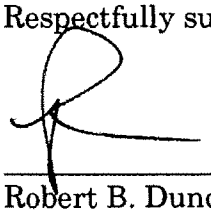
UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

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 20th day of January 2006 upon:

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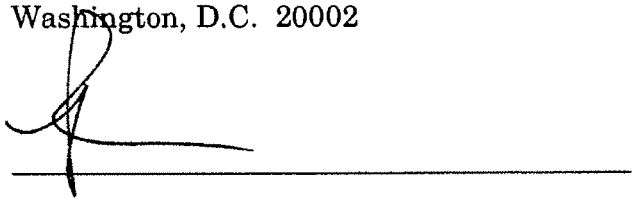

REPORT TO THE COURT

Court Monitor
Dennis R. Jones

January 20, 2006

Executive Summary

The highlights of the seventh Monitoring Report to the Court are as follows:

1. Implementation of Exit Criteria

   Progress toward meeting the Court-ordered Exit Criteria has taken longer than expected; however DMH does not appear to have a credible process in place to ensure that data collection is consistent and reliable. Specific timelines have been agreed to and it is expected that the July 2006 Report to the Court will reflect numeric scores for each of the 17 measures that require quantitative measures. It is anticipated that DMH will soon resubmit for review its documentation regarding compliance on one of the measures, Exit Criteria # 18 (Community Resources).

2. Comprehensive Psychiatric Emergency Program (CPEP)

   This program has been restructured as a part of the DMH Authority. Overall, its functioning is as intended in the Court-ordered Plan. The only major program concern is the limited capacity to provide mobile services. The DMH plans to move this function to the Homeless Outreach Team by March 2006 – which should be a much improved "fit" for the delivery of mobile services.

   The critical CPEP issue is still its totally inadequate physical space. The Court Monitor strongly believes that the District should put forward within 60 days a specific plan (including timelines) for the selection, space rehabilitation, and relocation of CPEP. Said plan, once reviewed, should have clear enforcement provisions.

3. St. Elizabeths

   There are two major issues regarding St. Elizabeths: a) the process and timeliness for building of a new Hospital and b) the organizational management of budgeting, performance and quality of care issues.

   As relates to the new Hospital, the District has indicated it plans to move forward to the District Council for approval of the financing package. However, issues around contracting out to a private vendor to build (and potentially manage) this new Hospital have surfaced. The Court Monitor strongly believes that a definitive plan (including timelines) for the construction of the new Hospital should be developed within the next 60 days. Such a plan, after being reviewed, should have clear enforcement provisions.

   The issues around organization structure and process emanate from a lack of clarity as to roles, processes and accountability for results between the Authority and the Hospital. A concrete example is the need for an improved model for

staffing – which needs to be developed and approved at all levels. The Hospital and DMH have made progress on many fronts (e.g. medical leadership and seclusion and restraint rules) but a clearer sense of urgency and accountability need to be instilled.

4. Budgetary/Provider Payment Issues

   The FY 2006 budget has been consumed with issues of payments to providers. The change in leadership at DMH and the Mayor's office surfaced the fact that there were unpaid claims totaling as much as $16.3 million from three previous fiscal years. The District found reserve funds to cover this short fall but could not work through its internal legal processes quickly enough to avoid a major crisis in cash flow for providers. Hence, the Federal Court was asked to order payment of $8.285 million at an emergency hearing on November 16, 2005. The Court's Order was properly carried out – with payment to providers within 48 hours. However, the remaining half (roughly) of the funds owed has still not been processed for payment. The DMH has issued one-twelfth of 2006 MHRS payments to providers pending resolution of all 2005 claims and timely processing of 2006 claims. The final ratification for remaining 2005 claims is targeted for Council approval during the Feb 7, 2006 legislative session.

   The most hopeful development is that the District has contracted for "a comprehensive assessment of the DMH's billing operations" and a "comprehensive assessment of DMH's resources to ensure budget sufficiency." This review is to be completed by January 31, 2006. It will be critical that the District find ways to manage the short-term payment issues to providers at the same time that it finds solutions to the systemic issues of its billing systems.

In sum, the District has shown assertive leadership via the Mayor's office (and the interim DMH Director) on the major issues that surfaced during the fall of 2005. Unfortunately, many of these issues had long histories with unsuccessful solutions (e.g. CPEP, St. Elizabeths and billing issues). Hence, it will be critical that meaningful solutions be found in a relatively tight timeframe. It is obviously also critical that the issue of permanent leadership at DMH be resolved as soon as possible.

I. Current Situation

In October 2005 the Federal Court approved the Monitoring Plan for October 1, 2005 through September 30, 2006. The Monitoring Plan included three primary areas for review during this period:

A. Monitoring the implementation and performance for each of the nineteen (19) Exit Criteria.

B. Monitoring the continued 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 requires a Monitoring Report to the Court twice per year. This is the seventh formal Monitoring Report.

II. Findings Regarding Exit Criteria

The Court-approved Exit Criteria fall into three categories: (1) review of demonstrated use of consumer satisfaction method(s) and consumer functioning review method(s); (2) the implementation of year four Consumer Service Reviews (CSR's) for both adults and children/youth; and (3) the demonstrated implementation of the fifteen (15) Exit Criteria for effective and sufficient consumer services.

