Clinic

- **The current DC CSA funding model has a negative impact on the functioning of the overall provider network** – by operating on a non-level funding mechanism than the rest of the MHRS providers, the DC CSA is currently able to impact the professional labor pool available to private

providers by retaining staff at a higher rate, paying staff higher salaries, and providing a larger benefit package. On a general level, the DC CSA funding model impacts the private provider community by decreasing the overall funds available for local reimbursements.

- **Services are being delivered by the DC CSA at significantly greater cost to the District –** There is a significant premium being paid for delivering services through a public provider – the same services delivered in FY 2007 by the DC CSA could be purchased through current fee-for-service arrangements with the private network for approximately $11-$14 million less.

## 5.2 RECOMMENDATIONS

Based on the observations noted above, the following are recommendations regarding the future operation of the DC CSA:

- **Continue direct government provision of a limited number of specialized services currently provided by the DC CSA –** Specialized services, which are provided only by the DC CSA, should be maintained as direct government provided services. These include:
    - **The Pharmacy operated by the DC CSA** - Stakeholders across all groups identified the DC CSA Pharmacy as an importance service for which there is no equivalent structure in the private provider network. In fact, it provides an important support to both private provider consumers without Medicaid or other insurance as well as DC CSA consumers. In addition, the Department of Defense (DOD) contractual mechanism through which the DC CSA acquires drugs and medications is not available to any other entity other than a governmental entity. As a result, the DC CSA Pharmacy provides an importance service to District mental health consumers that should be maintained
    - **The Outpatient Competency Restoration Program** - Assists the court to determine whether a defendant is competent to stand trial. The program's work is aimed at assisting defendants in understanding the legal process, their role in that process and their ability to function in it.
    - **The Psycho-Ed Program –** A unique program that is not replicated in the private provider network. While potentially available to be contracted out in the future, the program compliments current school-based programs carried out by DMH and should be maintained.
    - **Residency Outpatient Program** - The primary outpatient placement for psychiatric residents for the DMH/St. Elizabeths Psychiatric Residency Training Program - an ACGME accredited training program for over 30 third year psychiatric residents.

These programs should be linked to, and incorporate into a new direct services entity under the direction of the DMH Authority that could also include current Authority functions/programs such as CPEP and school based services.

In addition, the following should be considered for inclusion in specific requirements that must be fulfilled by the provider network:

- Capacity to provide walk-in unscheduled visits similar to the SURE Program.
- Provision of after hours child psychiatric coverage for the DC courts and DC child and youth serving agencies.
- Emergency Mental Health Response Teams – which DMH has already contracted for with the mobile crisis services for youth and adults.

- **Discontinue the delivery of the remainder of direct services by the DC CSA by transferring consumers receiving services otherwise provided by the private provider network on a phased basis to that network –** DC CSA consumers currently receiving the following services should be transitioned to the private provider network under the prevailing fee-for-service schedule. This includes the following:
  - Adult Services
    - Assertive Community Treatment
    - Rehabilitation Day Services
    - Housing
    - Supportive Employment
    - Community Support
  - Child and Youth Services
    - Intake
    - Community Support
    - Community-based Intervention
- **Broaden the provision of multicultural services across the private provider network –** Multicultural services represents a set of services otherwise delivered by the private provider network to a unique set of consumers. Such services delivered by the DC CSA should be transitioned to private providers based on the common service set. DMH will also need to establish a stronger language co-ordination component exercised within the Authority component of DMH.

- **Develop increased capacity to deliver ACT services to adults** – Given that the DC CSA provides the majority of adult ACT services, there is a need to focus on building more capacity to deliver ACT services to replace the DC CSA as the predominant provider. A first step in creating such capacity is the proposed adjustment of the ACT rate to allow a more appropriate business model to be put into place. In addition, start-up and administrative costs associated with establishing a growing ACT capacity need to be recognized with available seed or start-up grants.
- **Utilize resources that become available from the DC CSA transition to fund the mental health system redesign -** Significant resources will become available to be reallocated to the initial transition and then the strengthening of the overall public mental health system.
- **Implement a detailed transition plan** - A transition plan should be developed for the movement of consumers, by team on a staggered or staged basis, to new clinical homes. The transition should be staged in accordance with plans to implement any redesign of the public mental health system. More details on next steps are available in section 5.3.
- **Establish enhanced accountability mechanisms (also see section 5.3) -** Mechanisms to sustain and increase private provider accountability and monitoring should be put into place. Most notably this should include mechanisms to perform fidelity reviews on a regular basis.
- **Establish contractual mechanisms and obligations to solidify the public mental health safety net** – These requirements should be incorporated into provider agreements related to acceptance of consumers and availability of services. This should included:
    - Compliance with DMH requirements for hours of operation, including evenings, holidays and weekends;
    - A provision prohibiting discrimination on the basis of health insurance coverage; and
    - Offering same day services or urgent care.

## 5.3 FUTURE ACTIONS

This section identifies key steps to be taken should DMH choose to implement the recommendations contained in this report. Key steps have been categorized into the following areas:

- Implementation Management;
- Consumer Management; and

- Organizational Change.

Detailed actions in each of these categories are presented below:

**Implementation Management –** DMH should take the following steps to manage the implementation of recommendations proactively. These actions would utilize the plan/act model that DMH has successfully utilized for other major organizational initiatives. Specific implementation management actions include:

- Create a structure to manage the DC CSA change headed by an individual charged with the overall responsibility for its execution.
- Develop a detailed work plan and milestones that would be used to stage individual work tasks and frequently assess and report progress.
- Develop subsidiary plans including, but not limited to:
    - A Communications Plan;
    - An Organizational Change Management Plan;
    - A Risk Management Plan; and,
    - A Financial Plan.
- Develop and document processes and protocols for implementing the detailed work plan and the subsidiary plans.
- Develop key performance indicators to be assessed as the change process progresses.

**Consumer and Service Change Management –** Steps in this category are designed to allow for the creation of new entities to continue to provide services unique to the DC CSA, to provide clinically appropriate management of the transition, and to affect the transfer of consumers from the DC CSA to the private provider network. Specific actions include:

- Transfer key administrative units that support DC CSA unique services to the Authority, potentially creating a new organizational umbrella for such services within the Authority structure.
- Assess the caseloads of individual DC CSA teams.
- Establish transfer priorities and establish the order in which cases will be transferred and teams will be dissolved.
- Establish and document transfer protocols and reporting, including processes for consumer choice, enrollment, and entering of appropriate authorizations.
- Initiate transfer protocols and feedback reporting.

**Organizational Change –** Organizational change includes personnel actions, legal requirements, infrastructure changes and development of accountability mechanisms as follows:

*Personnel*

- Develop plans for personnel incentives and buyouts, as needed.
- Develop specific downsizing staff plans (keyed to consumer transfer plans).
- Consult with union organizations when and as needed.
- Create job opportunity mechanisms in conjunction with private providers and union organizations to be used by current employees, including:
    - Linkages to private provider employment opportunities;
    - Job fairs/job posting bulletin boards/resume banks; and,
    - Creation and implementation of severance and buyout packages.

*Legal*

- Identify full range of legal requirements to be met during the change process, potentially including:
    - Notifying Union of any proposed RIF.
    - Allowing Union reasonable opportunity to present alternatives.
    - Bargaining regarding impact and effect.
    - Providing Union with a copy of relevant Administrative Order.
    - Providing Union list of individuals eligible for regular retirement and discontinued service retirement.
    - Providing a copy of Standard Form 52 for unnamed incumbent for each position to be RIFed.
    - Providing 30-day notice to employee.
    - Utilizing Agency Reemployment Program.
    - Establishing Displaced Employee Program.
    - Estimating fully allocated cost prior to issuing a solicitation for any services being privatized.
    - Implementing displaced employee right of first refusal, as appropriate.
    - Prepare and submit a determination and finding regarding use of government employees, savings of at least 5%, etc as per DC Code 2-301.05b(c).

