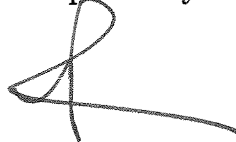
UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

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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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 25th day of January, 2005 upon:

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REPORT TO THE COURT

Court Monitor
Dennis R. Jones

January 25, 2005

I. Current Situation

In November 2004, the Federal Court approved the monitoring plan period October 1, 2004 through September 30, 2005. The Monitoring Plan included three principal areas for review during this time period:

A. Monitoring the progress of the requisite policy, practice, and data development capacity for each of the nineteen (19) Exit Criteria.

B. Monitoring the continued development and implementation of critical administrative and service 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 and/or the achievement of the required performance levels for the Exit Criteria.

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

The May 23, 2002 Court-approved Consent Order called for a Monitoring Report twice per year. This constitutes the fifth formal Monitoring Report to the Court.

II. Findings Regarding Exit Criteria

The Court-approved Exit Criteria tasks for FY 2005 fall into three categories: (1) the review of DMH-developed consumer satisfaction method(s) and consumer functioning review method(s); (2) the implementation of year three consumer service reviews for both adults and children/youth; and (3) the implementation of Exit Criteria for effective and sufficient consumer services. This Report will measure progress and current status for each of these areas.

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

The DMH has continued to refine its overall methodology for collecting and utilizing consumer satisfaction information. The current reported methods include four overlapping but distinct methods as follows:

1) Through its contract with the Consumer Action Network (CAN), consumer satisfaction will be obtained throughout the year – using a combination of formal surveys, focus groups, forums and other methods. The year one experience by CAN was very successful in terms of the

design of the instrument to be used; however it fell far short of expectations in terms of implementation due to a combination of DMH information system deficiencies (e.g. wrong addresses) and CAN's decision not to contact community providers for accurate information (due to concerns about confidentiality and consumer trust). Representatives from DMH and CAN have begun to problem-solve ways to make this an effective method for 2005. One of the positive learnings on all sides, however, is that a formal and comprehensive survey per se is not enough. Hence, CAN has proposed – and DMH continues to agree – that other methods should be added. These would include site-specific surveys and regular focus groups that give consumers and families the opportunity to voice their opinions.

2) DMH will conduct an annual Mental Health Systems Improvement Program (MHSIP) consumer satisfaction survey – which is done in compliance with the State infrastructure grant.

3) DMH will collect consumer satisfaction information from all providers on at least a semi-annual basis for analysis and aggregation.

4) DMH will log (by topic) all complaints that come to the Authority. The Office of Accountability and the Office of Consumer and Family Affairs will generate a report from this data on a quarterly basis.

The DMH intends to utilize the various streams of consumer satisfaction feedback in a variety of ways that would include: the DMH Quality Council (as described in the DMH Quality Improvement Plan); providing results to providers at regular meetings and seeking comment; and monitoring individual providers as to how they utilize consumer satisfaction and complaint information to improve care.

The DMH has likewise progressed in its proposed methods for measuring consumer functioning – with the intent of utilizing two major methods. The first is to utilize the existing Level of Care Utilization System (LOCUS) for adults and the parallel Child and Adolescent Level of Care Utilization System CALOCUS) for children and youth. Both of these standardized instruments provide the ability to assess individual consumer needs and then to ensure that the service system performs in a way that matches consumer need with actual service delivery. Hence these applications can be utilized at the individual consumer level but also in the aggregate to ensure the appropriate "fit" of service need to services provided. This becomes a dynamic tool in the constant need to balance both under and over utilization of services. The DMH requires that each consumer enrolled with a CSA have a LOCUS or CALOUS performed at the time of admission and then at 90 day intervals. The aggregate data obtained from this computerized process will be presented

quarterly to the DMH Quality Council – with the intent of analyzing the results to make ongoing systems improvements.

The second method proposed to measure consumer functioning is the Consumer Services Review (CSR) process. This is the method utilized by the Court on an annual basis as one of the ways to measure sufficiency and effectiveness of services. In the July 2004 Report to the Court, the Court Monitor recommended that the DMH develop ways to "internalize" the CSR methodology. It appears that DMH is in fact moving to do that. The DMH plan to utilize CSR is still evolving; however the basic framework is clear. DMH will utilize the HSO annual reviews to maximum advantage in terms of providing feedback to individual providers and service teams. For example the D.C. run CSA has indicated that it will utilize the CSR data to establish specific service improvement targets for the agency. This could well serve as a prototype for other CSA's. In addition, DMH intends to use the CSR method of evaluation (likely in modified form) to conduct its own routine oversight activities and any special reviews that are conducted. The DMH has scheduled a technical assistance session with HSO – with the clear intent of developing a rollout plan for the CSR process with all providers. This step will – over time – serve to reinforce the underlying philosophy of care embedded in the CSR model. It should also assist CSA's to adopt the CSR process in their own internal self-assessment and Q.I. activities. The DMH intends to share the aggregate data from its CSR-based reviews with the Quality Council. The overall intent – as with other areas – is to create a dynamic and continuous process for shaping the system.

Overall, the Court Monitor is pleased with the continued progress in conceptualizing and implementing both consumer satisfaction methods and consumer functioning methods. While both of these efforts are still in formative stages, it is encouraging to see efforts to both broaden and deepen these efforts. The next steps will be to formalize these plans and then to concretize the implementation strategies. The Quality Council needs to be formally put in place and the data-driven analyses need to be supported. The Court Monitor is very hopeful that the next year will see major steps forward in both of these areas.

B. Implementation of Year Three Consumer Services Reviews for Adults and Children/Youth

The Court Monitor has again contracted with Human Systems and Outcomes, Inc. (HSO) to conduct the reviews for both adults and children/youth. The same basic protocols as were utilized in years one and two will be used in year three. The target dates for the child/youth review are March 1 – 11, 2005 and for the adult review it is April 18 – 29, 2005.

