UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

WILLIAM DIXON, et al.,	)	
	)	
Plaintiffs,	)	
v.	)	Civil Action No. 74-285 (TFH)
	)	
ANTHONY WILLIAMS, et al.,	)	
	)	
Defendants.	)	

COURT MONITOR'S NOTICE OF SUBMISSION OF REPORT

Court Monitor, Dennis R. Jones, respectfully submits the attached Report to the Court pursuant to the Court's May 23, 2002 Order requiring regular reports concerning the status of Defendants' compliance with the Plan.

Respectfully submitted,

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

Counsel for Dennis R. Jones,
Court Monitor

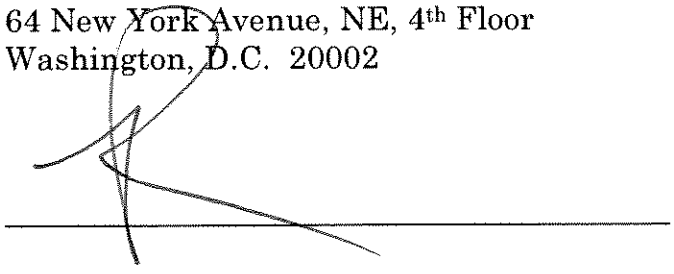
CERTIFICATE OF SERVICE

I hereby certify that copies of the foregoing COURT MONITOR'S NOTICE OF SUBMISSION OF REPORT and the Court Monitor's REPORT TO THE COURT were served by first class mail, postage prepaid, this 28th day of July, 2005 upon:

Peter J. Nickles
Covington & Burling
1201 Pennsylvania Ave, N.W.
Washington, D.C. 20004-2401

Tonya A. Robinson
Office of the Corporation Counsel
Mental Health Division
64 New York Ave. NE
Washington, D.C. 20002

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



REPORT TO THE COURT

Court Monitor
Dennis R. Jones

July 28, 2005

I. Current Situation

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

A. Progress in the implementation and measurement of the performance targets for all of the various categories in the Exit Criteria.

B. Monitoring the continued development and implementation of key 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.

This Report provides updates on the status of each of the above-named areas, identifies any barriers to progress, and makes recommendations for future actions. The May 23, 2002 Court Approved consent order called for a Report to the Court twice per year. This constitutes the sixth formal monitoring Report to the Court.

II. Findings Regarding Exit Criteria

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

The January 2005 Report to the Court detailed the DMH's approach to both Consumer Satisfaction Method(s) and Consumer Functioning Review Method(s). This Report will provide a brief update on both.

As relates to consumer satisfaction, DMH continues its contract with the Consumer Action Network (CAN). The comprehensive random satisfaction survey will again be done in the fall of 2005; however this year DMH will contact local agencies to ensure consumers are active and contact information is accurate. This will hopefully help greatly in CAN's response level. CAN is also doing a number of site specific satisfaction surveys and targeted forums throughout the year – both for adult and children/youth. DMH has completed its annual Mental Health Systems Improvement (MHSIP) consumer satisfaction. However, as of the time of this Report, the results have not been summarized.

As relates to consumer functioning, the DMH continues to require local agencies to complete LOCUS results for adults and CALOCUS for children/youth. The next step – not yet completed – is to access this data in an aggregated and electronic fashion. The intent is still to then present this data to the DMH Quality Council.

The other consumer functioning method to be utilized – the use of Consumer Services Review (CSR) process – is planned for the summer of 2005. As DMH conducts different reviews (audits) of CSA's, it also plans to do small subsets of full

CSR reviews. The initial reviews in the summer of 2005 will be of seven (7) agencies with the major focus on medical necessity. In addition though, the CSR reviews (perhaps 3-5 cases) will serve as a timely opportunity to reinforce the CSR process and also to use the full CSR as a potential way to complement the medical necessity reviews. It is noteworthy that all of the Office of Accountability (OA) and Provider Relations staff have been trained and certified as CSR reviewers.

B. Findings Regarding Year Three Consumer Service Reviews

Year three Consumer Services Reviews (CSR's) were conducted during the March-April, 2005 time period – with separate reviews for children/youth and adults. The same protocols were used as in previous years. DMH-trained staff were once again highly-willing participants in conducting approximately 50% of the reviews. The Court Monitor contracted with the Consumer Action Network (CAN) to provide upfront training to providers and consumers, schedule the reviews and coordinate the overall logistics. As such, CAN worked very closely with Human Systems Outcomes (HSO) in all phases of the project.

The major change from year two involved the pulling of the sample. For year 3, the initial sample (so-called triple sample) of 162 names was pulled from the DMH data base – but only for consumers who had received a billed service after June 1, 2004. This change eliminated one of the major sampling problems of previous years – namely the significant number of inactive consumers. The target of individual cases to be fully reviewed remained at 54. This proved to be a major challenge, particularly in the child/youth review – as will be detailed below.

1. Summary of Child/Youth Findings

There were 2013 children/youth who had received a billed service since June 1, 2004 – representing 15 different provider agencies. However, 7 agencies represented 97% of the individuals seen. The sample was drawn proportionally from these seven agencies – including one case from the remaining 3% of smaller agencies. The stratified sampling also takes into account the age of the child and the relative level of need. The target of 54 cases was not met due to a combination of factors including: parents/legal guardians choosing not to participate; difficulty in locating parents/guardian to gain consent; and the very concentrated timeframe (one month) for coordination, consent and scheduling. 43 cases were successfully reviewed.

The results of Year 3 – in terms of acceptable child/youth status – are very comparable to previous years. The aggregate child/youth status for year 3 was 73% favorable rating. This compares to 74% for Year 2. As with previous reports, some categories of measurement were quite high (e.g. Home and School placement – 88%) while others were relatively low (e.g. academic status 60%).

The Dixon Exit Criteria for CSR measures how the system is performing – measuring issues such as treatment team coordination, availability for unique resources, treatment implementation, etc. For year three the aggregate results improved from 43% in Year 2 to 47% for Year 3. This modest jump in systems performance comports with the perceptions of reviewers that clinical staff are generally more knowledgeable about care plan expectations. It may also be reflective of the strong DMH commitment to serve children/youth in other systems.

The HSO Report in Year 3 identifies numerous findings and recommendations. One of the major findings is that "the greatest opportunity for improving the CSR will be continued emphasis on forming appropriate service teams and then ensuring that … coordination of services within this team is done in a timely and sufficient manner." There were also multiple (and continued) statements from providers and stakeholders that systems issues (e.g. payments and limited flex funding) all serve to constrain the speed of positive change. In general, however, there is a sense that the child/youth system is moving in a positive direction – with the continued need for infrastructure stability, training and services refinement.

