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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

WILLIAM DIXON, et al.,	)	
	)	
Plaintiffs,	)	
v.	)	Civil Action No. 74-285 (TFH)
	)	
ANTHONY WILLIAMS, et al.,	)	
	)	
Defendants.	)	

COURT MONITOR'S NOTICE OF SUBMISSION OF REPORT

Court Monitor, Dennis R. Jones, respectfully submits the attached Report to the Court pursuant to the Court's May 23, 2002 Order requiring regular reports concerning the status of Defendants' compliance with the Plan.

Respectfully submitted,

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REPORT TO THE COURT

Court Monitor
Dennis R. Jones

January 30, 2004

I. Current Situation

In November 2003, the Court approved the Monitoring Plan for the period October 1, 2003 through September 30, 2004. The Monitoring Plan included three primary areas for review during this period:

A. Progress in obtaining final Court approval of performance targets for all of the various categories in the Exit Criteria and monitoring the operational implementation of each of these.

B. Monitoring the continued development and implementation of specific administrative and services functions as outlined in the Court-ordered Plan.

C. Monitoring the occurrence of events which may significantly impact the implementation of the Court-ordered Plan.

This report provides updates on the status and/or progress in each of the above areas, highlights any identified barriers to progress, and makes recommendations for future actions.

The May 23, 2002 Court-approved Consent Order called for a report twice per year. This constitutes the third formal monitoring report to the Court.

II. Findings Regarding Exit Criteria

The Court-approved Exit Criteria tasks for this year fall into four categories: (1) the review of DMH-developed consumer satisfaction method(s) and consumer functioning review methods; (2) the implementation of year two consumer services reviews for both adults and children/youth; (3) the establishment of Court-approved performance levels for consumer services reviews and system performance and; (4) the implementation of Court-approved performance levels. This report will identify current status and progress as it relates to each of these areas:

A. Consumer Satisfaction Method(s) and Consumer Functioning Review Method(s)

The Court-approved Exit Criteria call for the DMH to develop method(s) to assess consumer satisfaction with services and to assess consumer functioning. The Exit Criteria describes the role of the Court Monitor as one of review and approval of such proposed methods for consumer satisfaction and review of proposed functional review methods. In both areas, the Court Monitor will assess the degree to which the results

obtained are utilized as an integral part of the DMH's overall quality improvement process.
As relates to the consumer satisfaction method(s), the DMH has (as of September 15, 2003) contracted with a newly formed consumer organization called Consumer Action Network (CAN). The most recent DMH workplan (per agreement with CAN) calls for the first year plan for the consumer satisfaction project to be completed by January 12, 2004. The first year plan will include the identification of specific areas of satisfaction to be measured as well as the methods to be utilized in conducting surveys and the steps necessary to analyze and disseminate the results. The DMH workplan indicates that a six-month progress report with detailed methodology will be presented to the Court Monitor for review by April 30, 2004. The year one progress report and the long-term plan are to be submitted to the Court Monitor by November 30, 2004.

As an interim step to measure consumer satisfaction, the DMH conducted a telephone survey between October 20 – November 8, 2003. The DMH contracted with consumers who were trained specifically to carry out this task – with separate surveys for adults and children/youth. Of the 832 adults who were successfully contacted, 514 (or 62%) agreed to participate. For children/youth, 92 out of 110 contacted agreed to participate (84%).

The consumer satisfaction model that was utilized was the Federally-required MHSIP Consumer Satisfaction Survey. This survey includes an array of questions having to do with overall satisfaction, treatment participation, access to services, quality of care rendered, and the outcome of services for individual consumers (e.g. functioning in daily tasks such as school or jobs).

The Court Monitor reviewed the results of this survey. Over 92% of the adults interviewed expressed positive responses about access to services, quality of services, participation in treatment planning, and general satisfaction with services. More than 85% of the respondents expressed positive responses about the outcomes of services provided. Over 85% of the families interviewed expressed positive responses about access to services, quality of services, participation in treatment planning and cultural sensitivity of staff. More than 70% of the family respondents expressed positive responses about the outcomes of services provided. It is recognized by all that this is an initial effort to measure consumer satisfaction and that this method (i.e. willing telephone respondents) contains a margin of error. Nevertheless, it is significant that the process of asking consumers directly has begun. It is also significant that trained consumers are the ones doing the surveys.

The Court Monitor will continue to track this overall process. Now that the Office of Consumer and Family Affairs has new and energetic leadership, it is evident that the issue of hearing from consumers directly has taken on new meaning within DMH. It is also encouraging to see the beginning development of the Consumer Action Network (CAN). The Court Monitor believes that – over time – this new organization can bring enhanced vitality, timeliness and targeted feedback to DMH on the multiple issues affecting consumers.

