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,

Robert B. Duncan (Bar No. 416283)
HOGAN & HARTSON, L.L.P.
555 13th Street, N.W.
Washington, D.C. 20004
(202) 637-5758
(202) 637-5910 (fax)

Counsel for Dennis R. Jones,
Court Monitor

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 12th day of January 2007 upon:

Anthony Herman
Covington & Burling
1201 Pennsylvania Ave, N.W.
Washington, D.C. 20004-2401

Daniel A. Rezneck
Senior Assistant Attorney General
441 4th Street, N.W., Suite 600
Washington, D.C. 20002

Anne M. Sturtz
General Counsel
Department of Mental Health
64 New York Avenue, NE, 4th Floor
Washington, D.C. 20002

REPORT TO THE COURT

Court Monitor
Dennis R. Jones

January 12, 2007

Executive Summary

The ninth monitoring Report indicates there is progress on several key issues and concerted activity on most of the remaining identified priority concerns. Overall it is clear there remains a great deal of effort to meet the required performance levels. Two issues have not had adequate focus and need to be added to the priority list. These two include the need for a comprehensive crisis/emergency services plan and the need for concerted planning for a new governance/services model for DC CSA. A brief summary of the current status on key issues follows:

1. Implementation of Exit Criteria

   The time-consuming and intensive process of validating the data for the quantitive measures continues. DMH has only reported data in this Report on eleven (11) of the seventeen (17). This apparent slippage results from the fact that as DMH, the Court Monitor and the Monitor's Consultant have probed the data sources, there were four that require additional work before reporting to the Court. The process of data validation has been a very cooperative one between DMH staff and the Court Monitor. It is hoped that all seventeen measures will be reported in the July 2007 Report to the Court.

2. Comprehensive Psychiatric Emergency Program (CPEP)

   There are two issues regarding CPEP. First is identifying and effectuating the location of a suitable building. This is a long-standing issue that is still unresolved although there has been some progress. The District Council recently approved the ability for DMH to negotiate a ground lease at Greater Southeast on which to construct a new CPEP. The change in ownership at Greater Southeast is a complicating factor. It is unclear how quickly this issue will be resolved; it remains critical that the District resolve this issue quickly.

   The second CPEP issue is the need for a written plan that speaks to all of the elements of the crisis/emergency services program. Crisis services are not currently maximized or adequately integrated.

3. St. Elizabeths Hospital

   The two major issues at SEH include the approval and construction of the new 292-bed Hospital and needed action and oversight regarding quality of care issues.

   The Hospital construction has gotten final approval from the District Council as of November 14, 2006 and a ground breaking ceremony was held on December 19, 2006. Tompkins Builders, Inc. was awarded the construction contract of $139.9 million. There is now a planned 30 month construction phase before patients can occupy this new building.

The DMH has undertaken a five-part strategy to deal with serious quality of care issues at SEH. The most recent Fields report and the recent death of a patient while being restrained underscore the need for aggressive action. At the time of the Report, all of these strategies are moving forward, but there is a tremendous amount of concerted work to be done. The issue of ongoing DMH oversight of SEH has still not been resolved. The most positive development is the appointment of a new Director at SEH. Dr. Canavan brings strong clinical and senior management experience to the formidable task at hand.

4. Budgetary/Provider Payment Issues

The base FY 2007 budget is $2.1 million less than FY 2006. However, DMH has successfully sought and obtained approval for critical gaps in the 2007 budget. A $10.1 supplemental request has been approved by the District Council. $8.6 million of this will go to augment staffing and supply shortages at SEH in order to address DOJ findings. The other $1.5 million can be used for strategic management evaluation. DMH intends to use some of the $1.5 million to engage KPMG in the oversight and implementation of critical changes needed in the entire authorization, billing and payment system. Part of the KPMG contract will be to develop an RFP that would potentially contract out for the majority of these tasks to an administrative services organization (ASO).

The DMH has also gotten approval for an additional $13 million from the Medicaid reserve account. Up to $10 million of this total could be available for uninsured persons needing MHRS services.

The DMH has made concerted efforts to shore up the major problems in the billing and payment area. It would appear that these efforts have had some success in providing at least a semblance of stability and predictability. The planned movement of the payment function to Medicaid needs a thorough re-evaluation of its intent and, if it happens, appropriate timelines for working out all of the cross-agency issues (e.g. information system interface).

5. DC CSA

The DMH has not made any movement on this recommendation from the July 2006 Report to the Court. The current governance and services model at DC CSA is neither defensible not sustainable. An independent review is recommended again to explore viable options for both governance and service delivery and the new Mayor's office staff need to lend support.

6. Acute Care Beds

The new 20-bed unit at Greater Southeast has opened and is being utilized as part of the agreement with DMH. However, the number of acute admissions to SEH remain at 40-50 per month – matching levels prior to this unit opening. There appear to be multiple remaining issues at play including ones of bed capacity, legal mandates and lack of

clarity regarding discussion-making to use SEH versus Greater Southeast. The current performance – while improved – does not meet the mandates of the Court-ordered Plan.

In sum, the District/DMH have demonstrated a renewed willingness to tackle multiple priority issues at once. There has been discernible progress in some areas e.g. more timely payment of claims and approval for new SEH construction. However, most of the major issues remain at early stages of planning and resolution and some have not seen adequate progress to this point. It is seen as very positive that the DMH Director has been re-appointed by the new Mayor – as has the large majority of his Executive Services staff. Key DMH leadership vacancies are being recruited and some have been filled. The new Mayor and his staff have signaled an interest in tackling the multiple Dixon issues that still remain. Hopefully, the next six months will see demonstrable progress on many fronts.

I. Current Situation

In October 2006 the Federal Court approved the Monitoring Plan for October 1, 2006 through September 30, 2007. 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 ninth 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 five 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 utilizes the same format as the previous two Reports. Table I in IIC presents the current status of all nineteen (19) Exit Criteria and discusses specific progress and concerns.

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

The overriding concern for the Court Monitor regarding these Exit Criteria remains that the DMH needs to demonstrate that the data collected is being considered and utilized to improve the availability and quality of care.