2. Summary of Adult Findings

The Adult Review followed the same protocols and sampling methods as for the child/youth review. The target of 54 cases to be reviewed was nearly met (total of 51) – due to the diligent work of CAN staff in conjunction with HSO, DMH, and individual providers.

The Year 3 Reviews show a significant increase in the aggregate percentage of adults with a favorable status (67% for Year 3) versus 54% for year 2. Specific measures of safety (84%), living arrangements (75%) and satisfaction and services (76%) scored well. On the other end social network (47%), education/career preparations (31%) and work (42%) scored quite low.

In terms of measuring systems performance, the scores also improved measurably from 39% in Year 2 to 51% in Year 3. Many of the practice performance scales (e.g. service team formation and functioning, and personal recovery goals) also showed significant improvement from Year 2. The HSO recommendations for year 3 for the Adult reviews are similar to those for the child/youth reviews. Stakeholder interviews – which are done concurrent with the CSR process – reflected continued frustrations from providers regarding issues of timely payments, inability to project funding levels and the limited ability to "flex" the current service array to meet the unique needs of a given consumer. The HSO Adult Report also recommended further emphasis on CSR training targeted toward managers and front line supervisors. In general there was a reflection that the adult

system has developed to a point at which targeted service array improvements and training initiatives could be very useful.

In planning for the year 4 CSR process for children/youth and adults, there are a number of ideas that the Court Monitor will be discussing with CAN staff, DMH and the HSO in the next month. These ideas tend to center around: 1) ensuring that the Court Monitor has gotten clear feedback from at least a cross-section of previous participants 2) beginning the whole process several weeks earlier to avoid some of the inevitable time compression 3) working out clear interagency protocols in advance e.g. CFSA children/youth who have guardians and 4) tightening and clarifying tasks and timelines for the various parties who are involved in the process.

C. Implementation of Court-approved Performance Levels

As discussed in the January 2005 Report to the Court there are necessary prerequisite steps toward the performance and measurement of the fifteen (15) Exit Criteria that measure the effectiveness and sufficiency of consumer services. The first is the development and implementation of specific policies and practice requirements, including the documentation of any methods utilized to verify the degree to which relevant policy and practice is being followed by providers. The second prerequisite is the demonstration to the Court Monitor of the specific methods by which the DMH will collect and verify the integrity of the data points for each Exit Criteria. This Report will provide a summary of DMH progress on these two fronts.

1. Policy and Practice Development

The DMH has made significant progress in its policy development for specific Exit Criteria. The Court Monitor finds that final policies now exist for all the Exit Criteria – with one exception for Assertive Community Treatment (ACT) – which will take longer due to the fact that this policy will necessitate changes to the MHRS rules. The Court Monitor has reviewed all of the other relevant policies and finds them to be acceptable. They are clear, comprehensive and directly responsive to the requirements of the Exit Criteria. These policies are relatively new to the provider community so it is too early to know what steps providers have (or are) taking in response to these policies.

The major gap that still remains is to determine the degree to which providers are actually following the established policies. The Court Monitor has had beginning discussions with DMH staff – with a mutual commitment between the Court Monitor and staff to close this gap. Early discussion suggests that some combination of DMH provider reviews (audits) and the annual CSR reviews may provide a good starting point. Whatever methods

are selected, both the DMH and the Court Monitor need to have confidence that the DMH policies are being consistently followed.

2. Data Collection and Verification

The DMH has modified its electronic data system via providers in order to obtain data on several of the Exit Criteria. These enhancements – in the form of mandatory "event screens" – went into place in early April 2005. As of July 1, 2005, the required data will be tied to service authorizations – making reporting a mandatory process for providers. The next step will be – during the summer of 2005 – for the Court Monitor to do an initial review of the data sources and actual data collected on all of the 15 Exit Criteria. As planned, however, the Court Monitor will then engage an outside expert to conduct a data integrity review.

It should also be noted that the DMH has formally submitted evidence that it believes the District has achieved compliance with one of the Exit Criteria – namely the Criteria relating to the percentage of total resources directed toward community-based services. The Court Monitor is currently working with DMH fiscal staff to obtain an independent verification of the relevant fiscal data. Once that is accomplished, the Court Monitor will formally respond and make a recommendation to the Court.

Overall, the process continues to take longer than anticipated. However, the Court Monitor has every reason to believe that all of this continues as a high DMH priority. A high level group within DMH meets bi-weekly to discuss progress on the Exit Criteria. It is also noteworthy that DMH has hired a Chief Information Officer (CIO), who will have overall responsibility for upgrading and managing the IS operations. This should improve DMH's overall technology capability. The Court Monitor will continue to track progress and will report to the Court on a regular basis.

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

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

1. Quality Improvement and Provider Oversight

The principal responsibility for quality improvement and provider oversight resides in the Office of Accountability (OA). The OA staff carry direct responsibility for all of the major functions related to certification, licensure, policy development, and quality improvement. The OA Director role has been filled in the past six months by an individual who had served as a senior consultant to DMH on many issues that touch OA – e.g. residential services, ACT, CSR reviews, etc. As such she brings an in-depth knowledge of DMH services plus a wide base of knowledge and experience

in adult recovery-based models in other states. This Report will provide brief updates on activities in each of the major divisions of OA.

a. Division of Certification (DOC)

The level of activity for the DOC has maintained in FY 2005 at a level that at least matches that of FY 2004. The DOC in 2005 has certified/recertified eight (8) CSA's, eight (8) specialty providers, four (4) sub providers and four (4) specialty/subproviders (agencies certified to do both). The DOC has recommended one Residential Treatment Center (RTC) for Medicaid certification and has not recommended certification for 4 RTC's and two free-standing mental health clinics. The level of complaints for OA review in 2005 is at 84 (through June) – which appears to be consistent with the full year level for 2004 (131).

b. Division of Licensing (DOL)

For FY 2005 the DOL also appears to be on pace with FY 2004 activity levels. Thus far in FY 2005, the DOL has completed inspections of 153 Mental Health Community Residence Facilities (MHCRF's). They have issued 148 renewal licenses and five initial licenses. DOL has conducted 29 investigations of MHCRF's and has issued three Notices of Infractions (fines) thus far in FY 2005.

c. Policy Division

The policy Division has had a very busy year thus far. They have provided the necessary support for the issuance of thirteen (13) new policies and one new rule (Supported Housing). There are also seven (7) new policies in draft form and needed revisions for several existing rules.

d. Division of Quality Improvement (DQI)

In FY 2005, the DQI has conducted audits of 16 certified providers – doing targeted fidelity audits for ACT, Community Support, and Rehabilitation Day services. These audits use the MHRS standards as the basis for review – with required corrective action plans for any noted deficiencies. DQI staff also assisted the Medicaid agency in conducting Medicaid compliance audits for 11 community service providers – with DQI providing the actual staff to do the onsite reviews.