As relates to consumer functioning review method(s), there has been no additional progress in this area. DMH leadership indicates that other priorities need to precede any initiatives in this area; hence activity in this area will not begin until sometime in 2004. On balance, the Court Monitor agrees that consumer satisfaction development should take precedence. The only concern is that consumer functioning method(s) will take time to develop and it is hoped that this process would begin so as to allow necessary review of alternative approaches (as was envisioned by DMH prior to the July 2003 Report to the Court.

B. Year Two Consumer Services Reviews

The Court Monitor has again contracted with Human Systems and Outcomes, Inc. (HSO) to conduct year two reviews for both children/youth and adults. The same protocols as were established for the year one baseline reviews will be used for year two. The dates for the year two reviews have been established – with the period of March 1-12, 2004 for children/youth reviews and April 12-23, 2004 for adult reviews.

The randomly selected sample size will increase from 36 for year one to 54 for year two. This sample size should provide an estimate of performance at a 95% confidence level. In order to ensure that 54 service recipients are reviewed (for both children/youth and adult), an initial sample of 162 will be drawn. A limited profile of these 162 will be developed and included in the report to verify the accuracy of the DMH information system and the current active status of persons surveyed. It should be noted that DMH has developed – but not finalized – a policy that for adults would provide for a designation of "inactive/discharge status" for consumers who are not in active treatment in a CSA. Hence this "triple-sampling" approach will deal with some of the issues encountered in year one – namely the number of individuals who showed as enrolled in the DMH information system but who were, in fact, inactive.

The DMH has also begun the process of enrolling in CSA's children/youth who are in RTC's. DMH indicates that during the first two weeks of January 2004, that up to 64 children/youth who are part of CFSA will be enrolled. While this does not resolve the issue for other D.C. child-caring

agencies (e.g. Education) it is an important start point and will allow the inclusion of these children/youth in the overall sample for year two reviews. Of major significance – over the long term – is the fact that DMH and the other child-serving agencies in the District (CFSA, YSA, MAA and DCPS) are developing a strategy that would require that there be only one mental health contracting entity and therefore only one clinical case management system for children in RTC's. This would replace the parallel system in place today. The DMH indicates that the remaining youth who are in RTC's will be assigned to CSA's over the next three months.

One of the other issues from year one was one of consumer willingness to participate in the reviews. It is believed that a direct contact from the office of the Court Monitor will help to avoid potential misinformation and also provide reassurances to individual consumers about the importance of their individual participation. The Court Monitor will contract with individual consumers to contact consumers and family members directly in order to obtain consent, explain the process and hopefully obtain agreement to participate in the process.

The DMH has again agreed to select internal reviewers sufficient to conduct half (27) of the reviews. These reviewers will be fully trained and deemed qualified to conduct reviews by HSO. HSO will also, in year two, develop and conduct inter-rater reliability assessments between and among internal DMH reviewers and HSO-provided reviewers.

The results of both reviews – including final written analysis and recommendations – should be completed in time to be included in the July 2004 Report to the Court.

C. Establishment of Court-approved Performance Levels

On December 11, 2003, the Federal Court approved a Consent Order that establishes exit criteria in nineteen different areas together with the methodology that will be used to measure each of these nineteen and the performance levels required by the defendants in each area. This Consent Order followed a six-month period of discussion between the Court Monitor and the parties. The original exit criteria categories did not change; however, in some cases, more explicit targets were identified. The nineteen areas include two in consumer services reviews (adult and children/youth), two in Implementation of Consumer Satisfaction Method(s) and Consumer Functioning Review Method(s), and fifteen (15) in key areas of Systems Performance.

Needless to say, this Court approval (and the parties agreement) represents a major milestone in the history of Dixon. For the first time, it is now

clear what will be measured, how it will be measured and how well the defendants must perform in order to meet the Court's requirements for ultimate dismissal of the case. None of the measures – in and of themselves – represents a pure or complete picture of the system; nevertheless, in the aggregate these criteria measure a wide array of critical aspects in the systems performance. It is the Court Monitor's belief that these exit criteria comport very well to the Court-ordered Plan and do provide a clear and objective pathway for measuring performance of the DMH system.