This Report will, for the first time, summarize (see Table 1) the overall status of the nineteen (19) Exit Criteria. The presentation is structured so as to provide a snapshot of current progress on the multiple issues at play. These include: 1) requisite policy and practice development; 2) verification that data collection methods have integrity (this verification occurs first at DMH level and then via independent verification by the Court Monitor); and 3) presentation of the current performance levels for each criterion, with the understanding that data points will not be reported to the Court until the internal and external data system verification have occurred. The intent is to present this type of summarized status in each Report to the Court.

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

The DMH continues to contract with the Consumer Action Network (CAN) to do a comprehensive random satisfaction survey. This survey will be completed in January 2006.

The DMH has completed two specific consumer satisfaction measures. The Mental Health Statistics Improvement Program (MHSIP) was done as part of the Federal Block Grant requirements in the early part of 2005. DMH contracted with trained consumers to conduct telephone interviews with 724 adults and 162 children/youth. The survey tested satisfaction across a number of factors including access, quality and appropriateness, and outcomes. On the question of general satisfaction with services, the adult responses were 93.9% positive and the children/youth responses were 77.7% positive. On the question of outcomes the scores were at 77.9% positive for adults and 72.8% for children/youth. These types of survey measures are always difficult to assess, but it is hopeful that DMH will use these results as one of the methods for measuring consumer satisfaction.

The DMH also – as a part of its contract with CAN – received in July 2005 a Convenience Sample Report. This sampling methodology was intended to gauge – for both consumers and staff – the level of understanding of recovery/resiliency goals for treatment and assessment of progress toward stated goals. CAN reviewers visited fifteen (15) different programs that included an array of service and support programs – including a review of inpatients at St. Elizabeths.

The survey uncovered some interesting results. Perhaps the most revealing was the staff survey which indicated that fully 59% of the staff surveyed indicated that they knew little or nothing about the principles of recovery. This result alone suggests that the DMH (and its providers) have a long way to go in education, training and consistent implementation of recovery-based principles.

CAN indicates that it will repeat some variation of this convenience sampling approach. The Court Monitor finds that this is an excellent example of "real-time" measurement of consumer (and staff) expectations and satisfaction. As the Court Monitor reviews the DMH's use of satisfaction results, it would seem that these survey results would be a good litmus test of the systems ability to make meaningful changes based on data.

For consumer functioning, the DMH continues to mandate that local providers complete on a regular basis the LOCUS results for adults and CALOCUS for children/ youth. The DMH has not yet aggregated this data electronically. The reasons for this are two-fold: 1) verifying the integrity of the underlying

data as completed by providers – especially on the adult side and 2) prioritizing this effort in the overall array of information systems projects. The Court Monitor would encourage the DMH to begin aggregating this data – perhaps starting with the CALOCUS data. This data will be presented to the DMH Quality Council for review and recommendations.

It appears from DMH minutes that the DMH Quality Council is meeting regularly and has begun to coalesce in terms of its role. This is a positive sign. The key remaining issue – in terms of Court compliance – for both consumers satisfaction and consumer functioning – is to demonstrate that the DMH is not only collecting meaningful data but that it is utilizing this data in an organized way to improve the quality of services.

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

The Court Monitor has again contracted with Human Systems and Outcomes, Inc. (HSO) to conduct the review for both adults and children/youth. The same protocols utilized in previous years will again be used. The target date for completion of both reviews is April 2006. The target sample size will remain at 54 consumers, with the initial "triple sample" including only persons who have been seen in the past six months.

The Court Monitor has again contracted with the Consumer Action Network (CAN) to contract with and train individuals who will contact consumers and families to explain the process and obtain consents. CAN will also do the necessary scheduling for reviews (DMH reviewers and HSO reviewers), working in close coordination with the DMH liaison and HSO staff.

One of the positive developments in the past six months has been that HSO – as a part of its training for new reviewers – has also trained identified staff from a number of the local providers. The providers who participated have found this to be a very effective way to begin utilizing the CSR methodology within their agency. As this type of "buy in" increases, it should help to improve the overall performance levels in future reviews.
The results of both 2006 reviews should be completed in time to be discussed in the July 2006 Report to the Court.

C. Implementation of Exit Criteria

Table one is a summary of the current status.