The DMH has extended its existing contract with the Consumer Action Network (CAN) to perform consumer satisfaction activities. However, the DMH has recently released December 1, 2006 a new request for proposal (RFP) that is primarily focused toward grievance training and assistance. Imbedded in this RFP is the requirement that the successful bidder will also "conduct consumer satisfaction surveys (focus group and convenience sample only)." This RFP –

together with recent draft of a DMH policy on consumer satisfaction surveys (Policy No 115.2) clearly suggest that DMH intends to contract out for the convenience sample and focus group elements of an overall consumer satisfaction program. The DMH plan is to continue to conduct the annual Mental Health Statistics improvement program (MHSIP) via the Office of Consumer and Family Affairs. In addition, DMH has added a second annual survey – the Recovery Oriented System Indications (ROSI). The ROSI is a subset of persons who respond to the MHSIP survey and includes more detailed responses regarding recovery-oriented services within the DMH system. Hence these four methods would appear to constitute the DMH's ongoing approach to measuring consumer satisfaction.

The DMH has shared with the Court Monitor a draft of the MHSIP and ROSI survey results for 2006. Both of these surveys were done by telephone. The MHSIP surveys were distinct for adults and children/families. The DMH contracted via the Office of Consumer and Family Affairs for a team of consumer and family members to conduct the telephone interviews. The adult MHSIP Survey included 814 individuals out of the 10,085 adults who received services between April 1, 2005 and September 30, 2005. The trained telephone interviewers were constrained in many ways – most notably by the large number of inaccurate or unavailable phone numbers. There are also many inherent limitations in phone interviews e.g. the lack of accessible phones for consumers (homeless individuals). Hence it is important to represent the results (based on the methodology) as convenience sampling and not random sampling. Given all of the constraints, the consumer "team" did an excellent job of attempting to connect with people. The adult review showed overall scores in the 80% positive range for issues of access, quality and participation in treatment. Questions relating to treatment scored much lower with only a 40% positive for "doing better in school and work" and 64% positive for "housing has improved". In order to make such surveys more valuable, DMH and providers need to improve record keeping and minimize inaccuracies in patient phone records wherever possible. This would allow for a larger pool of survey results.

On the family MHSIP survey, 143 parents/guardians responded – out of the 2085 total families served during the April 1, 2005 – September 30, 2005 time period. The overall satisfaction was 75% positive. As with the Adult side, the area of outcomes scored lower with, for example, a 65.1% positive for "child better at handling daily life".

The ROSI survey was done this year for the first time. It included 354 adult consumers who had also participated in the MHSIP survey. The ROSI probes the system in more detail on issues of staff orientation and response to recovery-based services. Consistent with other surveys, the responses show that there are major challenges still to overcome. For example, only 45.2% of the respondents stated positively that "staff believe I can grow, change and recover". On the services

side, the areas of affordable housing and reliable transportation also scored very low.

The overall MHSIP and ROSI results are telling. While consumers are generally satisfied with issues of access and basic treatment services, the system is very spotty when it comes to more recovery-oriented services - i.e. housing and employment. While these are obviously resource-driven issues, there would appear to be some issues that are not contingent on additional resources – namely staff knowledge and practice of recovery-based values. The Court Monitor will be anxious to see what the DMH does with this survey once it is finalized in late January, 2006.

The overriding concern for the Court Monitor remains the same, namely that the DMH needs to demonstrate that "the consumer satisfaction data is being considered and utilized as appropriate to improve the availability and quality of care". The DMH Quality Council continues to meet; however, the DMH Quality Improvement Director position has been vacant for well over a year. There is a new effort underway to fill this position – which should help significantly to provide focus and continuity. As of Dec 11, 2006, the DMH has successfully employed a new deputy director for the Office of Accountability. This very experienced person has indicated that the employment of the Q.I. director is a high priority.

The same issue applies to the consumer functioning method(s) requirement. DMH continues to mandate that providers complete the LOCUS instrument for adults and the CALOCUS for children/youth. However this data has still not been aggregated electronically at the DMH level. Hence, it is not being analyzed and there is no demonstrated effort to utilize the results as part of a quality improvement process.

B. Implementation Results of Year Five Consumer Services Reviews (CSR's) for Adults and Children/Youth

The Court Monitor has again contracted with Human Systems and Outcomes (HSO) to conduct year five Consumer Service Reviews (CSR's). The same basic protocols will be utilized – with targeted samples of 54 consumers for both the adult and child/youth reviews. Only persons seen since July 1, 2006 will be included in the sampling methodology. DMH will again provide trained reviewers to conduct half (27) of the total reviews.

The Court Monitor has also contracted with CAN to conduct logistical support for the reviews – which have scheduled to be completed by the end of April 2007. The logistical support includes the necessary front end and education of consumers and providers, obtaining needed consents, scheduling of individual reviews and closely coordinating with both HSO and DMH staff throughout the process.

It is anticipated that HSO will again provide necessary training (including refresher training). The training will be opened to providers as a way of reinforcing the use of the CSR model in local agencies. This has proven to be effective in previous years.

The full results of the year 5 reviews will be discussed in the July 2007 Report to the Court.

C. Implementation of Court-approved Performance Criteria

Table 1
Exit Criteria
Current Status

January 2007

Aggregate data for October 1, 2005 – September 30, 2006

Exit Criteria	Policy in Place	Data Methods in Place	DMH Validated Data Methodology	Court Monitor Validated Data Methodology	Court Required Performance Level	Current Performance Level (Unverified) [1]
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	69%
4. Consumer Reviews (C/Y)	Yes	Yes	Yes	Yes	80% for Systems Performance	54%
5. Penetration (C/Y 0-17 Years)	Yes	Yes	Yes	In Process via Monitor's Consultant	5%	2.21%
6. Penetration (C/Y with SED)	Yes	Yes	Yes	In Process via Monitor's Consultant	3%	1.26%
7. Penetration (Adults 18 + Years)	Yes	Yes	Yes	In Process via Monitor's Consultant	3%	1.71%