*Financial*

- Budget Impact:
    - New/transferred positions and/or functions; and,
    - Costs avoided/eliminated.
- Budget Changes

*Infrastructure*

- Develop facility down-sizing plan based on status of property (rental, owned)
- Develop an equipment downsizing plan.

*Accountability*

- Implement a focused clinical oversight and treatment monitoring structure for transferred consumers.
- Assess care limits to be authorized to private provider community.
- Implement utilization review mechanisms.

# APPENDICES

1 Insurance at Enrollment and Conversions to Medicaid
2 Active Insurance Breakdown
3 Snapshot of Private Provider Referral Status
4 Breakdown of Consumer Zip Codes
5 Days to First Service
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## Appendix 1 - Insurance at Enrollment and Conversions to Medicaid

| Clinical Home | Total Enrolled | Medicaid at Enroll | | Local Only | | Convert to Med | |
|---|---|---|---|---|---|---|---|
| DC CSA | 2,330 | 1,278 | 55% | 964 | 41% | 88 | 4% |
| | | | | | | | |
| Private Provider Average | 4,822 | 3,660 | 76% | 1030 | 21% | 132 | 3% |
| | | | | | | | |
| Affordable Behavior Consultant, ABC | 2 | 1 | 50% | 1 | 50% | | 0% |
| Anchor Mental Health Association, Inc | 105 | 59 | 56% | 41 | 39% | 5 | 5% |
| Center for Multicultural Human Services | 47 | 23 | 49% | 21 | 45% | 3 | 6% |
| Center for Therapeutic Concepts CTC | 47 | 46 | 98% | 1 | 2% | | 0% |
| Coates & Lane Enterprises Inc | 1 | 1 | 100% | | 0% | | 0% |
| Community Connections, Inc. | 840 | 735 | 88% | 89 | 11% | 16 | 2% |
| Community Connections, Specialty Services | 1 | | 0% | 1 | 100% | | 0% |
| Family & Child Services of DC | 2 | 2 | 100% | | 0% | | 0% |
| Family Preservation CSA | 166 | 115 | 69% | 41 | 25% | 10 | 6% |
| Fihankra Place | 112 | 94 | 84% | 18 | 16% | | 0% |
| First Home Care Corporation | 341 | 316 | 93% | 23 | 7% | 2 | 1% |
| First Home Care, Specialty Services | 2 | 1 | 50% | 1 | 50% | | 0% |
| Greater South East Hospital | 1 | 1 | 100% | | 0% | | 0% |
| Greater Washington Urban League | 59 | 27 | 46% | 29 | 49% | 3 | 5% |
| Green Door | 541 | 362 | 67% | 150 | 28% | 29 | 5% |
| Hillcrest Children's Center | 54 | 40 | 74% | 14 | 26% | | 0% |
| Integrated Behavior SVCS Grp, IBSG | 1 | 1 | 100% | | 0% | | 0% |
| Kidd Inc., Specialty Services | 2 | 1 | 50% | 1 | 50% | | 0% |
| Kidd International Home Care Inc | 157 | 143 | 91% | 13 | 8% | 1 | 1% |
| Latin America Youth Center | 96 | 34 | 35% | 60 | 63% | 2 | 2% |
| Life Stride, Inc | 189 | 174 | 92% | 13 | 7% | 2 | 1% |
| Mary's Center for Maternal and Child Care, Inc. | 83 | 10 | 12% | 73 | 88% | | 0% |
| McClendon Center | 129 | 74 | 57% | 49 | 38% | 6 | 5% |
| MD/DC Family Resources | 100 | 95 | 95% | 3 | 3% | 2 | 2% |
| Neighbor's Consejo | 43 | 5 | 12% | 38 | 88% | | 0% |
| Pathways to Housing D.C., Specialty Services | 75 | 70 | 93% | 5 | 7% | | 0% |
| PIW CSA | 106 | 53 | 50% | 44 | 42% | 9 | 8% |
| Planned Parenthood of Metro DC | 42 | 39 | 93% | 3 | 7% | | 0% |
| PSI Services III, INC | 73 | 69 | 95% | 2 | 3% | 2 | 3% |
| Psych Cntr Chartrd, Specialty Services | 1 | | 0% | 1 | 100% | | 0% |
| Psychiatric Center Chartered | 35 | 19 | 54% | 14 | 40% | 2 | 6% |
| Psychotherapeutic Outreach Services | 17 | 12 | 71% | 5 | 29% | | 0% |
| Psychotherapeutic Outreach, Specialty Services | 1 | 1 | 100% | | 0% | | 0% |
| RCI _DC Counseling Center | 2 | 2 | 100% | | 0% | | 0% |
| Scruples Corporation | 399 | 340 | 85% | 46 | 12% | 13 | 3% |
| Unity Health Care, Inc. | 117 | 73 | 62% | 34 | 29% | 10 | 9% |
| Universal HealthCare Management Services, Inc | 476 | 387 | 81% | 80 | 17% | 9 | 2% |
| Volunteers of America | 12 | 3 | 25% | 8 | 67% | 1 | 8% |
| Washington Hospital Center | 344 | 232 | 67% | 107 | 31% | 5 | 1% |
| Woodley House, Inc. | 1 | | 0% | 1 | 100% | | 0% |

Source: eCura
Date: 7/25/2008

# Appendix 2 - Active Insurance Breakdown

**Summary**

| | Private | | DC CSA | | Variance |
|---|---|---|---|---|---|
| **MCO** | 1,348.17 | 19.5% | 635.83 | 13.7% | 5.8% |
| **Medicaid** | 4,639.83 | 67.0% | 2,917.00 | 62.8% | 4.2% |
| **Non-Medicaid** | 941.42 | 13.6% | 1,093.83 | 23.5% | -10.0% |
| **Total** | 6,929.42 | | 4,646.67 | | |

**Monthly**

| **Number of Consumers** | | **Month** | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Insurance** | **39,727.00** | | **39,758.00** | | **39,052.00** | | **1/2007** | | **2/2007** | | **3/2007** | | **4/2007** | | **5/2007** | | **6/2007** | | **7/2007** | | **8/2007** | | **9/2007** | |
| | | | | | | | | | | | | | | | | | | | | | | | | | |
| **DC CSA** | **MCO** | 636.00 | 13% | 637.00 | 14% | 641.00 | 14% | 650.00 | 14% | 640.00 | 14% | 636.00 | 14% | 633.00 | 14% | 631.00 | 14% | 653.00 | 14% | 624.00 | 14% | 624.00 | 14% | 625.00 | 14% |
| | **Medicaid** | 3,010.00 | 63% | 2,950.00 | 63% | 2,936.00 | 63% | 2,955.00 | 63% | 2,966.00 | 63% | 2,911.00 | 63% | 2,905.00 | 63% | 2,891.00 | 63% | 2,939.00 | 63% | 2,871.00 | 63% | 2,838.00 | 62% | 2,832.00 | 62% |
| | **Non-Medicaid** | 1,134.00 | 24% | 1,089.00 | 23% | 1,091.00 | 23% | 1,090.00 | 23% | 1,100.00 | 23% | 1,071.00 | 23% | 1,061.00 | 23% | 1,046.00 | 23% | 1,088.00 | 23% | 1,091.00 | 24% | 1,124.00 | 25% | 1,141.00 | 25% |
| **DC CSA Total** | | **4,780.00** | | **4,676.00** | | **4,668.00** | | **4,695.00** | | **4,706.00** | | **4,618.00** | | **4,599.00** | | **4,568.00** | | **4,680.00** | | **4,586.00** | | **4,586.00** | | **4,598.00** | |
| | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Private** | **MCO** | 1,158.00 | 18% | 1,179.00 | 18% | 1,206.00 | 19% | 1,219.00 | 19% | 1,264.00 | 19% | 1,301.00 | 19% | 1,336.00 | 19% | 1,369.00 | 20% | 1,460.00 | 20% | 1,513.00 | 20% | 1,574.00 | 21% | 1,599.00 | 21% |
| | **Medicaid** | 4,349.00 | 68% | 4,429.00 | 68% | 4,402.00 | 68% | 4,441.00 | 68% | 4,510.00 | 68% | 4,602.00 | 68% | 4,619.00 | 67% | 4,707.00 | 67% | 4,796.00 | 67% | 4,888.00 | 66% | 4,933.00 | 65% | 5,002.00 | 65% |
| | **Non-Medicaid** | 926.00 | 14% | 916.00 | 14% | 906.00 | 14% | 883.00 | 13% | 886.00 | 13% | 890.00 | 13% | 904.00 | 13% | 914.00 | 13% | 920.00 | 13% | 1,000.00 | 14% | 1,053.00 | 14% | 1,099.00 | 14% |
| **Private Total** | | **6,433.00** | | **6,524.00** | | **6,514.00** | | **6,543.00** | | **6,660.00** | | **6,793.00** | | **6,859.00** | | **6,990.00** | | **7,176.00** | | **7,401.00** | | **7,560.00** | | **7,700.00** | |