The sample size for each review will remain at 54. Given past experience, once again an initial "triple sample" of 162 names will be pulled. An initial profile of each of these 162 persons will be done – with the intent of ensuring that persons are, in fact, active within the system and also that the final sample is significantly representative (i.e. in terms of age, levels of functioning, and selected from multiple provider agencies). The DMH has approved (and modified) its policy regarding "inactive/discharge" status for adult consumers who are no longer involved with a CSA. More recently the DMH has approved and circulated to providers a parallel policy for children/youth. While these policies (as they are being implemented) will reduce the gap between persons who are enrolled versus those who are active, it is not likely to solve the problem for year three reviews. Hence, the Court Monitor is discussing with HSO and DMH the potential need to do a data run that only includes persons who have been seen within a recent period (e.g. past six months).

The Court Monitor will again take on the responsibility (out of the Court Monitor's office) for contacting persons whose names have been selected for the sample. This approach contrasts to the year one approach, which worked through providers to obtain consents to participate. The Court Monitor has formalized a contract with the Consumer Action Network (CAN) which is a relatively new consumer–run organization in D.C. CAN has agreed to take on the task of engaging and training persons who will contact consumers and family members directly to explain the process and obtain consents. CAN employees will also work closely with HSO staff to provide upfront education for both providers and consumers.

The DMH has again agreed to select internal DMH reviewers who will be fully trained in the CSR process. These DMH reviewers will conduct 50% of the total review (i.e. 27 cases). This process has worked well in previous years – with DMH staff providing energetic and in-depth participation. As discussed in section IV A of this Report, one of the core strategies in the CSR process is to create persons within DMH authority who understand it as a model and who can also help to inculcate this understanding throughout the provider community.

The results of both reviews – should be completed in time to be discussed in the July 2005 Report to the Court.

C. Implementation of Exit Criteria for Effective and Sufficient Consumer Services

The Court-approved Consent order of December 11, 2003 anticipated that there would be discrete steps in the overall process of achieving the required performance levels for the fifteen (15) Exit Criteria that measure the

effectiveness and sufficiency of consumer services. The first major step in the overall process is for DMH to put in place two major prerequisites: 1) the development and implementation of specific policies and practice requirements, including the documentation of any methods utilized to verify the degree to which relevant policy and practice is being followed by providers and 2) the demonstration to the Court Monitor of the specific methods by which the DMH will collect and verify the integrity of the data points for each Exit Criterion. The Court Monitor has been clear with DMH (for those Exit Criterion that require policy and practice development) that actual performance levels will not be reported to the Court until this first major step is accomplished. As noted in previous Reports to the Court these two prerequisites constitute a major effort by DMH in that many of the exit criterion measure relatively new (or underdeveloped) services; hence these are areas for which policy and practice development does not exist. In like kind, the existing electronic data system does not capture (at the provider level) many of the data points. The purpose of this Report is to provide an update on these policy, practice and data development efforts.

1. Policy and Practice Development

By the Court Monitor's count, fourteen (14) of the fifteen (15) systems performance measures require at least one major policy. Of these 14, the DMH has policies fully in place for seven. The necessary policies and plans for the other seven are in varying stages of development and review (either internal or external). The DMH has indicated that the target date to have all of these policies and plans at the final review stage is the end of January, 2005. While there have clearly been delays from the internal DMH timelines for the initial drafts (December 1, 2004), it does appear that the DMH top leadership has made this process a high priority. There is a specific meeting with involved staff on a biweekly basis to review progress. It should be noted that for some Exit Criteria, there may be more than one policy involved; it is also true that some existing policies are needing to be amended to meet the full range of concerns (e.g. continuity of care). In addition, both of the homeless Exit Criterion (C/Y and Adult) require DMH to "demonstrate the implementation of a comprehensive strategy to engage and serve" persons who are homeless and SED or SMI. Hence, this is a major effort that will require concentrated focus at top management levels.

It is the Court Monitor's intent, beginning in February 2005, to review all policies, plans and practice requirements as to their acceptability to meet the mandates of the Exit Criterion. This process of review will be formally documented to DMH – with the explicit description of any charges (or clarifications) that may be needed.

2. Data Collection and Verification

The whole area of data collection for each of the Exit Criteria is also a work-in-progress. The DMH has presented to the Court Monitor an overall outline for the development of data collection and data integrity systems. The DMH (as noted in previous Reports to the Court) will need to modify its existing electronic data system via providers in order to input data on many of the Exit Criteria. This will be done via enhancements to the eCura system and will require mandatory "event screens" in many categories to ensure that providers are accurately imputing information (e.g. referral data and acceptance into supported employment program)

The DMH has indicated that these information system upgrades should happen by April 2005. Following that, there will inevitably be a period of refinement and necessary training for all providers.

The Court Monitor intends to do an initial review of these enhancements. However, before actual data elements are certified to the Court, the Court Monitor will engage an outside expert to do an initial data integrity review.

Overall, the Court Monitor believes that this whole process of policy and data development is moving. However, timelines have slipped due to competing demands and/or other factors. It will be critical that the next 3 – 6 months show concerted progress in all of these areas. The Court Monitor will continue to document progress to the Court.

III. Findings Regarding Development and Implementation of Critical Functions in the Court-ordered Plan

A. Review of the Overall Functioning of Core Service Agencies (CSA's)

The Court Monitor reviewed the continued development of Core Service Agencies (CSA's) within the DMH system. For this Report, there was specific attention to: growth in capacity (both in the number of CSA's certified and in the total number of persons enrolled in the system); the ability of the DMH system (and individual providers) to stabilize core business functions (e.g. contracts, claims payments); an analysis of specific service volumes; a review of forecasted growth in the system vis a vis financial constraints; and the development of the Foster Care Initiative and it's impact on child/youth services.

1. Growth in Capacity

The DMH over the past year has certified six new CSA's; 2 previous CSA's have stopped providing DMH services – so that the total number of CSA's is currently at 23. In addition, one new specialty provider has been certified (current total of 2) and 4 new sub providers (total of 5). Hence, at the time of this Report that there are 29 different providers of service operating under DMH certification and financial support. It is also noteworthy that there are 19 new provider applications in process – of which 12 are agencies with a primary focus on children, youth and families.

