UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

WILLIAM DIXON, et al.,	)	
	)	
Plaintiffs,	)	
v.	)	Civil Action No. 74-285 (TFH)
	)	
ADRIAN M. FENTY, 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

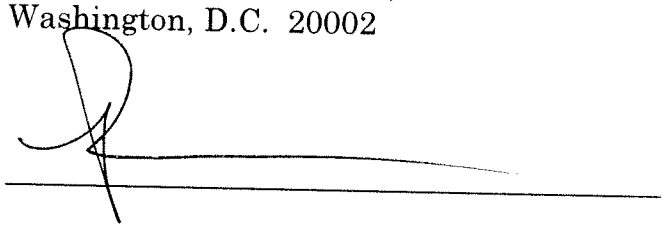
CERTIFICATE OF SERVICE

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 28th day of January 2008 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

John Dodge
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 25, 2008

Executive Summary

The eleventh Report identifies progress on several key areas. The Court Monitor recommends inactive status for one additional Exit Criteria – (#19). The Crisis Emergency Services Workgroup has completed its work and put forward a comprehensive strategy for adults. The child/youth area has also created an RFP that will hopefully generate a greatly enhanced crisis emergency response system. The rehabilitation of the CPEP building is finally moving forward.

1. Implementation of Exit Criteria

   This Report shows data on all seventeen (17) of the quantifiable measures. Fifteen (15) of the seventeen (17) have been verified for data integrity by DMH and the Court Monitor; this represents real progress since the July 2007 Report. The DMH has satisfied the Court Monitor that it met the Court-approved level on #19 (Medicaid Utilization) and hence inactive status is recommended. There are six additional criteria for which progress is noted. One of these (Supported Employment #10) is under active discussion as to whether it has achieved its required performance level. Most of the performance levels are on par with the July 2007 Report. Two that appear to have slipped considerably (Supported Housing - #9 and Continuity of Care #17) are actually the result of refinements to the data integrity process that have occurred since July 2007.

2. Comprehensive Psychiatric Emergency Program (CPEP)

   The DMH – through the work of the Crisis Emergency Services Workgroup – has put forward a truly comprehensive plan for adults with mental illness in the District. The next key task is to begin implementation with, for example, the creation of mobile crisis teams. The child/youth area is likewise looking to create greatly enhanced crisis response capability. An RFP is out that calls for both crisis beds for children/youth and a minimum of two Mobile Response Stabilization Teams (MRST). This new contract should be in place by July 1, 2008.

   The DMH has identified capital funds and is moving forward with the design and rehabilitation of the existing CPEP building. The intent is to create space for 8-10 observation beds as part of this major renovation. This project will take at least 180 days to complete. For the first time, it now appears there will be adequate space to perform the site-based functions at CPEP and provide the needed beds (and unique space) for extended observation beds.

3. St. Elizabeth Hospital

   The construction of the new Hospital is now 40% complete. Some design changes (plus prior delays) have pushed occupancy back to late 2009 or early 2010. The phase one project for RMB CT 7 and 8 is also underway – which will separate the energy source for the new Hospital from the other buildings. The complete interior renovation of RMB CT 7 and 8 will be dependent upon the DMH 2009 capital budget request.

St. Elizabeth's Compliance Officer has filed the first Report to the Department of Justice (DOJ) – as required under the Settlement Agreement. This December 21, 2007 Report identifies multiple points of progress, but also clearly delineates major areas that require concerted attention. The overall picture is that all of the basic organizational and infrastructure issues are being addressed, albeit not as quickly as desired. The next 6-12 months will be key in establishing demonstrable improvements in areas such as training, staffing levels and patient care.

4. Use of Local Hospitals to Provide Acute Care

There is some renewed movement on this long-standing issue. The sale of Greater Southeast Community Hospital to Specialty Hospital of Washington has renewed hope that the existing 20-bed unit will be fully operational and that the additional 20-bed unit will also be rehabbed. Positive discussions with Howard and Providence have occurred with the hope that contracts for 10 + additional beds could be developed. This planning needs to move to reality in the next 6 months.

5. Budgeting/Provider Payment Issues

The FY 2008 budget of $249 million represents the first time in several years that DMH has its full budget approved at the beginning of the year. It also appears that the $249 million should allow DMH to move forward on all of its critical priorities as regards Dixon.

On the provider payment side, DMH has continued its efforts to resolve any payment issues in a timely way. The DMH has hit a level of stability (and trust) with providers that it has not previously achieved. The overall MHRS payouts for FY 2007 are projected at $34 million which is 82% of the full dollar value of its task orders.

6. KPMG-Related Issues

The KPMG contract has been of assistance on several fronts. The funds recovery project for prior years is pretty much complete – with $9.5 million of Federal dollars received for prior periods. Approximately $10.7 million will need to be written off as uncollectible. The work with MAA is now resulting in initial claims acceptance rates of 80% - as compared to historic averages of 60% - 65%.

The transition of claims payment to MAA has gone smoothly. The internal planning and cross-agency collaboration on this complex project has been exemplary. All of the concerns in the January 2007 Report to the Court on this issue have been fully addressed.

The evaluation of the Administrative Services Organization (ASO) option has not occurred – in large measure because of the planned creation of a new (and more visible) Medicaid agency in the District. The Court Monitor believes the ASO evaluation should proceed even with this fact.

7. Planning for DC CSA

   Alternative options for the future regarding the current DC CSA services have been identified. KPMG – as part of its 2008 contract – will do a detailed analysis of these options. This issue needs to come to resolution by the time of the July 2008 Report to the Court.

8. Evaluation of Independent Personnel Authority

   The DMH has not moved forward with this recommended evaluation due to other pressing H.R. realities. The intent is to begin this effort in early 2008. There are parallel issues regarding contracts and procurement. The DMH has retained an outside consultant regarding procurement – with an expected completion date in April 2008.

9. MHRS Review

   The DMH has taken on a major review of its MHRS program – which will likely involve many core policy issues such as basic eligibility, services array, quality measurement and reimbursement strategies. It is anticipated that the group reviewing all of this will take 6-9 months to complete its work.

Overall, there has been discernible progress on some high priority areas in the past 6 months. Most notable is the comprehensive plan for crisis emergency services and the specific movement to rehab CPEP. The MAA transition is an example of the level of cross-functional planning and exertion that is now occurring. Trust in the DMH is much improved – as noted with consumers, providers, other government agencies and with the Mayor's Office. Nevertheless, many priority issues need focused attention in the next 6 months in order to maintain the momentum that has been established.

Based on the findings in this Report and previous Reports to the Court, the Court Monitor makes the following priority recommendations:

A. The District/DMH should move assertively to evaluate the use of its independent personnel authority to make needed changes to existing H.R. regulations. In like kind, the District/DMH should utilize the existing consulting agreement regarding the efficacy of the procurement system to make needed improvements and changes.

B. The District/DMH should conclude its internal analysis of options for the DC CSA in the next several months. These options (and any recommendations) should be presented to the Court Monitor in time for a final recommendation to the Court in the July 2008 Report to the Court.

C. DMH should proceed with evaluation of the Administrative Services Organization (ASO) option.

I. Current Situation

In October 2007 the Federal Court approved the Monitoring Plan for October 1, 2007 through September 30, 2008. 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 eleventh 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 six Consumer Service Reviews (CSR's) for both adults and children/youth; and (3) the demonstrated implementation of data collection methods and performance levels for the fifteen (15) Exit Criteria.

This Report utilizes the same format as previous Reports. Table I in IIC presents the current status of all nineteen (19) Exit Criteria and discusses specific progress and concerns.

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

The major concern for the Court Monitor regarding these two Exit Criteria remains the same as it has been for several years – namely that DMH needs to demonstrate that the data collected is being considered and utilized to improve the availability and quality of care.

The DMH has completed all telephone interviews for the 2007 MHSIP survey – which is one of the major methods for evaluating consumer satisfaction. This survey was contracted out to a consumer-operated group called The Gregory Project, which conducted the phone interviews for the standard MHSIP plus the

targeted ROSI survey. DMH staff are doing the needed analysis on this data – with a target completion date of early in 2008.