Source: eCura
Date: 7/25/2008

# Appendix 3 - Snapshot of Private Provider Referral Status

| MHRS Provider | Open | Closed | Closed Date | Re-open Date | Exceptions | Special Pops | Over T/O | By DMH |
|---|---|---|---|---|---|---|---|---|
| **CHILDREN'S PROVIDERS** | | | | | | | | |
| Affordable Behavioral Consultants | Open | | | | | | | |
| Center for Student Support Services | Open | | | | | | | |
| Center for Therapeutic Concepts | Open | | | | | | | |
| Community Connections, Inc. | | Closed | 10/15/2007 | 10/22/2009 | Medicaid Only | | | |
| Family Preservation Services | | | | | Open for Medicaid Only! | | | |
| DC Community Services Agency | Open | | | | | | | |
| Fihankra Place, Inc | Open | | | | | | | |
| First Home Care | Open | | | | | | | |
| Hillcrest Children's Center | Open | | | | | | | |
| Institute for Behavioral Change | | | | | | | | |
| Johmab | | | | | | | | |
| Kidd International Home Care, Inc | Open | | | | | | | |
| Latin American Youth Center | Open | | | | Medicaid Only | | No-Non-Medicaid | |
| Mary's Center | | | | | | | | |
| MD/DC Family Resources | | Closed | 4/23/2007 | 12/1/2007 | | | | |
| Planned Parenthood | | Closed | | | Medicaid Only | | No Non-Medicaid | |
| PSI | Open | | | | | | | |
| Psychiatric Institue of Washington | | | | | | | | |
| Progressive Life | | | | | | | | |
| Riverside Hospital | | Closed | | | | | | |
| Scruples Corporation | | Closed | | 2/1/2008 | Medicaid Only | | | |
| Universal Healthcare Management | open | | | | | | | |
| | | | | | | | | |
| **ADULT PROVIDERS** | | | | | | | | |
| Anchor Mental Health | Open | | | | All | | | |
| Community Connections | | Closed | | 0401/08 | CLOSED_ women | c0-occuring women;women with H/O trauma | | |
| D.C. Community Services Agency | Open | | | | Specialty Services | | | |
| Family Preservation | | | | | Open for Medicaid only!!!! | | | |
| Gateway Services Management | | | | | | | | |
| Greater Washington Urban League | | | | | | Adults 55 years and older | | |
| Green Door | Open | | | | none | | | |
| Life Stride | | Closed | | | Coates/Lane | | | |
| Mary's Center | Open | | | | | | | |
| McClendon Center | Open | | | 1/16/2008 | | | | |
| Neighbors Conseijo | Open | | | | | Spanish speaking | | |
| Planned Parenthood | Closed | Closed | | | Medicaid Only | | No Non-Medicaid | |
| Psychiatric Center Chartered | | Closed | | 2/11/2008 | All | **MRDDA** | | |
| Psychiatric Institute of Washington | Open | | | | | | | |
| Psychotherapeutic Outreach Svc | | Closed | | | | | | |
| Saga (Sub Provider) | Not active | | | | | | | |
| Scruples | | Closed | 10/16/2007 | | Medicaid Only | | | |
| Unity Healthcare | | Closed | | | | | | |
| Universal Healthcare Management | Open | | | | All | | | |
| Volunteers of America, Chesapeake | Open | | | | | | | |
| Washington Hospital Center | Open | | | | All | | | |
| Woodley House Inc. | Closed | Closed | | | All | | | |

Source: DMH Care Coordination

Date: 1/2008

# Appendix 4 - Breakdown of Consumer Zip Codes

| Zip Code | Private | | DC CSA | | Variance |
|---|---|---|---|---|---|
| **20024** | 1,578 | 12.94% | 599 | 5.45% | **7.49%** |
| **20002** | 1,622 | 13.30% | 1,839 | 16.73% | **-3.43%** |
| **20001** | 982 | 8.05% | 1,178 | 10.72% | **-2.67%** |
| **20019** | 1,683 | 13.80% | 1,278 | 11.63% | **2.17%** |
| **20011** | 868 | 7.12% | 934 | 8.50% | **-1.38%** |
| **20009** | 492 | 4.03% | 593 | 5.40% | **-1.36%** |
| **20010** | 495 | 4.06% | 554 | 5.04% | **-0.98%** |
| **20017** | 323 | 2.65% | 215 | 1.96% | **0.69%** |
| **20012** | 106 | 0.87% | 125 | 1.14% | **-0.27%** |
| **20020** | 1,488 | 12.20% | 1,316 | 11.97% | **0.23%** |
| **20032** | 1,405 | 11.52% | 1,288 | 11.72% | **-0.20%** |
| **20003** | 416 | 3.41% | 356 | 3.24% | **0.17%** |
| **20008** | 50 | 0.41% | 57 | 0.52% | **-0.11%** |
| **20015** | 27 | 0.22% | 36 | 0.33% | **-0.11%** |
| **20037** | 14 | 0.11% | 24 | 0.22% | **-0.10%** |
| **99999** | 12 | 0.10% | 22 | 0.20% | **-0.10%** |
| **20005** | 163 | 1.34% | 137 | 1.25% | **0.09%** |
| **20004** | 10 | 0.08% | 17 | 0.15% | **-0.07%** |
| **20018** | 313 | 2.57% | 290 | 2.64% | **-0.07%** |
| **20007** | 44 | 0.36% | 46 | 0.42% | **-0.06%** |
| **20040** | 8 | 0.07% | 2 | 0.02% | **0.05%** |
| **20036** | 18 | 0.15% | 13 | 0.12% | **0.03%** |
| **20044** | 2 | 0.02% | 0 | 0.00% | **0.02%** |
| **20029** | 3 | 0.02% | 4 | 0.04% | **-0.01%** |
| **20006** | 2 | 0.02% | 3 | 0.03% | **-0.01%** |
| **00000** | 1 | 0.01% | 2 | 0.02% | **-0.01%** |
| **2003** | 0 | 0.00% | 1 | 0.01% | **-0.01%** |
| **20039** | 0 | 0.00% | 1 | 0.01% | **-0.01%** |
| **20057** | 0 | 0.00% | 1 | 0.01% | **-0.01%** |
| **20064** | 0 | 0.00% | 1 | 0.01% | **-0.01%** |
| **20202** | 0 | 0.00% | 1 | 0.01% | **-0.01%** |
| **20210** | 0 | 0.00% | 1 | 0.01% | **-0.01%** |
| **20336** | 0 | 0.00% | 1 | 0.01% | **-0.01%** |
| **20447** | 0 | 0.00% | 1 | 0.01% | **-0.01%** |
| **2001** | 1 | 0.01% | 0 | 0.00% | **0.01%** |
| **02003** | 1 | 0.01% | 0 | 0.00% | **0.01%** |
| **20000** | 1 | 0.01% | 0 | 0.00% | **0.01%** |
| **20041** | 1 | 0.01% | 0 | 0.00% | **0.01%** |
| **20045** | 1 | 0.01% | 0 | 0.00% | **0.01%** |
| **20099** | 1 | 0.01% | 0 | 0.00% | **0.01%** |
| **20515** | 1 | 0.01% | 0 | 0.00% | **0.01%** |
| **20721** | 1 | 0.01% | 0 | 0.00% | **0.01%** |
| **20743** | 1 | 0.01% | 0 | 0.00% | **0.01%** |
| **20904** | 1 | 0.01% | 0 | 0.00% | **0.01%** |
| **20013** | 9 | 0.07% | 9 | 0.08% | **-0.01%** |
| **20035** | 2 | 0.02% | 1 | 0.01% | **0.01%** |
| **20016** | 38 | 0.31% | 35 | 0.32% | **-0.01%** |
| **00002** | 3 | 0.02% | 2 | 0.02% | **0.01%** |
| **20030** | 3 | 0.02% | 2 | 0.02% | **0.01%** |
| **20090** | 3 | 0.02% | 3 | 0.03% | **0.00%** |
| **20043** | 2 | 0.02% | 2 | 0.02% | **0.00%** |
| **20026** | 1 | 0.01% | 1 | 0.01% | **0.00%** |
| **Total** | 12,196 | | 10,991 | | |