D. Implementation of Court-approved Performance Levels

Now that the Court has approved the Exit Criteria and Performance Levels, the next major step is to begin the actual implementation of each of these areas. Considerable work remains to ensure that DMH policies and practices are in place – particularly for those measures that are based on percentages of referrals. The key issue is to ensure that providers are identifying and referring per established DMH policy. There is also the vital component of developing and implementing the electronic information systems necessary to ensure data integrity for all of the identified areas. The DMH has begun the internal process of assigning responsibility for each area. The formal discussions with the Court Monitor and DMH leadership on all policy, practice and timeline issues will begin in January 2004. The objective is to move as quickly as possible to develop a quarterly report format for all of those criteria that lend themselves to quarterly measurement. It is anticipated that by the time of the July 2004 Report to the Court that a detailed review of current status will be provided to the Court.

III. Findings Regarding Development and Implementation of Court-ordered Plan

A. Review of the Overall Functioning of CSA's

The Court Monitor reviewed the overall development of CSA's – similar in scope to the review that was done for the January 2003 Report to the Court. The specific focus of this review was to look at: growth in capacity (both in the numbers of CSA's and in the number of persons enrolled in the system); the ability for new consumers to access services in a timely way; the developmental status of the new DMH Report Cards for individual CSA's; the ability of the DMH system (and individual CSA's) to develop and standardize core business functions as relates to services growth, productivity management, claims payment; and overall problem-solving between DMH and the provider community.

In terms of growth, the DMH has certified six new CSA's over the past year for a current total of 19 CSA's; there are also three (3) certified

specialty providers. These six new CSA's all represent agencies that served predominantly children and youth. In terms of the number of persons enrolled in the system, DMH data indicated that there were a total of 8,425 consumers enrolled as of December 19, 2002. This 8,425 included 7,275 adults and 1154 children/youth. The most recent total enrollees (as of December 11, 2003) is 14,735 – including 12,015 adults and 2,720 children/youth. Hence, in a one-year period the overall system has grown by 75%. The adult system has grown at a rate of 65% and the children/youth system at a rate of 136%. These growth rates are certainly impressive. It is also evident that this growth has occurred almost entirely via those CSA's that have been part of the new MHRS system from its early development period (Spring – Fall 2002). The public CSA alone accounted for over 3,100 new enrollments in the system. It is evident that new persons are able to access the system in a timely way and that CSA's have – thus far – been willing and able to handle the growth demands. The cautionary note on total numbers is that these represent enrollments and not necessarily active enrollments. As mentioned previously, the DMH is in the process of finalizing a policy that will move persons who are not active in treatment into an active or discharge status. Once this policy is in place, the system will likely experience a dip in total enrollees. The approved methodology for the exit criteria will also only count persons who are both enrolled and active.

The DMH is in the process of developing a "Report Card" assessment for each CSA. The Report Card is intended to provide each CSA with periodic and specific point scores in select areas. These areas range (per the current draft) from meeting DMH report requirements to things such as ability to accept new referrals and meeting DMH clinical requirements. The DMH intends that the scores from these Report Cards would be public and would provide a level of "peer pressure" as relates to specific and overall agency performance. The initial thinking is that once such a system is in place that some dollar incentives could be tied to certain performance levels. Process-wise, the Partnership Council and others (providers and consumers) are providing feedback to DMH on the overall design. The Court Monitor supports this initiative with one suggestion. The suggestion is that dollar incentives not be attached until there is a level of confidence in what is measured and how it is measured.

Perhaps the major developmental process for CSA's has been the challenges associated with bringing up an entirely new community system for client enrollment, authorization, claims adjudication, and claims payment. As noted in the January 2003 Report to the Court, this entire process is – in most jurisdictions – a 2-3 year process, which the DMH has been forced to implement in a much more truncated fashion given that the previous system did not meet Federal requirements. The intent of this Report is to note areas in which progress has occurred and to also note

areas that continue to be troublesome. In all of this, it is critical to note that developmental issues have occurred at multiple levels – most notably with individual provider agencies and at the DMH and District governance level.

At the individual provider level, every single CSA with whom the Court Monitor spoke indicated the enormity of this change process within the agency. Agencies have had to shift from a contract mode to a fee-for-service mode, which requires the setting of productivity standards for individuals and teams. The new clinical philosophy imbedded in the MHRS standards has required new and different clinical knowledge and leadership within CSA's. The "back office" functions associated with information systems, billings and internal record keeping and auditing have all had to be developed from scratch or significantly strengthened. In the same way that these issues have hit DMH all at once, they have also hit individual CSA's all at once. In many cases, this inter-related set of issues has required the hiring of new senior management.