The Consumer Action Network (CAN) is doing the other two major methods of evaluating consumer satisfaction – focus groups and convenience sampling. The outstanding issue that remains is the DMH process for aggregating, analyzing and utilizing these data methods to improve care. The Office of Accountability has taken on the organizational leadership role through the Quality Improvement Director. OA has incorporated a process whereby the consumer satisfaction survey results and/or focus group results will be received by OA, then trended through Internal Quality committee. As a result of those trends, QI initiatives will be delivered and presented to the providers for implementation via the Quality Council. The Quality Council held a meeting on September 20, 2007; the next meeting is scheduled for January 17, 2008. The recent CAN report will be presented during that meeting. Secondly, the newly developed Fidelity Audit tool will track missed appointments and repeated changes of providers as a possible indication of consumer satisfaction.

The issues regarding consumer functioning review methods(s) remain the same. The LOCUS and CALOCUS are still being utilized by providers, but the data has not been aggregated and analyzed by DMH. The OA has also very recently assumed leadership on this criterion. DMH needs to have a clear strategy for analyzing and utilizing this data in place by the time of the next monitoring report.

B. Implementation of Year Six 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 six (6) Consumer Service Reviews (CSR's) with the same protocols as used in prior years. The Consumer Action Network (CAN) will again provide logistical support. However, there are a number of changes that will be made for the year six reviews as mutually agreed by the Court Monitor, DMH and HSO. The significant changes include the following:

1) Sample size – The sample size will be increased from 54 cases per review to approximately 85 cases for children/youth and 88 for adults. This will provide a 95% confidence level (+/- 10% error).
2) Review team composition – The mix of HSO and DMH reviewers will change from 50% each to two-thirds HSO reviewers and one-third DMH. HSO will work collaboratively with DMH in ensuring that all DMH reviewers have the requisite training and demonstrated skills to perform reviews.
3) Case findings – HSO will assign a case judge to review all DMH-reviewed cases and to the degree possible all HSO-reviewed cases as well. This should provide an added level of consistency across all reviewed cases.

4) Final sample – In previous years, there has been a significant need to replace individuals in the final sample for a variety of reasons, e.g. inability to locate consumers, unwillingness to provide consent, or lack of clarity for children/youth regarding who is legally authorized to provide consent. For year six, the presumption will be that the final sample will be reviewed, absent some overriding factor, e.g. the person has moved out of the area.

The planning period for the reviews has begun much earlier than in prior years to allow careful attention to the myriad of issues involved. The review period for children/youth is scheduled for March 3-14, 2008 and for adults June 2-13, 2008. All of the above-referenced issues have been discussed and supported by the parties. DMH has taken a very proactive role in embracing the CSR methodology and has committed senior leadership time to ensure its full implementation for year six.

C. Implementation of Court-approved Performance Criteria

Table 1 reflects the current status of performance on all nineteen Exit Criteria

Table 1 January 2008
Exit Criteria
Current Status

Aggregate data for October 1, 2007 – September 30, 2007

Exit Criteria	Policy in Place	Data Methods in Place	DMH Validated Data System	Court Monitor Validated Data System	Court Required Performance Level	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. No Evidence of Utilization
3. Consumer Reviews (Adult)	Yes	Yes	Yes	Yes	80% for Systems Performance	80%
4. Consumer Reviews (C/Y)	Yes	Yes	Yes	Yes	80% for Systems Performance	48%
5. Penetration (C/Y 0-17 Years)	Yes	Yes	Yes	Yes	5%	2.67%

6. Penetration (C/Y with SED)	Yes	Yes	Yes	Yes	3%	1.60%
7. Penetration (Adults 18 + Years)	Yes	Yes	Yes	Yes	3%	2.06%
8. Penetration (Adults with SMI)	Yes	Yes	Yes	Yes	2%	1.75%
9. Supported Housing	Yes	Yes	Yes	Yes	70% Served Within 45 Days of Referral	7.98%
10. Supported Employment	Yes	Yes	Yes	Yes	70% Served Within 120 Days of Referral	89%
11. Assertive Community Treatment (ACT)	Yes	Yes	Yes	Yes	85% Served Within 45 Days of Referral	51.94%
12. Newer - Generation Medications	Yes	Yes	Yes	Yes	70% of Adults with Schizophrenia Receive Atypical Medications	84.9% (Inactive Monitoring Status)
13. Homeless (Adults)	Yes	Yes	Yes	Yes	150 Served + Comprehensive Strategy	102 Comprehensive Strategy to be Developed
14. C/Y in Natural Setting	Yes	Yes	Yes	Yes	75% of SED With Service in Natural Setting. Must Have SED Penetration Rate of 2.5%.	65.9%
15. C/Y in own (or surrogate) home	Yes	Yes	Yes	Yes	85% of SED in Own Home or Surrogate Home. Must Have SED Penetration Rate of 2.5%.	91.4%
16. Homeless C/Y	Yes	Yes	In Process	No	100 Served + Comprehensive Strategy	57 Comprehensive Strategy to be Developed
17. Continuity of Care a. Adults b. C/Y	Yes	Yes	Yes	Yes	80% of Inpatient Discharges Seen Within 7 Days in Non-emergency	a. 35% b.45%

					Outpatient Setting.	
18. Community Resources	Yes	Yes	In Process	In Process Through the Monitor	60% of DMH Expenses for Community Services	67%
19. Medicaid Utilization	Yes	Yes	Yes	Yes	49% of MHRS Billings Paid by Medicaid	51.62% (FY '06) (Recommended for inactive Monitoring Status)

Table 1 shows the most recent status of the District's performance on all of the nineteen (19) Court-approved Exit Criteria. In general, the measurement period is for FY 2007 (October 1, 2006 – September 30, 2007). The notable exception is for # 19 (Medicaid utilization) which is a FY 2006 measurement due to the lags in claims payment and reconciliation between DMH and MAA. Hence, the FY 2006 is a truer reflection of performance for this measure than FY 2007. Fifteen (15) of the seventeen (17) quantifiable measures have been validated both by the DMH's internal process and also by the Court Monitor. The remaining two criteria (Homeless Children/Youth and Community Resources) still require additional work by DMH before the Court Monitor can test the validity of the data collection methods. Overall there has been good progress on the validation process and a continued high level of cooperation between DMH staff, the Court Monitor and the Monitor's consultant.

The following three categories reflect the Court Monitor's assessment of overall compliance on the 19 Exit Criteria:

1) Exit Criteria Met – Inactive Monitoring Status

- Prescribing Newer Generation Medications (Criteria #12)
  In the July 2007 Report to the Court, the Court Monitor found that this measure met the Court-approved performance level and should move to inactive status.

2) Recommended for Inactive Monitoring Status

- Medicaid Utilization (Criteria #19)
  The Court Monitor has recently received full documentation that the DMH has met both the data collection method validation test and the required performance level of 49%. A January 4, 2008 letter to the Court Monitor documents the agreed methodology and the FY 2006 performance of 51.62% on this measure. Hence under the terms of the November 2003 Consent Order, the Court Monitor believes that this measure should move to inactive status. It should be noted, however, that DMH is required to continue collecting and presenting data to the Court on this Exit Criteria.

3) Progress Noted but Exit Criteria Not Met – Not recommended for Inactive Status

There are six (6) Exit Criteria that require additional verification and/or performance before inactive monitoring can be achieved. The status of these six can be summarized as follows:

- Consumer Satisfaction Method(s) (Criteria #1)
  As discussed in II A, the DMH has clearly approved methods for measuring consumer satisfaction. It appears that the process for utilizing these results is beginning to take place via the Internal Quality Committee and the Quality Council.

- Consumer Service Review (CSR) for Adults (Criteria #3)
  As detailed in the July 2007 Report to the Court, DMH performed at the 80% required level in the 2007 CSR review; however, this was based on a limited sample size that did not produce a statistically valid result. The 2008 CSR reviews for adults will increase to approximately 88 to provide a sample size with confidence levels at 95% (+/- 10%).

- Supported Employment (Criteria #10)
  The DMH continues to show performance levels in excess of the Court-approved level. The outstanding issue is to provide verification that the DMH policy is in fact being followed by providers. The Court Monitor and DMH have tentatively agreed on supplemental measures to achieve the needed verification. Data is beginning to be captured on the supplemental measures – with the understanding that additional discussions, to include discussion with plaintiff's counsel, will occur in early 2008.