Table 1
Exit Criteria
Current Status

January, 2006

Exit Criteria	Policy in Place	Data Methods in Place	DMH Validated Data System	Court Monitor Validated Data System	Court Required Performance Level	Verified Current Performance Level
1. Consumer Satisfaction Method(s)	Yes	N.A.	N.A.	N.A.	Methods + Demonstrated Utilization of Results	Methods Completed Utilization in Process
2. Consumer Functioning Method(s)	Yes	N.A.	N.A.	N.A.	Methods + Demonstrated Utilization of Results	Methods Completed Utilization in Process
3. Consumer Reviews (Adult)	Yes	Yes	Yes	Yes	80% for Systems Performance	51% (April, 2005)
4. Consumer Reviews (C/Y)	Yes	Yes	Yes	Yes	80% for Systems Performance	47% (March, 2005)
5. Penetration (C/Y 0-17 Years)	Yes	Yes	Yes	Target 4/1/06	5%	Expected 7/1/06
6. Penetration (C/Y with SED)	Yes	Yes	Yes	Target 4/1/06	3%	Expected 7/1/06
7. Penetration (Adults 18 + Years)	Yes	Yes	Yes	Target 4/1/06	3%	Expected 7/1/06
8. Penetration (Adults with SMI)	Yes	Yes	Yes	Target 4/1/06	2%	Expected 7/1/06
9. Supported Housing	Yes	Yes	In Process Target: 2/15/06	Target 5/15/06	70% Served Within 45 Days	Expected 7/1/06
10. Supported Employment	Yes	Yes	In Process Target: 1/15/06	Target 5/15/06	70% Served Within 120 Days	Expected 7/1/06

11. Assertive Community Treatment	In process	In Process Target: 2/15/06	In Process Target: 3/15/06	Target 5/15/06	85% Served Within 45 Days	Expected 7/1/06
12. Newer - Generation Medications	Yes	Yes	In Process Target: 1/15/06	Target 5/15/06	70% with Diagnosis of Schizophrenia	Expected 7/1/06
13. Homeless (Adults)	Yes	Yes	In Process Target: 1/15/06	Target 4/1/06	150 Served + Comprehensive Strategy	Expected 7/1/06
14. C/Y in Natural Setting	Yes	In Process Target: 2/15/06	In Process Target: 3/15/05	Target 5/15/06	75% of SED With Service in Natural Setting	Expected 7/1/06
15. C/Y in own (or surrogate) home	Yes	In Process Target: 2/15/06	In Process Target: 3/15/05	Target 5/15/06	85% of SED in Own Home or Surrogate Home	Expected 7/1/06
16. Homeless C/Y	Yes	In Process Target: 2/15/06	In Process Target: 3/15/05	Target 5/15/06	100 Served + Comprehensive Strategy	Expected 7/1/06
17. Continuity of Care a. Adults b. C/Y	Yes	In Process Target: 2/15/06	In Process Target: 3/15/05	Target 5/15/06	80% of Inpatient Discharges Seen Within 7 Days	Expected 7/1/06
18. Community Resources	Yes	Yes	Yes	Yes	60% of DMH Expenses for Community Services	Request for meeting target under review
19. Medicaid Utilization	Yes	Yes	In Process Target: 2/15/06	Target 4/1/06	49% of MHRS Billings Paid by Medicaid	Expected 7/1/06

Table 1 clearly indicates that the requisite policies are in place for all of the Exit Criteria except one (ACT). This policy requires formal rule changes. It is imperative that DMH move forward as soon as possible to get this accomplished.

The DMH also indicates that there are basic data methods in place for twelve of the seventeen (17) Exit Criteria that require quantitive measures. In most cases, data are captured electronically; however, in some areas, the data are collected and aggregated on a manual basis. DMH has set February 15, 2006 as its end point to have data methods in place for all 17 measures.

The DMH has undertaken a formal internal project by which to ensure that each of the nineteen Exit Criteria have a database that tracks each metric; analyzes the data sources and ensures that the calculations for data capture and retrieval are reliable. The team that is assigned to this task meets every week. The DMH's new Chief Information Officer – a very experienced Systems Information manager – is helping to direct this effort. The Team has set three concrete objectives for each Exit Criteria: 1) stability – the development of a sustainable and accurate process for measuring each metric 2) meet the target objective – mobilize organizational efforts to achieve the Court target; and 3) sustain target objective – ensure that once a target is met, there is continued effort to keep organization at or above the target.

The DMH team has undertaken the detailed task of going through each and every Exit Criterion to analyze the clarity of the metric, the unique data source(s), and the calculations (and computational rules). This internal vetting is a critical and major first step in ensuring the consistency and reliability of data collection. Table 1 indicates that DMH has completed this process for seven (7) of the seventeen (17) Exit Criteria that require numeric measures. The remaining ten (10) are in process with a target date for completion of all the remaining elements by March 15, 2006.

The Court Monitor has reached an understanding with DMH that once the internal validation process has been completed, a consultant for the Court Monitor will conduct an external review. As Table 1 shows, the initial target date for completion of this external review is April 1, 2006 and the completion date for review of all the criteria is May 15, 2006. As the Court Monitor has indicated in previous Reports to the Court, it is critical that these internal and external checks on data integrity be completed before numbers are reported to the Court.

The Court Monitor is of the belief that there is now a solid process in place for DMH to collect, analyze and verify its current performance. It is the full expectation of the Court Monitor that all of the data validations (internal and external) will be completed in a timely way and that all cells of Table 1 contain substantive data by the time of the July 2006 Report to the Court. While this entire process has taken far longer that anyone expected, it does now appear – for the first time – that there is a common understanding as to process and timeliness. It should also be noted that the DMH has indicated it will soon resubmit for review its documentation regarding compliance on Exit Criteria #18 (Community Resources). The Court Monitor will review this request promptly and make recommendations to the Court.