Despite the transfer and current vacancy of the DQI Director, the OA Director has moved forward with the Quality Council. The Quality

Council is composed of the Quality Improvement Directors of each of the community providers and St. Elizabeths Hospital. It began its monthly meetings in February 2005. The Quality Council has taken on the need for revisions to the unusual Incident Policy as its initial area of focus.

Overall, the OA continues to function in a manner that is consistent with the Court-ordered Plan. It continues to evolve policies and processes that are required to meet the overall needs of the system. Much of the policy work – as noted elsewhere – ties directly to the requirements of the Dixon Exit Criteria. The OA will be a central player on multiple fronts that have been noted in this Report-namely: 1) the expanded knowledge and use of CSR methodology by local providers 2) the needed ability for DMH to determine agency compliance with the policies that are tied to Exit Criteria 3) the ability to formalize and monitor (at the Authority level) the quality and consistency of care at St. Elizabeths. It is also hoped that the Quality Council will broaden its scope so as to provide a vehicle for the system overall to measure how it is doing in key performance areas.

2. Consumer and Family Affairs

The Office of Consumer and Family Affairs (OCFA) appears to have made major strides over the past year – in terms of its visibility and viability. The OCFA role in managing the grievance process and Periodic Psychiatric Evaluations (PRE's) will be detailed in III A 3. But beyond its formal mandates, the hope was that the OCFA would be a vital element in the DMH authority –giving consumers a direct voice in the shaping and monitoring of this evolving system. There are signs that this is indeed happening. Some of the OCFA activities over the past year include:

- Conducted a Job Preparation Fair for consumers at the Work Adjustment Training Program and the Peer Recovery Specialists Training.
- Conducted the Peer Recovery Specialist Training.
- Coordinated the Mental Health Statistics Improvement Program (MHSIP) Survey regarding consumer satisfaction – using trained consumers and family members as surveyors.
- Developed an ongoing clothing donation drive for needy consumers.
- Conducted monthly Consumer Forums.
- Coordinated the 2004 Consumer Voter Registration Drive.

- Trained consumers to lead focus groups as part of the consumer choice Initiative Block Grant.

- Participated in the Dixon Consumer Services Review process.

- Coordinated and conducted many of the key components of two major Recovery D.C. conferences.

- Planning for consumer recovery events on a quarterly basis.

In all of these instances (and others) the OCFA has directly engaged consumers as core partners in the new DMH system. It is becoming increasing evident that consumers have both "a face and a voice" – something that was not there historically. The OCFA certainly deserves a share of the credit for this progress. It should also be noted that the DMH leadership has actively supported these efforts – encouraging creativity and supporting activities that are consumer-focused and consumer-driven.

3. Enforcement of Consumer Rights

The OCFA is the organizational unit that handles all consumer grievances. The final Consumer Grievance Procedure rule was published in October, 2003. This Grievance Rule (in compliance with the Mental Health Reform Act of 2001) has put in place a comprehensive approach that is intended to give consumers a fair and timely process to resolve grievances. Since October 10, 2003, 35 grievances have been filed. DMH data indicates that 28 of the 35 grievances have been resolved to the consumer's satisfaction. Under the Grievance Rule, if consumers are not satisfied with the results at the local level, they can appeal to OCFA (at the Authority level) for an "external review". Ten external reviews have been received since October, 2003 – of which eight were resolved via the mediation process, one resolved informally and only one that went through the independent reviewer for recommendation to the DMH Director.

The OCFA has conducted extensive training on this entire process to consumer and provider groups. The DMH has recontracted with Advanced Dispute Resolution Systems (ADRP) – a local firm that was heavily involved in the original design and implementation of the grievance process. ADRP will be assisting in new rounds of training and in the design and functioning of a web-based information system. ADRP and DMH staff are actively engaged with Calhoun Computer Services to agree on data base design, report generation capability and costs. The lack of an adequate information system has been a source of frustration for all involved – and hopefully will be resolved in the near term.

Perhaps the largest issue in the grievance process is the concern that the grievances process is underutilized. The DMH – in its rules and practice distinguishes between a complaint (typically an issue that can be resolved informally without extensive review) and a grievance (a more serious matter involving adequate services, supports or due process rights). The problem is that there is an inevitable "gray" area between these two. The OCFA during this period has received some 170 complaints; this does not count the complaints that may come to other areas of the Authority (e.g. the Office of Accountability). The DMH has identified two concerns in all of this: 1) there needs to be an integrated process within the DMH authority for logging and categorizing complaints, resolution, etc. 2) there is a concern that some complaints should in fact be grievances. DMH officials – to their credit – would rather see more grievances (if in doubt) because of the real potential through the grievance process for meaningful systems change. The Court Monitor agrees with this assessment but also believes that if the complaint process were more fully developed – and integrated – it could have the same potential for systemic review and change.

The OCFA also monitors the DMH system as regards timely performance of Periodic Psychiatric Exams (PRE's). Under the terms of the Ervin Act (and DMH policy) all mental health providers are required to perform examinations every 90 days for all involuntarily committed consumers (inpatients and outpatient commitments). This has been an ongoing issue of compliance concern, which has been heightened due to an audit by the office of the D.C. Inspector General. The basic findings of the OIG (in a Report that was conducted in 2003 and finalized on April 12, 2005) were that DMH did not have an adequate data system in place to track compliance and that DMH "did not ensure that outpatient clinics provided some consumers with periodic psychiatric examinations in accordance with District law". The OIG made multiple recommendations regarding DMH's internal monitoring – noting that DMH took aggressive action even before the OIG Report was in draft form. As an example, the DMH is now doing a monthly compliance report (by agency) which is presented at monthly CEO meetings. The most recent monthly report indicates that eight (8) of the eleven (11) providers with committed consumers have compliance rates of 80% or better.

B. Review of Systems of Care Development

1. Review of Adult Systems of Care Development

a. Organizational Effort to Develop Adult Systems of Care

The DMH has continued to embrace a systems of care model for adults. At the heart of the systems of care philosophy are the concepts of building cross-agency partnerships, shared responsibility

for ultimate outcomes, and the creative interplay of funding streams to achieve desired results. A systems of care model only works, however, if a true recovery-based philosophy is implemented. Despite the multiple systemic barriers, the DMH has continued to evidence its commitment to consumer recovery as a part of an emerging systems of care model. Concrete evidence of this commitment could be seen in the first Recovery D.C. 2005 conference. Attended by over 350 people, this conference was a moving and powerful demonstration of the DMH's commitment to a system in which consumers are full partners in shaping their own lives and the lives of others with serious mental illness. The DMH Director has also recently appointed a new Consumer Advisory Board – (with 15 members) – who will advise the Director on key policy issues.

