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,

/s/ Robert B. Duncan

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CERTIFICATE OF SERVICE

I certify that on January 28, 2011, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system, which will send notification to all counsel of record.

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REPORT TO THE COURT

Court Monitor
Dennis R. Jones

January 27, 2011

Executive Summary

The seventeenth Report to the Court demonstrates solid progress in meeting the nineteen (19) Exit Criteria; the District has now met thirteen (13) of the nineteen (19) with the addition of four (4) in the past 6 months. The most recent DOJ visit was the most positive to date. Budgetary cuts continue with an additional $4.272 million cut in the FY '11 budget for DMH. There is a critical need for DMH to address the PRTF issue with promulgated rules.

The major issues in this Report are as follows:

1. Implementation of Exit Criteria

   The District has now achieved compliance (and inactive status) on thirteen (13) of the nineteen (19) Exit Criteria. Since the time of the July 2010 Report to the Court, compliance has been achieved on: Consumer Satisfaction Methods (EC #1); Children/Youth in Own (or Surrogate) Home (EC #15); Assertive Community Treatment (EC #11); and Penetration Rates for Children & Youth (EC #5). The DMH continues to show progress on the remaining 6 Criteria.

2. Budgeting Issues

   DMH has been required to absorb an additional budget reduction of $4.272 million for FY '11. Previous budget cuts were largely absorbed in non-direct service areas. However, this cut will directly impact services – including an annualized 5% rate cut for services such as ACT. It is not yet clear what impact these rate cuts will have on the quantity and quality of services.

3. St. Elizabeth Hospital

   The sixth DOJ visit in November 2010 was the most positive to-date. The SEH has achieved substantial compliance on an a cumulative total of 72 provisions of the settlement agreement. This leaves 128 in partial compliance and 2 in non-compliance. These remaining provisions need to move from partial or non-compliance to substantial. DOJ will return in May 2011.

4. Community System Redesign

   The Redesign Workgroup at DMH is getting close to a final set of recommendations. The major areas have been informed by the parallel behavioral health report of the Rand Corporation. It appears that there will be important recommendations that include: a) the regulation, funding and role of Free-Standing Mental Health clinics and Independent Mental Health Practitioners; b) further review (via an interagency group) of the feasibility of a mental health carve-out from the current MCO's; c) improving the care and coordination between DMH & APRA for persons with co-occurring disorders and; d) improving the data infrastructure to provide for increased monitoring of utilization, quality of care and outcomes.

5. Regulation of PRTF's

   DMH and other child-serving agencies have made important progress in identifying the numbers of children/youth in PRTF's, source of payment and the need for greater standardization of assessments and post-placement monitoring. There is now a critical need for DMH to move forward with rule promulgation in order to ensure that, for example, all children/youth are assessed by the DMH medical necessity unit prior to admission to a PRTF. The District is spending millions of local dollars on unnecessary residential placements.

Based on the finding in this Report and prior Reports to the Court, the Court Monitor does not make any additional recommendations.

I. Current Situation

In October 2010, the Federal Court approved the Monitoring Plan for October 1, 2010 through September 30, 2011. The Monitoring Plan included three primary areas for review during this period:

A. Implementation and performance for each of the nineteen (19) Exit Criteria;

B. Continued implementation of critical administrative and service functions as outlined in the Court-ordered Plan and;

C. 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 Consent Order requires a Monitoring Report to the Court twice per year. This is the seventeenth formal Monitoring Report.

II. Findings Regarding Exit Criteria

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

The 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 Nine 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.

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

DMH has made notable progress on both of these Exit Criteria. For Exit Criterion #1 (Consumer Satisfaction), the DMH moved to inactive status via recommendation of the Court Monitor on August 16, 2010. DMH successfully demonstrated its efforts on the three (3) quality improvement responses that grew from the composite of DMH-identified consumer satisfaction methods.

For Exit Criterion #2 (Consumer Functioning) DMH continues its efforts on several levels. First, over the past year, DMH continued to strongly encourage providers to use the web-based application of

LOCUS/CALOCUS as opposed to manually completing the LOCUS/CALOCUS assessment. The amended LOCUS/CALOCUS policy (effective December 21, 2010) mandates use of the web-based application effective April 1, 2011. This creates the capacity for DMH to monitor use of the system, as well as system level resource needs and consumer outcomes, as part of its larger quality improvement strategy.

The DMH has developed a system-level approach to utilizing the results of the LOCUS/CALOCUS scores as one of the factors used to measure the appropriate utilization of select DMH services. These include CRF's, ACT and CBI. The concern is that, based on LOCUS/CALOCUS scores, some consumers may be utilizing higher intensity (and costlier) services than the functioning scores would suggest and others with greater need may not be receiving a more intensive level of service. DMH has been working to develop customized reporting that will allow a review of the consumer functioning scores and actual service provision on a regular basis. While there is considerable work yet to be done on this initiative, this would appear to be an excellent system-based use of the LOCUS/CALOCUS scores.

DMH has also developed a Q.I. initiative for use at the provider level. The DMH intends to provide needed training, technical assistance and reports to the local CSA's in order to improve the integration of LOCUS/CALOCUS scores into treatment planning. The Q.I. initiative was discussed with providers at the December 2010 Quality Council meeting. DMH has completed atechnical assistance and data reporting plan and began providing support to agencies in December of 2010. To date, twelve agencies have submitted requests or interest in receiving technical assistance and support to improve or enhance utilization. The training is currently being rewritten and expanded and all changes are expected to be completed by the end of March. The plan is to target a selected number CSA's but to expect all CSA's to participate.

While considerable work remains, DMH appears to be on a solid path toward achieving the "demonstrated utilization" requirement of Exit Criterion #2.

B. Implementation of Year Nine (9) Consumer Service Reviews for Children/Youth and Adults

The Year Nine (9) Consumer Service Reviews (CSR's) will be very consistent with prior years. Human Systems and Outcomes (HSO) will continue to oversee the individual case reviews, ensure needed

training of reviewers, perform case-judging and perform the data aggregation and analysis for the Court Monitor and the parties. The logistical support for the reviews has been moved out of the Court Monitor's budget and will be a responsibility of DMH. DMH has contracted independently with Far Southeast Family Strengthening Collaborative (FSFSC) for logistical support of the review process (obtaining consents, scheduling, etc.). All of this is consistent with the goal of strengthening the internal DMH CSR unit.

The dates for the 2011 reviews have been set – with the adult reviews in February 2011 and the child/youth reviews in May 2011. The DMH CSR unit will continue to expand its role – providing more of the reviewer training and again coordinating DMH's role in the sample selection, DMH reviewer selection and training, and necessary collaboration with other District agencies (e.g. CFSA and DCPS). DMH will again provide lead reviewers to conduct one-third of the total reviews. All DMH staff who conduct reviews will have case-judging by HSO. The results and recommendations for both the adult and child/youth reviews will be compiled in time to be included in the July 2011 Report to the Court.

C. Performance on Court-approved Exit Criteria

Table 1 shows the current status of all nineteen (19) Exit Criteria

Table 1
Exit Criteria
Current Status

Aggregate Data for October 1, 2009 – September 30, 2010

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 implemented. (inactive)
2. Consumer Functioning Method(s)	Yes	N.A.	N.A.	N.A.	Methods + Demonstrated Utilization of Results	Methods completed. Utilization in process.