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

A. Review of Access and Crisis Response Services

1. Access Helpline

The DMH as a part of the Authority function, continues to staff and run a 24/7 access helpline team that performs multiple tasks including: (1) telephone assessment and triage for all incoming calls for service (2) dispatching mobile crisis teams for both adults and children/youth (3) referral (or transfer) of non-emergency 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).

DMH staff indicates that there is a mixed pattern in terms of the volume of calls and activity within the overall Helpline and Care Coordination activities. The overall volume of new enrollments for consumers is up nearly 35% as compared to FY 2004. Prior authorization activities clearly reflect DMH policy shifts; Day Service authorizations are down dramatically while ACT and CBI authorizations are up, in like kind. Disenrollment – another DMH push – jumped from 149 in FY 2004 to 1489 in FY 2005. It is also noteworthy that prior authorizations for St. Elizabeths were reduced in half for FY 2005 (607 total) versus FY 2004 (1241 total). This matches data from other sources, but is a comprehensive number since all St. Elizabeths admissions are required to go through Care Coordination.

Overall the Helpline and Care Coordination functions continue to be consistent with the mandates of the Court-ordered Plan. It is an essential element for not only entry into the system but also for the appropriate authorizations of higher-cost services.

2. Capacity and Utilization of Mobile Teams

The DMH Authority has incorporated the CPEP into its overall Authority structure – as opposed to the previous structure under the DC CSA. Since the time of the January 2005 Report to the Court the DMH has hired on an experienced full-time Director for CPEP. CPEP continues to have primary responsibility for site-based emergency services (see III A 3) and adult mobile services. The child/youth mobile services continue to be performed by the Mobile Urgent Stabilization Team (MUST), a part of the youth services team at the

DC CSA. The MUST team has also begun to provide some adult mobile visits, functioning as a back-up to CPEP.

For adult mobile services, the same issues of apparent low utilization continue and the issues are very similar to those noted in the two previous Reports to the Court (January 2003 and January 2004). DMH data indicate that for the last quarter of FY 2005 there were approximately 10 outreach visits per month. This compares negatively to previous years (30 per month in FY 2003 and approximately 17 per month in FY 2004). The same issues remain – namely that the same staff who do mobile outreach also do site-based (including the staffing of the extended observation beds). Given the demands on staff and the increased time and effort associated with mobile services – it is easy to understand why mobile outreach does not happen with regularity.

The DMH indicates that the going forward plan is still to move the adult mobile crisis function from CPEP to the Homeless Outreach Team. The Homeless Outreach Team is willing to take on this function, but needs additional staff to make it possible. The target date for this transfer is March 2006. The Court Monitor is very supportive of this shift. The Homeless Outreach Team is, by its very definition and philosophy, a mobile team. It has an excellent reputation for responsive and effective outreach efforts.

On the child/youth side, the MUST Team reports an average of 13 mobile interventions per month. This compares to 17 per month for FY 2004 and 7 per month in FY 2003. It would appear that this is a viable function, although an in-depth review would need to be done to form solid conclusions.

The Court Monitor will continue to review mobile services with the intent that DMH will soon achieve an organizational structure that is adequately responsive to mobile service needs.

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

The DMH provides its site-based services for adults through CPEP; it contracts with Children's National Medical Center for Children/Youth.

The DMH continues its overall positive relationship with Children's National Medical Center (CNMC). Volumes for calendar year 2005 (to date) are on par with 2004 – averaging 148 visits per month. Children's Hospital continues to provide emergency evaluations for all children/youth that are brought to them. The biggest current issue is on the DMH side – namely that both of the DMH social workers who

were assigned to Children's left their positions – one in May 2005 and the second in October 2005. Neither of these positions has been filled yet, although DMH indicates that it intends to fill both positions as soon as possible. This creates not only basic coverage issues on the busy evening shift (to which they were assigned) but it also means that there is no DMH person who can authorize involuntary (FD12) admissions to Childrens. As a result all involuntaries must go to one of the other Childrens inpatient providers – normally Riverside or PIW.

With these vacancies, there is obviously still the remaining data issue which the Court Monitor has noted in previous Reports to the Court. Beyond the basic visit count, there is no basic data on the children/youth who are seen – diagnostic, demographic or disposition. This continues to be a significant gap which DMH and Childrens should address.

CPEP continues as the exclusive site-based facility for adults. The average number of persons seen per day for FY 2005 continues at FY 2004 levels – approximately 9 per day. The number of persons brought to CPEP involuntarily (FD 12's) has dropped from an average of 150 per month for FY 2004 to 130 per month for FY 2005. It is also noteworthy that the number of admissions to St. Elizabeths for FY 2005 is 43 per month – as compared to 52 per month in FY 2004. While this reduction is no doubt driven by the drop in the number of involuntaries, it is also noteworthy the number of admissions from CPEP to local acute care hospitals has shown a steady increase during FY 2005. During the first half of FY 2005, the percentage of total inpatient admissions was nearly equal between St. Elizabeths and local acute units. However, during the last quarter those percentages had shifted to 62% of admits to local acute units and only 38% to St. Elizabeths. This will be discussed more fully in III B 4.