Source: eCura
Date: 7/25/2008

Appendix 5 - Days to First Service

| | Days to First Service | | | | | |
|---|---|---|---|---|---|---|
| **Clinical Home** | **0-7** | **30-60** | **61-90** | **8-30** | **90+** | **none** |
| DC CSA Averages | 10% | 11% | 10% | 12% | 43% | 14% |
| | | | | | | |
| All Private Provider Averages | 11% | 13% | 13% | 15% | 41% | 7% |
| Detail: | | | | | | |
| Affordable Behavior Consultant, ABC | 0% | 0% | 0% | 0% | 0% | 100% |
| Anchor Mental Health Association, Inc | 10% | 8% | 12% | 16% | 51% | 2% |
| Center for Multicultural Human Services | 34% | 19% | 6% | 25% | 9% | 6% |
| Center for Therapeutic Concepts CTC | 2% | 9% | 11% | 5% | 68% | 5% |
| Coates & Lane Enterprises Inc | 0% | 0% | 100% | 0% | 0% | 0% |
| Community Connections, Inc. | 10% | 15% | 14% | 19% | 40% | 1% |
| Community Connections, Specialty Services | 0% | 0% | 0% | 0% | 0% | 100% |
| Comp. Psych. Emerg. Prog. | 21% | 4% | 0% | 4% | 71% | 0% |
| Family & Child Services of DC | 0% | 0% | 50% | 0% | 50% | 0% |
| Family Preservation CSA | 6% | 17% | 16% | 23% | 29% | 8% |
| Fihankra Place | 1% | 19% | 9% | 17% | 36% | 18% |
| First Home Care Corporation | 5% | 16% | 12% | 12% | 49% | 6% |
| First Home Care, Specialty Services | 0% | 0% | 0% | 0% | 50% | 50% |
| Greater South East Hospital | 0% | 0% | 0% | 0% | 100% | 0% |
| Greater Washington Urban League | 0% | 8% | 22% | 5% | 62% | 3% |
| Green Door | 9% | 11% | 9% | 13% | 47% | 10% |
| Hillcrest Children's Center | 5% | 10% | 5% | 5% | 45% | 30% |
| Kidd Inc., Specialty Services | 0% | 0% | 0% | 0% | 100% | 0% |
| Kidd International Home Care Inc | 4% | 11% | 17% | 8% | 50% | 9% |
| Latin America Youth Center | 22% | 14% | 10% | 18% | 32% | 5% |
| Life Stride, Inc | 1% | 15% | 21% | 7% | 39% | 18% |
| Mary's Center for Maternal and Child Care, Inc. | 27% | 21% | 10% | 21% | 17% | 3% |
| McClendon Center | 15% | 15% | 25% | 24% | 15% | 6% |
| MD/DC Family Resources | 2% | 9% | 15% | 9% | 59% | 6% |
| Neighbor's Consejo | 3% | 14% | 39% | 19% | 25% | 0% |
| Pathways to Housing D.C., Specialty Services | 4% | 3% | 3% | 0% | 89% | 3% |
| PIW CSA | 22% | 16% | 5% | 21% | 21% | 16% |
| Planned Parenthood of Metro DC | 5% | 3% | 5% | 18% | 65% | 5% |
| PSI Services III, INC | 2% | 4% | 9% | 2% | 66% | 17% |
| Psych Cntr Chartrd, Specialty Services | 0% | 0% | 0% | 0% | 0% | 100% |
| Psychiatric Center Chartered | 7% | 19% | 7% | 19% | 44% | 4% |
| Psychotherapeutic Outreach Services | 14% | 14% | 7% | 36% | 29% | 0% |
| Psychotherapeutic Outreach, Specialty Services | 0% | 0% | 0% | 0% | 0% | 100% |
| Scruples Corporation | 28% | 9% | 9% | 11% | 38% | 6% |
| Unity Health Care, Inc. | 20% | 14% | 13% | 17% | 30% | 5% |
| Universal HealthCare Management Services, Inc | 10% | 16% | 13% | 17% | 37% | 7% |
| Volunteers of America | 25% | 13% | 0% | 50% | 0% | 13% |
| Washington Hospital Center | 13% | 13% | 11% | 16% | 35% | 11% |
| Woodley House, Inc. | 0% | 0% | 0% | 0% | 100% | 0% |
| | | | | | | |
| Grand Total | 11% | 13% | 12% | 14% | 42% | 9% |

Source: eCura
Date: 7/25/2008

# Appendix 6 - CSR GAF and LOCUS Scores

| LOCUS | Private Providers | | DC CSA | | Variance |
|---|---|---|---|---|---|
| 0. Basic services (prevention) | 8 | 4.35% | 7 | 6.86% | **-2.51%** |
| 1. Recovery maintenance & health mgt. | 19 | 10.33% | 16 | 15.69% | **-5.36%** |
| 2. Low intensity community-based services | 60 | 32.61% | 36 | 35.29% | **-2.69%** |
| 3. High intensity community-based services | 59 | 32.07% | 21 | 20.59% | **11.48%** |
| 4. Medically monitored non-residential services | 13 | 7.07% | 10 | 9.80% | **-2.74%** |
| 5. Medically monitored residential services | 20 | 10.87% | 10 | 9.80% | **1.07%** |
| 6. Medically managed residential services | 2 | 1.09% | 2 | 1.96% | **-0.87%** |
| None provided | 1 | 0.54% | | 0.00% | **0.54%** |
| not available | 1 | 0.54% | | 0.00% | **0.54%** |
| (blank) | 1 | 0.54% | | 0.00% | **0.54%** |
| Grand Total | 184 | | 102 | | |

| CALOCUS | Private Providers | | DC CSA | | Variance |
|---|---|---|---|---|---|
| 0. Basic services (prevention) | 22 | 10.78% | 4 | 6.06% | **4.72%** |
| 1. Recovery maintenance & health mgt. | 9 | 4.41% | 3 | 4.55% | **-0.13%** |
| 2. Outpatient services | 79 | 38.73% | 38 | 57.58% | **-18.85%** |
| 3. Intensive outpatient services | 58 | 28.43% | 12 | 18.18% | **10.25%** |
| 4. Intensive integrat. serv. w/o psych. monitorin | 17 | 8.33% | 5 | 7.58% | **0.76%** |
| 5. Non-secure, 24-hr serv. w/ psych. monitoring | 7 | 3.43% | 4 | 6.06% | **-2.63%** |
| 6. Secure, 24-hr. services w/ psych mgt. | 3 | 1.47% | | 0.00% | **1.47%** |
| missing | 1 | 0.49% | | 0.00% | **0.49%** |
| N/A | 1 | 0.49% | | 0.00% | **0.49%** |
| Not available in file | 2 | 0.98% | | 0.00% | **0.98%** |
| Runaway from 5. Non-secure, 24-hr serv. w/ ps | 1 | 0.49% | | 0.00% | **0.49%** |
| Unknown | 1 | 0.49% | | 0.00% | **0.49%** |
| (blank) | 3 | 1.47% | | 0.00% | **1.47%** |
| Grand Total | 204 | | 66 | | |