8. Penetration (Adults with SMI)	Yes	Yes	Yes	In Process via Monitor's Consultant	2%	1.45%
9. Supported Housing	Yes	Yes	Yes	In Process via Monitor's Consultant	70% Served Within 45 Days	47.55%
10. Supported Employment	Yes	Yes	Yes	In Process via Monitor's Consultant	70% Served Within 120 Days	69.63%
11. Assertive Community Treatment (ACT)	In process Target: 6/30/07	Yes	Target: 1/31/07	Target: 3/31/07	85% Served Within 45 Days	Target: 1/31/07
12. Newer - Generation Medications	Yes	Yes	Yes	In Process via Monitor's Consultant	70% with Diagnosis of Schizophrenia	83.2%
13. Homeless (Adults)	Yes	In Process Target: 3/31/07	In Process Target: 4/30/07	In Process via Monitor's Consultant	150 Served + Comprehensive Strategy	Target: 5/31/07
14. C/Y in Natural Setting	Yes	Yes	Yes	In Process via Monitor's Consultant	75% of SED With Service in Natural Setting	72.52%
15. C/Y in own (or surrogate) home	Yes	Yes	Yes	In Process via Monitor's Consultant	85% of SED in Own Home or Surrogate Home	93.04%
16. Homeless C/Y	Yes	In Process Target: 3/31/07	In Process Target: 4/30/07	Target: 5/31/07	100 Served + Comprehensive Strategy	Target: 5/31/07
17. Continuity of Care a. Adults b. C/Y	Yes	In Process Target: 3/31/07	In Process Target: 3/31/07	Target: 5/31/07	80% of Inpatient Discharges Seen Within 7 Days	Target: 3/31/07
18. Community Resources	Yes	No	Yes	In Process via Monitor	60% of DMH Expenses for Community Services	Target: 3/31/07
19. Medicaid Utilization	Yes	Yes	Yes	In Process via Monitor	49% of MHRS Billings Paid by Medicaid	Target: 3/31/07

[1] It should be noted that claims –based data was computed on December 21, 2006 – before the end of the claims submission period of Dec 31, 2006. Hence claims-based measures could be higher if measured after Dec 31, 2006.

Table 1 again reflects the current status of DMH performance for FY 2006 on the Exit Criteria. It is important to reflect on the process that the Court Monitor and DMH have gone through over the past several months. First, the Court Monitor has engaged an outside consultant (Joan Durman, Ph.D.) to validate the data collection and analysis processes on ten (10) of the nineteen (19) Exit Criteria. This independent review includes Exit Criteria 5 through 10 and 12 through 15 inclusive. The Court Monitor is directly validating Exit Criteria 18 & 19. Dr. Durman's review has generated a number of issues that need additional DMH work. Most of these are relatively minor and include, for example, the need to refine definitions, clarify policy, or tighten the event screen that collects data from providers. Other issues Dr. Durman (and the Court Monitor) have uncovered can be considered more difficult to correct. For example, the C/Y metrics on penetration (#5 and 6) is less than 50% of the required performance level. However, to reach the required level will take concerted work with the MCO's in the District – who also provide some mental health services to children and youth. The original Court Order approving the Exit Criteria anticipated this issue; however, it remains for DMH to work with the MCO's in gathering data and ensuring the Court Monitor that these children/youth are receiving appropriate mental health services.

Numbers 18 and 19 measure the efficient use of resources. Both of these measures have substantive problems that must be resolved. Number 18 measures the percentage of total DMH resources spent on community resources. The current DMH staff are unable to replicate the methodology used for the July 2006 Report to the Court. The major issue is the allocation of costs at the Authority. DMH intends to contract with Innovative Costing Solutions, Inc. to develop a detailed methodology for allocation costs based on "random moment sampling." It is anticipated that this will be completed by March 31, 2007. In like kind, number 19 (Medicaid Utilization) performance is directly impacted by the difficulty DMH has had in reconciling with MAA and collecting available Federal Medicaid dollars. Until this is resolved, it is highly unlikely DMH can meet the required target.

In early November 2006 the Court Monitor conducted two focus groups (C/Y and Adult) to discuss relevant issues with providers and advocates. The ten Exit Criteria being reviewed by Dr. Durman were the specific area of discussion . From these meetings came additional questions as to data sources, definitions and data collection methods. For example, Exit Criteria # 13 (Homeless Adults) was thoroughly discussed. As a result, the DMH has agreed to revisit its data collection methods for this measure. It was agreed that the pre-existing methods do not reflect the intent of this measure. It is hoped that a new methodology will be in place by March 31, 2007.

It should also be noted that there is concerted effort underway to develop the needed data methodology for the three measures not reported in the July 2006 Report to the Court - #11 (ACT), # 14 (Homeless C/Y) and # 17 (Continuity of

Care). Each of these measures have unique complications in terms of data sources. One area of particular note is that the ACT policy has still not been developed. Given that this will likely take a change in the D.C. Medicaid Plan, it is critical that the DMH put this on a priority path.

Overall, the Court Monitor would note that the DMH staff have been very open to suggestions from the Court Monitor and consultant. While this is a tedious process, it has been a somewhat healthy process on all fronts. As the quality of the data system improves, it then sheds appropriate light on the underlying reasons for not meeting required performance levels. The Court Monitor will continue to work closely with DMH staff on both data refinement and the underlying performance measures.

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

A. Review of the Development and Implementation of Key Authority Functions

1. Access Helpline

The DMH Authority continues to manage as a discrete function the Access Helpline Team that handles multiple functions to include: 1) telephone assessment and triage for incoming calls for service 2) dispatching mobile crisis teams for both adults and children/youth 3) referral (or transfer) of non-emergency consumers to a CSA of choice and 4) the care coordination functions, which include prior authorizations for any admissions to St. Elizabeths, ACT services, CBI services and Day services.

The Access Helpline Team has identified multiple challenges which it is in the process of addressing. These include the recent installation of a new phone system – which will hopefully be an improvement over the previous system. However, in the short term there are the usual training and adjustments to be made. DMH is reviewing data regarding the call system and will work with the vendor on new reporting formats. These reports will be shared with the Court Monitor.

The Access Helpline/Care Coordination Team has been down three staff positions. One position has recently been filled. The other two positions should be filled within the next few weeks. An additional bi-lingual coordinator position has also been approved and should soon be posted for hiring. It appears likely that these staff vacancies have contributed to the overall difficulties in keeping up with current volumes.

The Care Coordination Director indicated that she is working on a revision to the DMH Authorization/Care Manual. There is an expressed goal to both clarify and simplify the manual. The target date for completion of

this task is early 2007. This will hopefully help to resolve some of the confusion and concern that continues to exist in the provider community regarding required authorizations. The Director also indicated that it is time to do a new round of community education and training for potential referring parties and providers. This community training is targeted to begin in March 2007. The Director has had direct responsibility for CPEP since it became an Authority function. This responsibility, however, will shift to the DMH Chief Clinical Officer in early 2007. This should provide at least some additional time to focus on other priority tasks.

Although the Access Helpline and care coordination functions are generally consistent with the requirements of the Court-ordered Plan, there are critical issues of staffing, response time, policy and role clarification regarding authorizations, and community education that must be addressed in the months ahead.