Of the five major recommendations noted by the Court Monitor in the January 2004 Report to the Court (taken from a DMH CPEP Review) one has been fully implemented – namely that CPEP be permanently incorporated into the DMH Authority. One has been partially implemented (the hiring of a CPEP Director) but the permanent Medical Director position is still unresolved. Of the three others not implemented, the separate staffing of the mobile crisis team has been discussed above. The daily conference call that was in effect for many months has been discontinued, but staff indicates that the strong interagency collaboration has been maintained. The last issue – formalized and discreet staffing for the Extended Observation Unit – has not been resolved. The Court Monitor – in discussion with CPEP staff – also expressed concern that there are not written protocols that

distinguish the "admission" of someone into the Extended Observation Unit – as separate from the rest of CPEP. Given the unique role of the Extended Observation Unit, it would seem prudent to clarify the clinical/legal conditions under which persons move into and out of these beds.

The July 2005 Report to the Court indicated – based on DMH leadership statements – that a suitable location for CPEP had been found. This plan now appears in serous doubt. The planned site – a rehabbed floor of the old D.C. General Hospital – sits partially on the building foot print of a potential new Capitol Medical Center Hospital. This new acute care hospital has been proposed (conceptually) but none of the necessary approvals by the D.C. Council have been obtained and there is considerable uncertainty as to its political support.

In the meantime, plans for CPEP are once again uncertain – in spite of the fact that the rehab dollars ($4 million) are available and the detailed space requirements are complete. The Court Monitor finds this to be an untenable situation. The vagaries of the new hospital are many: Will it happen at all? If so, when will a decision be made? Will public acute mental health beds be included in the design? What is the timeframe? All of these questions – and many others – need to be answered in a timely way. In the meantime CPEP (and the thousands of consumers and families who use it) continues to be housed in a facility that is totally inadequate in terms of design, privacy, access to medical care, and basic conditions of cleanliness and repair. The Court Monitor believes that the burden of presenting a viable plan for CPEP should be put forward by the District within a very tight timeframe.

In partial response to these concerns, it should be noted that the current CPEP did undergo (in December 2005) a significant "face lift" – with walls painted and doors and ceiling tile replaced. It should also be noted that DMH has been charged by the City Administrator's office with finding as alternative space for CPEP. The results of this effort obviously remain to be seen.

4. Development and Utilization of Crisis Residential/Respite Beds

Since April 2005 the DMH has been contracting for two separate crisis residential programs. Crossing Place – which is run by Woodley House – has a maximum of eight (8) beds. Jordan House – which is run by So Others May Eat (SOME) – has a maximum of seven (7) beds. The new crisis residential program began with Woodley House in November 2004 and then SOME in April 2005. Since that time

there have been a total of 285 total admissions to both programs. The DMH care coordinators can prior authorize up to 14 days of stay for a given consumer based upon individual need. Based upon the data provided, it would appear that the fifteen (15) beds are meeting the current demand. However, this assumes that consumers do not stay beyond the fourteen days maximum. As noted in previous Reports, the key issue is that crisis residential be utilized for short-term crisis situations – requiring that other parts of the system, e.g. ACT and supported housing, are prepared to provide necessary ongoing community supports.

The Court Monitor will continue to assess the utilization and adequacy of this critical service in the future Reports to the Court.

B. Review of DMH Role as a Provider

1. Planning for New/Consolidated Hospital

The District has made limited progress toward the construction of a new/consolidated Hospital at St. Elizabeths. DMH officials indicate that the early roads and utilities phase of the project is nearly on schedule. The basic financing package has been completed by all of the D.C. agencies involved – including the DMH, the Treasurer's office and the City Administrator. The overall financial model (Certificates of Participation – COP) remains the same and the leaser/trustee, who will sell the certificates to purchasers, has been selected. The next step is District Council approval for the financing package. The July Report to the Court indicated – based on DMH presentations – that the financing would go to the Council by early Fall 2005. This has not happened, although the indications from the City Administrator are that the financing package will go to Council during the January Council Session.

The major new development is discussion by city officials as to whether this new Hospital can/would be more cost-effective if it were contracted with a private entity. There are at least two major and separate elements to this discussion; the first is building the new Hospital via a private entity and the second is contracting with a private vendor to manage the Hospital. The District has indicated that it would do a side-by-side comparison of costs and timelines for a potential contracted model versus the current plan for the District to build own and operate the new Hospital. As of the time of this Report, the Court Monitor has not seen any comparative analysis, so obviously cannot comment.

The major overriding concern continues to be one of delayed timelines. The Hospital is already over two and a half years behind schedule from the original targets that were presented to the Court Monitor. The earliest occupancy date now – assuring no further delays – is early 2009. This assumes occupancy 32 months after the construction phase begins. The Court Monitor believes that this issue is now at a critical stage and needs very immediate resolution. While the decision to seek financing approval is positive, it is not clear what the next steps will be. The Monitor believes that the District should put forward in a very timely way a definitive plan for the new Hospital – with clear and explicit timelines included. As with CPEP, this issue simply cannot tolerate further ambiguities and delays.