The following sections detail progress in three critical areas – housing, employment and Assertive Community Treatment (ACT).

b. Housing Capability

The DMH provided the Court Monitor with a summary of overall housing occupancy comparing May 2005 to May 2004. The overall total shows a decline of 125 DMH housing-supported units (2400 in May 2004 to 2275 in May 2005). All of this decline occurred in Community Residential Facilities (CRF's). The overall CRF decline of 171 was partially offset by an increase of 46 in Supported Housing/ Subsidy Programs. These numbers do accurately reflect the overall DMH direction – which is to become less dependent on the more costly and highly-structured CRF's and more dependent on supported housing. This direction is clearly consistent with the Court-ordered Plan.

The declining overall numbers do mask, however, the number of supported units that are in the pipeline. The DMH is involved in seven different local or Federal housing subsidy programs. The D.C. Housing Finance Agency (HFA) is now the housing finance intermediary for the DMH. This DMH and HFA agreement is driven by a comprehensive work plan that defines how many new housing units and will be developed, what type of units and target completion dates. The HFA projects that by the end of FY 2005, 100 new housing units will be financed and an additional 50 units by June 2006. This new arrangement (with HFA as the lead agency for new development) has meant that Cornerstones (the historic DMH housing development agency) has had to make shifts in its working relationships. The DMH continues to encourage Cornerstones to develop scattered site projects. Parallel with these efforts to create

new housing stock are the issues of dollars for subsidies. The previous commitment by the D.C. Housing Authority to set aside 1000 housing vouchers for DMH (via the HUD annual contribution contract) has now been reduced to 500. A special cross-agency work group has been formed to manage these housing subsidies. Best projections are that at least 50% of these promised subsidies will be available over the next 12 months – including subsidies that will be needed to support capitol projects that are underway. Thus it would appear that overall supported housing capacity should grow by at least 500 over the next 12 months.

The ongoing demand for housing support continues – with approximately 500 people who have applied for DMH-supported housing since 2002. The DMH – by policy and practice – gives priority for "bridge" housing subsidies to four targeted groups: 1) consumers ready to be discharged from St. Elizabeths 2) consumers who are homeless (on the street or in a shelter 3) consumers in unsafe or substandard housing and 4) consumers in CRF's. Compounding the overall picture is the dramatic rise in the cost of housing in the District – putting tremendous pressure on housing subsidies and the ability to stretch limited dollars to meet the need. The DMH data indicate that 61 priority consumers were referred and placed into supported housing over the past year. Of those 61, 45 (or 74%) were placed within 45 days. This total of 61 consumers does not include all of those in the DMH priority groups – much less all of those who have been referred.

As the DMH moves to implement and enforce the Supported Housing Policy, the true demand should become clearer. There is a strong suspicion that the 500 who have applied for support does not tell the full story. In the meantime, it is hoped that the interagency partnerships that the DMH has developed (D.C. HFA and DCHA) will show real payoff. There are many forces at work on the housing front (i.e. changing policy, different D.C. agency roles and overriding economic forces). Through all of this complexity, the DMH has been clear about its commitment to provide supported housing as a part of a recovery-based philosophy. The degree to which it can carry out this philosophy should become much clearer in the months ahead. The issue of rising housing costs will require focused priority by all D.C. housing agencies – if the District is to meet its Dixon Requirements.

c. Supported Employment Capability

There are currently six providers for supported employment services. These six agencies – as of May 2005 – were providing supported

employment to 296 consumers. The DMH SEP Director – a very experienced and knowledgeable person – is working hard to expand capacity. An additional provider of SEP has been selected and will add capacity for 50 additional SEP consumers starting in the summer of 2005.

The DMH adult services staff continue their monthly teleconference with the Dartmouth consultant. They also meet regularly with the D.C. Rehabilitation Services Agency (RSA) and have established written procedure for referrals to RSA for supported employment. The DMH has also developed and begun to conduct annual fidelity assessments for SEP programs.

The major unanswered question – as with other new service areas – is the one of what the capacity for SEP should be. There is strong suspicion by the Court Monitor (and shared by DMH) that the current SEP is highly underutilized. As the new DMH policy takes hold, it should come clearer in the months ahead. In the meantime, the DMH has built a solid infrastructure to manage this growth.

d. Assertive Community Treatment (ACT) Services

The DMH, through the leadership of the Office of Programs and Policy (OPP), continues to address issues of ACT capacity and fidelity. Noteworthy developments include the following:

- The DMH has developed a draft of an ACT policy that appears to be consistent with the requirements of the Exit Criteria. However, this policy awaits formal changes to the MHRS Regulations. The timelines for this are not yet clear.

- The DMH is actively recruiting a full time Coordinator in Adult Services for ACT and Co-occurring Disorders (ACT/COD). This position has been approved. The person selected will have broad responsibilities for ACT program development, budgeting, policy enforcement, training and fidelity measurement.

- The DMH, in response to its October 2004 Request for Applications (RFA's), has selected three agencies to develop new ACT teams. These ACT teams will have different target groups (e.g. homeless and co-occurring) but all are expected to be operational by September 2005.

- The existing Pathways to Housing ACT Team has been operating since April 2004. This program – focused on persons with SMI and homelessness – has been highly successful in N.Y.C. The DMH Housing Authority has committed 75 housing choice Vouchers to this program. Pathways currently has placed 40 consumers in permanent supported housing. Those 40 consumers had been homeless for an average of 6.5 years

- Pathways to Housing will also be conducting a series of training modules for all of the existing and new ACT teams. This will include classroom training and opportunities to shadow Pathways staff at actual program sites.

The Court Monitor is pleased overall with the continued development of ACT capacity. The employment of a fulltime coordinator should help greatly to maintain focus on this priority area; this has been an identified area of concern in previous Reports to the Court. It is critical that the new MHRS rules (and concomitant DMH policy) are put in place as soon as possible. It is also critical that the DMH create the ongoing capacity to know if the ACT policy – once approved – is being followed and that there is reasonable fidelity to the ACT model. In sum, a great deal of work remains in this area.

2. Review of Child/Youth Systems of Care Development

   a. Organizational Efforts to Develop Child/Youth Systems of Care

   The DMH has continued to exercise a strong leadership role in the District in developing true systems of care for children and youth. As noted in the January, 2005 Report to the Court, the impressive aspects of child/youth development is not just in the growth of individuals served (78% increase over the past 3 years) but in the growing diversity of providers and services. The 6 year/$ 8 million Federal Systems of Care grant that DMH received in 2002 continues to serve as a unifying initiative; it clearly articulates the DMH commitment to a systems of care philosophy.