One of the major positive developments noted by CSA's was the DMH decision to contract with the National Council for Community Behavioral Healthcare to work with individual CSA's to develop the core business competencies necessary to make the enormous internal changes required. Virtually all CEO's with whom the Monitor spoke indicated that they incurred major financial challenges in year one due to their local difficulty in bringing up an entirely new model; however all also indicated that because of the consultative help they received from NCCBH, they believe they are now on more solid footing going forward. The CSA's uniformly expressed a desire for additional consultative help in refining and integrating the multiple clinical and administrative support systems. The Court Monitor took positive note of the fact that most CSA's now have a much broader and critical understanding of the internal pressures that need continued work. It is also noteworthy that CSA leaders have set clear growth targets for the agency – understanding that longer-term financial success is dependent upon spreading fixed costs across a larger clinical base. This growth strategy is in spite of the continued (and currently heightened) concerns about the predictability of agreements with DMH and the subsequent cash flow.

The DMH – to its credit – has worked consistently over the past year to resolve systemic issues and make needed mid-course corrections. Among the issues that DMH has addressed are: (1) The decision to not require an approved authorization plan prior to processing claims. Instead, the issue of verifying authorizations is done via the auditing process; (2) DMH has decided for 2004 to "roll up" the individual task orders for specific MHRS services into an aggregate task order. The net effect will be to remove the "cap" on payments for individual service categories; (3) DMH has

proposed a process of informing the District Council about MHRS payments on a quarterly basis – as opposed to having to seek approval once MHRS agreements hit the $1M level; (4) DMH has worked to process claims in a more timely way, including working with individual CSA's on unique payment problems (e.g. multiple services/same day); (5) Work with the OCFO's office to set up an accounts payable reserve for projected 2003 payments. This will allow the use of 2003 budget dollars for 2003 claims; (6) DMH – in working to resolve necessary HIPAA compliance requirements to the eCura system – has also worked out an electronic solution to the reconciliation issues. According to DMH officials, these information system changes should be in place by January 2004 and will allow providers to know electronically which specific claims have been paid (by consumer, date and service) and which specific claims have been denied and; (7) Follow-through on its contract with NCCBH, which, as noted above, has been overwhelmingly useful to individual providers.

Despite the above, there is an exceedingly high level of anxiety at the provider level at the time of this Report. Major concerns revolve around the timeliness of Task Orders for 2004 and subsequent payments for services since October 1, 2003. Ongoing cash flow concerns are at new heights. Individual agencies indicate that they do not know whether their planning/fiscal assumptions for 2004 match the DMH's and hence they are at a stalemate. Adding to the anxiety for some providers is the recent DMH decision to reduce residential service rates and attempt to offset these reductions with the provision of MHRS services. Providers are highly concerned that this issue has not been worked through – legally, clinically and financially – and that the original timeline for implementation (January 2004) was simply untenable. The DMH indicates that this is not a new issue and has in fact been part of ongoing discussion as a way to bill for those MHRS services that can – and should – be billed via Medicaid versus the locally funded residential rates.

It is evident to the Court Monitor that – despite the progress that has been made over the past year – the overall sense of predictability and mutual trust in the contracting and payment system is still an elusive goal. While the issues have shifted from one period to another, many of the underlying dynamics have not. On the provider side it should be noted that a fee-for-service model (with fixed rates) creates great demands for internal efficiencies and tends to weigh against smaller agencies with fixed overhead. All of this to say that while some solutions are systemic, there is also the reality that individual providers must critically assess their abilities to perform in this new model. It would appear that many have but some have not.

The Court Monitor recognizes that tension between the authority and the provider system is an inherent reality. However, a system that is as intertwined and interdependent as this one is needs to continue to find ways to work together. It is believed that the permanent filling of the Delivery Systems leadership position will help to crystallize relationships, priorities and communications. As this position takes hold, some suggested priorities would include: (1) the reevaluation of basic communication and joint problem-solving strategies with providers. New issues (e.g. the recent residential issue) need to be jointly discussed and hopefully resolved; (2) the re-engagement of NCCBH (or a similar strategy) to support the continued development of enhanced business and clinical processes within CSA's and to look at larger issues of CSA collaboration or consolidation and; (3) the clear articulation of DMH responses to the NCCBH recommendations entitled "Provider Network Priority Issues" – particularly those that are recommended for resolution in early FY 2004. (Note: The DMH has developed a detailed response to each of the priority areas identified, which, it is hoped, will be shared broadly with providers and others.)

B. Follow-up Review of ACT Services

Each of the previous two Reports to the Court identified significant and multiple issues with relation to ACT services. The July 2003 Report stated that these issues "included the fundamental questions of whether persons needing ACT services are receiving them and whether the existing ACT teams are performing with fidelity to the ACT model and the DMH standards." The July Report "strongly recommended that the DMH develop within the next 60 days a specific plan for improving ACT services. This plan – with specific timetables for action – should come to the Court Monitor for review and discussion."