These 29 providers have – in the most recent fiscal year (FY 2004) generated over $43 million dollars in community-based Mental Health Rehabilitation Services (MHRS). At a macro performance level, this development of a community-based system (with duly certified providers, distinct service categories and a Medicaid-reimbursable plan) stands in stark contrast to the non-system that existed less than three years ago. The 29 providers (including 22 CSA's) have enrolled nearly 20,000 persons total (adults, children/youth). Of this total, 4276 are children/youth and approximately 15,700 are adults. The overall growth in enrollments is 37% over the past year – including 31% for adults and 57% for children and youth. All indications are that the provider system to date has been willing and able to handle the overall growth in the system. As noted in II B, however, the total number of <u>enrollees</u> does not constitute <u>active enrollees</u>. As the disenrollment policies are implemented, DMH officials estimate that the number of enrollees may drop by as much as 25% (to approximately 15,000 total). It should be noted that the DMH disenrollment policies require that providers follow up and seek out consumers who have not kept appointments. This policy is intended to preclude premature disenrollment and to force needed outreach. The DMH is fully aware that only <u>enrolled</u> and <u>active</u> consumers count toward the established penetration rates as measured through the Exit Criteria.

2. Core Business Functions

In terms of core business functions, many of the same general issues that were reported on in the January 2004 Report to the Court still remain. These issues tend to cluster in three areas: (1) the inability for DMH to have timely access to its appropriated budget. (2) Delayed timeliness in developing 2005 contracts with providers. (3) Development of consistent business practices within DMH and by individual providers.

As relates to the to the 2005 budget, this issue will be discussed at length in Section III C of this report. The simple facts are that DMH has not had access to its full budget. In FY 2004 fully $37 million was held in

reserves ($35 million in a Medicaid reserve and 2 million in a pay-as-you go mandate). While DMH did eventually access all these funds, a large portion did not get approved until April 2004 – six months into the fiscal year. The net result was that DMH (since it cannot obligate funds it does not have loaded in its budget) had to negotiate a series of Task Orders with individual providers and was consistently in a "start-stop" mode in terms of planning and the timely payment of providers.

The 2005 scenario, unfortunately looks like a repeat of 2004. The DMH budget of 2005 has $11 million in reserves. Delays in the District's "loading" of DMH Medicaid revenue made it impossible for DMH to have signed Task Orders with providers until mid-November. Because of the reserve amount, the DMH has been forced to issue Task Orders (dollar contracts) only for the first quarter 2005. Depending upon the release of the $11 million reserves, the DMH maybe forced do quarter – to – quarter Task Orders. The DMH has attempted to be responsive to provider concerns as relates to the timely processing of Task Orders. However, in doing so, there has been significant disparity between DMH target dates (e.g. when Task Orders would be out to providers) and the reality. All of this leaves providers in an exceeding tenuous position as to when payments for 2005 services will occur, whether to keep accepting referrals for new consumers, and who and what to plan going forward. The Mental Health Coalition (a network of DMH providers) has described this in a November 12, 2004 letter to the DMH Director as "a growing crisis for providers". While the Court Monitor believes this short term crisis (in terms of Task Orders and claims payment) will be resolved soon, the longer-term challenge of predictability and stability in the fundamentals of the business model (e.g. timely contracting and payment for authorized services) is clearly not fixed.

One of the longstanding issues between DMH and providers appears close to resolution–namely the ability to reconcile with providers (on an electronic basis) the specifics as to which claims have been paid and which have not. DMH indicates that an electronic upgrade to its information system will be in place by January 31, 2005. These "remittance advices" will allow providers to know (for each batch of claims submitted) the exact payment status. This has been a source of frustration since the beginning of the MHRS system in that the previous reconciliation process was exceedingly labor intensive.

In terms of business processes for FY 2005, the DMH is also moving to implement tighter timelines for the adjudication and processing of claims for payment. All claims for a prior period must be received at DMH by the 10th of the month; DMH staff will then adjudicate and send forward for payment by the 15th of the month all claims that are "clean". The intent is that the subsequent "warrants" for payment will occur by mid-month,

allowing 14 days for accounts payable to make payments to providers. The DMH and the OCFO will no longer allow checks to be picked up; rather they will be mailed on a monthly basis. Hence, the goal is to complete the entire cycle from receipt of claim to actual payment within 30 days. It should be noted that DMH data indicate that for FY 2004, over 82% of claims were processed and "warranted" for payment within 30days. However, DMH data does not show when actual payments occurred. Anecdotally, providers indicate that there are frequent (and inexplicable) delays in actual payment once the warrants for payment to the D.C. Treasurer have occurred. The Court Monitor is pleased with the concrete steps that DMH is taking to refine its claims adjudication process. These steps in and of themselves do not solve the larger issues referenced earlier (access to funds and timely development of contracts); however, they do put the DMH and its providers in a position to do business in a more predictable fashion once Task Orders are in place. It is evident that many providers still have considerable work to do in refining there own internal business practices to ensure that claims going to DMH are timely and valid. It is also true that DMH – to meet its own ambitious 30-day payment cycle – will need to simplify and streamline its internal "hand offs" from one work section to another. The Court Monitor encourages the development of methods to measure the percentage of successful performance for each of the major steps in the process (i.e. claims adjudication, issuance of warrants, and actual payment to providers).