- Children/Youth in Natural Settings and in Own (or Surrogate) Home (Criteria #14 and #15)
  Both of these measures continue to score at reasonably high levels; the surrogate home measure, in fact, exceeds the Court-approved level. The outstanding issue is that the penetration rate for SED children (#6) must be at 2.5% before these performance measures can be considered. The current penetration rate is 1.6%.

- Community Resources (Criteria # 18)
  DMH reports that performance on this measure exceeds the Court-approved requirement. However, DMH has not yet completed the task of independent verification as it relates to the allocation of expenses of specific cost centers (e.g. DMH Authority). This task has been included in the 2008 KPMG contract – with the expectation that this will be completed by March 2008.

4) Significant Progress Not Noted – Not Recommended for Inactive Status

There are eleven (11) Exit Criteria for which there are significant remaining issues.

- Consumer Functioning Method(s)
  As discussed in II A, this Exit Criteria has not seen any progress over the past several years. Very recently, the Office of Accountability has stepped forward to take on lead responsibility for this issue.

- Consumer Service Review (CSR) for Children/Youth (Criteria #4)
  The DMH has initiated a targeted training effort to improve and expedite its overall family team meetings philosophy. Hopefully this will begin to show improvement for the more complex cross-agency cases that are reviewed.

- Penetration Rates (Criteria # 5-8)
  DMH continues to obtain data from the four MCO's regarding consumers (c/y and adults) who received mental health services. The DMH is still in the process of validating this data before submission to the Court Monitor for consideration. The broader issues for inclusion of these services (i.e. DMH authority, provider oversight etc) still remain.

- Supported Housing (Criteria # 9)
  The major issues relate to overall resources available to this program and the basic DMH definition of what can/should constitute a "supported housing service" within the Court-approved Exit Criteria. The Court Monitor has encouraged DMH to pursue this issue internally as a next step. It should be noted that apparent slippage on this criterion is due to putting the correct formula in place.

- ACT (Criteria # 11)
  The DMH has finalized its ACT policy, which has been pending for some time. It has also moved forward to fill the ACT coordinator position, establish an ACT Advisory Committee and review its overall ACT program. However, major issues remain regarding fidelity and ACT capacity within the system.

- Homeless Adults (Criteria # 13)
  DMH continues to report only those consumers receiving Housing First services via Pathways to Housing. While this specific program has the real potential to grow, DMH is actively considering whether to expand its data capture on this criteria to include other providers. The Court Monitor has indicated a willingness to pursue a broader approach – but awaits initiation by DMH.

- Homeless Children/ Youth (Criteria #16)
  A valid data system for this measure still has to be developed by DMH. The service levels for this program have slipped due to staff turnover. However, a full time person has now been hired. The DMH indicates that it intends to develop a comprehensive homeless strategy for both children/youth and adults. Staff assignments have begun, but it is not clear how quickly this task will be completed.

- Continuity of Care (Criteria #17)
  DMH – via the Care Coordination staff – are actively calling CSA providers regarding adults and children/youth who are admitted to inpatient units. While the performance data do not yet reflect it, there is at least a beginning process to improve scores for this criteria.

Overall there has been demonstrable progress on the DMH's ability to validate data – with only two of the seventeen quantifiable criteria still remaining. On the performance side, there have been limited gains in the past six months – with one additional criteria having met Court-approved levels. However, there are a number of criteria that are now receiving active DMH attention and should – with concerted effort – show significant progress by the time of the July 2008 Report to the Court.

III. Findings Regarding Development and Implementation of Court Ordered Plan

A. Review of the Development and Implementation of Crisis/Emergency Services

1. Overall Development of Crisis/Emergency Services Plan

a. Adult Services Planning

In February 2007 the DMH convened a Crisis Emergency Services Planning workgroup for adults. This workgroup met on a regular basis since that time and completed its final report on December 21, 2007. This workgroup was broadly composed of representatives of the major DC emergency service agencies (Metropolitan Police Department (MPD), and Fire and Emergency Services (FEMS)), plus the DC Superior Court, community providers, advocates and consumers. This workgroup identified a number of concerns in the current system including: fragmentation of services; lack of adequate extended observation beds at CPEP; limited mobile crisis response capability; over-utilization of police as primary responders for mental health issues; under-utilization of crisis residential beds; and lack of single point of entry across the multiple crisis response systems (e.g. MPD, CPEP, Access Helpline, and community-based providers)

The workgroup believes that an enhanced crisis emergency system should be framed by a set of values that drive the overall system as well as the individual components. These values include the following: 1) the system should be uniquely responsive to the individual consumer's perception of crisis – balancing the need for consumer (and family) direction with the need to intervene and protect for those consumers deemed likely to hurt themselves or others. The enhanced use of peer specialists in crisis response services is seen as one tangible way to create greater sensitivity and consumer engagement. 2) Prevention – Develop a range of strategies that would serve to prevent or ameliorate crises for individual consumers. These could include things such as more involvement of peer specialists, flexible funds for emergency consumer needs (e.g. rent, food) and structuring of incentives for CSA's to provide more immediate/crisis treatment for enrolled consumers. It was also recommended that more education and training for consumers and families would be helpful. 3) Cooperation and Collaboration – the workgroup recommended that the current working relationships between DMH and other crisis response agencies be strengthened and clarified via interagency agreements. These agencies include MPD, FEMS, and the Office of Unified Communications (OUC). These interagency agreements should reflect the specific recommendations of the Crisis Emergency Planning Workgroup Report. It was also recommended that a viable quality improvement function be built into the enhanced system – with the requisite need for timely data collection, consumer satisfaction, etc. 4) Cultural Competency – The DMH and all of its contracted crisis providers need to ensure that services are delivered in a culturally competent manner – including access to interpreter services for persons with limited English proficiency or those who are hearing impaired. 5) Workforce Development – An expanded education and training program was recommended for all crisis emergency services staff as well as all mental health providers. Included would be training on de-escalation, cultural competency and enhanced understanding of the consumer perspective on dealing with crisis.

Beyond the values, the workgroup identified five critical areas that need to be addressed in order to create a "well-functioning crisis emergency services system". These five (5) can be summarized as follows:

1) Access
   Create a dedicated 24/7 crisis hotline. This hotline must be staffed by well-trained individuals and must be capable of handling calls from non-English speaking and hearing-impaired callers. It should be the single point of triage for the mobile crisis team and should be able to connect easily with all

other DC emergency response systems (MPD, OUC and FEMS)

2) Walk-in or Urgent Care
The final report of the workgroup recommended that the District create capacity to provide urgent or same-day outpatient services. The range of urgent care services should include the ability to see an individual in a timely manner on an unscheduled basis, provide assessments and begin treatment immediately, including medication. Urgent care services would also offer short-term services with the intent of linking the individual for ongoing care. Urgent care services should be available at various sites across the District and could be co-located with primary health care services, Hospital ER's or existing CSA's. Ideally they would be available 24/7, although this might not be realistic at all sites. A good example is that the DMH is in the process of establishing an urgent care clinic at the DC Superior Court.

3) Mobile Crisis Outreach Teams
The DMH needs to develop full-blown mobile crisis teams to respond to families, consumers, and other citizens – as well as to MPD, FEMS and other emergency workers. The capacity should extend the ability to provide medications and other short-term crisis stabilization services in the home. Depending on funding capability, these mobile teams should be available 24/7. It was recommended that these mobile teams be an integral part of a restructured CPEP. The workgroup recommended a goal of three mobile crisis teams with two individuals on each team.

4) Crisis/Respite Residential Services
The DMH currently contracts for 15 crisis beds through two different community providers. There has been improved communication between CPEP and the crisis residential providers; however, there is room for continued improvement to ensure that these beds are maximally used to avoid unnecessary hospitalizations and/or stabilize psychiatric and living situations.

5) Comprehensive Psychiatric Emergency Program (CPEP)
The goal is to create a truly comprehensive CPEP – with the addition of fully functional mobile teams and an adequate number of extended observation beds. In addition, it is recommended that CPEP develop the capability to do medical evaluations onsite for those patients (approximately 10% of

total CPEP patients) who currently are sent to other facilities to do medical evaluations. These services could be done via a physician or physician extender (nurse practitioner or physician assistant).

The workgroup was in agreement with DMH that the organizational structure for crisis emergency services should be a combination of DMH-provided and privately-contracted services – as it is currently. DMH would operate the crisis hotline and continue to operate CPEP – which would take on the mobile crisis teams. The crisis residential component would continue to be contracted out.