2. Quality of Care at St. Elizabeths

As outlined in the July 2005 Report to the Court, the DMH contracted with Fields and Associates to assess and make recommendations in seven (7) different areas that directly or indirectly impact the quality of care at the Hospital including: active treatment; training and competencies of staff; clinical staffing; access to health care; use of seclusion and restraint; quality improvement; and hospital management. Dr. Fields issued a report to DMH in January 2005 that contained sixteen (16) recommendations for DMH and St. Elizabeths to consider for implementation. Of the 16 recommendations, the Court Monitor has the highest concern about those that relate directly to clinical staffing, staff training and competence, and patient safety. These areas include eight of the sixteen recommendations and can be summarized as follows:

1) All nursing vacancies be filled immediately
2) Refine staffing plan based on credible data (e.g. lengths of stay, patient acuity etc)
3) Conduct an acuity/time and motion study
4) Define a category of high risk patients (e.g. patients with history of self-injurious behavior). Provide special assessments and treatment intervention processes for these patients.
5) Ensure that St. Elizabeths policies and practices for seclusion and restraint meet all relevant national standards.
6) Conduct a hospital-wide training needs assessment, and then update the hospital/training plan accordingly.
7) Ensure that the Hospital Quality and Training departments collaborate in the development of a refined training curriculum.
8) Ensure training compliance meets a 95% compliance level.

Unfortunately, the DMH did not complete its new contract with Fields and Associates until late November 2005 – making it impossible for Dr. Fields to complete his planned report for December 2005. [Note:

Dr. Fields is scheduled to visit the hospital on January 23, 2006 and then issue a Progress Report] Nevertheless, the Court Monitor has met with leadership at St. Elizabeths and DMH to gauge progress on each of the eight (8) areas identified above. A brief summary of each follows:

1) Nursing Vacancies

There are currently a total of thirteen (13) Registered Nurse (R.N.) vacancies at St. Elizabeths, of which ten (10) have been vacant for more than 90 days. In addition there are also fifteen (15) nursing assistant level positions vacant of which thirteen (13) have been vacant for over 90 days.

There appear to be at least two major issues at work. First, there has been an ongoing concern (tied to budgetary constraints) as to which vacant positions are authorized to be filled.

Secondly, there is the issue of the difficulty in recruiting nurses given the tight market demand. There was a joint task force in early 2005 (St. Elizabeths and the DMH Authority) that looked at issues of timely recruiting; however, it is not clear that the recommendations of that group are being implemented. In any event, the Fields recommendation to fill nurse vacancies in a timely fashion is not being met. On the positive side, some twenty (20) positions have recently been freed up for hiring at St. Elizabeths, although it is not clear which of the nursing positions are impacted by this decision. The DMH indicates that the hospital has been approved to fill any vacancies since November 12, 2005.

2) Refine a Staffing Plan and 3) Conduct a Patient Acuity Time and Motion Study

There is a compelling need to establish a much more refined model for determining the clinical staffing needs at St. Elizabeths. One of the established Performance Improvement (P.I.) Teams at St. Elizabeths has looked at a variety of diagnostic, legal, length of stay and other patient characteristics for the entire population at St. Elizabeths. The responsibility for doing a Patient Acuity/Nursing Time and Motion Study is at the Authority level; it is not clear to the Court Monitor when and how this will be done. The general timeframe for using these different strands of data to build a staffing model is sometime in 2006 – with no specific dates yet established. The

Court Monitor believes this should be on a much tighter track. The goal should be for the Hospital leadership, the Authority and the Mayors office to agree on a clear staffing methodology that drives budgeting requests.

4) Identification and Response for High-Risk Patients

St. Elizabeths leadership indicate that the recommendations of this Performance Improvement Team will be implemented by the end of December 2005. The Court Monitor has not seen the final work of this team, so cannot assess its contents. However, the stated goal is consistent with Dr. Fields recommendation that there be a consistent process to identify high risk/intense invention patients and then implement review protocols via a multi disciplinary panel of senior clinicians. The Court monitor will track this issue in future Reports.

5) Seclusion and Restraint Policies

A special task force at St. Elizabeths completed the charge to revise the existing policy on seclusion and restraint to conform to all local DMH rules and national standards. This revised policy was approved for implementation in early January 2006. Given the number of changes inherent in this new policy, it is the intent of the Hospital to provide a 90 day period for implementation and retraining of staff.

This is another critical issue that will need to be monitored in several ways, including 1) staff compliance with the new policy 2) Comparison of current restraint and seclusion data to past Hospital performance and 3) benchmarking current data to relevant national standards. It is encouraging to see that the Hospital has moved forward on this issue.

6) Hospital-wide Training Needs Assessment

A Performance Improvement Team has completed its final report on hospital-wide training needs. The Court Monitor found this assessment tool to be reasonably comprehensive especially as it relates to issues of patient safety and staff perceptions of their competencies/training needs. This team made specific recommendations for action – including that training efforts be prioritized to include: enhanced techniques for de-escalating behavior, infection control and basic life support. The Hospital executive staff are in the process of

reviewing these recommendations and determining the next steps.

7) Hospital Quality and Training Departments

St. Elizabeths staff indicate that this goal has been accomplished. The Quality Improvement Director and Training Director are an integral part of the design and development of all training priorities.