The DMH did not submit a plan within the recommended 60 days. On November 24, 2003, the DMH did submit a brief "Summary of Activities to Date and Workplan" in response to the Court Monitor's inquiries as to current status. This summary highlighted DMH leadership efforts on several fronts to include: (1) the engagement – via a consulting agreement – of Frances Register-Joyner (since October 2001) to work with existing ACT teams and DMH to help improve ACT services, promote team development and identify systemic ACT issues for resolution; (2) the initiation of the use Level of Care Utilization System (LOCUS) with ACT teams beginning in March 2003. This assessment tool was completed for all current ACT consumers by May 1, 2003 and is being utilized for each consumer every ninety (90) days. The tool is also used to determine whether a consumer referred for ACT services requires that level of care; (3) on July 30, 2003, DMH held an ACT "summit" for all of the agencies that have ACT teams. This summit was targeted for both direct service

staff and for management staff. One of the outcomes of the day was to require each ACT team to develop and submit to DMH a plan by which to move toward fidelity with the ACT model. Each of these plans has been received by DMH and is being reviewed by Delivery Systems Management. Agencies will receive feedback by DMH and once plans are accepted each ACT team will be monitored for ongoing implementation and; (4) in January 2004, Ms. Register-Joyner will require monthly reports from each ACT team and by March 2004, the ACT teams will also be monitored using the Dartmouth ACT Fidelity Scale. Each team will receive feedback and needed technical assistance based upon the composite of plans of action, monthly reports and the results of the Dartmouth ACT Fidelity Scale.

The Court Monitor is certainly supportive of all of the actions that DMH has – or will be – undertaking to improve existing ACT services. The consistency of reports and necessary follow-up would seem to be a key ingredient in achieving true fidelity to the ACT model. All of these efforts are in the face of continued concern by many providers and community advocates that existing ACT Teams do not consistently provide the kind of services that comport to an ACT model. The Court Monitor believes that the DMH has undertaken a series of responsive steps to improve existing ACT teams and services; however, the concrete results of these efforts are not yet apparent, which may call for additional strategies by DMH and ACT providers to help inform the provider advocacy community about what is being done.

There is still, however, the larger question for the Court Monitor as to the overall identification and referral of persons needing ACT services. This issue will receive heightened focus as part of the implementation of the recently Court-approved Exit Criteria and Performance Levels. One of the prerequisites to actual measurement is for the Court Monitor to be assured that the DMH has in place the necessary policy and practice guidelines i.e. necessary means to assure that persons who need ACT services are in fact being identified and referred. Given the history of concern about ACT services, this policy and practices issue should get heightened focus by the Court Monitor and DMH. To this end, the Court Monitor was presented with a set of Practice Guidelines for ACT – which do identify things such as the specific criteria for referral to ACT. It is not clear to the Court Monitor as where this issue is in terms of implementation; however, this would seem to be the kind of policy and practice document which will be critical to full and appropriate implementation of ACT in the District.

The Court Monitor would also offer an additional observation as relates to ACT, namely the issue of consistency and scope of leadership within DMH as relates to ACT. It is, on the positive side, apparent that persons in key overall leadership positions understand and embrace ACT services.

However, there has not been consistent ACT-specific leadership over the past year. It is therefore not clear that ACT issues get the kind of concerted attention at the DMH level – including communication with providers and advocates – that it would seem to deserve. As the DMH looks to strengthen its Delivery Systems capacity, the Court Monitor would encourage careful review of this issue.

C. Review of Access and Crisis Response Services

This annual review of access and crisis services focused specifically on: (1) the 24/7 Access Helpline; (2) the capacity and utilization of mobile teams for children/youth and adults; (3) the development and utilization of site-based psychiatric emergency services and; (4) the development and utilization of crisis residential beds.

1. 24/7 Access Helpline – The 24/7 Access Helpline continues to be staffed and run directly by a specialized DMH team. With the filling of two vacant positions, this unit is fully staffed. The Access Helpline continues to handle a variety of tasks including the telephonic triage of all incoming calls, the dispatching of mobile crisis teams for adults and children/youth, the referral of non-crisis new enrollees to the chosen CSA and the management of primary care coordination functions for DMH (which include prior authorization for St. Elizabeths admission, ACT services, CBI services and day services). In its prior authorization role, the care coordinators are a key component of the overall continuity of care implementation for DMH. The Court Monitor found in an overall sense that this component of DMH is functioning as was originally envisioned in the Court-ordered Plan. For example, in the recent month of October 2003, the Helpline answered 2,805 total calls, with a 3% abandonment rate (abandonment typically represents persons who hang up before a call is answered.) The Helpline Director manages this percentage each month and would like to see the abandonment rate drop to 1%-2%.