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
3. Consumer Reviews (Adult)	Yes	Yes	Yes	Yes	80% for Systems Performance	77%
4. Consumer Reviews (C/Y)	Yes	Yes	Yes	Yes	80% for Systems Performance	49%
5. Penetration (C/Y 0-17 Years)	Yes	Yes	Yes	Yes	5%	5.05% (inactive)
6. Penetration (C/Y with SED)	Yes	Yes	Yes	Yes	3%	3.47% (inactive)
7. Penetration (Adults 18 + Years)	Yes	Yes	Yes	Yes	3%	3.40% (inactive)
8. Penetration (Adults with SMI)	Yes	Yes	Yes	Yes	2%	3.12% (inactive)
9. Supported Housing	Yes	Yes	Yes	Yes	70% Served Within 45 Days of Referral	18.0%
10. Supported Employment	Yes	Yes	Yes	Yes	70% Served Within 120 Days of Referral	84.7%
11. Assertive Community Treatment (ACT)	Yes	Yes	Yes	Yes	85% Served Within 45 Days of Referral	87.73% (inactive)
12. Newer - Generation Medications	Yes	Yes	Yes	Yes	70% of Adults with Schizophrenia Receive Atypical Medications	61.05% (inactive)
13. Homeless (Adults)	Yes	Yes	Yes	Yes	150 Served + Comprehensive Strategy	292 (inactive)
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%.	82.2% (inactive)

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
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%.	88.6% (inactive)
16. Homeless C/Y	Yes	Yes	Yes	Yes	100 Served + Comprehensive Strategy	101 (inactive)
17. Continuity of Care a. Adults b. C/Y	Yes	Yes	Yes	Yes	80% of Inpatient Discharges Seen Within 7 Days in Non-emergency Outpatient Setting.	Overall: 53.9% Adults: 55.5% C/Y: 49.8%
18. Community Resources	Yes	Yes	Yes	Yes	60% of DMH Expenses for Community Services	FY 06 - 60.45% FY 07 - 59.0% FY 08 - 57.0% FY 09 – 55.0% (inactive)
19. Medicaid Utilization	Yes	Yes	Yes	Yes	49% of MHRS Billings Paid by Medicaid	51.2% (inactive)

The Table 1 data are generally for the period from July 1, 2009 through June 30, 2010, because DMH has complete MCO data for this reporting period. Since many of the data are claims-based, it should be noted that the performance levels will likely show some improvement once all claims for this period are processed and paid. The last run date for claims-based data was January 25, 2010. There are a few exceptions to the FY 2010 timeframe for reporting. Exit Criterion #16 (Homeless Services to Children/Youth) is for calendar year 2010 in order to fully reflect the programmatic changes that DMH has made in its Homeless Outreach Program (HOP) for children/youth. Exit Criterion #18 (Community Resources) is for FY 2009 – which is the last full year for which DMH has an audited financial statement. This audit serves as the basis for the allocation methodology in EC #18.

The following three (3) categories describe the Court Monitor's assessment of current compliance:

1. Exit Criteria Met – Inactive Monitoring Status

There are now thirteen (13) Exit Criteria that have moved to inactive status – including four (4) since the time of the July 2010 Report to the Court.

- Prescribing New Generation Medications for consumers with a diagnosis of schizophrenia (#12). This criterion was moved to inactive status as of the July 2007 Report to the Court. This performance level continues to be below the Dixon standard. DMH has not made any changes to policy with regard to prescribing practice and believes that the apparent drop in performance level may result from a combination of difficulties with data reporting and the fact that newer research suggests that atypical medications may not be more effective than the older medications. The atypical medications have increasingly been associated with weight gain, diabetes, metabolic syndrome and cardiovascular conditions. DMH now has a new Chief Clinical Officer, whose tasks will include monitoring practice patterns.

- Medicaid Utilization (#19). Moved to inactive status in January 2008.

- Community Resources (#18). Moved to inactive status in July 2008. This Exit Criterion has also dropped below the Dixon standard. In the Court Monitor's review of this criterion, the DMH makes the following points as it relates to this issue:

  ■Total DMH expenditures have decreased by approximately 7% or $17.5m from FY 2007 to FY 2009. However expenditures for the Mental Health Authority (MHA) and the proportion of expenses directed to community activities within the MHA have increased over that time by over $16 million.

  ■At the same time, despite the overall decrease in total DMH expenditures and the closure of the DC CSA, the number of persons served in the community from 2007 to 2009 has increased significantly. This trend continued in FY 2010.

	FY 2007	FY 2008	FY 2009
Children/Youth	3,101	3,228	3,633
Adults	9,843	11,819	13,907

  ■There has been a slight increase in spending directed to St. Elizabeths Hospital as a proportion of total budget from FY 2007 to FY 2009 ($2.6m or 5%). During this period, St. Elizabeths Hospital was implementing a new information system platform, addressing the terms of the Department of Justice Settlement Agreement, and preparing for the opening of a new facility.

- Penetration – Adults with SMI (#8). This criterion was moved to inactive status in January 2009.

- Homeless Services for Adults (#13) and Children/Youth (#16). These two criteria were moved to inactive status in January 2009. The Child/Youth performance had dropped to 80 as of the July 2010 Report, but has improved due to some changes in the operation of the Homeless Outreach Program, which are discussed in section III.A.5 below. Current performance is 101 children for the period from January 1, 2010 through December 31, 2010.

- Penetration – Child Youth with SED (#6) and Adults (#7). These two criteria were moved to inactive status in July 2010.

- Child/Youth in Natural Setting (#14). This criterion was moved to inactive status as of July 2010.

- Consumer Satisfaction Method(s) (#1). Following full review, this Exit Criterion formally moves to inactive status as of this Report.

- Children/Youth in Own (or Surrogate) Home (#15). Following extensive review, this Exit Criterion formally moves to inactive status as of this Report.

- Assertive Community Treatment (#11). Following extensive review, this Exit Criterion formally moves to inactive status as of this Report.

- Penetration – Children/Youth (#5). This Exit Criterion also formally moves to inactive status as of this Report.

2. Notable Progress but Exit Criteria Not Met – Not Recommended for Inactive Status

   There are three (3) Exit Criteria that show notable progress but still require additional effort to meet the required performance level:

   - Consumer Functioning Method(s) (#2). As noted in II.A., DMH has put together a solid plan to demonstrate the utilization of LOCUS/CALOCUS data.

   - Consumer Service Reviews (CSR) for Adults (#3). DMH performed at a 77% level in May 2010 – with the requirement at 80%. Hopefully the February 2011 review will see additional improvement.

   - Supported Employment (#10). DMH is beginning to analyze the agency-specific data from the quarterly event screens to determine the

degree of compliance with the DMH policy. Targeted interventions are being made. DMH has also solidified its agreement with RSA which will result in an expansion of the existing supported employment capacity; the capacity should grow from its current level of 475 to 595 by early 2011 with the addition of $300,000 in grant funds to supported employment providers. There is also an additional $200,000 (80 slots) which will be made available to providers as utilization grows to capacity.