| GAF (higher number = higher functioning) | Private Providers | | DC CSA | | Variance |
|---|---|---|---|---|---|
| GAF ≥ 71 | 15 | 8.15% | 11 | 10.78% | **-2.63%** |
| GAF 61-70 | 31 | 16.85% | 29 | 28.43% | **-11.58%** |
| GAF ≥ 61 | 5 | 2.72% | 7 | 6.86% | **-4.15%** |
| GAF 41 - 60 | 14 | 7.61% | 10 | 9.80% | **-2.20%** |
| GAF ≤ 60 | 114 | 61.96% | 41 | 40.20% | **21.76%** |
| GAF ≤ 40 | 3 | 1.63% | 2 | 1.96% | **-0.33%** |
| Not available | 2 | 1.09% | 2 | 1.96% | **-0.87%** |
| Grand Total | 184 | | 102 | | |
| *Note: two CSR forms were used over the study period. | | | | | |
| **C-GAF** | **Private Providers** | | **DC CSA** | | **Variance** |
| In level 8-10 | 37 | 18.14% | 14 | 21.21% | -3.07% |
| In level 6-7 | 112 | 54.90% | 33 | 50.00% | 4.90% |
| In level 1-5 | 50 | 24.51% | 19 | 28.79% | -4.28% |
| NA (under age 5) | 3 | 1.47% | | 0.00% | 1.47% |
| (blank) | 2 | 0.98% | | 0.00% | 0.98% |
| Grand Total | 204 | | 66 | | |

Source: 2004-2008 CSR Data, Human Systems & Outcomes

Date: 7/15/2008

Note: Not statistically valid at provider level

Appendix 7 - Adult CSR Outcomes

| Person Overall Status | Private Providers | | | DC CSA | | Variance |
|---|---|---|---|---|---|---|
| 1-3 Improve | 71 | 38.59% | | 23 | 22.55% | 16.04% |
| 4-6 Maintain | 113 | 61.41% | | 79 | 77.45% | -16.04% |
| Grand Total | 184 | | | 102 | | |

| Overall Progress | Private Providers | | | DC CSA | | Variance |
|---|---|---|---|---|---|---|
| 1-3 Improve | 88 | 47.83% | | 38 | 37.25% | 10.57% |
| 4-6 Maintain | 96 | 52.17% | | 64 | 62.75% | -10.57% |
| Grand Total | 184 | | | 102 | | |

| Practice Performance | Private Providers | | | DC CSA | | Variance |
|---|---|---|---|---|---|---|
| 1-3 Improve | 69 | 37.50% | | 30 | 29.41% | 8.09% |
| 4-6 Maintain | 115 | 62.50% | | 72 | 70.59% | -8.09% |
| Grand Total | 184 | | | 102 | | |

| Review Outcome Category | Private Providers | | | DC CSA | | Variance |
|---|---|---|---|---|---|---|
| 1 (4-6 Status + 4-6 Perf) | 93 | 50.54% | | 63 | 61.76% | -11.22% |
| 2 (1-3 Status + 4-6 Perf) | 22 | 11.96% | | 9 | 8.82% | 3.13% |
| 3 (4-6 Status + 1-3 Perf) | 20 | 10.87% | | 16 | 15.69% | -4.82% |
| 4 (1-3 Status + 1-3 Perf) | 49 | 26.63% | | 14 | 13.73% | 12.90% |
| Grand Total | 184 | | | 102 | | |

| Six Month Prognosis | Private Providers | | | DC CSA | | Variance |
|---|---|---|---|---|---|---|
| Continue-status quo | 91 | 49.46% | | 69 | 67.65% | -18.19% |
| Decline/deteriorate | 47 | 25.54% | | 12 | 11.76% | 13.78% |
| Improve | 46 | 25.00% | | 21 | 20.59% | 4.41% |
| Grand Total | 184 | | | 102 | | |

Source: 2004-2008 CSR Data, Human Systems & Outcomes
Date: 7/15/2008
Note: Not statistically valid at provider level

## Appendix 8 - Child CSR Outcomes

| Children Overall Status | Private Providers | | | DC CSA | | Variance |
|---|---|---|---|---|---|---|
| 1-3 Improve | 56 | 25.23% | | 9 | 13.04% | 12.18% |
| 4-6 Maintain | 166 | 74.77% | | 60 | 86.96% | -12.18% |
| Grand Total | 222 | | | 69 | | |

| Overall Progress | Private Providers | | | DC CSA | | Variance |
|---|---|---|---|---|---|---|
| 1-3 Improve | 91 | 40.99% | | 22 | 31.88% | 9.11% |
| 4-6 Maintain | 131 | 59.01% | | 47 | 68.12% | -9.11% |
| Grand Total | 222 | | | 69 | | |

| Practice Performance | Private Providers | | | DC CSA | | Variance |
|---|---|---|---|---|---|---|
| 1-3 Improve | 135 | 60.81% | | 35 | 50.72% | 10.09% |
| 4-6 Maintain | 87 | 39.19% | | 34 | 49.28% | -10.09% |
| Grand Total | 222 | | | 69 | | |

| Review Outcome Category | Private Providers | | | DC CSA | | Variance |
|---|---|---|---|---|---|---|
| 1 (4-6 Status + 4-6 Perf) | 83 | 37.39% | | 31 | 44.93% | -7.54% |
| 2 (1-3 Status + 4-6 Perf) | 4 | 1.80% | | 3 | 4.35% | -2.55% |
| 3 (4-6 Status + 1-3 Perf) | 83 | 37.39% | | 29 | 42.03% | -4.64% |
| 4 (1-3 Status + 1-3 Perf) | 52 | 23.42% | | 6 | 8.70% | 14.73% |
| Grand Total | 222 | | | 69 | | |

| Six Month Prognosis | Private Providers | | | DC CSA | | Variance |
|---|---|---|---|---|---|---|
| Continue-status quo | 99 | 44.59% | | 35 | 50.72% | -6.13% |
| Decline/deteriorate | 87 | 39.19% | | 20 | 28.99% | 10.20% |
| Improve | 36 | 16.22% | | 14 | 20.29% | -4.07% |
| Grand Total | 222 | | | 69 | | |

Source: 2004-2008 CSR Data, Human Systems & Outcomes
Date: 7/15/2008
Note: Not statistically valid at provider level