   In analyzing the array of calls it is evident that this unit does provide – on any given day – a centralized resource that is readily available to consumers, families, DMH providers, community agencies, law enforcement and the community at large. Staff are trained to carry out a variety of functions – ranging from acute crisis/suicide to general information and referral. This unit does provide the key link for consumers and providers and does work consistently to provide the necessary communication, linkage and prior authorizations for key services (e.g. St. Elizabeths admissions).

Areas that been have identified as needing continued work include: (1) strengthening the follow-up for consumers who are referred for mobile crisis to determine outcome; (2) working with other DMH leadership to further strengthen the continuity of care for both adults and children/youth. As indicated elsewhere in this report, the children/youth CSA gap for youth placed in RTC's is still a work in progress and; (3) working to develop a trained volunteer-based telephone line to provide "warm line" and wellness checks. The Helpline Director is beginning to explore this option.

2. Capacity and Utilization of Mobile Teams

The DMH-run CSA provides mobile capacity for both adults and children/youth. The adult mobile service is provided as one of the core functions of CPEP. The children/youth mobile services are now provided (as of June 2003) by the children/youth team via the Mobile Urgent Stabilization Team (MUST). In FY 2003, CPEP averaged approximately 30 mobile visits per month (or one/day) and in recent months (June-September 2003) these numbers were even lower – approximately 20 visits per month. This low utilization of mobile services is perplexing – particularly given the stated DMH philosophy of resolving crises (and providing services) on site whenever possible. The reasons are not entirely clear, but may revolve around the fact that mobile crisis does impose additional demands on staff – as compared to doing site-based interventions. The CPEP Director is tracking the decline in mobile visits and is taking several steps to enhance mobile outreach response – including additional staff training, "secret shopper" quality checks, enhanced communication with other clinical directors, and specialized training for psychiatry residents.

For children/youth, most of the referrals for mobile crisis come via the Access Helpline (roughly 80%) while the remainder come from CSA's or the public schools. The MUST Team is staffed from 8:00am-9:00pm (Monday-Thursday), from 8:00am-6:00pm (Friday), and 10:00am-2:00pm (Saturday). All other hours are handled via an on-call system that is rotated among staff. Staff make every effort to respond within one hour if there is a true emergency. Helpline referrals are generally not "second-guessed" by MUST, although final decisions are made by the MUST staff as to whether to provide a mobile response.

The same volume issues for adults are also evident for children/youth. Backing out the youth forensic evaluations (a time-limited phenomenon), MUST provided 42 mobile visits over a recent six-month period – an average of seven/month. While some of this may be attributable to summer (non-school) months, it nevertheless calls into question whether mobile services are being utilized as needed and appropriate.

The DMH response to this drop in mobile visits is this may be a positive fact – namely that it may reflect that enrolled consumers are using CSA supported services for crisis (e.g. community support or ACT Teams).

Nevertheless, the Court Monitor finds that – while mobile services are available – there is significant concern about the low utilization of mobile services vis a vis other forms of crisis intervention. This area needs additional review by DMH before any valid conclusions can be drawn.

3. Development and Utilization of Site-Based Psychiatric Emergency Services

The DMH continues to provide site-based services for adults directly via CPEP and it contracts for site-based services for children/youth with Children's Hospital. The DMH indicates that the arrangement with Children's Hospital is working well overall. DMH contracts with Children's to augment its pre-existing staffing levels to handle this additional responsibility. It is noteworthy that the volumes of site-based visits continue to run higher than originally anticipated. Beginning in the fall of 2002 (and throughout 2003) the volumes for most months has been 140 children/youth visits or higher. As noted in the January 2003 Report to the Court, this has put pressure on both Children's Hospital staff and DMH to find ways to respond. DMH, on its part, has increased the dollar value of the contract (currently $250,000 per year) and has hired and deployed two DMH social workers from the Access Unit to help cover the evening shifts. In addition to the additional coverage, these DMH staff will have the ability – once trained – to approve the admission of FD-12's directly to Children's. Currently, FD-12's must go to alternative inpatient units.

At the moment, the amount of data collected on children/youth that are seen at Children's is minimal. It is anticipated that this gap will be closed via the cooperation of Children's staff and

with the addition of onsite DMH staff to assist with data collection and retrieval.