8) Training Compliance

St. Elizabeths leadership indicates that the target of 95% of the staff compliance in training is being addressed. One of the major issues is a factual one – namely that it is appropriate (in terms of the 95% target) to only count staff who are currently working – as opposed to those who are sick or on leave.

Beyond the eight (8) issues above, the Court Monitor also discussed budgetary issues for FY 2006. The St. Elizabeths budget for FY 2006 was recently finalized. However, given the above discussion as to the need for a more dynamic staffing model, it is unclear as to the overall adequacy (or inadequacy) of the St. Elizabeths Budget.

It is also relevant to note that all new furniture has been ordered for the existing clinical buildings (RMB, CT 7 & 8) in direct response to the concerns about the condition of existing furnishings. This new furniture should be delivered by February 2006.

In sum, there are some positive signs of progress at St. Elizabeths. The Hospital has systematically tackled most of the recommendations from Fields and Associates. The general working relationship with the DMH Authority has improved. Medical leadership has been put in place to address major clinical concerns. On the other side, there are many ongoing concerns. The physical conditions themselves are a major impediment to adequate care. There is an overriding lack of clarity as to the roles, responsibilities and accountabilities between the Hospital and DMH Authority. The Court-ordered Plan envisioned a Hospital that would be run "more like a free-standing Hospital than a traditional governmental facility." The reason for keeping independent personnel and procurement authority was so that these support functions would look to expedite and innovate – as opposed to being stuck in the usual bureaucratic constraints. As a practical matter, there does not appear to be a written performance agreement between the Authority and the Hospital that delineates mutual expectations. Other than the DMH Director, there is no one at the

Authority whose job it is to help bring both support and accountability on key issues (e.g. timely hiring of staff and budget resolution).

All of these systematic issues need to be addressed at the same time that specific quality measures are tracked. The Court Monitor will – in future Reports – attempt to coordinate review efforts with Dr. Fields. The Monitor will also review other management issues that are beyond the scope of the Fields contract (e.g. budget, timely hiring of staff, etc.)

3. Review of Progress in Use of Local Hospitals for Acute Inpatient Care

The DMH has made some progress in its ongoing efforts to contract for acute inpatient services via two local Hospitals. Greater Southeast Hospital has been admitting public voluntary patients with an identified payment source throughout this period; they have also been accepting involuntary patients on a limited basis if they have a payment source e.g. Medicaid. Admissions to Greater Southeast increased starting in June 2005 as a part of the agreement to take involuntaries. For the five months since that time (June 2005-October 2005) the number of admissions averaged nearly thirty (30) per month. This was nearly double the admissions per month for the first five months of the year.

Because of concerns about adequate security for involuntary patients at Greater Southeast Hospital, the DMH has provided Greater Southeast with a grant of up to $750,000 in capital funds to provide the necessary facility enhancements for issues such as locks, security and suicide-related precautions. The target date to have these upgrades completed is March 2006. The service goal is to have an additional inpatient acute unit open at that time which would handle involuntary admissions. The DMH also has worked out a services agreement (as of October 20, 2005) which appears to deal with the necessary legal and payment issues for patients who are indigent. The basic understandings – as detailed in previous Reports to the Court – remain in place.

At George Washington University Hospital, the current DMH plan is still to have four beds set aside for involuntary patients. There are not renovation or payment issues at GWU. DMH and GWU appear to have resolved the issue of providing expert testimony regarding patients at probable cause hearings and providing transportation for patients to said hearings. DMH officials indicate they are willing to provide these services in order to get GWU's participation. As of the time of this Report, final negotiations have not yet been settled between the parties. The only know substantive concern remaining is

the willingness of GWU medical staff to accept the additional work load at current fee-for-service rates.

While some progress appears to have been made in the past six months, the essence of the acute care solution is dependent upon the financial and organizational viability of Greater Southeast – which at the time of the Report is uncertain. The future of a possible new Capitol Medical Center, as discussed in III B1, is obviously also a major unknown – and the particular question of whether emergency and impatient psychiatric services would be included in such a facility. Hence, the Court Monitor has to conclude that the requirement to provide for acute inpatient services – both voluntary and involuntary – has yet to be met. The Court Monitor will continue to monitor this issue in each Report to the Court.

C. Review of FY 2006 DMH Budget

The FY 2006 budget period has been an exceeding eventful one. Concurrent with changes in leadership at both DMH and in the Mayors office was the awareness of major unpaid financial claims for previous fiscal years (FY 2003, FY 2004 and FY 2005). These claims totaled as much as $16.3 million. Over $2.1 million of this amount was for unpaid Mental Health Rehabilitation Services (MHRS) claims dating back to FY 2003 and FY 2004. The remainder (approximately $14.2 million) represents a variety of MHRS claims, residential claims and other community contracts. The simply stated cause for this problem was that the DMH did not have sufficient funds in its FY 2005 budget. This problem was multiplied by the lack of timely identification and disclosure of the magnitude of the shortfall. The District, to its credit, stepped forward to identify 2005 reserve funds that could be used to pay these claims. However, since these were claims that exceeded DMH task orders, the Districts legal determination was that these claims would have to go through a contract ratification process as required by District law. This ratification process requires a very detailed review of each provider agreement and underlying claims by the Office of Contracts and Procurement (OCP). Subsequent to this OCP review is District Council approval for any contracts over $1 million.