The Court Monitor is highly supportive of this comprehensive plan for crisis emergency services. The inclusive process of developing the plan should help assure buy-in by the key stakeholders. Key factors regarding the successful implementation of the plan still remain. These include: 1) identifying budget resources that will allow priority areas to move forward e.g. mobile crisis teams and extended observation beds 2) clarity regarding where and how accountability for this new model will be fixed 3) ongoing oversight from the workgroup meet (or a successor group) to ensure continued momentum. It should be noted that DMH has committed to having the Workgroup meet at least quarterly to review implementation progress – with the first follow-up meeting scheduled for February 13, 2008.

b. Child/Youth Planning

On the child/youth side, the DMH is also looking to make major strides in expanding its capacity to provide crisis emergency services. This initiative is directly responsive to the Feb 27, 2007 LaShawn Amended Implementation Plan (AIP) which calls for the implementation of a new crisis service to include mobile crisis teams and crisis beds. An RFP to accomplish both of these services went out in early October 2007 – with required submissions due on January 4, 2008. The RFP clearly delineates the expectation that there will be four (4) crisis beds developed and a minimum of two Mobile Response Stabilization Teams (MRST). The mobile services must be available 24/7 and will respond to crisis as defined by the caller (as opposed to the current model of clinically-determined crisis response). The goal is to stabilize the situation, develop a safety plan, connect (or reconnect) the family to ongoing service provision and avoid inpatient hospitalization and disruption of foster care placement whenever possible. The availability of crisis beds should also provide short-term stabilization (up to 14 days) as a way to avoid unnecessary inpatient admissions and placement disruptions for children/youth ages 6-21.

The successful bidder will serve all children/youth – but with a strategic focus on CFSA children, youth and families.

The review panel will evaluate proposals during January 2008 and make a final determination based on a pre-determined scoring methodology that was included in the RFP. The expectation is that the necessary legal and contract reviews will happen in February and that the D.C. Council will receive this for approval in March 2008 – as the contract is expected to exceed $1 million. If the award is made by the end of March 2008 the expectation is that the new entity will be fully up and running by July 1, 2008.

This RFP on the child/youth side creates a major opportunity for the District to expand and integrate its crisis services for children, youth and families. The expanded use of 24/7 mobile teams should take pressure off of other crisis services (e.g. Children's National Medical Center (CNMC) emergency room) and also provide greater stabilization and connectivity to ongoing service providers than the current system provide. It should also help to avoid some of the inpatient admissions for children/youth that are currently occurring.

2. Access Helpline

The DMH Authority continues to directly operate the Access Helpline (AHL). The AHL provides multiple functions including: 1) telephone assessment and triage for incoming calls and requests for mental health services 2) dispatching mobile crisis teams for both adults and children/youth 3) linkage or transfer of non-emergency consumers to a CSA of choice and 4) care coordination functions – including prior authorizations for any admissions to SEH contracted acute beds at Greater Southeast or PIW, ACT services, CBI services and Day services.

The Care Coordination Team has taken on several priority tasks over the past year. These include: 1) hiring three (3) additional staff who are specifically targeted toward care coordination for CFSA consumers in need of mental health services 2) actively managing the process of ensuring that individuals coming out of acute hospitals (or SEH) are connected to community providers. This continuity of care issue is one of the nineteen Dixon Exit Criteria. It is encouraging to see this issue being directly addressed by DMH 3) managing the process of disenrollment of consumers in CSA's. This is a long-standing issue for which DMH has an existing policy. The AHL staff indicate that DMH is more on top of this process than in years past. For FY 2007, the AHL data indicate that there were 6165 new enrollments and 6307 disenrollments indicating that the overall process is working. However, DMH is still unable to differentiate those consumers who are still recorded in eCura but are not active. 4) the hiring of a bilingual staff person who is now

available during day time hours Monday – Friday 5) enhanced efforts to reach out to community groups to explain the Access Helpline and Care Coordination functions. Targeted meetings included one with the Superior Court judges.

The major current frustration is with the 2006 installed telephone system (Telequent). AHL staff experience regular difficulties with the phone system, including lost calls and the inability to put callers on hold. This has resulted in a number of complaints from consumers and other callers. It is unclear whether the problems are at a technical (software) level or at a network level. The Telequent data (as analyzed by AHL) reports for 2007 show an abandonment rate on calls of 7%. While DMH staff believe that this percentage is higher than the true rate, it nevertheless represents a rate that is of high concern. Certainly some of these abandoned calls are a direct result of phone system problems. The lack of a dependable phone system only adds to the challenge of managing the "front door" to the mental health system.

The DMH CIO indicates, in response to this problem, that there are several inherent problems in the current telephone system – including the fact that this system was selected without programs staff input and that there is no support agreement. The going-forward plan is to evaluate a telecom platform (AVAYA) that is standard for the District Government, including the 911 system. The joint evaluation of this new option (IT staff and AHL staff) occurred in mid-January 2008. The AHL Director and CIO have decided to move forward with this new system. Necessary funds are available. The next steps are the development of a project plan and the assignment of dedicated staff at DMH and OCTO to move toward implementation. It is unclear how long this project will take, but it is likely that it will be 3-6 months to plan, purchase and install. The Court Monitor will continue to closely track progress. The CIO also indicated that the DMH IT Department has hired a person in January 2008 who has extensive background in telecommunication. This should help considerably with resolving future problems and intersecting with telecom staff at OCTO.

Overall, it is clear that that the AHL and Care Coordination staff are committed to carrying out the multiple tasks that are assigned to them. Good progress is noted on several fonts. However, the lack of quick response to the phone system problems reinforces the need to have greater IT capability within DMH. It is simply not acceptable for a service that is so telephone-dependent to operate with such an inadequate system.

3. Capacity and Utilization of Mobile Teams

The primary responsibility for adult mobile services remains with the Homeless Outreach Team (HOT). In addition to the range of homeless services provided by HOT, the team does respond to requests for mobile

outreach; these requests come from a variety of sources including the Access Helpline. For the 6-month period of May – October 2007 the HOT provided an average of nearly 35 mobile outreach services per month. This is up slightly from the same period for 2006 (32 average per month) and continues to represent a much higher level of mobile support than when the mobile service was being done by the site-based team at CPEP. The May – October 2007 data show an average of 9 FD-12's per month. The Mobile Urgent Stabilization Team (MUST), which is a part of the DC CSA also continues to provide limited adult mobile crisis services, but only upon request from the Access Helpline. The most recent yearly data from MUST (October 1, 2006 – September 30, 2007) show a total of 35 adult mobile visits by MUST – or an average of three per month. This is up from one per month for the same period in 2006. Hence, the combined volume of adult mobile crisis is now averaging 38 responses per month – far surpassing the volume for any period since there were separate mobile teams in 2002.

As noted in III A 1, the crisis plan going forward is to create separate mobile team(s) as a part of more comprehensive CPEP. While the Homeless Outreach Team has taken on this task very responsibly for the last two years, the reality is that there are multiple homeless outreach tasks that require the focused attention of HOT. Hence, the Court Monitor is in strong agreement with DMH that distinct mobile team(s) under CPEP is the preferred model.

For children and youth, MUST continues to provide mobile crisis response. For the October 2006 – September 30, 2007 fiscal year, MUST provided a total of 98 mobile crisis visits for children/youth or an average of approximately eight per month. This is down considerably from the FY 2006 – which showed an average of 20 mobile visits per month. Of these 98 visits, fully 33 involved inpatient admissions to Children's National Medical Center (CNMC). Hence, it appears that though volume may be down, the severity of the cases is up. This increase in severity does not, however, explain the decrease in volume.

The DMH conducts a Quarterly Monitoring Report of MUST services. In review of the most recent report, the Court Monitor noted a number of identified concerns. These concerns included 1) discrepancies between progress notes and billing information 2) lack of documentation that MUST staff contacted CSA's regarding crisis calls for existing consumers or consistently attempted to link new consumers to a CSA 3) lack of overall documentation in the record regarding interventions, safety plans and follow-up linkages. The DMH will continue to do quarterly reviews during this interim period in which MUST continues to provide mobile services. Presumably, the mobile services will shift in July 2008 to the successful bidder under the RFP discussed in III A 1b.