2. Capacity and Utilization of Mobile Teams

The primary responsibility for doing adult mobile crisis services was transferred from CPEP to the Homeless Outreach Team in April 2006. The HOT performs a variety of outreach functions to homeless persons with mental illness. This new responsibility is fully integrated into the overall team function. Hence, there is not a separation of duties for non-homeless individuals who receive mobile crisis services. During the 6 month period of May – October 2006, the HOT team averaged nearly 32 mobile visits per month. The majority of these (24 average per month) involved involuntary admissions. This is the highest level of mobile support since 2003. The HOT takes calls directly from any referring source – including the Access Helpline. It should also be noted that the Mobile Urgent Stabilization Team (MUST) provides a limited number of adult mobile crisis visits. These come exclusively upon referral from the Access Helpline. Data from the most recent fiscal year (Oct 1, 2005 – Sept 30, 2006) show a total of 13 adult visits – or approximately one month.

The indication from DMH staff and leadership is that the current placement of mobile crisis with the Homeless Team is not the preferred model. The Court Monitor strongly agrees. The current model fits in the sense that the HOT is by definition an outreach-oriented team. However, the demands for homeless services are great and it appears that the mobile crisis outreach for non homeless is still an inadequately developed service. The agreed going-forward plan is to develop a truly comprehensive role for CPEP which include a distinct mobile crisis team. Part of the work of this team would be to help educate the community as to the appropriate role for mobile crisis. The leadership at DMH and CPEP are in full agreement with this approach.

Overall, the Court Monitor concludes that the current mobile crisis efforts for adults falls short of the Plan's requirements. The Court Monitor strongly supports a comprehensive CPEP approach. DMH could and should develop a full written plan, with accompanying budgetary implications. This could help to crystallize and mobilize organizational energies.

On the child/youth side, MUST continues to provide mobile crisis response. For the past year, MUST data show an average of nearly 20 visits per month. This compares favorably to 13 per month for FY 2005 and 17 per month for FY 2004. The major issues on the child/youth side are a larger one for DMH – namely how to provide home-based and short-term services for families in crisis. The MUST model is normally one visit only. The DC CSA child/youth Team (of which MUST is a part) is working on an MOU with the CFSA to provide these services for CFSA families. Among the tasks is to define clear protocols as to when a family in crisis moves from a pure crisis response (via MUST) to a Community-based Intervention (CBI). One of the positives for DC CSA to provide this service is that the DC CSA is also a certified CBI provider. Hence there is the potential to transition youth that require additional home-based stabilization into CBI – which is designated as a 90-day program. It is critical that DMH – as part of its overall working relationship with CFSA – ensure that there is ready access and workable services for families in crisis.

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

The DMH continues to provide site-based services via a contract with the Children's National Medical Center (CNMC).

The DMH has continued on a positive track with CNMC. Volumes for calendar year 2006 are averaging 162 visits a month – which is up slightly from 2005 – but on par with 2004. The major change from previous years is that DMH is now contracting with CNMC to hire the two evening social work positions – as opposed to DMH hiring them. The DMH has increased its overall contract with CNMC to $400,000 per year to pay for these positions and psychiatrist coverage. This arrangement began in June, 2006 after a full year of unsuccessful efforts by DMH to fill these positions. DMH has also worked out the necessary legal arrangements for these social workers to be certified to handle FD 12 involuntary admissions. This now allows the possibility for children/youth to be admitted to CNMC as well as other inpatient units in the District. The major data gap (e.g. demographics, diagnosis and disposition) is also being addressed as part of the new agreement with CNMC.

CPEP continues to be the exclusive site-based facility for adults. The volume of visits has remained very consistent for the past several years at slightly over 9 visits (average) per day or 280/month. The percentage of involuntaries for 2006 has gone back to 2004 levels of 155/month; there was a drop to 130/month for 2005. Overall, 34% of the people seen at CPEP are subsequently admitted to an inpatient unit. Of those admitted from CPEP during the first nine months of 2006, 43% (364 individuals) went to St. Elizabeths, 40% (343 individuals) went to Greater Southeast and 17% (145 individuals) went to PIW. The number of admissions to St. Elizabeths from CPEP is averaging 40 per month during this period. The total authorized admissions to St. Elizabeths (including committed outpatients who are readmitted) is 48 per month over the past seven months. The uses of Greater Southeast as an alternative to St Elizabeths will be discussed further in III B 3.

It is noteworthy that CPEP has hired a very experienced Medical Director. Together with the Director (also very experienced) CPEP now has a leadership team with a full appreciation for the value and need for comprehensive emergency services. Notable programmatic improvements have occurred. These include a significant reduction in the use of seclusion and restraint – which has dropped to a 3% rate i.e. 3% of consumers who have had any restraint or seclusion. CPEP leaders attribute this to additional staff training, better use of medications, available male staff and greater cooperation with police officers. It was also noted that the overall working relationship with police officers has improved – as CPEP has worked to collaborate actively with them.

The major issue of a suitable building for CPEP has seen some progress. The Office of the Attorney General (OAG) has issued a certification of the legal sufficiency for the legislation that would allow DMH to negotiate the terms of a Ground lease with Greater Southeast Hospital to finance the construction of a new building adjacent to the existing hospital. The District Council approved the emergency legislation to authorize the negotiation of the ground lease on November 14, 2006. The next step is for the District to negotiate the specific terms of the agreement. The major variable at play in all of this is that Greater Southeast Hospital is being sold. It is unclear to the Court Monitor when this sale will be consummated and what impact new owners will have on the current mental health planning. The DMH will have considerable stake in the degree of stability and commitment to mental health service by new owners. While it is hoped that the District Council and the new Mayor will wield major influence, there are still major unknowns. The Court Monitor will continue to track these developments closely with both DMH and the new Mayors staff. The overall expectation that a new and suitable

facility be identified and occupied in a timely way still remains. This must remain a high priority item.