# Appendix 9 - Active Consumers per Month

| Servicing Provider | Month of FY2007 | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | **Avg/Mth** |
| | | | | | | | | | | | | | |
| DC CSA | 1,968 | 1,827 | 2,026 | 1,933 | 1,946 | 2,334 | 841 | 2,386 | 2,418 | 1,812 | 1,726 | 1,727 | **1,912** |
| Total DC CSA | 1,968 | 1,827 | 2,026 | 1,933 | 1,946 | 2,334 | 841 | 2,386 | 2,418 | 1,812 | 1,726 | 1,727 | **1,912** |
| | | | | | | | | | | | | | |
| Affordable Behavior Consultant, ABC | 22 | 37 | 45 | 75 | 90 | 93 | 90 | 84 | 75 | 20 | 16 | 19 | **56** |
| Anchor Mental Health Association, Inc | 344 | 339 | 359 | 351 | 339 | 346 | 319 | 314 | 322 | 341 | 320 | 326 | **335** |
| Anchor, Specialty Services | 8 | 9 | 10 | 10 | 10 | 11 | 9 | 12 | 12 | 3 | 4 | 5 | **9** |
| Beyond Behaviors, Inc | | | | | | | | | | 1 | 1 | | **0** |
| CARECO Mental Health Services, Inc | 59 | 55 | 55 | 53 | 52 | 45 | 54 | 49 | 43 | 60 | 56 | 54 | **53** |
| Center for Multicultural Human Services | | | 1 | 3 | 6 | 13 | 8 | 8 | 12 | | | | **4** |
| Center for Therapeutic Concepts CTC | 46 | 41 | 42 | 47 | 46 | 42 | 43 | 50 | 45 | 42 | 43 | 40 | **44** |
| Coates & Lane Enterprises Inc | | | | | 9 | 8 | 9 | 7 | 8 | | | | **3** |
| Community Connections, Inc. | 1,405 | 1,397 | 1,512 | 1,528 | 1,554 | 1,586 | 1,501 | 1,555 | 1,567 | 1,308 | 1,341 | 1,352 | **1,467** |
| Community Connections, Specialty Services | 34 | 28 | 24 | 26 | 28 | 31 | 31 | 26 | 22 | 33 | 33 | 31 | **29** |
| Deaf - REACH, Specialty Services | 33 | 28 | 33 | 33 | 33 | 37 | 29 | 24 | 19 | 33 | 35 | 1 | **28** |
| Family Preservation CSA | 35 | 48 | 54 | 55 | 59 | 83 | 93 | 90 | 70 | 35 | 39 | 35 | **58** |
| Fihankra Place | 25 | 26 | 27 | 21 | 5 | 21 | 48 | 162 | 109 | 13 | 11 | 19 | **41** |
| First Home Care Corporation | 467 | 527 | 531 | 559 | 588 | 550 | 550 | 518 | 475 | 503 | 499 | 503 | **523** |
| Greater Washington Urban League | | | | | | 6 | 6 | 19 | 11 | | | | **4** |
| Green Door | 745 | 777 | 823 | 824 | 830 | 829 | 857 | 836 | 835 | 673 | 670 | 672 | **781** |
| Hillcrest Children's Center | 8 | 12 | 14 | 12 | 11 | 2 | 5 | 4 | 5 | 4 | 4 | 4 | **7** |
| Kidd International Home Care Inc | 115 | 121 | 136 | 132 | 143 | 140 | 135 | 120 | 110 | 106 | 112 | 120 | **124** |
| Latin America Youth Center | 43 | 45 | 58 | 47 | 55 | 44 | 44 | 38 | 32 | 42 | 43 | 49 | **45** |
| Life Stride, Inc | 114 | 106 | 110 | 138 | 147 | 135 | 129 | 120 | 144 | 152 | 159 | 157 | **134** |
| Life Stride, Inc., Specialty Services | | | | | 1 | | 19 | 39 | | | | | **5** |
| Mary's Center for Maternal and Child Care, Inc. | 24 | 13 | 8 | 20 | 17 | 30 | 38 | 37 | 34 | 17 | 23 | 21 | **24** |
| McClendon Center | | | | 10 | 30 | 46 | 64 | 95 | 100 | | | | **29** |
| McClendon Center, Specialty Services | 10 | 6 | 6 | 2 | 2 | 2 | 2 | | | 24 | 11 | 12 | **6** |
| MD/DC Family Resources | 57 | 57 | 65 | 79 | 92 | 93 | 86 | 85 | 76 | 63 | 64 | 61 | **73** |
| Neighbor's Consejo | 6 | 6 | 6 | 11 | 14 | 19 | 16 | 9 | 7 | 5 | 5 | 4 | **9** |
| Pathways to Housing D.C., Specialty Services | 90 | 99 | 102 | 89 | 99 | 97 | 99 | 101 | 93 | 64 | 48 | 90 | **89** |
| PIW CSA | | | 3 | 2 | 4 | 9 | 16 | 25 | 11 | | | | **6** |
| Planned Parenthood of Metro DC | 76 | 42 | 29 | 1 | | | | | | 48 | 60 | 64 | **27** |
| PSI Services III, INC | 12 | 6 | 21 | 21 | 18 | 3 | | | | 14 | 12 | 8 | **10** |
| Psych Cntr Chartrd, Specialty Services | | | | | | 5 | 38 | 57 | 38 | | | | **12** |
| Psychiatric Center Chartered | 70 | 74 | 53 | 76 | 82 | 86 | 75 | 42 | 70 | 61 | 74 | 93 | **71** |
| Psychotherapeutic Outreach Services | 96 | 119 | 107 | 115 | 87 | 88 | 78 | 70 | 65 | 130 | 91 | 90 | **95** |
| Psychotherapeutic Outreach, Specialty Services | | 1 | | | 8 | 25 | 27 | 20 | 25 | 1 | | 2 | **9** |
| SAGA Adventures,, Inc | | | | | 5 | 8 | 3 | 6 | 5 | | | | **2** |
| Saint Paul Baptist Church | | | | 3 | 3 | 4 | 5 | 5 | 4 | | | | **2** |
| Scruples Corporation | 160 | 132 | 159 | 167 | 173 | 215 | 230 | 196 | 157 | 139 | 158 | 134 | **168** |
| Unity Health Care, Inc. | | | | 15 | 27 | 32 | 29 | 27 | 42 | | | | **14** |
| Universal HealthCare Management Services, Inc | 215 | 202 | 245 | 237 | 251 | 223 | 219 | 160 | 134 | 244 | 247 | 229 | **217** |
| Wade and Wade,, Inc. | | | | | | | | 1 | 2 | | | | **0** |
| Washington Hospital Center | 256 | 268 | 290 | 287 | 332 | 306 | 262 | 250 | 255 | 265 | 289 | 240 | **275** |
| WHC, Specialty Services | | | | 1 | 1 | | | | | 36 | 59 | 9 | **9** |
| Woodley House Crossing Place, Specialty Services | | | | 18 | 13 | 23 | 30 | 23 | 26 | | | | **11** |
| Woodley House, Inc. | 57 | 52 | 59 | 63 | 66 | 62 | 55 | 57 | 58 | 153 | 141 | 136 | **80** |
| Youth Villages, Inc . | 50 | 59 | 52 | 49 | 47 | 49 | 46 | 46 | 45 | 42 | 41 | 44 | **48** |
| | | | | | | | | | | | | | |
| **Total Private Providers** | **4,682** | **4,732** | **5,039** | **5,180** | **5,377** | **5,447** | **5,397** | **5,387** | **5,163** | **4,675** | **4,709** | **4,624** | **5,034** |