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

CPEP continues as the facility for providing site-based services for adults. The overall volume of persons seen at CPEP continues to run very true to previous years – 9.5 day average for the first nine months of 2007 compared to 9/day for 2006. The percentage of people seen at CPEP who are subsequently admitted to an inpatient psychiatric unit is also consistent with previous periods – 35.2% for 2007 vs. 34% for 2006. There is a noteworthy drop, however, in the number of acute admissions to SEH. For January – September 2007 there were a total of 286 admissions to SEH – (31.8/month) as compared to 364 individuals (40.4/month) for 2006. This appears to be a consistent and positive trend, which reflects an effort to make greater utilization of acute inpatient settings at Greater Southeast and PIW. It is even more impressive to see the trend lines for July – September 2007 – which show average admissions to SEH down to 25/month. The overall utilization of acute inpatient care is discussed further in III B3. It is also significant to note that CPEP appears to be making increased use of the 15 crisis residential beds that are under contract. For the first nine months of 2007, 126 individuals were admitted to crisis residential beds (an average of 14/month). This is a major change from prior years and represents the increased communication and collaboration between CPEP and the crisis bed providers.

The major concern regarding the need for a suitable building for CPEP continues. The current plan is for DMH to completely renovate the existing CPEP building. This renovation will include the addition of extended observation beds, an area designated as a walk in clinic (on the front side of the building) and an area for the additional outreach staff. Most of the work will be done on the vacant side of the building so there is no longer a need for the CPEP operations to move to temporary quarters. The firm of McKissack and McKissack has once again been engaged to design the space. DC Housing Enterprises (a subsidiary of the DC Housing Authority) has been engaged to manage the project on behalf of the DMH. Design is estimated to take approximately 90 days and construction an additional 90 to 120 days. However, these estimates are dependent on what is found during demolition of the space that will be renovated. It appears that there would be adequate space in the rehabbed building to create distinct space for 8-10 extended observation beds and to significantly upgrade the quality and utilization of space for site-based services – including adequate space for families. The saga of developing adequate space for CPEP has been a long one. The previous plan to locate at Greater Southeast was fraught with many issues – most notably its distance and the instability of hospital ownership. The ideal would be to locate CPEP contiguous to a medical emergency room and an inpatient psychiatric unit. This option does not appear feasible in the near term. However, DMH is hopeful, with the planned development of Reservation #13 (DC General), that there will be provisions for health care facilities so the CPEP can join with a medical health facility on the same campus. Given all of these options, the Court Monitor is in agreement that

rehabbing the existing building makes the most sense. The Court Monitor will continue to track developments on this long-standing issue.

Overall, CPEP is functioning in a very stable and positive manner. It is noteworthy that the CPEP Director and Medical Director have been at the heart of the planning for an expanded array of crisis emergency services in the District. This plan reflects growing confidence that CPEP can, and should, take on an expanded role into the future.

The DMH continues to provide site-based services for children and youth via a contract with the Children's National Medical Center (CNMC). A recent 9-month review of visits (March through November 2007) indicates that the average number of visits has dropped significantly from 2006 (109 average visits per month for 2007 versus 162 average for 2006). However, it is telling that there were 490 acute inpatient admissions out of the 980 visits for this 9 month period (50%). The large majority of these inpatient admissions (388 out of the 490) were direct admissions to CNMC. Thus it would appear that while overall visits to the emergency room for children/youth are down, those children/youth who are presenting have high levels of psychiatric acuity – prompting high percentages of inpatient admissions. The overall working relationship with CNMC continues to be a positive one. The full contract model (psychiatrists plus social workers) has worked well. CNMC is providing regular (daily) data regarding demographics, diagnosis and disposition. However, it is not clear that the data is being aggregated, trended or utilized by anyone at DMH. There would appear to be many important questions as to how this site-based service connects to the rest of the child/youth system. The Court Monitor believes that the child/youth crisis RFP discussed in III A 1 should be used to provide a vehicle to achieve this integration.

5. Development and Utilization of Crisis Residential Beds

The DMH has two contracts for crisis residential beds – with a total of 15 beds. Crossing Place, which is run by Woodley House, has eight (8) beds; Jordan House, operated by So Others May Eat (SOME), has seven (7) available beds. The DMH conducted a second fidelity audit of the crisis residential providers in May 2007. The initial fidelity audit identified several concerns which were highlighted in the January 2007 Report to the Court. The May 2007 audit indicates that there has been significant progress by both providers. Of particular note was that crisis providers are generally admitting (with some exceptions) individuals who demonstrate a need for crisis residential level of care. This contrasts to the 2006 DMH retrospective audit which found that 56% of the admissions to crisis residential beds were not warranted and that the crisis residential beds were being used more as "step down" programs than as true crisis residential. The 2007 audit found that those individuals (44%) that did not meet the crisis test for admission did fall

into a "step-down" category. Unfortunately, DMH does not officially have "step-down" beds available within its current taxonomy.

It was also noteworthy that 100% of the crisis residential records had a clear treatment plan for consumers who stayed beyond 2 days. This fact was indicative of great improvement in internal practices and focus on continuity of care. In spite of the tightened focus on serving consumers in crisis, the crisis residential programs are running at nearly an 80% occupancy level – with average lengths of stay at 8 days. Clearly the crisis residential programs are now fulfilling a critical niche in overall crisis services programs.

Going forward, the 2007 audit raises again the issue of the need for "step-down" capacity within the DMH system. The existing crisis residential providers get called upon to fulfill this function even though it is not part of their designated role. The DMH needs to carefully evaluate the number of beds needed in each category (crisis vs "step-down") and make a determination as to whether the 15 existing beds are adequate to meet the full need. This has been an ongoing issue that – as part of the larger crisis emergency services planning – needs resolution over the next 6-12 months.

B. Review of DMH Role as a Provider

1. Planning for New/Consolidated Hospital

The construction of the new 292-bed hospital is moving forward at full pace. As of the end of December 2007, 75% of the steel installation was complete, the masonry bearing walls were completed and the brick veneer installation was being completed on both the civil and forensic wings. Overall, the Hospital construction was 40% completed. DMH reports that as of January 4, 2008, the contractors are setting steel in the last section of the building and completing roofing for winter work. Floors have been installed on both levels of the building.

There are some needed design changes that have been ordered by DMH leadership. These changes include a specialized wall finish in many of the common areas of the hospital including patient day rooms and treatment malls, the re-design of the Hospital auditorium and the inclusion of a separate transition unit for medically-impaired patients. These changes will clearly impact the completion schedule and the total costs. It appears that the current contingency fund will not be adequate to cover the current and anticipated change orders; DMH is planning to request an additional $15 million from the District Council in 2009 capital budget request to cover all known (and currently unknown) change orders.

The projected occupancy is for late 2009 – assuming that the current design changes can be accomplished in a timely way and that there are no further

delays of consequence. Realistically, it is likely that the occupancy will not occur until early 2010. However, it should be noted that the DMH and Hospital leadership are working closely with Gilbane (the construction manager) on issues large and small. Any further delays are the inevitable consequence of mid-course program rethinking by new leadership and the unavoidable impacts of weather, etc. Overall there is a great deal of excitement by leadership, staff and patients as this long-awaited Hospital takes shape.

The RMB CT 7 & 8 phase one project is also moving. Phase one involves separating the energy source for the new Hospital from other buildings. The current work is focused on necessary demolition of existing utilities-related equipment and asbestos abatement. $13 million dollars has been approved for this phase one project. The projected timeline for completion of phase one is March 2009. The DMH intends to request adequate capital funds in its 2009 budget to completely rehab the interior of the RMB CT 7 & 8. Given the current likelihood that the new Hospital will not be able to accommodate all of the patients, it is critical that DMH continue its planning for additional bed space.

2. Quality of Care at St. Elizabeths Hospital

The May 10, 2007, Settlement Agreement with the Department of Justice (DOJ) provides a comprehensive framework within which quality of care issues must be addressed at SEH. One of the key elements of the Agreement was the selection of a Compliance Officer who would report directly to the Hospital CEO and serve as liaison among SEH, DMH, DC government and DOJ. Janet Maher was selected by the District and began full time employment in early July 2007. The District is required under the terms of the Settlement Agreement to file a status report every six months with DOJ to review the status of all elements of the Agreement plus projected compilation dates. The first 6-month report was issued by the Compliance Officer on December 21, 2007 and represents an excellent overview of progress made as well as areas in which progress has lagged or not really begun. On the positive side, this first Report to DOJ (plus discussions with the SEH Director Dr. Canavan) indicates there are multiple points of progress. Examples of these include:

- Maintenance of federal certification by CMS following a survey in February 2007.