4. Development and Utilization of Crisis Residential Beds

The DMH continues to contract with two different organizations for crisis residential beds. Crossing Place, which is run by Woodley House, has eight (8) beds. Jordan House, which is run by So Others May Eat (SOME), has seven (7) available beds. Crossing Place started in November, 2004 and Jordan House in April 2005. Both of these programs are designated as crisis beds and are reimbursed on a per diem basis. Both providers have experienced periods of reduced utilization. The stated concern was that the prior authorization process – via the DMH Care Coordination team – was serving as a barrier to needed admissions. Hence, in July 2006, DMH agreed to a 90 day trial period during which the providers could screen their own admission and accept consumers for an initial 2 day period. At the end of the 90-day period DMH did a retrospective record review of 110 consumer records. The overall conclusion was that allowing 2 day stays prior to authorization did reduce bed vacancies, but that 56% of the admissions would not have been authorized by DMH staff. The review also confirmed the fact that both programs function more as residential "step-down" programs than as true crisis beds. The lack of true crisis beds was also borne out by CPEP staff, who used the crisis programs very minimally – in large part due to the lack of psychiatrist availability to manage acute patients needs (i.e. need for adjustments to medications)

The DMH report suggests the need to re-evaluate the overall system's needs for crisis bed vs. step-down beds. The Court Monitor strongly concurs. Lack of crisis beds for consumers in acute phases continues to put additional pressure on inpatient admissions – some of which might be diverted if crisis residential beds were in play. It is equally true that step down beds are needed to shorten lengths of stay inpatient units or serve as a less intense alternative for other high-risk populations (e.g. homeless, substance abuse or medically compromised). Hopefully, the DMH will take steps to refine its current programs to meet both sets of needs. One initial step that has started is to invite representatives of the two crisis programs to participate in CPEP rounds. As of this Report, one of the programs has responded.

Overall, the Court Monitor finds that the major elements of a comprehensive crisis/emergency program are in place. However, they are neither maximized nor adequately integrated. It is time for the DMH to develop a comprehensive plan that can serve as a clear roadmap for all future actions.

B. Review of DMH Role as a Provider

1. Planning for New/Consolidated Hospital

The District has made definitive progress toward the construction of the new 292 bed hospital. The financing mechanism (certificates of participation) was finalized in May 2006. The Invitation for Bid (IFB) was published in early June, 2006 – with two bids received on August 24, 2006. Tompkins Builders, Inc. was selected as the successful bidder. Legal sufficiency has been completed and the D.C. Council approved the $139.9 million contract via emergency legislation on November 14, 2006. The groundbreaking ceremony was held on December 19, 2006. It is anticipated that the construction phase will begin in early 2007. It is still assumed that the full construction phase will be 36 months, including the demolition of John Howard. However, 30 months is still the planned construction timeline for the new hospital – after which patients should be ready to occupy. This would target occupancy in mid 2009.

The DMH is concurrently moving forward with the planned renovations of RMB CT 7 & 8 – which includes approximately 184 patient rooms. The first phase of this project will involve the consolidation of utility systems, with the need to run power to the new Hospital and separate the Hospital from the Federal power and electric systems. This project will go out for bid by early 2007. Funds have been identified to accomplish this phase. The second phase – for which funds are not yet appropriated – will involve building infrastructure (e.g. plumbing) and quality of living enhancements to the patient living areas. The overall goal is to have these additional beds as backup to the new Hospital beds – if needed.

It is encouraging to finally see this Hospital project ready to move to the construction phase. This should provide solid encouragement to the patients, families and staff who have had to live with current totally substandard buildings and environment over this many decades.

2. Quality of Care at St. Elizabeths Hospital

Care provided at St. Elizabeths Hospital remains an area of significant concern. The DMH has developed a multi-faceted plan for St. Elizabeths. The broad-based strategy includes the following major elements:

1) Improve the physical conditions at the Hospital
2) Improve staffing ratios for critical areas
3) Ensure appropriate leadership and accountability systems are in place
4) Ensure that the Hospital is "right-sized" via aggressive efforts at diversion and outplacement of individuals not needing St. Elizabeth level of care.

5) Ensure that internal quality of care tracking systems are in place to meet DOJ and other relevant review standards.

These five areas have all seen considerable work by DMH and the District since the time of the July 2006 Report to the Court.

- Physical Conditions

  As discussed in III B 1, this process is finally on track and moving toward a new 292-bed Hospital and sufficient additional rehabbed beds if needed.

  Nevertheless, the Department of Justice Report has identified a number of unacceptable physical conditions at SEH, and has found that SEH "is rife with serious eviromental hazards," which "exacerbate the plethora of deficiencies in patient care and treatment…" Rectifying these environmental dangers must be a priority.

- Staffing Concerns

  This was a major part of the DOJ Report. There are two major strategies involved in solving the staffing shortages: 1) Develop a more efficient and timely process for filling vacancies that already are available to St. Elizabeths and 2) Request additional funds to improve staffing ratios in key areas.

  The DMH Human Resources leadership has a clear charge to help remove the barriers in hiring new staff. These barriers are multiple – including issues of competitive salaries, timely processing of vacant positions, recruitment strategies, working conditions, lack of information technology etc. While none of these are simple issues to overcome, it is critical that DMH have an aggressive plan with priority H.R. focus. This now appears to be happening. It is telling, for example, that at the time of this Report there were 35 nurse vacancies alone out of 75 total vacancies. Clearly, a nurse recruitment strategy is a critical component.

  The DMH has obtained supplemental funds in its 2007 Budget for SEH. This will be discussed more fully in III C. The direct personnel part of the request (both hired staff positions and contracted) is nearly $5.5 million. The major costs are in areas of additional General Medical Officers, Nursing (RNs and LPN), Psychiatrists and Psychologists. The allocation of significant dollars to contracted personnel will allow DMH to move more quickly to fill priority needs while some of the hiring issues are being addressed.

This request has been presented to the office of the Chief Financial Office (OCFO) and to the District Council and was approved by mayor on December 28, 2006.

- Leadership and Accountability

  The issue of leadership and accountability regarding St. Elizabeths has surfaced in many venues. These issues play at both the Authority level and the Hospital level. The DMH Director has taken steps to ensure that there is strong and capable leadership at both levels.

  At the Authority level, Ella Thomas, Deputy Director of the Office of Programs and Policy, has been given the primary charge to work with SEH on the full gamut of issues including staffing needs, quality of care, and discharge planning. This allocation of responsibility is very recent, and it has not yet been possible to evaluate its impact, if any, on conditions at SEH. As noted earlier it is clear that H.R. (Authority) leadership is now committed to a priority focus on SEH hiring concerns.

  As of January 2, 2007, a new Director has been appointed as SEH. Patrick Canavan, Psy. D. is a licensed clinical psychologist who previously worked as a clinical Administrator at SEH. More recently he was the Director of the D.C. Department of Consumer and Regulatory Affairs (DCRA). He brings to the position strong clinical and management experience. It is hoped that he will provide a style of leadership that will aggressively address the multiple and ongoing concerns at SEH.

- Alternative Community Care

  At present, there remains a lack of community-based care alternatives for individuals who are otherwise prepared for discharge from St. Elizabeths.