3. Progress Noted, but Major Issues Remain – Not Recommended for Inactive Status

   There are three (3) Exit Criteria that will require concerted DMH/District effort to achieve the required performance level:

   - Consumer Service Reviews (CSR) for Children/Youth (#4). DMH has expanded its technical assistance and coaching to select child-serving CSA's in an effort to improve scores for the 2011 child/youth reviews. Agency-specific action plans were developed for each CSA that addressed: the specific areas of practice performance that needed to be improved, the individual agency CSR scores, and most importantly, enhancement of the quality of care provided to consumers. The major areas addressed in the action plans included: team formation, team functioning, engagement of youth and families and training of CSA staff on treatment planning and the child and family team model. The DMH CSR staff met with each agency multiple times to assist them in developing specific strategies to address areas of need, review performance data over time and make mid-course corrections to improve performance. Additionally, the CSR team provided technical assistance to several agencies in the development of tools to be used to implement their practice improvement strategies.

   - Supported Housing (#9). DMH continues to work on a strategic plan for Supported Housing and to look at improved ways to identify the District's current efforts to provide supported housing to persons with SMI. In December 2010 DMH learned that 182 mental health consumers were eligible to receive Housing Choice Vouchers through a grant to the District's public housing authority from the U. S. Department of Housing and Urban Development. These vouchers are for individuals in need of housing and support services.

     The DMH housing program has historically required that individuals applying for housing subsidies through the Home First Subsidy program also apply to the District of Columbia Housing Authority.

DHCA agreed to give priority to individuals on its waiting list, who were also either receiving a DMH Home First Subsidy or on the DMH waiting list. As a result, DMH consumers were eligible for 182 of the 200 vouchers awarded to the District. Some of the eligible consumers are currently receiving a Home First subsidy and others are on the waiting list for a subsidy. These vouchers will allow DMH to move consumers from both the waiting list and from the Home First Subsidy program to these federal vouchers, thereby opening housing opportunities for those mental health consumers currently on the DMH Home First subsidy waiting list.

- Continuity of Care (#17). DMH, through its Integrated Care Division, has made concerted effort (via targeted staff strategies) to improve continuity of care for adults and has seen significant improvement in performance during the period from April 1, 2010 – present as further discussed in section III.C.4 below. Similar efforts for children/youth are now beginning.

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

A. Review of the Development and Implementation of Court-Ordered Plan

1. Update on Implementation of Crisis/Emergency Services

The DMH continues to use the 2007 Crisis/Emergency Services Plan for Adults as its framework for monitoring progress. Many of the components of that plan are described in the Sections of III.A. (e.g. mobile crisis teams, role of CPEP, etc.). The original workgroup that developed the plan has continued to meet and monitor overall progress toward completing the comprehensive plan. It appears that the original version has been largely completed, but the workgroup will continue to meet on a periodic basis (i.e. every six (6) months as opposed to quarterly).

One of the elements of the original plan was to improve walk-in or urgent care capacity in the system. Section III.C.5 describes the role that the MHSD currently plays in meeting that need. It is not yet clear how the system redesign effort (see III.A.) will broaden the availability of urgent care in the outpatient settings. One of the major access issues for the court system has been met through the funding and development of the Court Urgent Care Clinic (CUCC). The CUCC began in June 2008 (via contract with PIW) in response to the Superior Court need for individuals to be immediately screened, assessed and, when needed, provided short-term treatment. In addition, in October 2010, the

CUCC began providing the same service for defendants charged with nonviolent felonies who are eligible for the Mental Health Diversion Court. For the second full year of operation (June 2009-May 2010), the CUCC saw a total of 364 referrals and provided a total of 2,603 service units – including case management, medication management, and follow-up clinical appointments. The Pre-trial Services Agency (PSA) continues to be the largest source of referrals (59.7%), followed by DMH (13.4%) and the Traffic and Misdemeanor Court (11.9%). This has been a very successful collaboration with the courts. The multi-disciplinary staff provide immediate access to services upon referral. The effort then is to stabilize the individual and to connect (or re-connect) to CSA's for ongoing mental health treatment as needed. The CUCC staff are physically on-site at the Superior Court and have developed strong working relationships with the Judges, PSA, prosecutors and others. For misdemeanants, it is a regular outcome that charges are dropped if the consumer agrees to follow through with mental health treatment. The D.C. Addiction Prevention and Rehabilitation Agency (APRA) has been running a parallel screening and referral service via the Superior Courts. The decision has been made to contract (via DMH) with PIW to provide an integrated mental health/substance abuse screening, assessment and short-term treatment process. The existing APRA staff will have the opportunity to apply for these new positions. This arrangement makes good sense given the large number of persons with co-occurring disorders. The integrated clinic began operating January 15, 2011.

2. Access Helpline

The Access Helpline (AHL) continues its vital role as the front-door to the system. The AHL continues to provide multiple functions including: telephone assessment (24/7) and triage for consumers and referral sources – with linkage or transfer for non-emergency situations to the CSA of choice; telephonic suicide prevention hotline for D.C. residents; coordination and referral to the adult and child youth mobile crisis teams with the ability for referrals also to be made directly to mobile crisis teams and; provision of care coordination functions – including prior authorization for acute inpatient admissions, ACT services, CBI services and day treatment services.

The total staff complement is currently at nineteen (19), including the Director; all staff positions are currently filled. This includes the 3-person clinical team that is assigned to CFSA

intakes for needed mental health referrals. This function is a part of the Amended Implementation Plan (AIP) under LaShawn.

The AHL has seen a significant increase in the volume of calls for FY 2010 as compared to FY 2009. The average number of monthly incoming calls increased from 3,160 for FY 2009 to 4,200 per month for FY 2010 – an increase of 33%. DMH staff are unsure of the reasons for this large increase, but believe it could be some combination of improved access (via the new telephone AVAYA system) and overall outpatient consumer growth for DMH. Of the total calls, 69% are non-crisis, 27% are crisis, 2% are suicide-related and 2% are outreach calls. The AHL maintains a Special Initiatives line for community-based emergencies that could warrant immediate mental health intervention – e.g. shootings, fires, major accidents. The AHL has been successful in reducing its call abandonment rate to under 3%; this has been the ongoing goal so it is encouraging to see this benchmark achieved. The average wait time for answered calls remains at 20 seconds.

The AHL continues to assume responsibility for District residents who call the National Suicide Prevention Lifeline (NSPL). The AHL continues to have provisional certification until the reviewers for the reviews for the American Association of Suicidology complete their official visit and review. Hopefully this process will be completed and full certification will be obtained in the next several months.

3. Capacity and Utilization of Mobile Teams

   a. Adult Mobile Crisis

   The adult mobile crisis team has now completed its second full year of operation as of November 1, 2010. It continues to be based at CPEP and operates 16 hours per day (9:00 am-1:00 am.) 7 days a week. The primary role of this team is to provide a 2-person on-site response for a range of crisis/emergency situations. The mobile team is deployed either through direct calls or via the Access Help Line. For FY 2010 (October 1, 2009-September 30, 2010), the adult mobile team served a total of 1,693 individuals (unduplicated). As compared to FY 2009, this represents a 15% increase in service demand. 43.6% of the total service responses by the mobile staff were face-to-face. The mobile team delivers services in all settings – with the consumers' home (45%) as the most prevalent. Mobile crisis data show that in over 54% of the service contacts, the goal is

to help the consumer connect with a new mental health provider or re-connect with an existing one.