   The following specific areas detail progress and remaining challenges in the child/youth arena.

   b. School-based Services

The D.C. School Mental Health Programs (SMHP) continues to offer a comprehensive set of school-based services to children, youth and families. The SMHP is currently providing services in approximately 30 public and public charter schools. The D.C. SMHP is structured to be able to provide: 1) primary prevention services (e.g. classroom-based substance abuse and violence prevention program); 2) secondary prevention/early intervention services (e.g. targeted social skills training groups); and 3) clinical services (e.g. individual and family counseling or referral for more intensive services outside of the school).

For the current school year, some 541 students have been formally referred and provided services, plus an additional 2140 students who were seen as "walk-ins". In addition, there were consultations to parents (1412), teachers and school staff (3938), classroom observations (1627), and staff development in-services (106). There volumes represent slight growth from the previous year.

The SMHP has received high levels of satisfaction from children/youth, principals, and administrators. The SMHP has put together an impressive 2000–2004 Report on the overall development and preliminary impact of the school-based program. This Report "provides scientific and anecdotal evidence that school-based mental health systems have a powerful influence on the factors that relate to student learning and success in school". Among the conclusory comments are ones with which to Court Monitor strongly agrees – namely that a growing body of research "has demonstrated that a focus on strengthening systems that surround a child and family is more effective than solely attending to the individual characteristics of a child or youth".

Going forward, the DMH school-based Director indicates that there are multiple new initiatives for the school-based program in FY 2006, to include:

- Columbia Teen Screen – the two pilot schools that are using this universal screen for depression, anxiety and substance abuse will be expanded into an additional three schools in the Fall of 2005.

- Supported Employment Project – This program will provide identified adolescents the opportunity to explore choices by matching them with a job (for 5 weeks during the summer) in their area of career interests. School-based job coaches assist in this process.

- Program Evaluation – Early data on changes in clinical functioning (e.g. depression, anger/aggression) will be completed by August 2005. The next phase will include more comprehensive evaluation of the school-based interventions – to include a randomized treatment study, a detailed cost-benefit analysis, whole school comparisons using a matched-school design and a more advanced school climate study.

- Funding – The SMHP Director will develop an overall funding strategy by the fall of 2006 that seeks to augment DMH-appropriated dollars. A first step will be application for a Federal "Adolescents at Risk" grant, which is due June 1, 2005 – targeted toward identifying and linking youth who are suicidal. The 2006 Budget (see III E) will add $1.3 million to this effort.

- Externship Programs – The current externship program will expand to include two psychiatry fellows who will spend four-month rotations in community psychiatry and school-based mental health consultation.

- Crisis Response Protocol – the school-based crisis response protocol will be expanded to include public charter schools.

Overall, the Court Monitor is very impressed with the continued growth, diversity, and support for the school-based mental health initiative. It has had strong and consistent leadership throughout. As a result it is now widely supported within the D.C. public schools. The ultimate goal of being available in all D.C. schools will be dependent upon the ability to generate support for both additional local finds as well as alternative finds e.g. Federal and private.

c. Capacity for Children/Youth to Live in Our Home or Surrogate Home

The DMH continues to provide leadership efforts that maximize the ability for children/youth to live (with needed services and supports) in their local communities – as opposed to the current over-utilization of Residential Treatment Centers (RTC's). Toward this end, the DMH is currently completing a two-phased approach. The first phase will create the needed infrastructure (in terms of staff, and interagency policy and common assessments) and the second phase will be the actual services implementation of this community-based focus.

The DMH has continued to work on many fronts in an effort to create a time model for systems of care that has at its heart the belief that children and families should – to every degree possible – be supported in their own homes or in surrogate homes. The D.C. Federal Systems of Care grant (D.C. CING's project) continues to serve as the overall conceptual and implementation framework. That grant is soon entering its fourth (of a six year) grant cycle. The following describes major activities over the past year:

- The Multi-Agency Planning Team (MAPT) continues to serve as the common process to assess youth who are at risk of out-of-home placement. Three interagency MAPT Teams continue to meet on a regular basis. Since its inception in November 2002; the MAPT process has reviewed 1082 cases. Of that total, fully 77.8% have been diverted to community-based services. This is an impressive record given the historic baseline of 5% - 10% diversions.

  Nevertheless, several major challenges remain:

  1) The Harmony Information System that was installed in 2004 to track services and care levels did not perform up to standards. Hence it has been discarded. The DMH child/youth leadership is actively looking at new software that will accomplish the needs for a user-friendly model to provide comprehensive tracking and reporting. The target date for a new system is the end of summer 2005. The effect of not having an information system is that there is no reliable basis to track and evaluate children/youth who are diverted from residential care.

  2) The previous Mental Health Care Sub Council has not proven to be an effective mechanism for cross-agency efforts. Hence, a new governance council is being created that will be composed of senior level agency representatives and also families and youth (at least 51% of total membership). In addition to giving youth and families a much stronger voice, it is also noteworthy that this new structure will require that agency representatives be authorized to enter into binding decisions at meetings.

  3) The MAPT process has not had – until recently – a standardized protocol that requires all children/youth to be assigned to a CSA. This, coupled with

questions about the consistency of follow up by family liaison staff, leads to an overall concern about current practice. DMH child/youth leadership are taking aggressive steps to tighten polices and practices. The DMH is planning – in its leadership role – to ensure that there is a common assessment and monitoring process that cuts across all child-caring agencies. The target date is fall 2005.

4) On a positive front, the Youth Advisory Council (YAC) has been a consistently viable group – allowing youth a safe place to talk about their own mental health concerns and to help shape the overall direction of mental health services for youth. Once the youth coordinator position is filled, this group will take on additional projects such as co-sponsoring a city wide Youth Conference focused on mental health and other elements of the system of care.

- Closely related to the MAPT process is the whole issue of characteristics and costs associated with children/youth who are currently being placed into residential care. DMH has begun to track these data across all D.C. agencies. FY 2005 data shows that there have been 485 children youth placed into residential care thus far in FY 2005 (approximately eight months). The best estimates available are these 489 youth have cost $49.9 million year-to-date (Federal and local dollars). While the District does not have solid historical data, DMH officials indicate that this aggregate spending may be as much as 50% below what it was 3 – 4 years ago.

  Several things jump out from these data:

  1) In spite of the MAPT process, large numbers of children/youth are still going to very expensive residential care.

  2) Looking at the MAPT data (as compared to this overall data) suggests that not all agencies are utilizing the MAPT process (e.g. D.C. Public Schools).

  3) There is not a common data system that allows child-caring agencies to understand the characteristics of children/youth who are in residential care, lengths of

stay and composite needs for additional community services for these children, youth and families.