  The St. Elizabeths Discharge Plan identifies several critical strategies toward both diverting consumers to alternative community resources and placing current SEH patients in more appropriate community settings. The diversion efforts are not new; they tie directly to the development of community-based acute care capacity (see III B3), the expansion of observation beds in the new CPEP and the expanded use of crisis residential beds (III A4).

  The out placement component has identified 172 patients that are potential candidates for alternative placement. Of these the target for

the first phase is 110 persons – of whom approximately 100 will be from the civil side and 10 from John Howard. Some initial action steps are underway. Pathways to Housing , Inc. has agreed – as part of its existing contract with DMH – to outplace 50 persons into identified supported housing slots. They will also use existing ACT slots to provide intensive support services.

DMH has also initiated contact with a local nursing home who has expressed a willingness to accept individuals who need this level of care. DMH has indicated that up to 30 individuals might be appropriate for nursing home level of care.

Organizationally, DMH is planning to hire a Project Team leader for this effort. This person will be responsible to carry out the action steps identified. A Project Team will be composed to oversee this effort including representatives form critical areas including: ACT, Housing, Consumer and Family Affairs, Access Helpline, CPEP, SEH, and community providers. DMH projects that 55-65 persons should be placed by July, 2007.

The intent is that these beds at SEH, once vacated, will not be backfilled. This has obvious implications in terms of enriching the staffing levels for remaining patients. The $8.6 SEH million budget request was submitted with the presumption that these out-placements would occur in a timely way. If these out-placements do not occur in a timely manner, funding problems for SEH may be further exacerbated.

- Internal Quality of Care Monitoring

  Improvement in the quality of care at St. Elizabeths has been inadequate and inconsistent. The recent death of a patient underscores the need for the District to give priority focus on this area for significant improvement.

  The July 2006 Report to the Court summarized the full array of quality of care concerns at SEH – highlighting the major issues identified in the May 23, 2006 report from the Department of Justice. The DMH has developed a comprehensive performance improvement tracking log that details each of the DOJ findings, SEH actions in response, and current status. Discussions with the DOJ are ongoing, but it appears evident that both the incoming Mayor and DMH leadership are anxious to resolve all of the major DOJ findings.

Concurrent with all of this is the ongoing work of Dr. Richard Fields. Dr. Fields and his team have developed – in conjunction with DMH and SEH leadership – an explicit set of progress indicators on critical areas. As noted in the July 2006 Report to the Court, many of these areas of measurement directly relate to the DOJ concerns. They include, for example:

1) Patient safety – focus on decreasing incident rates for the most dangerous patients
2) Care quality – measurement of patient participation in the treatment mall
3) Care quality – measurement of medical record documentation of discharge planning
4) Staff effectiveness – focus on improved periodic assessment of staff
5) Unit Staffing – measurement for staffing consistency and effectiveness
6) Seclusion and restraint – compliance with JCAHO standards for seclusion and restraint
7) Patient Rights – measurement of improvements in the grievance process

The Fields team recently visited SEH and have issued their report of current status on identified priority areas.

The Fields report shows "modest, but inconsistent improvement." Out of a total of 27 specific (and measurable) objectives, the SEH fully met only 41% of those objectives for the past six months. One of the high priority objectives was clearly not met – that being the efforts to decrease incident rates of dangerous/disruptive patients.

The overall conclusion of the Fields report is that the pace and consistency of change is inadequate. The report argues that there should be clear success goals (e.g. Joint Commission reaccredidation) and detailed strategies to achieve these goals. The issue of outside oversight is also addressed; the report recommends that there should be "oversight by an entity with sufficient authority to affect accountability and require (not just request) the necessary changes" (Fields December 30, 2006 Report, p.5). The Court Monitor strongly concurs with this conclusion – as detailed in previous Reports to the Court. The current reality is that DMH does not have this capacity at the Authority level and the Fields contract has been reduced to review visits every six months. The new Director at SEH – together with the DMH Director and the new Mayoral staff – must build in specific mechanisms to ensure ongoing oversight and accountability.

The DMH has continued its planning efforts toward the full implementation of an integrated information system – to include both clinical and business functions. The project has three distinct modules for overall software development. The first is the practice management, which includes the composite of services provided, associated fees, etc. The target date for completing the draft for this module is early 2007. The second module is the development of the Clinical Work Station (CWS) – which includes all of the clinical elements of treatment assessments. The target completion date for this module is October, 2007. The third module includes ancillary services (pharmacy, lab, etc) and is targeted for completion in early 2008. While the project is being developed in phases, the implementation will be done as a complete package. The overall target date to "go live" is June 2008 – with full training and implementation by late 2008.

There are several significant issues for this project to be successful: 1) There needs to be dedicated staff time for this effort. Currently the project team members all have other priority tasks, which makes the tight timelines difficult at best. There also needs to be clinical/psychiatric leadership dedicated to the project 2) The legal sufficiency review for the software is now in its fourth round at the OAG. It is unclear what the issues are, but it is critical that they be resolved in a timely way. The contractor is currently working on a letter agreement basis 3) There is an open question as to the adequacy of the budget for this project. $2.1 million of the $3 million budgeted has already been committed – which may well prove to be inadequate.

The lack of an information system further compounds all of the other issues at SEH. It is a positive development that this project is underway and is a clear priority for Chief Information Officer (CIO) at DMH. It will be critical that this effort receive the needed leadership, staff and financial support to stay on its planned implementation track.

On the positive side, it is noteworthy that the Psychiatry Residency program at SEH has recently been re-accredited by the Accrediting Council for Graduate Medical Education (ACGME). This residency program is not only a major source of psychiatry training but also provides a pipeline of potential psychiatrist recruits for the Hospital. The leadership at SEH is rightfully proud of this accomplishment.

Overall, there has been considerable effort regarding improving the care and conditions at SEH. The Court Monitor finds that there is

now the sense of urgency that has heretofore been lacking. It is critical that all of the five areas identified in this Report stay on track. If anyone of them fails to move forward, it makes achieving the others that much more difficult. For example, the failure to "right-size" the hospital means that people are being inappropriately maintained in the most restrictive setting – which is in contradiction of the Dixon case and the 1999 Olmstead Supreme Court decision. It also means – as a practical matter – that more expensive care must be provided and generally without the availability of Federal Financial Participation (FFP). On the other side, those persons who are at St. Elizabeths demand a consistent quality of care that everyone involved can measure and feel good about.

The Court Monitor will continue to evaluate progress in each Report to the Court.

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

The use of acute services outside of SEH has not been adequately resolved.