One of the advances in the past year has been that the mobile crisis team is now deployed on a regular basis to assess individuals in crisis who are located at community hospitals. As a result, hospital staff working in an acute hospital emergency room will contact the mobile team to do an on-site evaluation. If an FD 12 (involuntary admission) is warranted, the person can be admitted directly to the acute care unit without the police having to take them to CPEP. This accounts for the large jump in involuntary admissions directly to community hospitals from 2009 to 2010 (increase from 38 to 124). Overall, the severity of cases is reflected in the fact that of the 1,693 consumers evaluated, 664 went on as admissions to an acute inpatient unit or to the site-based services at CPEP (including extended observation beds). This represents a 28% increase over FY 2009.

Beyond its primary mission, the mobile team continues to provide other community-focused services. The team continues to reach out to families and other impacted persons whenever there is a suicide, homicide or other tragedy. The team is involved in a pilot project regarding a specific intervention model for homicide survivors. The mobile team can respond 24/7 to do immediate onsite interventions with families or others. The goal is to provide immediate psychological aid and then to follow up with connecting individuals to needed grief and loss programs.

Overall, the adult mobile team continues its "hands-on" philosophy. It continues to find ways to reach out to consumers in crisis but also to provide the critical connectivity to other services. It has worked exceedingly well in complementing the work of MPD and the CSA's. It is no surprise that the mobile crisis effort has been so well-received in the District.

b. Child and Youth Mobile Crisis

The Child and Adolescent Mobile Psychiatric Services (ChAMPS) has also now finished its second full year of operation (as of October 28, 2010). This program is contracted with Catholic Charities/Anchor Mental Health. The ChAMPS program continues to operate from 7:30am to 10:00pm (Monday-Friday) with staff on-call after hours and on

weekends. The basic model is similar to the adult mobile team – with two-person teams that are deployed as required; the teams are composed of one master's level clinician and one bachelor's-prepared mental health specialist. The expectation of staff (including on-call) is that they will arrive on the scene within one hour.

For FY 2010, ChAMPS served a total of 414 children and youth (unduplicated). There were 1,015 total calls, which resulted in 558 actual on-site deployments (55%). This represents a growth in total calls of 35% as compared to average monthly volume for FY 2009. Of the total calls, 279 (27%) were regarding CFSA-enrolled children/youth. The ChAMPS staff continue to communicate regularly with CFSA staff, groups of foster parents and MPD to encourage foster families to utilize the ChAMPS for emergency situations as opposed to calling 911 or MPD. The exception is for cases that involve immediate health or safety risks.

For FY 2010, there were a total of 74 FD-12's and 76 total hospitalizations. Hospital admissions occurred on only 14% of the cases in which there was an on-site deployment. This is a slight decrease from FY 2009 which saw a 16% admission rate. The ChAMPS team also conducts routine follow-up with children/youth and families within 72 hours after the intervention. Some of the time these follow-ups are done by phone although the new norm in FY 2010 is to do actual face-to-face follow-up visits. Of the total 694 follow-up contacts in FY 2010, 452 (65%) were done in person and 242 (35%) were done by phone. ChAMPS staff believe that face-to-face follow-up provides a richer assessment of the overall child/family status. The plan is to continue this protocol.

The FY 2010 contract with ChAMPS called for a revised plan for Catholic Charities to develop and operate a 4-bed crisis home for children ages 10 and over. However, due to low utilization and budget cuts this program has been eliminated from the contract. ChAMPS staff believe that the loss of crisis beds has been negligible; they are normally able to find other community resources to meet this need.

Overall, the ChAMPS program continues to mature and has provided an essential component in crisis/emergency services for children and youth. The issues with the District's ability to contract with Catholic Charities have fortunately been resolved. There are still over-riding issues about the high level

of acute inpatient admissions for children/youth in the District (see III.A.4.). Hopefully the DMH can work with local hospitals and ChAMPS to expand the opportunities for on-site mobile team evaluations of youth in crisis and with that the potential for diverting more acute hospital admissions.

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

CPEP continues to be the DMH-run site-based facility providing emergency and short-term psychiatric services to residents and visitors of the District of Columbia. Individuals admitted to the psychiatric emergency services receive psychiatric assessment, stabilization, community referrals, and if necessary, referrals for hospitalization.

The overall volume for CPEP for FY 2010 was 3,941 persons served – or an average of 10.8/day. This is down slightly from FY 2009 which was 11.7 average/day. The percentage of persons seen at CPEP admitted to an inpatient unit was at 30.9%; this includes direct psychiatric hospitalizations (28.8%) and medical unit admissions (2.1%). This overall inpatient admissions percentage is up slightly from FY 2009 (29.4%) but well below historic levels. The number (and percentage) of direct admissions to SEH continued to drop; for the entire year there were only 60 (5.3%) direct admissions to SEH – as compared to 8.5% for FY 2009 and 28.9% for FY 2008. This corroborates the fact that community hospitals (with limited exceptions) are now the point of admission for acute care. It also reflects the availability of Extended Observation Beds (EOB's) and the mobile crisis team. The percentage of consumers discharged from CPEP to self-care continues to rise; it went up to 60.4% for FY 2010 – as compared to 55.5% for FY 2009. CPEP has done some restructuring of the work periods for psychiatrists – with the goal of shortening shifts and making more psychiatrists available during peak volume periods (11:00am-7:00pm). In addition, there are two General Medical Officers (GMO's) on duty 10 hours/day. The net result has been shorter wait times for consumers and fewer occasions when a person needs to be sent to a hospital for medical clearance or 911 episodes. The average monthly volume in medical clearance/911 fell from 23/month in FY 2009 to 13/month in FY 2010.

The Extended Observation Beds (EOB's) continue to be well-utilized. The EOB program was used for 508 individuals (duplicate) in FY 2010 – with an average stay of slightly over 34

hours. This is over 42 admissions/month for FY 2010 as compared to 38/month for FY 2009. The EOB was utilized for 14.5% of the total admissions to CPEP; this confirms the critical role this unit has played in stabilizing many individuals and avoiding unnecessary inpatient admissions. The need for time to address and stabilize is further reinforced by the fact that a high percentage of consumers are potentially withdrawing from alcohol or drugs. In FY 2010, 45.6% of all consumers who consented to a drug/alcohol test had a positive result for one or more substances.

CPEP has reached out to CSA's in some critical ways. First, it has implemented a Quick Base software system that allows CPEP to notify all CSA's and ACT teams whenever a CSA and/or ACT consumer presents at CPEP. This immediate communication has directly increased the responsivity of CSA's in coming to CPEP to re-engage with their consumer. CPEP also participates with the DMH Integrated Care Division in tracking and assessing high hospital utilizers who are operationally defined as consumers who had three (3) or more acute admissions in 12 months. Individuals with 4 or more CPEP visits in a year are also tracked as part of CPEP's high-utilization initiative. Regular data is provided to individual CSA's and high-utilizer meetings are held quarterly to discuss individual consumers and overall system issues. These outreach activities are highly commended as a way of engaging CSA's with a sense of shared responsibility for improving services to high-risk individuals.