3. Service Volume Analysis

The Court Monitor also looked in this review at the issue of the relative use of individual MHRS services as part of the total mix. Perhaps the most compelling fact is that – out of the total of $43 million in MHRS services for FY 2004 – fully $13.8 million was billed for Day Services. This represents nearly 1/3 of total dollars billed (30.9% for Adults and 36.9% for Children/Youth). The concern is that Day Services – as part of the overall array of services – represents a somewhat generic and composite mix of services. As a result, many mental health jurisdictions across the county are moving away from the open-ended funding of Day Services to services that are more targeted and/or time limited (e.g. ACT or supported employment services for adults and community support or CBI services for children, youth and families). It is telling, for example, that ACT services only generated $749,270 for FY 2004 and CBI an additional $231,172. Note: DMH indicates that some ACT services in 2004 may not have been billed appropriately. Nevertheless, all of this points to a major maldistribution of service dollars as one looks at the basic principles of adult recovery and childhood resiliency as outlined in the Court Ordered Plan.

The DMH – to its credit – is taking on this issue frontally. It has clearly signaled to providers that it intends to cap services starting in 2005 and will be looking to redirect these dollars to services that are more clearly targeted to the goals of recovery and resiliency. As indicated in the July 2004 Report to the Court. DMH has committed to the development of four new ACT teams in FY 2005. DMH has also indicated to providers that it will begin to limit the time periods for Day Services – with the intent of making these services both more focused (in terms of treatment goals) and time-limited. While the details of this redirection of funds are still being developed, it is clear to the Court Monitor that the DMH is moving assertively to begin correcting this imbalance in the system. Like most issues, this will not be a short-term fix; providers will need to be given adequate direction and time to make necessary programmatic and personnel shifts.

4. Forecasted Growth

Another major issue reviewed by the Court Monitor was the question of financial sustainability of the community system – given the overall growth in providers, persons enrolled, and services provided. It does not appear that the current trajectory of growth can be sustained. The community system generated $36.4 million in MHRS dollars in FY 2003; 2004 totals are not yet final, but will likely be in excess of $45 million. With a flat overall DMH budget, even the redirection of funds (e.g. residential funds – as noted in the July 2004 Report to the Court and the Day Services funds as noted earlier in this section) there will not be sufficient dollars to support current growth patterns. The DMH is engaged in the discussion of several strategies – each of which will be important to the longer-term management of an effective community –based system. The Court Monitor has discussed with DMH leadership five different strategies:

a) Capping 2005 contracts
The DMH has sent a clear message to providers that – even if the $11 million reserve issue is resolved – there will not be sufficient funds to meet projected provider spending. That magnitude of the gap is born out in the fact that providers (in the aggregate) made requests for $89 million in funding for 2005. DMH will have roughly half of that amount. Hence it will be critical for DMH to negotiate as soon as possible with individual providers as to total dollar contracts and the specific service targets. While 2005 projections are obviously the most pressing, these discussions will need to become multi-year – so that both DMH and individual providers have a clearer sense of realistic forecasting. To date, most providers have assumed that any eligible MHRS service that was provided would be reimbursed. For 2005 that assumption will not be valid. Hence, expectations must be

managed via a combination of limiting referrals to providers, pre-authorizing (and capping) certain services and capping overall dollars available. Needless to say, the sooner in the year 2005 contracts are finalized the better for all.

b) Implementing the policy of priority populations.
Both the Court-Ordered Plan and the Mental Health Establishment Act were careful to articulate the fact that financial realities would dictate that priority populations be "first in line" to receive public support. These priority populations are broadly defined as adults with serious and persistent mental illness (SPMI) and children/youth with severe emotional disturbances (SED). To date, the DMH has not had to emphasize this policy – but FY 2005 appears to be the necessary time to begin this transition. DMH leadership estimates that 50% of current enrollees meet the definition of priority population and that eventually this percentage should be closer to 80%. The DMH has begun to form work groups (inclusive of providers) that will work through the multiple issues in this effort.

c) MCO enrollees
The District of Columbia, through its Medicaid office, has four health care plans for Medicaid recipients that are contracted to privately operated managed care organizations. These plans all have built into them a limited mental health benefit – which includes e.g. inpatient care, outpatient counseling and pharmacy. There are two major issues of concern – one being the coordination of care and the second the coordination of benefits. DMH estimated that there may be as many as 3700 individuals (primarily children/youth) who are currently enrolled in the DMH provider system. The problem is that currently DMH is paying for the entire cost of care through the MHRS billing system, as there is no mechanism in place for either DMH or individual providers to bill MCO's for eligible services provided to MCO enrollees. DMH is currently working on a method to identify MCO consumers at the time of enrollment. Policy discussions are also occurring at leadership levels (and two interagency workgroups have been meeting) as to how best to coordinate care and how to "panel" individual providers so that they can bill. In a constricted resource environment, it will be essential that DMH tap into available benefits and revenue that can take some of the burden off DMH.

d) CFSA enrollees in DMH
The DMH and CFSA have worked together in a very collaborative manner in bringing up the Foster Care Initiative (to be discussed in detail later in this section). The use of start up Federal grant funds should be a major step forward for both systems. The overall goal – beyond the Foster Care Initiative per se – has been to create within

DMH the capacity to meet the mental health needs of CFSA children, youth and families; this contrasts to the historic model which was that CFSA had to develop and fund its own mental health system to meet its needs. DMH indicates that approximately 1000 CFSA children, youth and families have been referred to DMH since the spring of 2004 – which is concrete evidence that the new interagency model is beginning to work. The concern, however, is similar to that of the MCO's – in that it does not appear that CFSA has transferred any funds to the DMH to help support the local match requirement. It is reasonable to assume that these CFSA purchased services have historically been primarily from local funds. Hence, any CFSA contribution would – at most – only have to be at the 30% match level. The Court Monitor encourages the two agencies to work out a shared funding approach that matches their excellent record-to-date on the program side. As with the MCO issue, this can be another way (from a revenue standpoint) to support the continued development of child/youth services through DMH.

e) Peer Specialist Initiative
The DMH has started a process that is intended to shift services in a way that is fully congruent with the recovery model. One of the ways to do this is to engage consumers in a very direct way. This can take the form of actively engaging consumers as to recovery-based ideas. It can also go all the way to consumers organizing to actually provide services. The DMH is committed to the full continuum of options. One of the specific ideas that is currently in process is the Peer Specialist Program. This is an intensive training program – with 16 candidates having finished the 2 week classroom training in November 2004. The process now will include "field" placements for these 16 customers. As a critical component of this initiative, DMH is moving to ensure that all certified providers (in compliance with MHRS standards) hire Peer Specialists for community support, ACT and CBI services. The Specialists have also been providing evening services at St. Elizabeths 4 times per week and on Saturday; this service has been very well received. The future intent is to begin soliciting proposals from consumers for drop-in or other consumer-run programs in the Spring of 2005. National experience indicates that consumer-run programs can be highly effective in terms of engaging other consumers in innovative, recovery-oriented models.