Source: eCura

Date: 7/25/2008

# Appendix 10- Anasazi Services Breakdown

| | Description | Client Hours | Units of Service | MHRS Code | MHRS Rate | units* rate | % dollars | Number of Contacts | % contact | Server Hours | % hours |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 10 | Comprehensive Assessment | 4,027 | 14,115 | T1023 | $0.00 | $0.00 | 0.00% | 2,690 | **1.97%** | 4,027 | 3.49% |
| 11 | Psychiatric Diagnostic Intrvw | 2,728 | 10,595 | T1502 | $32.47 | $344,019.65 | 3.50% | 3,145 | **2.31%** | 2,728 | 2.36% |
| 12 | Psychological Evaluation | 75 | 0 | T1023 | $0.00 | $0.00 | 0.00% | 47 | **0.03%** | 75 | 0.06% |
| 20 | Medication Review | 9,388 | 36,667 | T1502 | $32.47 | $1,190,577.49 | 12.11% | 15,574 | **11.43%** | 9,388 | 8.13% |
| 21 | Medication Education/Trng Ind | 4,345 | 17,489 | T1502 | $32.47 | $567,867.83 | 5.77% | 8,470 | **6.22%** | 4,345 | 3.76% |
| 22 | Medication Education/Trng Grp | 403 | 1,614 | T1502 | $19.33 | $31,198.62 | 0.32% | 395 | **0.00%** | 117 | 0.10% |
| 23 | Laboratory Services | 3 | 12 | T1502 | $32.47 | $389.64 | 0.00% | 4 | **0.00%** | 3 | 0.00% |
| 30 | Individual Counseling | 8,137 | 32,397 | H0004 | $16.25 | $526,451.25 | 5.35% | 7,915 | **5.81%** | 8,137 | 7.04% |
| 31 | Group Counseling | 1,871 | 7,233 | H0004 | $10.45 | $75,584.85 | 0.77% | 1,798 | **1.32%** | 453 | 0.39% |
| 32 | Family Counseling | 385 | 1,314 | H0004 | $16.25 | $21,352.50 | 0.22% | 428 | **0.31%** | 385 | 0.33% |
| 33 | Individual Psychotherapy | 5,323 | 20,722 | H0004 | $16.25 | $336,732.50 | 3.42% | 5,635 | **4.14%** | 5,323 | 4.61% |
| 34 | Group Psychotherapy | 1,045 | 3,851 | H0004 | $10.45 | $40,242.95 | 0.41% | 946 | **0.69%** | 255 | 0.22% |
| 35 | Family Therapy | 370 | 1,082 | H0004 | $16.25 | $17,582.50 | 0.18% | 378 | **0.28%** | 370 | 0.32% |
| 35 | Family therepy offsite | | | | $23.19 | $0.00 | 0.00% | | | | |
| 36 | Ind Psychotherapy w/Meds | 2,484 | 9,679 | T1502 | $32.47 | $314,277.13 | 3.20% | 4,054 | **2.98%** | 2,484 | 2.15% |
| 40 | Individual Skills Training | 538 | 2,152 | H0036 | $20.10 | $43,255.20 | 0.44% | 512 | **0.38%** | 538 | 0.47% |
| 41 | Group Skills Training | 8,635 | 34,556 | H0036 | $8.67 | $299,600.52 | 3.05% | 8,077 | **5.93%** | 1,841 | 1.59% |
| 42 | Individual Vocational Trng | 21 | 83 | H0036 | $20.10 | $1,668.30 | 0.02% | 11 | **0.01%** | 21 | 0.02% |
| 43 | Group Vocational Training | 7 | 26 | H0036 | $8.67 | $225.42 | 0.00% | 7 | **0.01%** | 3 | 0.00% |
| 44 | Monitoring for Safety | 3 | 0 | | | $0.00 | 0.00% | 4 | **0.00%** | 3 | 0.00% |
| 50 | Service Coordination | 52,390 | 209,592 | H0036 | $20.10 | $4,212,799.20 | 42.84% | 55,175 | **40.51%** | 52,390 | 45.35% |
| 55 | Housing Supports | 1,610 | 6,417 | H0036 | $20.10 | $128,981.70 | 1.31% | 1,327 | **0.97%** | 1,610 | 1.39% |
| 56 | Employment Supports | 98 | 386 | H0036 | $20.10 | $7,758.60 | 0.08% | 63 | **0.05%** | 98 | 0.08% |
| 57 | Treatment Planning/Review & Up | 11,504 | 45,754 | H0036 | $20.10 | $919,655.40 | 9.35% | 9,090 | **6.67%** | 11,504 | 9.96% |
| 58 | Discharge Planning | 154 | 484 | H0036 | $20.10 | $9,728.40 | 0.10% | 132 | **0.10%** | 154 | 0.13% |
| 70 | Legal Support Services | 81 | 326 | H0036 | $20.10 | $6,552.60 | 0.07% | 52 | **0.04%** | 81 | 0.07% |
| 100 | Community Mental Health Respon | 12 | 0 | | $20.10 | $0.00 | 0.00% | 11 | **0.01%** | 12 | 0.01% |
| 102 | Crisis Service | 726 | 2,743 | H0036 | $20.10 | $55,134.30 | 0.56% | 547 | **0.40%** | 726 | 0.63% |
| 103 | Mobile Outreach | 71 | 239 | H0036 | $20.10 | $4,803.90 | 0.05% | 32 | **0.02%** | 71 | 0.06% |
| 300 | Injection Services | 4,533 | 18,226 | T1502 | $32.47 | $591,798.22 | 6.02% | 7,555 | **5.55%** | 4,533 | 3.92% |
| 400 | Monthly Progress Note | 5 | 2 | | | $0.00 | 0.00% | 14 | **0.01%** | 5 | 0.00% |
| 401 | Periodic Psychiatric Eval | 13 | 14 | T1502 | $32.47 | $454.58 | 0.00% | 15 | **0.01%** | 13 | 0.01% |
| 404 | Outreach Prior to Enrollment | 209 | 0 | | $0.00 | $0.00 | 0.00% | 164 | **0.12%** | 209 | 0.18% |
| 405 | Administrative Supervision | 113 | 0 | | $0.00 | $0.00 | 0.00% | 139 | **0.14%** | 113 | 0.10% |
| 407 | Discharged Consumer Outreach | 125 | 0 | | | $0.00 | 0.00% | 195 | **0.14%** | 125 | 0.11% |
| 408 | Pre-Enrollment Day Srvc Group | 142 | 0 | H2022 | $26.58 | $0.00 | 0.00% | 144 | **0.11%** | 31 | 0.03% |
| 700 | Rehab Day Services | 3,348 | 590 | H0025 | $144.77 | $85,414.30 | 0.87% | 1,461 | **1.07%** | 3,348 | 2.90% |
| 950 | Token Disp. | 2 | 0 | | | $0.00 | 0.00% | 1 | **0.00%** | 2 | 0.00% |
| **Total** | | | | | | **$9,834,107.55** | | **136,207** | | | |

Source: Anasazi
Date: 7/9/2008

Appendix 11 - Demographics

| Age Group | Private Network | DC CSA | Variance |
|---|---|---|---|
| Age 0 to 12 | 11.19% | 6.96% | 4.23% |
| Age 13 to 17 | 14.61% | 6.25% | 8.36% |
| Age 18 to 22 | 8.06% | 2.92% | 5.14% |
| Age 23 to 64 | 62.99% | 76.54% | -13.55% |
| 65 and Older | 3.14% | 7.33% | -4.18% |

| Gender | Private Network | DC CSA | Variance |
|---|---|---|---|
| Other | 4.82% | 3.29% | 1.53% |
| F | 48.49% | 48.56% | -0.07% |
| M | 46.68% | 48.15% | -1.46% |

| Ethnicity | Private Providers | | DC CSA | | Variance |
|---|---|---|---|---|---|
| Unspecified | 1,337 | 19.37% | 802 | 24.93% | **-5.56%** |
| Other known Race | 210 | 3.04% | 184 | 5.72% | **-2.68%** |
| Hispanic | 161 | 2.33% | 83 | 2.58% | **-0.25%** |
| Chinese | 1 | 0.01% | 4 | 0.12% | **-0.11%** |
| Vietnamese | 1 | 0.01% | 3 | 0.09% | **-0.08%** |
| Asian Indian | 12 | 0.17% | 8 | 0.25% | **-0.07%** |
| Unknown | 10 | 0.14% | 7 | 0.22% | **-0.07%** |
| Guamanian/Chamorro | 1 | 0.01% | | 0.00% | **0.01%** |
| Other/Asian | 12 | 0.17% | 4 | 0.12% | **0.05%** |
| American Indian | 7 | 0.10% | 1 | 0.03% | **0.07%** |
| More than one race identified | 16 | 0.23% | 3 | 0.09% | **0.14%** |
| White | 364 | 5.27% | 115 | 3.57% | **1.70%** |
| Black/African American | 4,772 | 69.12% | 2,003 | 62.26% | **6.86%** |
| Grand Total | 6,904 | | 3,217 | | |

Source: eCura
Date: 7/25/2008

Appendix 12- Language

| Language | Private | | DC CSA | | Variance |
|---|---|---|---|---|---|
| | | | | | |
| **Unspecified** | 4,671 | 67.66% | 2,395 | 74.45% | **-6.79%** |
| **Primary Language - Other (specify)** | 31 | 0.45% | 44 | 1.37% | **-0.92%** |
| **Primary Language at home - Amharic** | 1 | 0.01% | 11 | 0.34% | **-0.33%** |
| **Primary Language - Vietnamese** | | 0.00% | 2 | 0.06% | **-0.06%** |
| **Primary Language - Sign Language** | 15 | 0.22% | 8 | 0.25% | **-0.03%** |
| **Secondary Language - Amharic** | | 0.00% | 1 | 0.03% | **-0.03%** |
| **Secondary Language - Vietnamese** | | 0.00% | 1 | 0.03% | **-0.03%** |
| **Secondary Language -Other (specify)** | | 0.00% | 1 | 0.03% | **-0.03%** |
| **Secondary Language at home - English** | 10 | 0.14% | 5 | 0.16% | **-0.01%** |
| **Primary Language at home - Chinese** | 4 | 0.06% | 1 | 0.03% | **0.03%** |
| **Secondary Language - Spanish** | 8 | 0.12% | 1 | 0.03% | **0.08%** |
| **Primary Language at home - Spanish** | 89 | 1.29% | 26 | 0.81% | **0.48%** |
| **Primary language at home - English** | 2,075 | 30.06% | 721 | 22.41% | **7.64%** |
| **Grand Total** | 6,904 | | 3,217 | | |