The adult site-based is done exclusively through CPEP. Overall visits to CPEP per month have experienced a significant decline from 2002 (down about 16%). Current visits average approximately 12/day. This decline appears to be attributable to two things – the transfer of children/youth emergency services and the current ability of the Access Helpline to authorize admissions to St. Elizabeths. Previously these St. Elizabeths admissions all went through CPEP. It should be noted that DMH is working with MPD and the Mayor's office in an attempt to change the underlying order that requires all FD-12's to go to CPEP. The intent is to officially authorize the ability for officers to take FD-12's to the nearest acute care hospital with psychiatric capacity. Needed admissions to St. Elizabeths would then be authorized by the Access Helpline.

The CPEP is staffed around the clock and has restructured its triage process to divide presenting consumers into different categories based on clinical need. Persons who fall into the severe or critical categories require clinical intervention within 15 minutes and those in the urgent or intermediate range within 30 minutes. All others are seen as soon as possible. The full process of triage, health/psychiatric evaluation, multi-disciplining case presentation and final disposition decisions by the psychiatrist averages a little over seven hours from initial presentation to discharge.

CPEP continues to function as the primary site for evaluation of involuntary psychiatric emergencies (FD 12's). In FY 2003, there were 1,548 episodes of consumers who were brought to CPEP involuntarily by the police – fully 39% of all site-based referrals. Of the total CPEP consumer visits in 2003, 35% were admitted to St. Elizabeths and 10% were admitted to community hospitals. This represents a decline in total numbers referred to St. Elizabeths from CPEP of 525 as compared to 2002. Some of this drop is a result of the fact that the Access Helpline can now authorize admissions to St. Elizabeths (236 Direct Admits in FY 2003). However, other contributing factors include an increase in the number of consumers admitted to community hospitals (both from CPEP and the Helpline) and the improvement in the overall milieu within CPEP.

CPEP also has the capacity to staff a limited number of extended observation beds. These function essentially as 23-hour beds and

have been an important component of the overall capacity of CPEP. With the addition of two additional extended stay beds in July 2003, CPEP is now averaging approximately 30 extended observation stays per month. It is noteworthy that over 77% of these consumers were diverted from inpatient admissions.

The CPEP staff have also worked to decrease the amount of time that police officers spend at CPEP with involuntary evaluations. Since May 2003, CPEP has arranged for ambulances to transport consumers to the D.C. General Emergency Department who may need emergency medical evaluation or care. Previously this transportation was done by the police and often involved multiple hours of waiting by the officers. In addition, the CPEP Director (and the DMH Director of Organization Development) have met with the MPD to address a variety of mental health-related issues – including public intoxication, hypothermia and the training needs of MPD officers. DMH has provided expanded information/training to MPD officers in 2003 – including the distribution of business cards with key DMH phone numbers on it and the FD 12 criteria for involuntary psychiatric emergencies. Additional mental health training for MPD's is being planned for 2004.

The continued remaining issue for CPEP is its location, poor condition and lack of easy connectivity to either medical services or other acute mental health services (e.g. inpatient care). This has been an ongoing issue and point of discussion between the Court Monitor and DMH leadership. DMH officials indicate that they have been meeting with the D.C. Hospital Association on this issue and the related issue of developing community-based inpatient care capacity that would be able to take involuntary admissions. While it is too early to tell for sure, the Court Monitor is encouraged that specific and concrete discussions are underway as to alternative ways to deal with these outstanding major issues. The Court Monitor will continue to track both of these issues very closely in the coming months.

4. Development and Utilization of Crisis Residential Beds

Each of the two previous Reports to the Court identified the need to provide crisis residential beds in order to preclude the unnecessary use of inpatient care for consumers in a crisis situation and requiring 24-hour intervention. As promised, the DMH did issue two RFQ's in the summer of 2003 – one for eight (8) crisis residential beds and one for Residential "Low Barrier" Crisis Services for the Homeless. Initially, the DMH received

one response to the RFQ for low-barrier beds. Subsequently the proposed response for low barrier beds was converted to a crisis bed proposal. The only initial response for crisis beds was from CPEP – to add two crisis beds. As noted above, there is now one additional 8-bed proposal for crisis beds under consideration. DMH has indicated its intent to move forward on both of these proposals. The issue of a lack of operating crisis residential beds remains and all conversations with DMH staff supported the conclusion that this service gap is continuing to put pressure on other parts of the acute care system – including admissions to St. Elizabeths.

The Court Monitor understands that DMH is ultimately dependent on viable providers to step forward on this service gap. The Court Monitor will continue to track this issue carefully and will continue to report to the Court on progress until this issue is successfully resolved.