The newly renovated inpatient unit (20 beds) at Greater Southeast opened in September 2006. The new financial arrangement is also now in place – which provides payment by DMH for indigent patients up to 15 days. Hence, there now should be no financial barriers to admission to Greater Southeast for patients needing acute inpatient care. However, it is clear there are other reasons why acute patients continue to be admitted to SEH as opposed to Greater Southeast. These include: 1) committed out patients needing acute admission must go to SEH per the Ervin Act 2) voluntary and uninsured referrals from CPEP are not included in the Greater Southeast agreement. Hence, these persons are sent to SEH for acute care. 3) per DMH policy and practice, patients from emergency rooms in the District who need acute admission go to SEH as opposed to Greater Southeast 4) patients who are assessed to need more than 15 days in the Hospital go directly to SEH 5) there are occasions when the 20 bed unit at Greater Southeast is full, thus necessitating admission to SEH.

While it is still too early for a full evaluation, it would appear that the new 20-bed unit has had a negligible impact on acute admissions to SEH. The total admissions to SEH continue to run between 40 – 50 per month. DMH staff – at the Monitor's request – did an in depth analysis of admissions to SEH over a three month period (August – October 2006). The data indicates that there were 60 admissions to SEH during this period for which there is no clear indication as to why the person went to SEH as opposed to Greater Southeast. *These numbers are above and beyond the legal or policy issues noted above that constitute legitimate (but correctible) reasons for SEH admissions.* The DMH acknowledges that it does not yet have a solid

handle on this issue. While it is recognized that this 20 bed unit is not adequate to meet full need, it is not clear that DMH is fully maximizing the current resources available.

Going forward, the additional 18-bed unit (currently closed) has not been rehabbed and there is no immediate resolution in sight given the ownership/management changes at Greater Southeast. Staff within DMH have reopened discussions with other acute care hospitals in the District as to the possibility of working out arrangements similar to those at Greater Southeast. There is also a desire to continue a contract with PIW for acute services. The delimiting factor for PIW is that its IMD status precludes Medicaid payments for adults.

The Court Monitor is very supportive of the DMH strategy to re-engage other local Hospitals. The Greater Southeast situation is too tentative to instill confidence. However, even if the ownership and management issues stabilize there, it still seems prudent to have multiple options for persons needing acute care.

The use of acute services outside of SEH remains unresolved. The DMH needs to look at ways it can further maximize the existing 20 bed unit in the short term. In the intermediate to longer term, the strategy of diversifying into multiple hospitals seems highly prudent.

C. Review of 2007 DMH Budget

The DMH 2007 base budget was at $2.1 million less than the base budget for 2006. This makes it more difficult for DMH to achieve he goals set forth in the Court-ordered Plan. The DMH 2007 base budget is $229 million of which $173 million is local funding. There are two high-profile issues for 2007 that are have gained approval. First is the $8.6 million in additional funding for St. Elizabeths, of which $5.4 million will go for additional professional staff – primarily in areas of physicians, psychiatrists and nursing. The remainder of the requested funds ($3.3 million) will go for equipment, supplies, maintenance and repair. This 8.6 million total for SEH was augmented by an additional $1.5 million for strategic management evaluation. This total $10.1 million was approved by the Council on December 19, 2006 – to be paid from reserve funds.

The second priority request is $13 million to cover persons who are uninsured but in need of MHRS services. This request is very consistent with the demonstrated need from prior years. The immediate concern is that some $3 million of the $13 million total will be needed to restore funding short-falls for the Multi-Systemic Therapy (MST) Program and the Juvenile Court-based Assessment Center. This will then leave $10 million to cover the cost of the uninsured, which is below historic levels. There are also a series of contracting steps that will need to be taken to effectuate this request if it is approved. The source of funds for this request is the

Medicaid Reserve account. This transaction is being done via an MOU to be signed by the DMH Director and the OCFO Director.

The other major issue of concern is the $1.2 million cut in funding for the DMH housing program. This cut flies straight in the face of Dixon Exit Criteria #9 for Supported Housing. This Report to the Court indicates that the DMH is only at 47.55% on this measure – with a requirement of 70%. DMH indicates that they will restore this cut through the reallocation of other funds. The Court Monitor will review the details of this reallocation to ensure housing levels are at least sustained.

Another major pending financial issue for DMH is the ongoing difficulty in reconciling and billing for all eligible Medicaid services. It appears there are multiple millions of dollars in uncollected Federal funds. The first step in the process is to reconcile DMH files with those of the Medicaid Administration (MAA). This process has formally begun. DMH is also exploring the possible need to contract out this task to an independent party with experience in this area. This failure to collect obviously impacts the DMH's credibility and puts further pressure on scarce local funds. Hopefully, this project will be undertaken and resolved in a timely fashion.

IV. Follow-up on Recommendations from July 2006 Report

The District has been timely and responsive in providing monthly status reports to the Court on high priority issues. The purpose of this section is to summarize those issues from the Court Monitor's perspective.

A. Provider Payment and Service Authorization

DMH has undertaken a multi-faceted approach to these issues – some of which are short-term in nature and others longer-term.

1. Timely Payments to MHRS Providers

DMH appears to have made progress on this front. Past payments for 2005 have been made to all providers except three. This issue rests primarily with these providers to resolve. DMH has made a major shift in its authorization process that allows providers to submit individual authorization requests without regard to the task order limits. While the overall task order ceiling still applies in terms of payment, this step has removed one of the initial barriers to getting authorized services. DMH expects to receive all of the initial 2006 claims by December 31, 2006. Any claims that need to be reworked by DMH and providers must be resolved by March 31, 2007. Hence final payment for 2006 should occur by April 30, 2007. As of December 29, 2006 the DMH has received $34,516,700 of unduplicated claims for FY '06. Given that December 31, 2006 is the clear cut off point for claims submission, this number will likely increase. DMH staff are

working through the various issues for potential denials. The total is approximately 6.9 million. However, DMH staff indicate that the large majority of these denials will likely get paid. Hence, the total payment for MHRS Claims for FY '06 will likely be somewhere in the $33 - $35 million range. This compares to the full allocation for FY 2006 of $40.8 million. One of the major unresolved issues involves the receipt of multiple services by a given consumer on the same day. All of these same-day services are being rejected for FFP by Medicaid. Hence, DMH is left with the question of whether to pay these services entirely out of local funds. This is among the going-forward issues to be resolved with MAA.