In addition to these five major initiatives, it is worth underscoring the issues that were raised in the July 2004 Report to the Court as relates to the DMH – run public CSA (DC CSA). As dollars get tighter – the pressure for all CSA's to meet productivity and billing targets will increase. The continued gaps between gross revenue and gross cost at the DC CSA are a source of continued discussion and perceived lack of

fairness among contracted CSA's (501c3's). The Court Monitor believes that FY 2005 will "tell the story "as to whether this part of the CSA system can perform at levels that are acceptable and sustainable going forward.

5. Foster Care Initiative

The last major CSA issue reviewed was that the Foster Care Initiative and its initial impact on DMH and CSA's. As described in the July 2004 Report to the Court, the U.S. Congress appropriated $14 million in Federal funds to be used by CFSA and DMH – with the goal of significantly improving the care and treatment of children, youth and families who are in the D.C. Foster Care System. The Mental Health component was 3.9 million for FY 2004. The DMH, as a part of this initiative, issued five different Notices of Funds Availability (NOFA's). Of these five, three initiatives are at a point where providers have been selected, contracts have been negotiated, and services are soon to begin. These three initiatives include:

a) Multisystemic Therapy (MST)
This initiative will be provided by Youth Villages, an organization new to the District but with a very successful track record in other jurisdictions. The MST program will begin in January 2005 and will be targeted to youth ages 10-17 who are currently in or returning from residential treatment settings (or who are at risk of out-of-home residential placement). MST is a high intervention model for youth and families with complex and multiple problems (e.g. histories of violence, drug abuse, and school failure). It is targeted to reach up to 96 families in year one.

b) Intensive Home and Community-Based Services (IHCBS)
This contract will be with First Home Care Corporation, a child and family-based agency with a very positive track record in the District. First Home will – as part of the IHCBS grant – provide intensive home-focused services to children and youth who are seriously emotionally disturbed/behaviorally disordered and who need an array of mental health and support services: The focus is team-based – with teams available 24/7. 72 – 90 different children/families will be served in year one.

c) Mobile Response and Stabilization Services (MRSS)
This initiative has been awarded to the Drenk Center – a New Jersey – based organization that has successfully implemented similar programs in different New Jersey counties. The MRSS program will provide mobile crisis support to foster youth, families, and others (ages 5-21) at the site of any escalating behavior. Not only will

immediate crisis intervention occur, but Drenk will provide up to 8 weeks of follow-up crisis stabilization if needed. The demand for these services will dictate the volume.

In addition, DMH is negotiating with several national organizations to develop a training "toolkit" for local child/youth providers in order to improve trauma treatment for children/youth. Funds are designated for this effort, and it appears that DMH will soon negotiate a final contract with a leading trauma center from North Carolina.

DMH is also in the process of expanding the capacity of its existing Assessment Center- with the goal of providing CFSA with a local resource that provides timely and relevant evaluations for foster care youth – especially as it relates to placement planning. The wait times for evaluations to be done are now down to two weeks or less; this contrasts with the 3-6 months waits from a year ago.

All of these initiatives are being planned with ever-increasing collaboration between DMH and CFSA. The Court Monitor is very pleased with the breadth and depth of these initiatives–utilizing both local agencies and highly-recommended outside organizations. The DMH has also made major strides in it's work with the Youth Services Administration (YSA) – which will be detailed in the July 2005 Report to the Court. The major concern is the longer-term sustainability of these efforts–given that these FY 2004 funds which must be fully obligated by the end of FY 2005. Congress has appropriated an additional $1.25 million for FY 2005, but these funds are largely dedicated to supporting the Assessment Center expansion and creating the necessary infrastructure within DMH. The key to future sustainability will be in the ability to successfully build MHRS capacity for these new services. This will take concerted work by DMH, CFSA and MAA. It will likely mean changes to existing MHRS services. Ideally a process of implementing MHRS billing can be implemented before grant-funded programs expire. The Court Monitor will continue to track the development of this exemplary interagency effort.

B. Review of Access and Crisis Response Services

1. Access Helpline

The DMH continues to directly staff and run a 24/7 specialized Team that performs a variety of functions including: (1) telephone assessment and triage of all incoming calls for service (2) dispatching mobile crisis teams for both adults and children/youth (3) referral (or

transfer) of non-emergent new consumers to a CSA of choice and (4) the care coordination functions for the DMH authority (including prior authorization for any admissions to St. Elizabeths, ACT services, CBI services and Day services).

In terms of volume, the average number of calls answered per month in 2004 is slightly over those of 2003. The percentage of abandoned calls (persons who have hung up before a call is answered) is running about 2%; this represents a decrease from the previous year, in which the abandonment rate was at 3%.

It is evident that this unit continues to function in a way that matches the "Hub" concept as articulated in the Court-ordered Plan. These include the following: initial telephone triage on a 24/7 basis; mobile team dispatch as clinical assessment dictates; crisis backup and dispatch support to other health and safety systems (e.g. MPD and YSA); source of information, assessment and referral for new consumers; and serving as an integral part of the necessary prior approval and continuity of care system for DMH (e.g. prior approval for admissions to St. Elizabeths).

2. Capacity and Utilization of Mobile Teams

As will be discussed below, there has been a major interim shift as relates to the Comprehensive Psychiatric Emergency Program (CPEP). For a number of reasons, the DMH Authority has assumed the direct responsibility for managing CPEP (as opposed to the previous management as a part of the DC CSA). The Director of the Access Helpline has been deployed to also manage CPEP on an interim basis.