5. Review of FY 2004 DMH Budget

As documented in the July 2003 Report to the Court, the FY 2004 base operating budget is at $194.8 million, with an additional $21.7 million reserve for potential Medicaid shortfall and a $2 million reserve to cover Court-mandated expenses. Including the reserve fund, the total 2004 Budget is $218.5 million. As of the time of this Report, the local funds component of the District's budget has been approved by Congress. The Federal funds portion is in a separate bill and has not yet been approved.

The Court Monitor has had particular concerns about DMH's access to the reserve funds for 2004 and as a result met with officials of the Office of the District's Chief Financial Officer (OCFO) on September 17, 2003. The Court Monitor requested and received a detailed response to specific questions as relates to the 2004 Budget. Given the critical nature of these questions and responses, the October 2, 2003 response from Dr. Gandhi (the District's CFO) is attached to this report (Attachment A). Perhaps the key statement is the response that relates to overall spending availability for DMH to which Dr. Gandhi responds, "I can assure the Court that the DMH Budget for FY 2004 will be supported at the $218.4 million level under all current and foreseeable circumstances."

The additional issue for the 2004 Budget relates to the accuracy of the projections for Medicaid and the question as to whether

the $21.7 million in Medicaid reserves will be adequate to make up the potential shortfall in budgeted Medicaid revenue versus actual. The OCFO response indicates (in question #5) that "we estimate that the potential shortfall (including the $21.7 million) could be as high as $34.1 to $35.5 million." The response further indicates that the DMH's ability to access these additional funds out of the reserve will likely be dependent upon reserves not being utilized by the other District Human Services agencies.

Overall, the Court Monitor believes that this letter was highly responsive to the critical budget issues identified. Nevertheless, multiple 2004 Budget challenges remain, to include: the ability of the District-run CSA to meet revenue and productivity targets; the ability to reprogram dollars into appropriate cost centers; the ability to forecast contracted CSA volume by agency and in the aggregate; the ability to effectuate Task Orders in a timely way with providers and that "rolls up" to an overall Task Order for each agency; and the ability to access the necessary reserves in a timely fashion so that both DMH and individual providers know the amount of funds that will be available for expenditure in 2004. The Court Monitor will continue to closely track 2004 Budget issues as well as the 2005 Budget process. (Note: It should be noted that as of this time of this Report that the OCFO has authorized DMH to expend the $21.7 million reserve, although official D.C. Council approval must still be obtained.)

6. Recommendations

The Court Monitor makes the following recommendations based upon the findings in this Report:

A. Multiple (and shared) issues still remain as regards the DMH's ongoing relationship with CSA's – both in the aggregate and for individual CSA's. It is recommended that DMH put together a 2004 Action Plan that details the major issues and proposed steps to resolve or improve these issues. The NCCBH high priority items should provide a basis for many of the issues. It is also recommended that the issue of individual provider capacity to perform in this new model be addressed in a frontal way – perhaps with the assistance of NCBBH.

B. The DMH has taken (or plans to take) concrete steps to improve ACT services. The steps are duly noted. It is recommended, however, that DMH review its overall capacity (going forward) to provide consistent leadership,

direction, and communication for ACT services in the District. The overall strategy to improve "what is" (i.e. existing ACT services) needs to be balanced with a strategy to develop "what should be" (i.e. new ACT services). This is a highly visible and critical service component that remains underdeveloped.

C. The DMH has clearly espoused a "mobile" philosophy for crisis services. Nevertheless, actual mobile services appear to be declining. It is unclear as to the factors that are prompting this change. It is recommended that DMH review the situation as relates to the use of mobile services for both youth and adults and report these findings back to the Court Monitor.

D. The DMH has undertaken a process that will hopefully result in both a new "home" for CPEP and community-based acute care beds that can manage the more difficult acute cases that currently go to St. Elizabeths. The Court Monitor strongly supports these efforts and recommends that the DMH present a detailed progress report to the Court Monitor by no later than March 31, 2004.

E. Efforts to-date to contract for crisis residential beds have been unsuccessful. The reasons as to why are unclear. The Court Monitor recommends that a careful analysis be undertaken within the next 60 days as to new options for successfully resolving this outstanding gap in crisis services. The results of this analysis should come to the Court Monitor for review and discussion.

CERTIFICATE OF SERVICE

I hereby certify that copies of the foregoing COURT MONITOR'S NOTICE OF SUBMISSION OF REPORT and the Court Monitor's REPORT TO THE COURT were served by first class mail, postage prepaid, this 2nd day of February, 2004 upon:

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