These continued delays once again exacerbated cash flow issues for local providers – many of who were at or approaching a crisis stage. In order to expedite an infusion of cash for these claims, the Plaintiffs and the Defendant's Counsel agreed to a consent order, which the Federal Court approved on November 16, 2005 after an emergency Court hearing. This order required the payment of up to $8,285,632.78 to mental health providers within 48 hours of the issuance of the consent order. This $8.285 million included all 2003 and 2004 Medicaid claims, all 2005

residential and other community service contracts (non-Medicaid) and unpaid 2005 MHRS claims that had been approved. Subsequent to this order, the Court monitor verified the process payments as ordered totaling $8,276,170.28.

The Court Order further required that the District make every effort to ratify and pay the remaining $8.1 million (approximately) during the December District Council Session. Unfortunately, the District did not meet this timeline – running out of time getting ratification packages reviewed and approved and legal sufficiency completed by the last Council Session on December 20, 2005. This delay has once again heightened provider concerns as to timely payments. The District indicates that it is working to obtain necessary administrative and legal approvals for the ratification process – with a target for Council approval during the February 2006 legislative session. The DMH has issued one-twelfth of the annual MHRS contract amounts to providers to help with immediate cash flow needs.

This funding crisis has resulted in the decision by the Office of the Deputy Mayor for Children, Youth, Families and Elders to contract for "a comprehensive assessment of the DMH's billing operations" as well as a "comprehensive review of DMH's resources to ensure budget sufficiency moving forward." This review will be done by KPMG – a large national accounting and consulting firm with offices in the area. The size of work will include (on the billing side) issues such as organizational design, staffing, information technology, and quality control. For the budget resources component, KPMG will look at issues such as revenue projections, historic spending pressures, service delivery trends and financing trends. This assessment component – which is an addendum to a larger KPMG review of all District agencies providing Medical services – is to be completed by January 31, 2006.

The Court Monitor is very pleased to see this independent review on both issues. There are multiple issues at play. First, there is a fundamental legal/policy question as to whether Medicaid services should be included in a Task Order. Medicaid, as an entitlement program, does not lend itself to an inherently "capped" funding methodology. Second, knowledgeable people both within DMH and outside indicate, for example, that DMH's information system has multiple deficiencies and is in serious need of upgrade or replacement. In addition The FY 2005 budget situation has highlighted the serious shortfall in payment for MHRS-eligible services for non-Medicaid individuals. DMH data indicate that there was $12.1 million spent for non-Medicaid MHRS services in FY 2005. The FY 2006 budget only has $2 million loaded for non-Medicaid services – predicting a shortfall of at least $10 million. The DMH has begun the process of requesting a supplemental appropriation of $13 million for FY 2006 – and

has received positive response from the office of the Chief Financial Office (OCFO). However, the indication is that this request will not be acted upon until after the second quarter of the fiscal year. Current projections would indicate that the $2 million will be depleted before the end of the first quarter. The Court Monitor is very concerned that this dynamic will result in a) another round of ratification for providers who serve this population without dollars in their task orders b) refusal to serve or c) referral to the DC CSA as the only Core Service Agency without an explicit task order. All of these alternatives are very problematic.

On the positive side, the DMH has written full year task orders for residential providers and MHRS providers – as opposed to quarterly task orders previously. The DMH has moved forward to maximize funding for consumers who are enrolled in an MCO – which does provide limited mental health benefits. The task orders with providers are separate for Medicaid-eligible MHRS services and non-Medicaid eligible. While this has highlighted the shortfall in non-Medicaid dollars, it does create real incentives for DMH and its providers to get consumers onto Medicaid who are eligible. DMH data indicate that the percentage of Medicaid-eligible consumers grew from approximately 60% in FY 2004 to 68% in FY 2005. It is hoped that further work at all levels will bring this percentage above 70% in FY 2006. The DMH is hiring on an eligibility specialist to assist in this effort.

In sum, there are some positive developments on the financial front – but major remaining issues. The Court Monitor is anxious to see the results of the independent assessment – with the hope that many of the underlying issues will be addressed on a frontal basis.

IV. Recommendations

A. The District should develop within the next 60 days specific plans (including timeliness) for the selection, space rehabilitation and relocation of CPEP. The Court Monitor, after consultation with the parties should make recommendations to the Court about the approval, modification and enforcement of said plan.

B. The District should develop within the next 60 days a specific construction plan (including timeliness) for the new 292 bed hospital at St. Elizabeths. The Court Monitor, after consultation with the parties, should make recommendations to the Court about the approval, modification and enforcement of said plan.

C. The DMH should develop and implement an organizational structure and process that creates clear accountability and support for the ongoing issues

at St. Elizabeths. This structure should deal frontally with the systemic and quality of care issues as identified in this Report. One of the tasks of this revised structure should be to create a staffing model that incorporates the relevant factors (e.g. patient acuity, patient safety, professional staffing requirements and rehabilitation goals).

D. After review of the KPMG assessment, the District should develop an aggressive plan for implementation of the priority recommendations.