DMH continues to contract with the Children's National Medical Center (CNMC) for site-based services for children and youth. The data transmission issues that were identified in the January 2010 Report to the Court have largely been resolved. There continue to be some holes in the required data set; for example the required inclusion of insurance type is not reported for 40.2% of the individuals seen. The overall numbers of children/youth assessed at CNMC was very consistent for FY 2010 (1,090) as compared to FY 2009 (1,093). The CNMC contract is now managed by the child and youth division of DMH, which allows for greater connectivity to other programs, e.g. ChAMPS. There are two (2) program-related issues that need additional evaluation. The first is to identify and analyze the number of children and youth (of the 1,090 total seen) who are already enrolled in the DMH system. This analysis would hopefully lead to increased communication and engagement by the CSA's in a timely way. The second issue is the fact that 53.6% of all

CNMC evaluations are subsequently admitted to an acute inpatient unit. This strikes the Court Monitor as inordinately high and suggests the need for careful discussion as to reasons and potential alternatives.

5. Development and Utilization of Homeless Outreach Program (HOP)

   The Homeless Outreach Program (HOP) was organizationally moved to become part of CPEP in the fall of 2009. The intent of that move was to create closer integration between HOP and the rest of the crisis/emergency services. It would appear that this goal is, in fact, occurring; the HOP manager has become an integral part of the CPEP leadership team.

   The primary mission of HOP has not changed; its goal is still to engage in-person with homeless individuals and families with mental illness and whenever possible to connect them with mental health care. The HOP team has a full staff complement of eight (8), and currently has one vacancy (mental health specialist). It operates from 9:00am to 9:00pm (Monday-Friday). The HOP team continues to serve both adults and children/families. HOP responds to crisis calls regarding homeless individuals who are having a psychiatric crisis. All HOP staff are certified to do FD-12 petitions for involuntary hospitalizations. For FY 2010, HOP did 57 FD-12 petitions, which is very consistent with prior periods. Overall, HOP directly assisted with 95 admissions (voluntary and involuntary) either to an acute inpatient unit, an emergency room or a crisis bed placement. The HOP continues – via a separate federal grant from the District – to provide the assessments for homeless persons as part of the Homeless Prevention and Rapid Re-housing Program (HPRP). For FY 2010, this included 218 assessments. HOP staff make weekly visits (and sometimes more) to the numerous homeless providers in the community (shelters, meal programs, drop-in centers or other places where homeless persons gather) to engage and assist with needed linkages. On some occasions HOP makes direct referrals to ACT teams for persons who are not amenable to more traditional outpatient services; in FY 2010, HOP referred 26 homeless persons directly to ACT.

   HOP also hosts Emergency Rounds and Family Emergency Rounds once per month. Homeless providers and outreach teams discuss persons at particularly high-risk due to psychiatric or physical health concerns. Overall for FY 2010, HOP served

1,498 consumers (unduplicated). This represents a 12.5% increase from the prior reporting period (April 1, 2009 – March 31, 2010). The large majority of HOP contacts (72.4%) were one-time only; the other 27.6% had two or more HOP contacts during this period.

The Court Monitor was concerned about the drop-off in the number of homeless children/youth engaged – with 80 counted for the period reflected in the July 2010 Report to the Court; the Court-approved standard is a minimum of 100. Clearly part of the issue has been the staff loss of the dedicated child/youth specialist – a position which has been approved and is being recruited. HOP leadership re-distributed these duties among the other staff and for the most recent reporting period of January 1, 2010 – December 31, 2010, the number of children/youth engaged was 101, which exceeds the performance target. The other HOP staff have also received specialized training in doing child/family assessments. HOP has also reached out to the School-based Mental Health Program (SMHP) in an effort to better coordinate services to homeless children/youth who are assigned to specific schools.

Overall, the HOP continues to provide a comprehensive array of services to the homeless. It appears that the outreach to children/youth and families is back on track. . The HOP is looking to become fully staffed and to increase staff coverage during evening hours – a peak time in terms of need. The integration with CPEP has shown positive impact - with clearer coordination of roles and increased accountability.

6. Development and Utilization of Crisis Residential Beds

DMH continues to contract for fifteen (15) adult crisis residential beds; eight (8) of those are at Crossing Place and seven (7) at Jordan House. For FY 2010 there were a total of 473 crisis bed admissions – as compared to 394 for FY 2009. There were 381 (unduplicated) consumers who were served – with 71 consumers having two or more admissions during the year.

The variances between the two programs appear to have evened out. Both programs had an average length of stay of 9.9 days. Crossing Place had an occupancy rate of 84% for the year, and Jordan House was 88%. DMH staff note that staff stability and the completion of necessary renovations at Crossing Place during FY 2009, have been positive factors in FY 2010 performance.

The overall referral sources to the two programs shows that 77% were referred by their CSA, 11% by CPEP, 4% by DMH/ contract Hospitals, and 8% from other sources.

There are two issues for the crisis residential program. The first is that the DMH once again did not conduct fidelity audits for FY 2010 due to staff shortages and other priorities. There is acknowledgment by DMH staff that these audits have been very useful in monitoring admission consistency (per contract requirements), treatment documentation, and continuity of care. The crisis residential program will be organizationally placed under the AHL manager in FY 2011. With this change, DMH has again committed to undertake fidelity audits.

The second issue that surfaced is the fact that crisis residential programs are not licensed or certified by DMH. There are separate contracts and different contractual requirements were negotiated for both programs. DMH will be convening a group of stakeholders, which will include representatives from both providers to review the crisis bed program and develop regulations and rates for the program.

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

1. Organizational Development

a. Training Institute; Crisis Intervention Training for Police Officers

Among the broad offerings of the DMH Training Institute, the Division of Organizational Development (DOD) has continued to take a lead role in the specialized training of MPD officers. This 40-hour training for MPD officers who volunteer has the dual goals of: 1) increasing consumer and officer safety and; 2) diverting individuals with mental illness out of the criminal justice system into the mental health system. Officers learn critical information about the identification of mental illness, techniques in engagement and de-escalation, and knowledge about community resources. The ultimate training goal is to have 15%-20% of all officers trained so as to improve the likelihood of having an available CIO-trained offer in all precincts and all shifts. This goal will take several years to accomplish; DMH plans five (5) CIO trainings in 2011 – with 30 officers per class. As of December 30, 2010, DMH has

trained and certified 195 officers in nine (9) different training sessions; the first training was in April 2009.