CPEP continues to have direct responsibility for the provision of mobile crisis services for adults. The child/youth mobile services are done as a part of the DC CSA child/ youth team via the Mobile Urgent Stabilization Team (MUST).

On the adult side, the same issues of low utilization for mobile crisis continue (as discussed in the January 2004 Report to the Court). By way of comparison, over 30 mobile crisis units per month were done in FY 2003. Starting in the summer of 2003, these numbers dropped to about 20 per month. For FY 2004, DMH staff orally indicate that approximately 17 mobile crisis units per month are being done (hard copy of data could not be obtained).

The apparent reasons for this dropping utilization are that the same staff that do site-based intervention (including staffing the extended observation beds) also do mobile crisis. The net result appears to be

that mobile crisis services occur if (and only if) adequate staffing is available.

The Court Monitor agrees with the DMH Report entitled "CPEP 90 Day Recommendations." Among many other recommendations in this report are ones that propose that mobile outreach be organizationally separated from the rest of CPEP. This would remove the staffing conflict. It is also suggested that the separate mobile crisis team be physically housed at the mental health Authority and operate under the direct control of the Access Helpline. This model would then provide for a more focused and better trained staff that could also be available to provide a range of in-home or onsite crisis stabilization services.

The DMH leadership has expressed support for this new structural approach and for all of the other substantive recommendations. The intent is to accomplish this new model in this fiscal year – with funds having already been identified.

On the child/youth front, the MUST Team appears to have increased significantly its volume from 2003 to 2004. The January 2004 Report to the Court noted with concern that only 7 mobile units per month were done for the last 6 months of 2003. 2004 data as provided by MUST show an average of 17 crisis responses per month. While it is not possible (with this data alone) to make judgments as to the overall adequacy of this service, it does appear that there is a clear team – based structure for children/youth and that a variety of interventions and responses are being performed by the MUST Team.

The Court Monitor is hopeful that the upcoming year will see significant improvement in the availability and utilization of adult mobile crisis services – consistent with community need and the DMH's own philosophy of care.

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

The DMH continues to provide site-based services for adults through CPEP – with the interim organizational structure as discussed in III B 2. The DMH continues to contract with Childrens National Medical Center hospital to provide site-based Psychiatric Emergency Services for children/youth.

The DMH staff continue to be pleased with the contractual arrangement with Childrens. Overall volumes appear to have stabilized – with lower summertime volumes (low 100's per month in terms of units) and the remainder of the year ranging form 157 to 212

per month. These overall averages for 2004 are slightly higher than 2003. The basic arrangement between DMH and Childrens remains the same. Childrens Hospital has specially trained staff who provide the front-line evaluations for children/youth; this includes psychiatric staff. Childrens has assigned a nurse to this effort for the evening time period (4-12 p.m.) when volumes are greatest. DMH continues to provide two social workers who work collaboratively with Childrens staff during the 4–12 p.m. timeframe. Children/youth who need inpatient admission (and who are voluntary) can be admitted to Childrens or to other local inpatient units. Involuntaries (FD-12's) need to have the authorization of one of the specially trained DMH social workers if they are to be admitted to Childrens. Without this authorization, they must go to an alternative inpatient unit (typically either Riverside or PIW). The Court Monitor is pleased with the overall development and progress of the site-based service for children/youth. The one continuing gap is the lack of data on children/youth seen at Childrens (e.g. basic demographic, diagnostic and disposition data). It would appear that this kind of basic data would be critical for both DMH and Childrens to make further decisions about this program.

CPEP continues to function as the exclusive site-based facility for adults. In terms of overall volume, the number of total consumers seen at CPEP has continued to decline – from approximately 12 per day in 2003 to 9 per day in 2004. However, those averages mask several significant things that have happened at CPEP in the past year. First, as noted earlier, the DMH Authority took over the direct management of CPEP in the spring of 2004. This decision was made in tandem with the bed crisis at St. Elizabeths – which caused intense focus on the front–end assessments done at CPEP. The DMH certified CPEP to provide extended psychiatric assessments, stabilization and observation at CPEP–moving from a 23 hour maximum stay to 72 hours. DMH also instituted a daily conference call with high-level representation from various sections (e.g. DMH authority, CPEP, Office of the Attorney General and the DC CSA). The purpose of this call was to ensure that all available community resources were utilized prior to a decision to admit to St. Elizabeths. These two elements (use of extended observation beds at CPEP and an aggressive community triage effort) have reduced the number of involuntary admissions at St. Elizabeth's by nearly 2/3rd (as compared to the prior year). Even though the facility crisis at St. Elizabeth's was abated (at least temporarily) these triage efforts proved so successful that DMH has continued them. The total number of involuntaries brought to CPEP is running higher than 2003 (currently at an average of approximately 150 per month); however, only 52 out of the 150 are subsequently admitted to St. Elizabeths (roughly 1/3). This is an impressive

performance on the face of it – assuming that adequate alternatives are being found.

During the summer and fall of 2004-as part of the interim DMH authority management–there has been an overall evaluation as to the future role, structure and location of CPEP. Among the recommendations made to the DMH Director are several that are of high import to the Court Monitor. These include: (1) that CPEP be permanently incorporated into the functions of the DMH Authority–working as an integral part of the Care Coordination Team. (2) that the leadership positions of Director for CPEP and Medical Director be actively recruited (3) that the daily conference call be maintained among the interested parties (4) the number (and staffing) of the extended observation unit be formalized and; (5) the mobile crisis unit be staffed separately and be made accountable to the Director of the Access Helpline.