- Initiation of a fully trained project on trauma-informed care on two units – with plans to expand to all 12 units in the next year-18 months.

- Implemented a smoke-free campus policy as of August 2007. Emphasis is on helping those patients who continue to smoke through group treatment and/or nicotine replacement therapy.

- Filled key leadership positions with highly-qualified individuals. These include a new Chief Operating Officer (October 2007 start), a new Director of Civil Services (Spring 2007) and a new Director of Medical Affairs (December 2007). The position for Director of Training and Organizational Development is being actively recruited. While there has been some lag in recruiting these key positions, it appears that the overall leadership team will soon be in place.

- Converted managers and supervisors to the District's Management and Supervising Service (MSS). This affects approximately 70 staff that will now function as "at-will" employees – with implementation of individual performance agreements to measure and monitor performance.

- Implementing an organizational model that separates clinical and administrative duties at the unit level. Many of these positions have been filled and will allow for greater focus on clinical issues.

- With the support of the DMH Director, created a delegation-of-authority model for human resources at the SEH level. The SEH Director (as of October 2007) now has delegated authority via his own HR Team to make decisions relative to recruitment, position classification and salary negotiations. This should help with the ability to recruit and hire in a timely way. The fully-staffed HR team also includes a nurse recruiter (started November 2007).

- Completing the first year of a forensic fellowship training program in conjunction with Georgetown University.

- Added 72 new positions as of the FY 2008 budget – most of which are in the clinical area.

It is clear to the Court Monitor that all of these efforts (leadership roles, clear management accountability, enhanced training, ability to hire in a timely way) are foundational requirements to accomplishing the multiple tasks that remain.

Despite the above-stated progress, there are multiple areas identified in the DOJ Report for which significant improvement is still required. These include:

1) Human Resources

The delegation of H.R. functions should help the timeliness of hiring. However, as of October 2007, SEH had 1052 total positions – of which 150 were vacant; 78 of these were vacancies from 2007 Fiscal year and 72 were the result of new positions added in the 2008 budget. Just counting the carry-over vacancies 24 were in nursing and nine in psychiatry. When psychology, social work and rehabilitation services are added, nearly 50% of the vacancies are in DOJ-related clinical positions. Clearly the challenge to hire (and retain) qualified professionals still remains. In addition to HR delegation and MSS conversion, SEH has also been approved for inclusion in a new District-supported Loan Repayment Program for physicians and nurses. This program will provide up to $120,000 in student loan repayments for M.D.'s and up to $66,000 for nurses. The amount of loan repayment is dependent on years of service. SEH officials believe this will be a useful recruitment method.

There are early signs that the infrastructure improvements are positively affecting recruiting; since October 1, 2007, SEH has hired 43 staff with an additional 10 offers of employment finalized. This hiring has produced a net gain in staff. From December 12, 2007 through the January 22, 2008 pay periods, SEH has hired 20 staff compared with only 5 separations or retirements.

2) Contracts and Procurement

There have been significant contract delays for many basic (and critical) support functions – including food, medication, HVAC and five alarm systems, water and oxygen. As reported by the DOJ compliance officer, these delays are apparently due to the fact that these contracts in the past were not purchased in accord with District procurement regulations; hence there was significant "clean up" for 2008 contracts. At the SEH level, however, this raises serious operational concerns and calls into question the overall viability of the current contracts and procurement system. The DMH Director is in agreement that the whole contacting and procurement process needs to be evaluated. To this end, an independent consultant (TCBA) has been engaged to evaluate the contracts and procurement system. This report (with specific recommendations) is due by April 2008. The Court Monitor will discuss the whole procurement issue in more detail in the July 2008 Report to the Court.

3) Information and Technology

The planning and implementation of the Hospital's new information system (AVATAR) is approximately 50% complete. When fully implemented, this system is intended to provide an electronic medical

record and provide full support for billing and needed management and service reports. The first phase is scheduled to be completed by spring, 2008; this phase (the Practice Management Module) will include all data for admissions, discharges, and billing – plus laboratory and pharmacy orders. The major issue for phase 1 is the amount of training needed – given that nearly 800 staff will need to be trained. The intent is to create a "train the trainer" model. Overall it is estimated the training will take 8 weeks to complete. There are also issues of hardware. Many staff who will be using AVATAR are still without computers.

Phase two (the Clinical Workstation Module) will include assessments, treatment planning, and case notes. This is the phase that will bring up the electronic medical record (EMR) for patients. This phase is estimated at 6-9 months after phase 1 is completed. DMH and the Hospital have also purchased an additional option (EMAR) to assist with medication monitoring.

It is encouraging to see this long overdue IT system underway. It should be recognized that this is a huge project that is made even more challenging given that the fact that SEH staff have existed without any electronic support. This creates enormous gaps in terms of hardware and software needs – but also large challenges in training staff, many of whom are not computer literate. The overall concern is whether the three dedicated IT staff will be sufficient to support this effort. SEH leadership are very concerned that, given the enormity of the project, this is an insufficient commitment of resources. There is also concern that the new system must be able to create needed management reports – not just for DOJ but for all functional areas.

4) Training

The Hospital is actively recruiting for an expanded Director-level position called Office of Training and Professional Development. The filling of this key position in a timely way is critical so that an overall training plan for the Hospital can be developed in an expedited way. The intent is to create an integrated plan across all disciplines with the ability to collect training data in an automated framework. The DOJ requirement is for competency-based training for all clinical staff in key functional areas such as clinical assessments, treatment planning, case formulation and appropriate use of special interventions.

5) Quality Improvement

Under the overall leadership of the Compliance Officer, SEH has restructured to create an Office of Performance Improvement. This

will include the major functions of policy development, quality improvement and monitoring systems; each of these functions will have a manager. These integrated sets of functions are obviously critical to SEH's ability to do self-assessments (for DOJ purposes) and to provide viable performance improvement capacity within the Hospital. The Compliance Officer's assessment in her Report to DOJ is that the current self-assessment capacity is limited in terms of frequency, data integrity and quality of analysis. The November 2007 self-assessments related to the treatment planning process and environment of care, and for the first time, involved a statistically significant sample of cases. In addition, in December, the Hospital produced a trend analysis of some indicators, including treatment planning, attendance, seclusion and restraint and unusual incidents. This analysis will be produced monthly from now on, and will be expanded as data becomes available. The goal is also to develop an intensive case review process by 2008 that may resemble the CSR model done via Dixon.

6) Discharge Planning

The DMH/SEH Hospital Discharge Plan has had some success. For calendar year 2007 (January-mid November) 142 patients have been discharged from SEH who had stays longer than 30 days. The original intent to place individuals who have been at SEH for longer-term periods has had some success. However, there are several major factors at work that are obviating reductions in overall census at SEH. First, is that – while overall admissions on the civil side are down for FY 2007 (compared to previous years) – so are discharges. For the first nine months of 2007 (January through September) there were 349 total civil-side admissions versus 328 discharges for the same period. As noted in the July 2007 Report to the Court, there is indication that while some of the longer-term patients are leaving, newer admissions (on average) are staying longer. The Hospital and DMH Authority staff continue to identify several subpopulations of patients who represent distinct placement challenges. These include primarily individuals with co-occurring disorders – including mental retardation, chronic medical conditions, drug and alcohol abuse, and sexual deviancy. Specific placement strategies need to be developed for each of these subpopulations; this is beginning to happen again, for example, with the Developmental Disabilities Agency. Another subpopulation includes 20 plus patients who are candidates for nursing home placement – but without any current nursing homes who are willing to accept this population.

On the positive side, there is a working group of SEH and DMH Authority staff who meet on a weekly basis to review individual

patient discharge issues. This group is also taking on the task of aggregating data for these identified subpopulations and recommending systemic strategies. In addition, DMH is in the process of issuing an RFP to local providers that would create a risk-based financial incentive to take 25 longer-term patients out of SEH. This would be an all-inclusive service model that should reach to some of the higher-risk patients previously discussed. The goal is to have this initiative up and running by Spring 2008.