On September 13, 2010, the MPD Chief of Police signed a special order to codify the CIO policy and protocols for all officers. This is additional indication of the MPD support for this initiative. There remains the task of collecting and analyzing the basic data regarding the impact of CIO-trained responses vs. non-CIO trained. DMH staff are working with MPD to get greater consistency by officers in completing the CIO tracking form. DMH is also working with CPEP to get data regarding whether officers who deliver consumers to CPEP are CIO-trained or not. DOD staff are also looking into the need for continuing education for CIO-trained officers. Overall, this has been a very successful initiative, but one that will take continued work by both DMH and MPD to reach its full potential.

b. Internal CSR Unit

The DOD also continues to support the three-person internal CSR unit. While the unit consists of three experienced staff members, there is not yet an established management position for the unit. The CSR unit will also be overseeing the contracted organization that will provide logistics support for the next round of Dixon CSR reviews. In addition to the formal Dixon reviews, it is anticipated that this contract will also support the CSR unit in its ongoing efforts to internalize CSR throughout the provider system. The CSR unit staff have assumed a leadership role for DMH in the organization, training and logistics of the CSR reviews. The CSR unit has been the focal point of DMH's targeted quality improvement strategy for six (6) CSA's following the 2010 CSR reviews. This has involved agency-specific interventions – all with the goal of helping local CSA's embrace the CSR model and take it down to the front-line staff. The results of these efforts will be carefully tracked in the 2011 reviews. As was noted in the July 2010 Report to the Court, there is still the going-forward question of how DMH can best leverage ongoing quality-of-care improvements. There is no doubt that DMH is committed; there is also no doubt that targeted interventions have thus far shown marked improvements in scores. The issue is how to best sustain and leverage quality growth throughout the large number of CSA's in the system.

C. DMH's Role as a Provider

1. Status of New/Consolidated Hospital

With the full occupancy of the new Hospital in May 2010, the DMH continues with its Phase 3 work – which includes the asbestos abatement and demolition of the John Howard building, the building of a new recreation yard for forensic (intensive) patients and the completion of additional surface parking and landscaping.

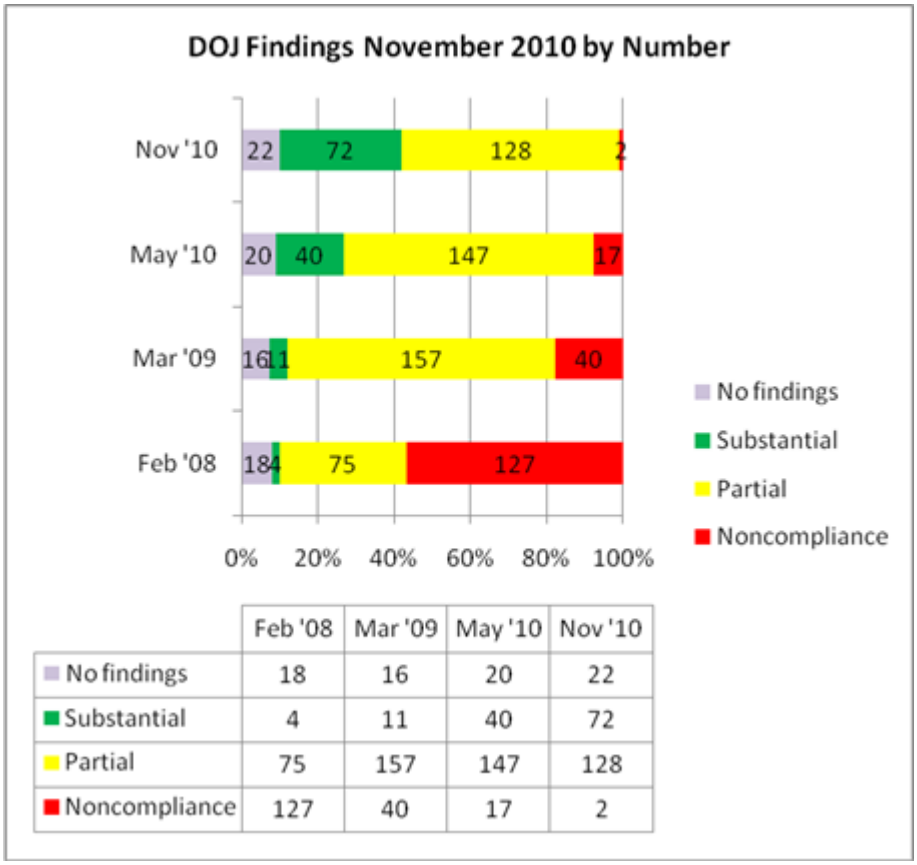
The asbestos abatement has been completed and demolition has begun. The overall Phase 3 should be completed within 12 months. The contract award for Phase 3 is $9.9 million
The District has also contracted out to identify and remediate the underlying issues for the lower-than-desired water pressure levels on campus. This new project, beginning the week of November 15, 2010, will replace all of the fire hydrants on campus and will also examine all of the water lines to determine the need for replacement. This entire project may take 6-9 months.

The RMB building is planned to be renovated for two distinct purposes. The first floor will include up to 50 overflow beds for the new Hospital. DMH intends that within the reasonable future all patients will be cared for in the new Hospital; nevertheless modest renovations are still planned in case of short-term overflow need. The larger plan for the RMB building is the major renovation of the upper floors for use by the DMH Authority. DMH is working with the Department of Real Estate Services (DRES) to finalize a plan to move the Mental Health Authority to RMB. The build out of the RMB space for occupancy by the Mental Health Authority will not be completed until approximately March 2012. The lease for the office space currently used by the Authority expires in November 2011. DRES will identify potential temporary office space for the Authority should the current lease not be able to be extended. It is believed that the renovation of RMB for the Authority office space would provide a less costly alternative to privately leased space over the long term. Current estimates for renovations are in the $13-$14 million range.

2. Quality of Care Issues at SEH

The Department of Justice (DOJ) conducted its sixth visit to SEH (November 1-5, 2010) since the June 2007 Settlement Agreement. The five (5) DOJ reviewers did a more in-depth review than previously – including the review of 183 patient records, observation of 11 IRP conferences, five (5) patient groups, and visits to three (3) community programs. The final written report has not been received at the time of this Report. However, comments at the Exit Conference provided the following:

a. Overall - The final written DOJ Report was received by the District on January 5, 2011. Overall, this was far and away the most positive visit. SEH has achieved substantial compliance with 35 additional provisions since the time of the last visit, bringing the total provisions with substantial compliance to 72 and the total number in partial compliance to 128. The following chart shows the progress with regard to compliance since March 2008:



	Feb '08	Mar '09	May '10	Nov '10
No findings	18	16	20	22
Substantial	4	11	40	72
Partial	75	157	147	128
Noncompliance	127	40	17	2

b. Areas Noted as Having Progressed – The following are examples of areas that have shown progress:

- Engagement of patients and specific reviews of strengths, life goals and intervention preferences.
- Training regarding patient engagement now meets the requirements of the Agreement.
- Improved attendance at IRP meetings by CSA's.
- Substance abuse interventions are excellent and have grown in number since prior review.
- The clinical chart audit tool is well-designed and is being used.
- The accuracy of diagnosis by psychiatrists now meets standards – as do risk assessments.
- The medication guidelines are excellent and there is now improved practice regarding high-risk medications.
- Tremendous overall growth in the utilization of the Therapeutic Learning Centers (TLC's) – with good patient stratification based on cognitive functioning and readiness for change.
- Improvement in discharge planning and coordination with community was noted.

c, Areas Needing Continued Improvement – The following are examples of areas that need continued development:

- Continued improvement is needed on the linkages between mall groups and staff intervention on the unit – with need for greater specificity and consistency.
- There is need for greater understanding and specificity on the patient's criteria for discharge. Currently this is often either blank, too general or not attainable.
- There is still a high level of concern with general medical practice.
- Need to improve the timeliness of final mortality reviews.
- The overall infection control program needs to improve.
- Social work assessments are improved but need to resolve the discrepancies and conflicting information in social histories.
- The intensive (forensic) mall program still shows many patients not in groups. Reviewers

recommend a third mall for those not engaged – with focus on motivation.