Overarching all of these issues is the ongoing dilemma of finding a suitable building and site for CPEP. The DMH was very hopeful during the summer/fall of 2004 that a building had been located that would meet the CPEP's needs. However, unfortunately this possibility fell through due to issues of the long-term financial viability of the building's owner. DMH has subsequently begun discussions with District Officials about the possibility of rehabbing a portion of the old D.C. General Hospital to use for CPEP. While it is too early to say for certain whether this site will work for all concerned, there are clearly some positives to this site, and apparent support from the key players e.g. Office of Property Management. These include: (1) space that would work much more effectively for the extended observation unit; (2) access in the building to the urgent care center for purposes of providing medical triage and support; (3) access to other medical supports (e.g. stat lab) and (4) only moderate amounts of rehab that would need to be done for the building to be functional.

Overall, the Court Monitor is pleased with the heightened focus that CPEP has gotten in the past year. While this was initially prompted by the St. Elizabeths facility/bed crisis, the DMH has maintained high levels of energy toward creating an effective adult site-based program. The recent CPEP recommendations have been positively received by the DMH Director. The next 90 days will be critical in terms of moving on this recommendation and continuing the quest to find a suitable long-term "home" for CPEP. The Court Monitor will continue to provide updates on all of this in each Report to the Court.

4. Developments and Utilization of Crisis Residential Beds

Previous Reports to the Court have detailed the struggles that DMH has had in finding viable providers for needed crisis residential beds. Progress has been made in the past year. One existing provider (Woodley House) has converted its pre-existing 8 bed transitioned residential unit to a crisis residential model. The crisis residential program requires higher levels of staffing (e.g. psychiatric and nursing availability) and is therefore able to take persons who are at higher levels of acuity. A second facility (So Others May Eat – SOME) will begin to operate a 7 – bed crisis program on March 1, 2005. It appears that all of the issues (certificate of occupancy and the type of certification) have now been resolved.

8 beds (plus 7 to come) will hopefully begin to meet the previously unmet need. The ongoing issues will be in managing lengths of stay – which ties directly to the availability of the community supports (e.g. supported housing). The Court Monitor is pleased with the progress in this area and will continue to track utilization and the overall adequacy of this much-needed service.

C. Review of FY 2005 DMH Budget

As noted in the III A section on Core Service Agencies, the issue of the FY 2005 budget continues to be a major one for DMH and the Court Monitor. $11 million for FY 2005 DMH budget was placed into a reserve under the requirements of the "criteria for spending Pay-As-You-Go Funding Act of 2004 (DC Act 15-487, enacted August 2, 2004). The major provisions for accessing these funds centered around assuring the OCFO that necessary improvements in the cost reimbursement process were made and documenting that Medicaid revenue projections necessitated these additional funds. Both this Report to the Court and the July 2004 Report to the Court have documented the enormous toll that these reserves place on DMH and the provider community. The costs can be measured in several ways; 1) the dollar cost for local providers who have had to borrow funds in order to keep operating – due to delays in receiving timely payments; 2) the costs in terms of the "trust" factor between D.C. Government (with DMH as primary) and the provider community. At a time when stability and predictability in core business functions should be in place, there has instead been a prevailing climate of uncertainty and lack of trust that D.C. Government could and would consummate contracts and pay bills and; 3) the "opportunity" costs – which translates into the fact that top leadership both at DMH and individual providers spend inordinate amounts of time and energy managing money flow. The net result is that critical leadership tasks (e.g. improving service mix, doing multi-year strategic planning and implementing service improvement methods) all get short shrift. As noted in the July 2004 Report to the Court, FY 2005 was anticipated as a year in which to make major studies in service improvements. The Court Monitor finds that this service

improvement focus has not happened with needed force and attention – due directly to all of the budgeting and payment uncertainties.

On the positive front, the OCFO has (as of Dec 22, 2004) taken the major step of certifying to the Mayor and the District Council that the $11 million for DMH should be released. Specifically the letter to the Mayor (dated Dec 22, 2004) indicates that (as relates to DMH) "improvements in the cost-reimbursement process have been made and Medicaid revenue projections indicate that the requested funds remain necessary". The District Council has reconvened for calendar year 2005 and every indication is that the Council will act on this request in a timely manner; if the Council does not raise objections, funds could be released as early as February 7, 2005. This will then allow DMH to move forward as quickly as possible to negotiate and finalize Task Orders with providers for the remainder of the year.

Going forward, the Court Monitor will track very closely the development (in terms of total request) and the accessibility (in terms of any reserves) of the FY 2006 Budget request. Simply stated, the current methodology (with all of its attendant uncertainties) is an untenable model – if the DMH is expected to move aggressively toward the requirements of the Court-ordered Plan.

IV. Follow-up on Previously Identified Recommendations

A. Congressional Action on the Ervin Act

As noted in previous Reports to the Court, there have been inordinate delays in getting Congressional action on the needed amendments to the Ervin Act. The Court Monitor is pleased to report that Congress did pass H.R. 4302 (District of Columbia Mental Health Civil Commitment Modernization Act of 2004) on November 30, 2004 and it was subsequently signed into law by the President. Both the DMH and the Mayors office should be commended for their concerted efforts this year to get action on this bill.

This legislation puts into final form the key components of the modernization of the civil statutes for the District as mandated by the Court-ordered Plan. It also makes it legally possible for local acute-care hospital patients to accept involuntary patients – another key mandate of the Court-ordered Plan (as discussed in IV C).

The next major step for DMH (beyond the acute care initiative) is to work out the protocols and coordination for the processing of the nearly 500 persons who are currently committed – and whose rights should be enforced under the terms of the new statute. The Court Monitor will continue to track the implementation of this effort. The delays in legislative action should not cloud the fact that this element of the Court-ordered Plan is now in place and

it will provide another critical building block toward "the development of an effective and integrated community-based system of care in the District."

B. Implementation of the Local Acute Care Bed Plan

The DMH has been actively working with the local Hospital Association and with individual acute care hospitals regarding the implementation of the acute care plan. Timelines for implementation have been extended due to unforeseen complications but it now appears that two local hospitals are ready to participate if both facility and rate issues can be resolved.