The DMH, in response to all of these identified gaps, is planning to create a small team within the child/youth services division; this unit (to be developed by the fall of 2005) will be tasked with creating uniform methods to assess and monitor all children/youth who are in Residential Care. This will be done across all child-caring D.C. agencies – with the possible exception of D.C. Public Schools. This is viewed as Phase 1 of an overall Residential Treatment Reinvestment Initiative. Phase 2 – armed with much better information about the needs of this population – will be to expand the community –based systems to meet these needs to every degree possible. The financial goal is to use Medicaid-eligible services but also to develop non-traditional services.

- The DMH has been heavily invested in the whole Juvenile Justice arena. The DMH has two intensive initiatives underway with the Department of Youth Rehabilitation Services (DYRS); both of these are in a developmental state. The first is called the Front End Assessment Team (FEAT), which began on January 24, 2005. The goal of FEAT is to provide universal screening for mental health for all youth who are detained by the Metropolitan Police Department (MPD) and whenever possible and appropriate, to divert these youth into community-based alternatives. Since its inception, this program has screened 590 youth. Seven of the nine staff for this unit have been hired. The screening process has had to be scaled down somewhat to better meet the needs. The FEAT staff is also attempting to be more assertive at early stages to find viable community alternatives. Needless to say, this whole process has taken considerable work across agency lines – most notably with DYRS, MPD and the new Youth Services Center (YSC).

  The second major initiative is also targeted toward assessment and diversion but involves youth who are already in secure detention or are committed to DYRS. Thus far some 102 youth have been referred for evaluation from detention or step-down from commitment. As these youth move into step-down facilities, the goal is to identify youth with mental health needs and to get them enrolled in a Core Service Agency (CSA). The DMH has proposed an interagency process that simulates the one DMH has with CFSA. This whole process of clarifying protocols and

working out both policy and practice is a dynamic one. There are early positive results noted; of the 102 youth referred, 51 (or 50%) have been diverted or stepped-down.

In addition to these major initiatives, it should also be noted that DMH operates the Assessment Center for the D.C. Superior Court (as noted earlier in this Report) and provides mental health service staff at the YSC and at Oak Hill Youth Center. All told, DMH has some 20 FTE's dedicated just to Juvenile Justice Initiatives – not counting manager positions.

d. Homeless Outreach to Children and Families

One of the approved Exit Criteria requires that DMH provide – with in a given 12 month period – services to 100 children/youth/families who are homeless. Organizationally, the DMH has decided to fix the responsibility for this effort with the Adult Homeless Outreach Team (HOT). The HOT has been given authority to hire a full-time staff person to coordinate this effort. The expectation is that this staff person will be hired by the fourth quarter of 2005. The focus of effort by this person will be on: regularly visiting homeless programs for families; providing homeless outreach to children and families; making referrals as appropriate to other DMH services; facilitating other needed services (e.g. crisis services and housing).

The Court Monitor is pleased to see this focused effort on homeless services to children, youth and families. The HOT has a strong reputation for being responsive and proactive in its outreach efforts to the homeless who are mentally ill. It should also be noted in the Court-approved Exit Criteria that – in addition to engaging 100 children/youth who are homeless – the "DMH will demonstrate the implementation of a comprehensive strategy to engage and serve children/youth who are temporarily or chronically homeless". It would appear that the DMH is making efforts to develop and implement a comprehensive strategy. The Court Monitor was provided with a recent document entitled "Outreach Plan – Homeless Children/Youth and Families" – which sets forth both a conceptual approach as well as specific tasks and timeliness. The hiring of the staff person – as noted above – will be an integral part of this overall strategy. It is also noteworthy and commendable that the planned approach includes a needs assessment process including the other D.C. agencies that currently provide services to homeless families. The Court Monitor will continue to track progress in this area as the actual implementation occurs.

e. Child Welfare/Foster Care Initiative

The January 2005 Report to the Court detailed the initiatives DMH has undertaken as a result of the congressional appropriation of the funds ($14 million overall including 3.9 million for mental health) to improve the care and treatment of children, youth and families who are in the D.C. foster care system. In carrying out this initiative, the DMH is implementing five (5) new targeted services for foster care recipients, with current status noted:

1) Multi-Systematic Therapy (MST)

   Youth Villages, a nationally certified MST provider, is on track to serve 96 youth and families during its first year. Youth Villages is seeking certification as an MHRS provider for DMH. At the same time, DMH is looking to revise its own MHRS standards to incorporate the MST model.

2) Intensive Home and Community-based Services (IHCBS)

   First Home Care's IHCBC team is on track to serve the 72-90 youth/families that was contracted for year one. First Home is a fully certified DMH provider. DMH is also looking to incorporate the IHCBC model into its overall MHRS array of Medicaid-eligible services.

3) Mobile Response and Stabilization Services (MRSS)

   The Drenk Center is fully operational and has the capacity to respond to 12-14 interagency calls per week. The initial request for these services has been low; Drenk staff, along with DMH and CFSA, are working to ensure that families are fully aware of this available service. Drenk is seeking MHRS certification.

4) Trauma Training

   The DMH awarded a grant to the National Association of State Mental Health Program Directors (NASMHPD) and the Center for Child and Family Health (CCFH) to provide training for trauma treatment. The Trauma-focused Cognitive Behavioral Therapy (CBT) is an evidence-based practice which views working with parents as an integral component of treatment. The initial trainings occurred on April 28-29, 2005 with advanced training on June 9-10 and August 12, 2005.

5) Assessment Center

The DMH- run Assessment Center has expanded its capacity to do evaluations for foster care youth – especially in regards to placement planning. The Assessment Center experienced a 44% increase in requests in 2004 and has shown an 81% volume increase in 2005. The net result is that the Assessment Center is not meeting the Congressionally-established timeframes for completion of assessments. A plan is in place to deal with these timeframe concerns.

The key issue – going forward – will continue to be the one of sustainability of these new services. DMH and the providers involved appear to be working hard to achieve MHRS certification and to change the existing MHRS standards to incorporate these new models. Both of these will need to be accomplished in a timely fashion in order continue these services after the Congressional funds terminate.

By way of commentary on the overall child and youth services efforts, it is important to state that DMH has shown tremendous leadership, commitment and follow through on multiple agency fronts. Given the absolute dearth of child/youth mental health services three short years ago, it is extremely gratifying to see a true child/youth system taking shape. It should also be noted that the interagency systems of care "work" – while it is the most critical – is also the toughest to accomplish. Systems resist the kind of shared decision-making and policy reformation that has to occur. It is in this arena that the DMH director – and child/youth staff – have shown tremendous skill in setting direction, building capacity, negotiating solutions and staying at it. While the child/youth system is far from a finished product, it represents what could become a national model for building true systems of care for high needs children, youth and families.