Overall, the DMH appears to have made significant progress on the billing and payment front. Although significant work remains to be done, DMH has taken multiple steps to improve the current system: 1) It has removed a major barrier in getting front-end authorizations. 2) It has increased the warrant cycles to twice per week. 3) It has developed a consistent (weekly) reporting system to identify current status and is expanding the data set to "drill-down" on specific issues e.g. reasons for denials. 4) It has improved oral and written communications with providers. 5) It has simplified Task Orders for FY 2007 so that funding sorts into only three categories – federal funding, local match and local only (non-Medicaid).

The payment system is now functioning at an improved level, and some providers report payments in less than 30 days. However, some providers continue to report payment delays. DMH must continue to improve the operation of its billing and payment system.

2. Claims Payment and Processing Metrics

The Court Monitor has had several conversations with DMH staff regarding the need for clear and timely metrics on key performance functions within the overall authorization, payment and collections system. The agreed metrics involved occur in at least four areas; 1) enrollment 2) authorizations 3) claims 4) Federal Financial Participation (FFP). The DMH has given this new reporting model a name – Operational Analysis and Reporting System (OARS). The DMH has had discussions with an outside vendor who is interested and able to develop the necessary software to manage this function. The intent is to have this model in operation within the next 90 days. There will be a necessary pilot phase to ensure accuracy. The goal is to have a summary page called the "pinpoint" as well as backup detail. The responsible managers for each of these functions will be held accountable for results.

3. Transition of Claims Payments for MHRS from DMH to MAA

DMH and Medicaid have had ongoing discussions and work teams to accomplish this transition. There are multiple issues still to be resolved, including: the alignment of information system edits between DMH and MAA; the coordination of reporting and monitoring of claims payment; finalizing financing methodology; determining responsibility for communications and training and; revising the MOU between DMH and MAA.

Under this arrangement, the DMH would retain the front end responsibility for authorizations up through the stage of establishing a "clean claim". All of the backend payment and FFP recoupment would come from MAA. DMH believes this will be a cleaner and more effective division of roles between the 2 agencies. While the Court Monitor understands the intent, the concern is that the respective IT systems need to interface smoothly. It is also a fact that the current arrangement still presumes that Task Order or Human Service agreements will be in place. This was one of the major arguments for making the move to Medicaid. DMH expects this transition to occur in early 2007. The Court Monitor strongly encourages the DMH and Medicaid (with needed help from KPMG) to re-evaluate the value of this move. If it does occur, it should be on a time schedule to allow working out all of the potential glitches.

4. Evaluation of Cost to Outsource Some Functions to an Administrative Services organization (ASO)

   The primary functions in question include enrollment and eligibility; claims payment and processing; utilization review and management; provider training and support; and claims auditing. This issue – among others – will be discussed in the section on KPMG.

5. Improved Collections of Medicaid

   As discussed in FY 2007 Budget section, the issue of reconciling with MAA and collected available FFP is a major issue. The reality is that neither DMH nor MAA really know how much money is potentially available for FY 2006 and prior years. DMH is looking to engage an outside vendor to quantify the value of these Medicaid claims and to develop a process for rebilling.

   Going forward, it is DMH's intent that the move to MAA handling payments will force the needed reconciliation of Eligible claims on the front end and expedite FFP on the backend.

B. Planning for New CPEP

The status of planning for the new CPEP was discussed in III B 3. It is unclear – given the uncertainties regarding Greater Southeast – how soon this issue will get legally resolved and definitive timeliness can be set.

C. Construction Status of the New St. Elizabeths Hospital Building

As detailed in III B 1, for the first time since the Court Monitor has been monitoring this issue, it now appears that this project is moving forward with clear timelines.

D. Quality of Care Issues at St. Elizabeths

The multiple issues at SEH were discussed in III B 2. The Court Monitor will continue to track all of these closely.

E. Implementation of KPMG Recommendations

As detailed in the December 2006 DMH report to the Court, the DMH has solicited a follow-up proposal from KPMG to help the DMH transition to new and improved models for authorizing, billing, and collecting. DMH has accurately assessed its internal limitations; it needs overall help in managing the potential transition to MAA and the viability of an ASO model. Hence, the KPMG proposal has four components: 1) Project management support services for DMH improvement initiatives, 2) management support for Medicaid-denied claims recovery, 3) management support for movement of Medicaid claims processing to Medicaid and 4) the development of an ASO request for proposal (RFP).

It is the DMH's intent to have this contract in place by January 16, 2007. Once the agreement is signed, the term would be for a 6-month period.

F. Status of Utilizing Acute Care beds as an alternative to SEH.

As detailed in III B 3, this is an ongoing goal that has had some success via the contract with Greater Southeast. However, additional work is needed to achieve the intent of the Court-ordered Plan.

G. Evaluate Alternative Governance and Service Options for the DC CSA.

It does not appear that the DMH has made any movement on this issue, although it recognizes that the current model is not defensible or sustainable. The current model costs the District an additional $10 million - $15 million (at a minimum) due to the high cost structure, lack of adequate infrastructure, and limited productivity gains. It is time to move this issue forward. The Court Monitor continues to believe that an independent review by a team of qualified persons is the best course of action. Clearly internal resources are already overloaded by the

myriad of tasks noted in this Report. This project also needs the active support of the new Mayor's office in order to gain any real traction.

V. Recommendations

Based upon the findings in this Report and previous Reports to the Court, the Court Monitor makes the following recommendation:

A. The District should continue to submit to the Court progress reports to the Court on high priority items. These should include (at a minimum): a) status of provider payments and development of relevant metrics to measure performance, b) planning for CPEP, c) quality of care issues at St. Elizabeths – including hiring status of additional staff (new positions and current vacancies), d) implementation of KPMG recommendations, e) status of developing and utilizing acute care beds as alternatives to St. Elizabeths, f) implementation status of SEH discharge plan g) progress on development of alternative governance and service options for the DC CSA. It is recommended that these reports begin April, 1, 2007 and be submitted every two months through the remainder of 2007 (i.e. report dates of April 1, June 1, August 1, October 1, and December 1).

B. The DMH should develop a comprehensive plan for all crisis/emergency services. It is recommended that an initial draft of this plan be completed by March 31, 2007.

C. The DMH (as part of the KPMG engagement) should carefully re-evaluate both the viability and the timing of the planned movement of payment functions to MAA. Clear goals for this move need to be re-assessed, and if a move occurs, realistic timelines need to be developed to provide the resolution of the major issues between DMH and MAA (i.e. IT systems, policy variance, continued use of Task Orders, etc.)