Source: eCura
Date: 7/25/2008

Appendix 13 – Cost of Services Rendered by Team

| DC CSA Team | Allocated Cost | Service Hours Recordeed | Cost Per Hour | Cost Per 1/4 Hour | Net Difference DC CSA vs FFS |
|---|---|---|---|---|---|
| ***ACT1/2- Allocated Cost per Team*** | ***$ 1,233,764.96*** | ***7151.39*** | $ 172.52 | ***$ 43.13*** | ***$ (473,429.17)*** |
| ***ACT 3 - Allocated Cost per Team*** | ***$ 1,119,599.07*** | ***7263.45*** | $ 154.14 | ***$ 38.54*** | ***$ (347,277.34)*** |
| ***ACT 4 Allocated Cost per Team*** | ***$ 1,174,023.96*** | ***7055.91*** | $ 166.39 | ***$ 41.60*** | ***$ (423,839.61)*** |
| ***DAY 2/3 Allocated Cost per Team*** | ***$ 942,789.12*** | ***6855.96*** | $ 137.51 | ***$ 34.38*** | ***$ (651,766.96)*** |
| ***CST 2/3 Allocated Cost per Team*** | ***$ 1,551,123.60*** | ***8827.77*** | $ 175.71 | ***$ 43.93*** | ***$ (861,747.90)*** |
| ***CST 4 Allocated Cost Per Team*** | ***$ 1,248,733.79*** | ***3952.42*** | $ 315.94 | ***$ 78.99*** | ***$ (914,027.08)*** |
| ***CST 5 Allocated Cost per Team*** | ***$ 1,314,973.32*** | ***7508.16*** | $ 175.14 | ***$ 43.78*** | ***$ (726,684.56)*** |
| ***CST 6 Allocated Cost Per Team*** | ***$ 1,197,737.17*** | ***5498.24*** | $ 217.84 | ***$ 54.46*** | ***$ (740,981.24)*** |
| ***CST 7 Allocated Cost Per Team*** | ***$ 800,766.20*** | ***4622.96*** | $ 173.22 | ***$ 43.30*** | ***$ (417,575.49)*** |
| ***CST 8/9 Allocated Coste Per Team*** | ***$ 2,357,154.26*** | ***8598.48*** | $ 274.14 | ***$ 68.53*** | ***$ (1,665,567.65)*** |
| ***CST 11 Allocated Cost Per Team*** | ***$ 956,160.12*** | ***3662.77*** | $ 261.05 | ***$ 65.26*** | ***$ (637,913.79)*** |
| ***CST 15/16 Allocated Cost Per Team*** | ***$ 849,236.36*** | ***4475.15*** | $ 189.77 | ***$ 47.44*** | ***$ (533,073.06)*** |
| ***CST 17/18*** | ***$ 716,564.54*** | ***2829.68*** | $ 253.23 | ***$ 63.31*** | ***$ (508,388.21)*** |
| ***CST 19/20Allocated Cost per Team*** | ***$ 1,148,206.97*** | ***5258.32*** | $ 218.36 | ***$ 54.59*** | ***$ (807,838.75)*** |
| ***CST 21 Allocated Cost per Team*** | ***$ 1,201,917.33*** | ***5178.81*** | $ 232.08 | ***$ 58.02*** | ***$ (754,798.69)*** |
| ***CST 23 Allocated Cost per Team*** | ***$ 640,272.53*** | ***3213.84*** | $ 199.22 | ***$ 49.81*** | ***$ (382,567.08)*** |
| ***PSY Allocated Cost per Team*** | ***$ 4,127,229.16*** | ***15866.71*** | $ 260.12 | ***$ 65.03*** | ***$ (2,199,824.79)*** |
| ***KCLIN Allocated Cost per Team*** | ***$ 1,291,305.39*** | ***5863.47*** | $ 220.23 | ***$ 55.06*** | ***$ (813,321.52)*** |
| ***NCLIN/ CST 10 Allocated Cost per Team*** | ***$ 857,288.12*** | ***6327.07*** | $ 135.50 | ***$ 33.87*** | ***$ (330,229.41)*** |
| ***Adult Community/ none*** | | 4.67 | $ - | ***$ -*** | ***$ -*** |
| ***CBI 1/CBI2*** | ***$ 631,435.82*** | 657.94 | $ 959.72 | ***$ 239.93*** | ***$ (562,609.71)*** |
| ***MUST*** | ***$ 596,200.15*** | 90.79 | $ 6,566.80 | ***$ 1,641.70*** | ***$ (18,981.37)*** |
| **ALL TEAM TOTAL** | **$ 25,956,481.93** | **120763.96** | | | **$ (14,772,443.38)** |

*Note: Pharmacy and PsychoEd have been removed*

Appendix 14 - Transfers In and Out of a CSA within 3 Months of Enrollment

| Clinical Home | Number of Consumers |
|---|---|
| DC CSA | 307 |
| | |
| Total Private Providers | 517 |
| | |
| Anchor Mental Health Association, Inc | 22 |
| Center for Multicultural Human Services | 2 |
| Center for Therapeutic Concepts CTC | 4 |
| Community Connections, Inc. | 115 |
| Family & Child Services of DC | 2 |
| Family Preservation CSA | 17 |
| Fihankra Place | 11 |
| First Home Care Corporation | 37 |
| First Home Care, Specialty Services | 1 |
| Green Door | 64 |
| Hillcrest Children's Center | 4 |
| Kidd International Home Care Inc | 20 |
| Life Stride, Inc | 23 |
| Mary's Center for Maternal and Child Care, Inc. | 1 |
| McClendon Center | 26 |
| MD/DC Family Resources | 9 |
| Neighbor's Consejo | 4 |
| Pathways to Housing D.C., Specialty Services | 3 |
| PIW CSA | 19 |
| Planned Parenthood of Metro DC | 2 |
| PSI Services III, INC | 6 |
| Psychiatric Center Chartered | 5 |
| Psychotherapeutic Outreach Services | 5 |
| Scruples Corporation | 31 |
| Unity Health Care, Inc. | 14 |
| Universal HealthCare Management Services, Inc | 33 |
| Washington Hospital Center | 37 |

Source: eCura
Date: 7/25/2008

Appendix 15 – Employee Turnover Rate

| Turnover Rate | | |
|---|---|---|
| DC CSA | Provider 1 | Provider 2 |
| 11% | 78% | 40% |

Source: DMH
Date: 9/2008

Appendix 16 – Place of Service Comparison

| Number of Contacts By Place Of Service | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Provider 1 | | Provider 2 | | DC CSA | | Variance | |
| POS | Contacts | | Contacts | | Contacts | | 1 | 2 |
| C-Center | 121,239 | 77% | 30826 | 44% | 114,312 | 84% | **40%** | **7%** |
| H-Home | 17,924 | 11% | 19664 | 28% | 9,528 | 7% | **-21%** | **-4%** |
| I-St Elizabeths | 792 | 1% | 2353 | 3% | 1,678 | 1% | **-2%** | **1%** |
| J-Jail | 191 | 0% | | | | | **0%** | **0%** |
| M-Community Mental Health Center | 238 | 0% | | | 2,681 | 2% | **2%** | **2%** |
| W-Residential Tx Ctr/Detention | 479 | 0% | | | | | **0%** | **0%** |
| Y-Community | 17,032 | 11% | 16575 | 24% | 8,008 | 6% | **-18%** | **-5%** |
| **Total** | 157,895 | 100% | 69,418 | 100% | 136,207 | 100% | **0%** | **0%** |

Source: eCura, DMH
Date: 7/25/2008