C. Review of DMH Progress in Maximizing Funds

The DMH has made continued progress in maximizing funds on both the local front (DMH vis a vis other D.C. agencies) and Federal Medicaid billings.

On the local side, the January 2005 Report to the Court detailed concerns about MCO enrollees and the issue of local match for CFSA referrals to DMH. DMH has made significant progress on both. As relates to the MCO's, DMH has been working closely with the medical Assistance Administration (MAA) to put in place both care coordination strategies and appropriate payment policies. It is clear that DMH has been paying the full cost for certain mental health services that should be

reimbursed by the four contracted MCO's. As of June 1, 2005, electronic edits have been put in place in DMH's claim processing system to deny DMH payment for any services provided after May 1, 2005 that are eligible for payment by the MCO's. These specific services include diagnostic assessments, counseling and medication somatic treatment. The explicit expectation is that local DMH providers must bill the MCO's directly for these eligible consumers and services. Other MHRS services that are not covered by the MCO's will continue to be billed to DMH. DMH officials are meeting regularly with the MAA, individual MCO's and DMH providers to ensure a smooth transition. As of June 3, 2005, there were 3498 consumers enrolled in an MCO and also being served by an MHRS provider. It is not yet clear what the positive fiscal impact of this will be for the DMH budget, but it will obviously be of some help.

The DMH has also recently signed MOU's with DYRS and CFSA for FY 2005. These dollars ($300,000 for DYRS and $1 million for CFSA) will be used to provide the local match for targeted Medicaid services that are – or will be – provided through DMH providers.

On the overall Federal Medicaid front, the DMH has provided the Court Monitor with charts that detail progress on the issue of maximizing Medicaid payments. Since the inception of the MHRS billings, the overall percentages (Federal Financial Participation (FFP) as a percentage of total MHRS payments) have increased from 42.5% (2002) to 45% (2004) to 52.2 % (FY 2005 year to date). While these percentages need to be verified by the Court Monitor, they would appear to support the belief that DMH is meeting one of Exit Criteria – namely the maximization of Medicaid funding (with a performance threshold of 49% FFP). The Court Monitor will work with DMH to validate these numbers prior to any formal recommendation to the Court.

The remaining issues as relates to Federal revenue are three fold: 1) Securing sufficient local match to support a growing community system (see III E regarding 2006 budget) 2) changing MHRS rules to include new (or modified) service components (see III B in this Report) and 3) accelerating the cycle for payment to DMH by MAA for approved Medicaid claims. The DMH has a specific strategies for each of these issues – all of which should be in place by the FY 2006 budget.

The Court monitor is pleased with DMH progress on revenue maximization as relates to the specific Exit Criteria. Hopefully, in the near future, the Court Monitor will be in a position to make a formal recommendation on this matter.

D. Review of DMH's Role as a Provider

1. Evolving Role of St. Elizabeths

St. Elizabeths continues to evolve toward the role that was envisioned in the Court-ordered Plan – namely as a tertiary care Hospital (on the civil ride)

and a forensic Hospital. Sections III D 3 and 4 of this Report detail the DMH's efforts toward construction of a new/consolidated Hospital and its efforts to obtain needed acute care services from local hospitals. Obviously the successful resolution of both of these issues is absolutely essential to achieving the Court-ordered Plan. In the meantime, the DMH has continued its daily efforts to assess and redirect consumers who present at CPEP to alternative services. This concerted effort has allowed for the admission to local hospitals (or community services) of virtually all voluntary patients. The continued use of the extended observation unit at CPEP (up to 72 hours) has also helped to stabilize and redirect many patients who otherwise would need admission at St. Elizabeths. Over the past six months, admissions at St. Elizabeths have averaged approximately 50 per month – virtually all involuntary patients.

The other major initiative at DMH is to actively assess patients at the Hospital in terms of their readiness for community placement. The Director of the office of Planning and Programs (OPP) has continued to provide hands on leadership in ensuring that specific consumers are actively being assessed for community readiness and that CSA's are actively engaged in the discharge process. This proactive approach to continuity of care has been very successful.

The net effect of all of these efforts – diversion and aggressive outplacement – is that the S. Elizabeths census was at 413 (as of June 30, 2005). This is the lowest census at St. Elizabeths in modern times and provides tangible evidence that the DMH can (and is) making progress toward the mandates of the Court-ordered Plan.

2. Quality of Care Initiatives at St. Elizabeths

The DMH has – over the past year – had a series of external reports and findings that have raised numerous patient care concerns. These reports have included both the local D.C. Protection and Advocacy organization (University Legal Services) and the Federal Centers for Medicare and Medicaid Services (CMS). As relates to CMS, the DMH – in response to a December, 2004 survey – has now resolved all outstanding concerns as identified by CMS surveyors. In a letter from CMS, dated June 9, 2005 CMS officials indicated that "St. Elizabeths Hospital is once again in full compliance with the Medicare Special Conditions of Participation for Psychiatric Hospitals". The ULS concerns have resulted in the filling of an independent Court action which is currently in front of the D.C. Federal Court. The purpose of this Report is not to recite all the detailed legal actions but rather to describe the Court Monitor's review of the DMH's actions in response to the clinical care (and related) issues identified.

In response the multiple concerns raised, the DMH contracted for an independent review with Fields and Associates – an Atlanta-based firm. Dr. Richard Fields is a prominent psychiatrist with a well-established reputation in State Hospital care and management, and in developing quality improvement projects and processes. Dr. Fields completed his initial report and recommendations in seven (7) areas including: active treatment; training and competencies of staff; staffing; access to health care; use of seclusion and restraint; quality improvement; and hospital management. Dr. Fields and his consultant colleagues (two nurses and a consumer representative from CAN) found – in general terms – that the areas of active treatment and access to health care were adequate, but that the other areas (training and competency of staff, staffing, use of seclusion and restraint, quality improvement programs, hospital management and patient advocacy) all needed considerable improvement. Dr. Fields made numerous recommendations in each of the aforementioned areas. The DMH – with this report in hand – has subsequently contracted with Dr. Fields to provide in-depth consultations and clinical assistance. Dr. Fields has been providing monthly onsite consultation plus regular telephone consultations. All of this is a part of an organized Strategic Performance Project – with very specific improvement targets and the built-in ability to measure progress. Fully sixteen (16) Highest Priority Opportunities (HPO's) have been identified in the focus areas of communications, patient safety, performance improvement and staff training, and staff competency. All indications are that the senior managers at St. Elizabeths have embraced these recommendations and are actively involved in implementing the needed improvements. It should also be noted that SHE has recently employed two senior level psychiatrists. Together they should provide improved ability to exercise clinical oversight and medical management at St. Elizabeths.