Overall, the process at SEH can primarily be measured in terms of putting the needed leadership structure in place and moving aggressively to develop needed infrastructure (e.g. IT). These are essential first steps. It is hoped that by the time of the July 2008 Report to the Court there will be evidence of people and processes in place that can demonstrate more complete self-assessments and at least incremental evidence of quality improvement at the patient care level.

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

Progress on the development and use of local hospitals to provide acute care beds is mixed. Greater Southeast Community Hospital (GSCH) has been sold to Specialty Hospital of Washington. This transaction was completed in October 2007. This sale should have positive implications for DMH in that it will hopefully bring stability in ownership and key personnel. However, in the short term, the situation has been very bumpy – with reduced access to beds at Greater Southeast, greater reliance on PIW, and continued reliance on SEH for acute care.

An analysis of the acute admission data for the period of June 2007 through October 2007 shows several noteworthy facts. First, it is clear that the DMH's ability to use Greater Southeast fell off sharply beginning in October 2007. GSCH had been averaging approximately 32 admissions per month since June 2007; this fell to 20 admissions in October due to the sale and transition of psychiatric coverage. In like kind the DMH has had to make increased use of PIW for adult admissions – reaching a high of 39 admissions in October 2007. As noted in previous Reports to the Court, PIW is unable to bill Medicaid for patients over 21 and under 65; hence, DMH is bearing the financial burden for reimbursement. In spite of the continued uncertainties regarding acute beds, DMH has reduced its overall reliance on SEH. Since June 2007 the average total admissions to SEH is 35 per month. This compares to prior periods which have averaged 45 admissions per month. It should also be noted that nearly 7 admissions per month to SEH come at the end of the 14-day acute care admission period. It could be argued that this 7 admissions per month is the true target if the acute care system were fully working and requisite changes were made to DC laws and practice.

There are several other positive developments underway. Howard University has expressed strong interest in developing a contract with DMH to admit involuntary patients under an arrangement similar to that with Greater Southeast – namely that DMH will pay for uninsured patients and transfer to SEH after 14 days. There is indication that this could open up an additional 10 beds for DMH use. In addition, Providence Hospital has developed a partnership with PIW and is also interested in a contract with the Department to provide acute services to involuntary committed individuals. The addition of Howard and Providence would allow DMH to significantly reduce its reliance on PIW. The new owners and leadership at Greater Southeast have signaled their intent to fully utilize the existing 20 bed unit and also rehab the additional 20 bed unit that was originally planned. These 40 beds (if completed and staffed) plus the 10 beds at Howard and the additional beds at Providence, would put the DMH squarely in range of the total number of acute beds it believes it needs. The other noteworthy development is the plan to open up additional extended observation beds when CPEP is renovated. As discussed in III A 4, the plan is operate up to 10 extended observation beds. Clearly this will take additional pressure off of the acute care system and allow DMH to stabilize and divert some patients at the front end.

In summary, there has been some progress on the acute care front, although it is still too early to have full confidence given the rocky history on this issue. There is no doubt DMH is committed to an effectively operating acute care model outside of SEH. Nevertheless, the Court Monitor continues to find that DMH is not in compliance with the Court-ordered Plan as it relates to this issue. As the acute care strategy unfolds, the Court Monitor will work with DMH regarding the specifics of what constitutes compliance on this issue.

C. Review of FY 2008 DMH Budget

The approved FY 2008 DMH budget is $249 million – which represents a $5.37 million increase over the FY 2007 budget that was ultimately approved. The two most notable things about the FY 2008 budget are, first, that it appears that DMH will be able to meet its identified objectives within this budget (including Dixon mandates) without needing to ask for supplemental funds. The second major fact is that the DMH budget is fully loaded at the front end of the year; for several years, DMH has had to request funds beyond its base budget from the Medicaid Reserve account or from supplemental funding via the DC Council. In FY 2006, the Medicaid Reserve request was $13 million. The impact of these supplemental requests (either from Council-approved reserve accounts or from the Medicaid Reserve) has been a high degree of uncertainty as to full budget availability for multiple months into the fiscal year. This uncertainty has compounded DMH's planning ability and contributed to past problems regarding, for example, provider payments. So, in fundamental ways, FY 2008 represents a milestone year for DMH. It also represents growing confidence by the District Council, the OCFO and the Mayor's office that DMH is capable of managing its financial affairs.

The $249 million includes $99.6 million for SEH. This budgeted amount includes full support for the 72 additional staff needed to achieve compliance with the DOJ settlement agreement. It also includes: $4.6 million to cover costs associated with union and non-union salaries; an increase of $1.2 million to increase the capacity for extended observation beds; $4.3 million to support school based Mental Health programs; $300,000 to develop a peer- operated wellness center; $2 million to continue jail diversion programs for persons with mental illness and an increase of $3.1 million to cover the costs associated with meeting the mental health needs of CFSA children/youth per the LaShawn agreement .

Overall, this represents a strong base budget for the DMH. The combination of direct appropriations plus the ability to reprogram dollars from one area to another should allow DMH the necessary financial resources to make solid progress on many fronts that are directly or indirectly tied to Dixon compliance.

IV. Follow-up on Recommendations from Previous Court Reports

A. Provider Payment and Service Authorization

1. Payments to MHRS Providers

The DMH has not yet closed out its 2007 fiscal year. All claims from providers must be at DMH by December 31, 2007 – 90 days after the end of the reporting period. DMH will then have 90 days to deal with any outstanding denials or rework that is necessary before officially closing out the 2007 claims payment process on March 31, 2008.

As of December 10, 2007 the DMH had received unduplicated claims for 2007 of $40.1 million – of which it had warranted for payment $32.3 million. Of the $7.5 million in denials, the DMH estimate that $1.1 million of this will be paid. The remainder is the result (primarily) of duplicate billing or provider billing at their full rates versus the DMH-approved Medicaid rate. This then results (on paper) a higher denial rate than occurs in reality. The DMH projects that its ultimate payout for contracted MHRS claims for 2007 will be approximately $34 million. This compares to a final payout of $32.7 million for FY 2006. Despite billing lags earlier in the fiscal year (as noted in the July 2007 Report to the Court) it appears that DMH will end the 2007 year at approximately 82% payout - $34 million out of the $41.2 million in task order allocations.

The Court Monitor agrees with one of the OIG Report findings that DMH should reduce the number of providers based on performance. DMH has in fact, begun to address this issue. The two criteria developed thus far for de-funding providers are: 1) lack of any billing by a provider for four

consecutive quarters or 2) quality audit findings that suggest the need for de-certification (and hence de-funding). The provider roster indicates that there are fourteen agencies that either did not receive a task order or received a small allocation; none of these 14 have provided any billable service for FY 2007. It seems prudent for DMH – at this stage of its development – to put in place a clear process for decertification and de-funding of non-performing providers.

2. Metrics for Claims Payment and Processing Functions

The process of developing and approving an RFP for this effort was delayed for many months due to the need for internal and external approval of this overall concept. However, an RFP was issued on July 3, 2007 and a vendor (Computer Intelligence Associates, Inc.) has been selected and is now fully engaged. This "dashboard" project is still intended to provide managers within the DMH authority with readily available data with which to evaluate and manage the key functions of enrollments, authorizations, claims etc. The goal for the first phase of this project is to have 20 different metrics within the Authority. The timeline for completing the first phase is February 2008.

While this project has been delayed, it nevertheless begins to address a vital need within the DMH system – namely the need to create an integrated data system with timely (and easily accessible) report capability. The Court Monitor regularly hears the frustration that individual directors and managers have in accessing needed information. The limited resources that have historically been available to the CIO have forced resources to be put on only the highest priority projects. This has begun to change; thus it appears that now is the time to develop an overall IT plan. The dashboard project is an excellent start, but – even if developed across the system – will not meet the full need. The CIO has conceptualized a three-pronged approach that must be developed into the future; this includes: 1) data collection 2) full implementation of the dashboard model and 3) self-reporting capacity. Fortunately new software technology in the industry makes these tasks easier to envision. It will be important for DMH – through its top leadership – to agree on an overall IT plan and identify the requisite resources to make it a reality.