The population in question are persons with acute and severe mental illness who are admitted as involuntary patients. Historically (and currently with few exceptions) these persons are admitted to St. Elizabeths. The goal (per the requirements of the Court-ordered Plan) is for involuntaries to be admitted to local acute care hospitals with specialized psychiatric units. Several developments in the past 6 – 9 months are noteworthy. First, the DMH continues to work very aggressively to divert admissions from St. Elizabeths whenever that is clinically and legally appropriate. Admission rates to St. Elizabeths have dropped dramatically because of this effort. Up until April 2004 (when the facility crisis at St. Elizabeths mandated action, the average admissions per month at St. Elizabeths was typically 130 – 150 per month. Since June 2004, the average admissions per month are 52; this constitutes a decline of nearly two-thirds. The major lessons learned are that: (1) aggressive care management strategies can avoid many inpatient admissions altogether; (2) the extended observation unit at CPEP (up to 72 hours stay) can help to stabilize persons who need extended observation and; (3) persons who are voluntary and in need of hospitalization can access existing beds in the community.

Hence, the remaining challenge is to deal with the <u>involuntary</u> admissions. The overall diversion efforts have led DMH to believe that a total of 17 beds are needed to handle involuntary admissions. The general parameter of agreements with willing hospitals would be: (1) DMH will assist in funding the capitol upgrades necessary to provide adequate security; (2) involuntaries who need more than 15 days of inpatient care will be transferred to St. Elizabeths; (3) Hospitals will bill 3rd party sources for the care and treatment (including Medicaid) if the patient is covered; (4) DMH will reimburse hospitals for patients who are indigent (both the inpatient daily rate and professional charges).

One of the two hospitals that are interested has four available beds. This facility will need some upgrades to handle security. The other remaining issue is working out the protocols (and the mechanics) to do video conferencing at the Hospital for necessary Court proceedings. The District Superior Court has expressed its willingness to handle Court proceedings via

video-conferencing – but the details are still being arranged. As soon as the facility and video-conferencing issues are resolved, this facility will be ready and willing to take involuntary admissions.

The other hospital has capacity to provide 13 beds. The major issue at this site is that the current Medicaid DRG rate is too low too handle this population at the projected lengths of stay. Hence, the DMH (through the Office of Medicaid) will need to amend the current Medicaid State Plan. DMH staff have begun working on this State Plan Amendment (SPA). Best estimates as to when the SPA will be approved and facility upgrades completed is late spring/early summer of 2005. DMH leadership is committed to beginning this effort with local funds until the Medicaid DRG rate issue is resolved – provided that overall negotiations with the hospital are concluded. The DMH has also begun work on an information system upgrade that will allow DMH to know – on a daily basis – the essential facts on all involuntarily admitted patients. The target date for this upgrade is March 2005.

The Court Monitor is concerned about the delays, but has every reason to believe that DMH is doing everything within its power to move forward on this critical issue. The Court Monitor will continue to track these developments closely and to report findings to the Court.

C. Follow-up on Status of Assertive Community Treatment (ACT)

As indicated in the July 2004 Report to the Court, the DMH has moved forward with its commitment to expand ACT services by adding four additional teams. The DMH has targeted one of the four new ACT Teams for Pathways to Housing – an organization that serves persons with co-occurring serious mental illness and substance abuse – and who are also chronically homeless. This very successful model has one ACT Team currently that will serve up to 75 individuals. The existing ACT team has successfully found housing for 33 consumers. DMH and the Housing Authority have worked out an arrangement for 65 permanent housing vouchers and 75 "bridge" vouchers so that people can get housing quickly.

The DMH issued a Notice of Funding Availability (NOFA) in late October 2004 for organizations interested in applying for one or more of the these three additional ACT Teams. This NOFA clearly targets persons who have Serious and Persistent Mental Illness (SPMI) and in addition have histories of one or more of the following: substance abuse, mental retardation, homelessness, repeated or long-term hospitalizations, involvement with the criminal justice system and unsuccessful engagement through more traditional mental health services. The Court Monitor was especially pleased to see that the NOFA announcement expressly states that "there will be costs not reimbursable by Medicaid and persons whose eligibility for

Medicaid is temporarily lost or no longer available. Therefore DMH will make a substantial commitment of local funds to sustain this project, as well as providing 30% of Medicaid funding as its match." The issue of flexible funds is one that has come up repeatedly within DMH and with providers – especially as it relates to providing innovative "whatever it takes" care and support to persons with multiple and severe problems. It is recognized by all that Medicaid (MHRS) funding needs to be maximized if the community system is to be cost-effective. However it would appear, at a systemic level, that now is the time for DMH to articulate and support the concept of flexible funding for high-risk groups. This NOFA would appear to be a clear step in that direction.

The timeline for response to this NOFA was December 15, 2004. DMH has committed $500,000 as a part of this start-up initiative. It is too early – at the time of this Report – to know the results of this NOFA; however, the Court Monitor is very pleased to see the DMH move forward on this initiative. Future Reports to the Court will detail ongoing progress in this critical service area.

V. Recommendations

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

A. The DMH should update for 2005 its detailed work plan on the Exit Criteria – including tasks and timelines – to ensure the timely progress of all policies and data development efforts. This should be shared with the Court Monitor for concurrence.

B. The DMH should continue to articulate to all the sequential steps (and timeline standards) in the overall claims processing system. The DMH (together with the OCFO) should measure its performance against standards at each major step (i.e. claims adjudication, accounts payable approval of warrants, and actual payments to providers). Performance should be measured regularly and quality improvement processes should be employed with all involved staff and functions.

C. The DMH (and the Mayor) should forward the FY 2006 DMH proposed budget to the Court Monitor and the plaintiffs counsel within two weeks prior to the submission of the Mayor's proposed budget to the D.C. Council. The intent is to reinforce the language and process that is required in the Court-ordered Plan. The 2 week period is to allow the parties time to assess and resolve whether the proposed budget is sufficient to carry out the provisions of the Court-ordered Plan.