- Social workers need to have a better understanding of what services are available in the community and the skills an individual will need to succeed in the community.
- There is still an insufficient number of RN's to provide adequate supervision.
- The overall nursing operation needs to be more systematic – with continued need to make the links between a patient's needs/strengths and the specific treatment intervention.
- Basic nursing practices still need improvement, e.g. medication education, and administering medications and insulin.
- The whole area of Performance Improvement (PI) has not really developed and needs significant work. (Note: a new P.I. Director was recently hired.)

Overall, there were many encouraging messages in this most recent Report by DOJ. Most of the disciplines (e.g. Psychiatry, Psychology) have made major progress. The TLC's have proven to be an effective model for operationalizing treatment goals; the major challenge is that subset of patients who have little motivation for engagement. Nursing continues to be a major challenge and will be a high area of focus in the next 6 months. Despite the progress that has been made, the DOJ letter of January 5, 2011 points out that there are still 130 provisions that need to be brought into substantial compliance. To that end, DOJ is requesting a plan by February 5, 2011 that details how SEH intends to achieve substantial compliance on the remaining 130 provisions before the time of the next DOJ visit in May, 2011.

3. Review of Progress on Use of Local Hospitals for Acute Care

The DMH use of local hospitals to provide acute care has taken another step of improvement. For the six-month period of April-September 2010, there were only 21 acute care admissions directly to SEH. This contrasts to a total of 40 for the two (2) preceding six-month periods. There were only four (4) instances when a person was not admitted to an acute care hospital due to the lack of an available bed. For the period of April-September 2010, UMC has averaged nearly 29 acute admissions per month

and Providence nearly 30. PIW continues to be used as a backup facility when other units are unavailable.

The total number of admissions to SEH (acute and sub-acute) for the April-October 2010 period was nearly 18 per month; this contrasts to 21 for the prior 6 months.

The overall picture is one of relative stability – with some apparent trending in even more positive numbers for delimiting the use of SEH for direct acute admissions. The situation at UMC also appears to be stabilizing as the District continues to work with UMC to find a consistent revenue stream for its operations. The DMH has successfully negotiated with the Washington Hospital Center for four (4) acute inpatient beds. This arrangement will begin soon, pending the resolution of some tax compliance issues for the Washington Hospital Center. Hopefully, this pilot will expand further and may be especially useful for patients with significant medical issues. The Court Monitor is pleased to see this development as it provides another viable alternative for acute care. If successful, hopefully this contract can expand in future periods.

4. Development and Implementation of the Integrated Care Initiatives

The Integrated Care Division (ICD) at the DMH Authority has continued to play a critical role in providing intensive care management and care coordination for high-risk populations in the system. This includes the identification, community preparation and discharge monitoring for the most difficult-to-place patients at SEH; it also includes the monitoring of consumers as they leave inpatient settings and move to an outpatient status.

For SEH, Washington Hospital Center continues (via contract with DMH) to operate the New Directions program. Of the 27 patients enrolled, 17 have actually been placed in the community. The continued experience shows that it takes multiple months to create community readiness and engage SEH patients – with lots of up-front resistance to the idea of living in the community. Nevertheless, this has been a successful initiative and DMH has increased the contract up to a capacity of 30.

The ICD continues its efforts to identify and monitor the timely movement of consumers from inpatient settings to follow-up outpatient appointments with a CSA. This effort is consistent

with the requirements of Exit Criterion #17 (Continuity of Care) which requires a non-emergency outpatient visit within 7 days of discharge from an inpatient unit. DMH has made significant progress on the adult side. In April 2010, the ICD began an intensive effort with all adult inpatient facilities to identify and facilitate the timely referral to CSA's. The results have been encouraging; for the six-month period of April-September 2010, the CSA self-reported data shows a 7-day performance level of 75% - with SEH at 90% and Providence at 68%. It should be noted that the Dixon measure only counts when there is a valid claim for the outpatient visit. Hence ICD is also tracking the actual claims experience for all self-reported data. While the annual Dixon data is still low for adults (55.5%), the more recent months are an indication that – with intensive effort – the DMH can perform at significantly higher levels than its historic base.

The ICD would like to implement a similar model to manage the discharge process for children and youth in acute care facilities. The issue has been to have an identified staff person to take on this time-intensive task. DMH has recently selected an internal candidate to fill this position.

The Court Monitor is encouraged by overall progress but looks forward to successful movement on the child/youth side. This issue will be carefully tracked in the months ahead.

5. Development and Implementation of the Mental Health Services Division (MHSD)

The DMH has continued to evolve its provision of direct outpatient services following the March 31, 2010 final closeout of the DC CSA. All adult services are housed at 35 K Street and all child/youth services at 821 Howard Road, S.E. The child/youth site has also added a primary mission of prevention and early intervention. The child/youth program will be reviewed as part of the July 2011 Court Monitor's Report to the Court. The primary mission of the MHSD is to provide an array of specialized mental health services for adults. In April 2010, the MHSD was fully certified as a CSA to provide MHRS services. For FY 2010, the MHSD served a total of 4,874 consumers (unduplicated) in its various programs. The largest program is the same-day-services walk-in clinic at 35 K Street. This service averages 265 consumers/ month. This service is staffed by a combination of a triage nurse, approving qualified practitioner (AQP) and psychiatrists. Of the total of the 3,181 adults seen in this program, there were 713 consumers (22%)

who met the 2 criteria of having their first contact with the DMH system be an intake at 35 K Street, and also having been assessed as needing further care, and so assigned to a CSA.

The MHSD manages a physician practice group (PPG) which has two (2) major roles. The first is to function as a sub-provider for other CSA's to provide medication management; 1,089 consumers were seen for this service in FY 2010. The second role is to support CSA's on-site to provide psychiatric support for their consumers. Nine of the MHSD psychiatrists do this on a part-time basis for eight (8) different CSA's; this is the equivalent of 3.8 FTE's, and provided services to 1,215 consumers in FY 2010.

The MHSD continues to provide a specialty multi-cultural clinic (488 consumers in FY 2010) and services for persons who have mental illness/intellectual disabilities and mental illness/deaf or hard-of-hearing (175 consumers). Both of these services are unique in the District in terms of the depth of staff training and multiple language/sign language capabilities.

The MHSD leadership team has been addressing the two (2) major issues on the business side – staff productivity and billings/collections. On the productivity side, all of the service units saw productivity gains from FY 2009 to FY 2010, with increases in the average number of hours billed per month per staff FTE. For the different service units the average increases from FY 2009 ranged from 6 hours to 11 hours. Of note, the MHSD adult division overall achieved an average of 77 hours/month/FTE, which was a 12 hour increase from FY 2009. For FY 2011, the minimum productivity requirements have again been raised and are now at 65% of available hours for psychiatrists and 60% for all other staff. These expectations seem realistic but will clearly take concerted effort to achieve, given the current baselines of performance. The issue of productivity is dealt with for staff as part of an overall performance appraisal. On the billings side, MHSD far exceeded the expected gross claims level for FY 2010. This is no doubt a direct reflection of the attention to maximizing billing potential that has occurred. A break-even analysis was done just for the PPG to determine the relative gap between gross expense and gross revenue for psychiatric time. The gross expense was at $2.15 million versus $1.0 million for gross revenue. A simple analysis suggests two conclusions. The first is that productivity levels (as noted earlier) need to be higher; the second is that there are built-in inefficiencies in staffing a walk-in service with

variable demand levels. MHSD estimates this "surge" capacity cost at approximately $600,000.