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

The movement of MHRS payments to Medicaid was delayed by one month (from October 1, 2007 to November 1 2007) due to the need to align payment rules between DMH and MAA – specifically as it relates to DMH consumers who are also involved with MCO's. The additional month also allowed DMH to do additional testing of the new payment protocols.

DMH and KPMG staff indicate that the transaction is going smoothly. The process of sorting out MCO obligations for payment vs. DMH is still ongoing. The DMH/KPMG joint team are meeting with providers on a weekly basis to provide updates. They have also developed a Frequently Asked Questions (FAQ) document which is updated and distributed on a regular basis to providers.

The Court Monitor wishes to commend DMH leadership (with KPMG support) for undertaking a planning and implementation process for this transition that is exemplary. The joint DMH/KPMG team has met multiple times per week to review the overall work plan, provide updates and resolve new (or old) issues. Policy issues have been taken to the Steering Committee, which has made timely decisions. The team has communicated regularly and transparently with the provider community. It has, in like kind, met regularly with MAA staff to ensure there was alignment on key issues of services eligibility and IT system edits. The net result is that the DMH/MAA working relationships have never been better and the trust level among providers is also significantly improved. The Court Monitor has encouraged the joint team to write up its "lessons learned" so that this process could be replicated in other complex planning efforts that involve cross-functional teams.

4. Evaluation of Administrative Services Organization (ASO)

The DMH issued a Request for Information (RFI) in July 2007 regarding the potential of contracting out to an ASO for many of the authorization and claims functions that are currently done internally. KPMG – as part of its 2007 contract with DMH – has completed an analysis of the three responses that were received from the RFI.

While this analysis was useful as a first step, the critical development is that the District is moving to create a new Health Care Finance Administration as a separate agency within D.C. government. The District Council has passed legislation and the bill is now being considered by the Mayor. The net effect of this initiative has been to forestall the KPMG analysis of the pros and cons of various options as relates to contracting with an Administrative Services Organization.

The Court Monitor raises several points of thought/concerns regarding all of this: 1) The creation of an independent (and more visible) Medicaid agency would seem to make good sense for the District. The growing liability (and concurrent opportunity) for managing, auditing and utilizing Medicaid dollars is very real. Increased scrutiny at the Federal level makes this initiative very timely 2) The role of this new agency needs to be carefully discussed. Across the country, Medicaid agencies that have

taken on too much power and authority tend to dominate the planning and policy arena in unhealthy ways. This is especially true in mental health; the ability to set rational policy needs to occur via DMH leadership (in conjunction with Medicaid) and not via a more limited Medicaid view of the world. The ability to create meaningful service models involves both Medicaid and local funds. Hence, leadership on this should happen at the DMH level. 3) The creation of this new agency may not preclude the need for an ASO. It would seem prudent to press on with the KMG analysis of the pros and cons – factoring in the possibility for a new Health Care Finance Administration. This would allow a more detailed analysis of the issues and the respective roles of a new HCFA vis-à-vis DMH. The obvious concern is that a new agency takes years to be fully staffed and operational. In the meantime, while DMH has made significant progress, many of the underlying infrastructure issues are still in play. The ASO analysis should proceed without delay.

The Court Monitor will continue to track all of this and discuss it in greater detail in the July 2008 Report to the Court.

5. Medicaid (FFP) Collections from Prior Periods

Since September 2006, DMH has been working aggressively to capture past Medicaid claims that have been denied for a variety of reasons – as noted in past Reports to the Court. Since that time, DMH has worked with Value Options to help quantify, prioritize and resubmit denied claims. KPMG – as a part of its 2007 contract with DMH – has also helped by providing management consultant services to help develop a detailed work plan and establish replicable processes. The DMH has responded to an Office of Inspector General audit (dated November 13, 2007) that speaks to this issue – among others. The DMH analysis indicates that there was a total of $25.1 million in claims to be submitted for possible reimbursement. This includes $16.1 million in denied or suspended claims and $9 million in submitted but not reimbursed (SNR) claims. As of this Report , DMH has resubmitted a total of $15.9 million out of this $25.1 million total, of which it has collected $9.5 million. This $9.5 million is the 70% Federal portion of all approved claims. DMH indicates that it has now submitted all allowable claims for past periods. The gap of $10.7 million will likely need to be written off due to some combination of incorrect program codes, unknown eligibility or having exceeded filling deadlines. Despite these past problems, it does appear that the hard work that began in September 2006 is paying off. The OCFO has indicated that collections for 2007 are higher that at any period in the history of MHRS program. The edits in the DMH eCura system are now matched to those used by MAA, so that initial claims acceptance rates are running at 80% versus historic averages of 60% to 65%.

B. Planning for DC CSA

The DMH Director and the DC CSA leadership have continued to meet on a regular basis to discuss alternative options as it relates to the future of the DC CSA. The original target date for completing this review and developing a plan was October 2007; this date has not been met. However, in fairness to the overall process, this latest delay should not be interrupted as a lack of priority on this issue. It is clear to the Court Monitor that candid and comprehensive discussions are occurring and that the process is leading toward a limited set of options for the future. The DMH has indicated that KPMG will – as a part of its 2008 contract – do a detailed analysis of the pros and cons of these options. This analysis should be completed by April 2008. The Court Monitor also appreciates the sensitivities in the process given the obvious concerns of advocacy groups, the DC Council, Mayor, and employees.

It is the Court Monitor's strong view that this issue needs to be brought to resolution. It is encouraging that the DMH has committed the resources of KPMG in evaluating limited options. It is the Court Monitor's intent to evaluate the KPMG analysis and make a definitive recommendation in the July 2008 Report to the Court. There is no reason to delay beyond that point.

C. Evaluation of Independent Personnel Authority

The recommendation to engage outside consultation (in conjunction with the District's Human Resources Director) has not moved. DMH leadership expresses continued interest in this analysis but concluded that pressing H.R. issues (e.g. conversion to MSS, delegation of H.R. Authority to SEH and handling of non-union pay raises) needed to be done before taking on this new task. The plan is to begin this effort in early 2008. The Court Monitor would again strongly encourage this process to begin without delay. It will take any consulting group some time to analyze and form coherent recommendations. Hence, while other H.R. issues will continue to press, this more systemic analysis needs to be done concurrently.

V. New Initiatives

A. MHRS Review

The current Medicaid-approved model for providing community-based services through DMH has been in place since 2001. Since that time much has changed: 1) the number of approved providers has increased dramatically 2) the DMH has shifted to a fee-for-service payment system for all approved MHRS services 3) the billing and payments system has had a rocky path but has finally begun to stabilize 4) the projected MHRS expenditures and anticipated Federal revenue has also begun to stabilize 5) the Federal government (through CMS) has proposed significant changes in the rules that govern the Medicaid Rehabilitation Option

(MRO). These changes will likely require all States (including D.C.) to change its State Plan for MRO-services 6) the CSR data has demonstrated very uneven performance by individual providers.

For all of these reasons (and more) the DMH Director has decided to undertake a thorough review of the existing MHRS service array over the next 6-9 months. A broadly-based steering committee has been constituted to oversee and advise on this task. This Committee has had initial meetings and is formulating its specific logistics and task areas. Among specific areas likely to be addressed are: 1) basic eligibility for publicly-funded mental health services 2) re-evaluation of the array of MHRS services 3) quality of care measurement 4) issues of access, fidelity to evidence-based models, medical necessity, etc. and 5) reimbursement strategies.

The Court Monitor is pleased to see this broad-based review occurring. Internal and external policy shifts mandate periodic re-evaluations of any service/funding systems. The fact that there is relative stability in the current system makes this an ideal time to undertake this task. There is also the probability that changes to the MRO rule at the federal level will require major changes in any event. The Court Monitor will track this process and continue to provide updates to the Court.

VI. Recommendations

Based on the findings in this Report and previous Reports to the Court, the Court Monitor makes the following priority recommendations:

A. The District/DMH should move assertively to evaluate the use of its independent personnel authority to make needed changes to existing H.R. regulations. In like kind, the District/DMH should utilize the existing consulting agreement regarding the efficacy of the procurement system to make needed improvements and changes.

B. The District/DMH should conclude its internal analysis of options for the DC CSA in the next several months. These options (and any recommendations) should be presented to the Court Monitor in time for a final recommendation to the Court in the July 2008 Report to the Court.

C. DMH should proceed with evaluation of the Administrative Services Organization (ASO) option.