Overall, the MHSD has worked hard to maintain, streamline, and improve its unique service mission. It has also tackled the tough issues of staff productivity and billings – with clearly a ways to go. The DMH will be evaluating the going-forward role of the PPG in particular and the MHSD in general. Hopefully, this review will be completed in time for the July 2011 Report to the Court.

D. Review of Status of 2011 Budget

Over the past two years, DMH has absorbed multiple budget reductions. The previous major reductions occurred in July 2009, with a $9.0 million loss of local revenue (4.5%). This was followed by a $7.0 million reduction for FY 2011 (4.0%). These cuts, like the previous two, were largely made in areas that did not affect direct consumer services.

However, due to District-wide revenue shortfalls of $175 million, there is now direct discussion of an additional $4.272 million cut in the approved FY 2011 budget for DMH. If fully implemented, these cuts will have direct impact on consumer services, including Dixon-related services. For example, this cut would mean a 5 % reduction in rates for ACT services – one of the areas in which DMH has intentionally grown capacity. DMH has made efforts to reduce the impact on providers – for instance, keeping the providers informed of any rate cuts, and decreasing extra burdens – for instance, eliminating the requirement for a secondary treatment plan (ISSP) from specialty providers and reducing the requirement for treatment plans from every 90 days to every 180 days. DMH is hopeful that with these measures, there will be no decrease in services as a result of the decrease in reimbursement rates.

It is unclear at the time of this Report when budget decisions will be made. The Mayoral transition adds to the complexity of decision-making. The Court Monitor has directly expressed concerns to decision-makers regarding the latest round of potential cuts. The reality is that the previous cuts have eliminated all of the potential non-direct service areas for absorbing cuts; further reductions now will inevitably reduce service capacity and/or quality. The Court Monitor will closely track these budget discussions.

IV. Follow-up on the Other Previously Identified Recommendations

A. Status of Community System Redesign

The DMH Workgroup on Mental Health System Redesign continues to meet on a regular basis and it appears that the group is moving toward a final set of recommendations. The four (4) subcommittees that were created in early 2010 have made recommendations in the areas of: 1) information technology; 2) children's services; 3) free-standing mental health clinics – with emphasis on Co-occurring Disorders (COD) and; 4) provider structure. The overall original seven (7) principles/goals of the redesign effort have remained the same. Since the workgroup began, there have been parallel studies that have helped to inform the effort. The most notable is the Rand Corporation study, which has now finished an in-depth review on the public behavioral health system in the District. It would appear that the Rand study and DMH workgroup initial recommendations coalesce around some key recommendations. These include the following:

1. Under the DMH umbrella, develop, regulate and fund a system to support Free-Standing Mental Health Clinics and Independent Mental Health Practitioners. The goal is to significantly improve access for persons with mild or moderate mental health disorders. The intent is also to create additional capacity for mental health care in and through primary health care clinics and Federally Qualified Health Centers (FQHC's).

2. Convene an interagency workgroup that includes representatives from DHCF, other District agencies and stakeholders to examine the current delivery of mental health services by the Managed Care Organizations (MCO's) and the feasibility of a mental health carve-out. It is believed, with the appropriate funding level, a carve-out could help to reduce some of the fragmentation and complexity in the current structure – especially for children, youth and families.

3. Improve the coordination of care for persons with both mental health and substance abuse conditions. There is a strong need to improve care coordination between APRA and DMH service providers. It is also recommended that issues of unified provider certification be developed for agencies providing both mental health and substance abuse services and efforts at cross-training be improved.

4. Upgrade the data infrastructure of the public behavioral heath care system to provide for increased monitoring of utilization, quality of care and consumer outcomes.

   It is encouraging to see the overall redesign efforts coming to a state of final recommendations. However it is unclear how

quickly the recommendations can be brought to final administrative decisions and then implemented. The new Mayor and District Council will clearly need to evaluate some of these recommendations as they impact current budgets, legislation and organizational structures. For example, the current separation of APRA and DMH in terms of structure, funding, and provider base needs to be carefully evaluated. The Court Monitor will continue to track the redesign efforts in future Reports to the Court.

B. Status of Integrated Service Delivery for High Risk Children and Youth

The Court Monitor notes some progress in this long-standing issue. DMH has made concerted efforts to engage at a policy protocol level with both education (DCPS/OSSE) and DYRS regarding the need for more centralized and consistent management of PRTF placements. DMH officials indicate there is now conceptual agreement with OSSE that DMH should issue the medical necessity determination for children/youth who are potential referrals to a PRTF; this would provide a fiscal boost to the OSSE/DCPS budgets as children/youth need a medical necessity determination from DMH to have their PRTF stay covered by Medicaid. There are currently 122 children/youth from OSSE who are in PRTF's. DMH received a commitment from all of the above mentioned agencies that they would provide a representative to participate in the PRTF Review panel for level of care medical necessity committee which would meet bi-weekly to review all referrals for PRTFs.

For DYRS, there has also been some progress. DYRS also appears to be in agreement conceptually, but has two major concerns about DMH issuing the medical necessity determinations. First is the issue of the timeliness of issuing a medical necessity determination. The second is the concern about safety issues – both for the community and the child; even if medical necessity cannot be met, DYRS may want to place a child anyway, due to safety issues. DMH is moving to address the timeliness issue by re-assigning an existing staff half time to assist in the review of the PRTF referrals for completion and to gather any additional information required prior to sending it on to the Psychiatrist for a determination. In addition, DMH is asking OSSE and DYRS to commit additional staff resources to the medical necessity determination process. Pending budget considerations, there appears to be willingness to do this.

DMH will be maintaining a list of the District children who are placed by District agencies in PRTFs. This list will include children placed by DCPS, OSSE, DYRS and CFSA, as well as DMH. Currently, all of the

agencies are meeting on a bi-weekly basis to refine the payment, placement and monitoring considerations for these children. The discussion on this issue is ongoing. There has not been resolution on the question of which agency should do follow-up monitoring for children/youth placed in PRTF's. The model of having common monitoring standards but with individual agencies actually monitoring their own placements seems the most likely.

DMH and DHCF are participating in a work-group that they anticipate will soon include members for CFSA, DYRS, DCPS and OSSE, to clarify the District's PRTF issues and coordinate cross-agency efforts. The agreements of this workgroup in regards to the DMH role, specific referral and assessment processes and any necessary exceptions (e.g. Court-ordered placements) will be memorialized in regulations as appropriate. The Court Monitor strongly believes that this lingering policy issue needs to get resolved. It will provide both more consistent decision-making for high-risk children and youth but it will also save the District millions of dollars for placements that are today 100% supported by local funds. The DMH needs to move expeditiously to publish a proposed rule, receive public comment and then promulgate a final rule.

V. Recommendations:

Based on the findings in this Report, the Court Monitor does not have any additional recommendations to make.