As the Hospital leadership itself moves to make incremental, but major, improvements, it raises the question of the rightful oversight role of the DMH Authority. The DMH Director has charged the Office of Accountability with developing a specific set of performance indicators against which the Authority can measure progress. These specific indicators are still being refined, but are expected to be fully in place by the last quarter of FY 2005 (July – September).

The Court Monitor is pleased to see the comprehensive approach that has been taken to improving the quality and consistency of care at St. Elizabeths. It is obvious that physical plant issues must be addressed via a new Hospital and that the role of St. Elizabeths must be delimited – as discussed in other sections of this Report. But it is also true that the internal dynamic of progressive and measurable improvement in the quality of care must be in place. It appears that this is now happening. The Authority's oversight role must also be well-defined and consistently applied. The

Court Monitor will continue to track all of these developments in each Report to the Court.

3. Planning for New/Consolidated Hospital

The DMH has made discernible progress toward the construction of a new/consolidated Hospital at St. Elizabeths. Contracts have been let and construction has begun on the early roads and utilities phase of the project. This will provide the basic infrastructure necessary to support the Hospital construction phase. The target date for completion of the early roads and utilities phase is the end of calendar year 2005.

DMH and District officials also have agreed on the overall parameters of a financing package for the Hospital construction. The financing model that is contemplated is called a Certificate of Participation (COP) which effectively allows multiple lending institutions to pool dollars at an agreed borrowing rate for a specific project. This model has been used successfully in D.C. for other public projects (e.g. the Unified Communications Center). At this point, the D.C. Treasurer's office has been assigned to do the necessary due diligence for an overall financing package. The Treasures office intends to issue an invitation for bids on the financing package by the end of July. Given this schedule, the final Council approval on the financing could occur by September 21, 2005.

Once the financing is approved, then the DMH can bid and award the construction project itself – which will take an additional 90-120 days. DMH estimates that once construction begins it will be at least 30 months before occupancy. Hence, the most ambitious timeline would allow occupancy by mid 2008. To the degree there are delays in the financing approval process, these timelines will obviously lag. There is also the inevitable reality that with each passing month the overall construction costs (in an escalating market) are going up. The construction portion of the project has already risen to an estimated $116 million.

The new Hospital planning still assumes 292 beds – with 178 forensic beds and 114 civil beds. Concurrent with new Hospital planning, the DMH has also secured capital financing ($14 million) to significantly rehabilitate 3 current buildings on the east campus. The target date for completion of the design phase is Sept, 2005 with completion of this project by the end of calendar year 2006. The intent is for each of these buildings to function (from a utilities standpoint) as a decentralized unit – so that in the future each of these buildings can be utilized or shut down as patient census dictates.

Overall, the Court Monitor is pleased to see concrete progress on the long journey toward a new Hospital. The DMH staff have been persistent in their

effort to move this project to resolution. However, the seemingly interminable delays in necessary approvals (design, environmental impact, certificate of need, zoning and now financing) have moved the estimated timelines for occupancy back by a full two years. The only good news in all of this is that the DMH has had – during this past two years – the opportunity to "grow" the community system and develop viable plans for providing acute care in local hospitals (see III D 4). As of the time of this Report, the current census at St. Elizabeths stands at less than 420 patients – the lowest it has ever been. These aggressive efforts to "right size" St. Elizabeths will hopefully result in a scenario that will allow the new Hospital to meet (or nearly meet) the full demand for State Hospital services (civil and forensic).

Nevertheless, the Court Monitor wishes to express – in the strongest possible terms – that the timelines for the new Hospital must not slip any further. The current hospital units do not meet contemporary standards for quality care and must be replaced by the District in order to meet the basic conditions of Dixon.

4. Review of Progress on Use of Local Hospitals for Acute Inpatient Care

The DMH indicates that it is close to formal agreements with two local Hospitals to provide involuntary inpatient beds for DMH-referred consumers. One hospital has four available beds and the other five at this point in time. There continue to be facility-specific issues for each of these two hospitals (e.g. payment issues and required psychiatric coverage at "probable cause" hearings). However, DMH officials indicate that these hospitals have begun to accept involuntary patients who have Medicaid as a first step in this initiative. The target date for the formal initiative is October 1, 2005 – assuming that there is Federal approval of the State Plan Amendment (as regards payments to one of the hospitals).

The basic parameters remain the same as discussed in the January 2005 Report to the Court – namely:

1) Involuntary patients admitted under this agreement who require more than 15 days in the Hospital will be transferred to St. Elizabeths.

2) Hospitals will bill 3rd party sources (including Medicaid and Medicare) for care and treatment if the patient is covered.

3) DMH will reimburse Hospitals for involuntary patients who are indigent at an agreed upon rate (both the inpatient costs and professional charges)

In addition to these nine beds, the DMH has also recently sent out to local Hospitals an RFQ (Request for Quote) indicating the availability of up to $750,000 in capital monies to provide necessary renovations (including security) for an inpatient unit for involuntary patients. The working assumption is that DMH will need at least 17 total involuntary beds to meet the current admission rates of approximately 50 involuntaries per month. Hence this new unit – once rehabbed – should allow sufficient overall capacity to meet the projected need.

The Court Monitor is pleased to see definitive progress on this critical issue. While the nine beds will not meet the full need, it will at least allow the new process to begin in a substantive way. Undoubtedly there will be protocols and processes to be refined. The Court monitor will continue to closely track this process – including the timely development of the additional beds.

5. Management and Role of DMH-Operated CSA

The DMH continues to operate directly the largest CSA, currently referred to as the DC CSA. Past Reports to the Court have detailed both the progress of this entity and remaining concerns. The past year has seen major progress on multiple fronts. One of the major historic gaps has been the lack of an electronic information system. The DC CSA now has an IS system that is being implemented in three phases. The first is the billing module, which has been fully implemented. The second is the is the module for scheduling – which has been partially implemented, but is planned to be completed by August, 2005. The third is the clinical module, which is currently in the design development phase. The DC CSA has implemented its IS system with careful attention to needed staff training both before and after implementation. One of the most impressive developments over the past year has been the full implementation of key performance measures – targeted toward reviewing key financial and operational objectives. These include key areas such as: revenue/cost analysis, staff productivity, location of service and service intensity. With the use of its IS data, top management reviews these priority measures each month; reviews occur at an individual staff level (e.g. productivity), at a team level and for the DC CSA overall. This management tool has provided focus and discipline at all levels.

The DC CSA has also invested significant time and effort in training and implementing the principles of a consumer-focused clinical care model. A detailed clinical supervision process and protocol was begun in February 2005. Perhaps the most visible result of these clinical efforts was the 2005 CSR reviews for children/youth and adults. Throughout both reviews, the DC CSA staff was highly engaged and actively supportive in locating consumers, encouraging consumers to participate and working out logistics. Both the CAN staff and the HSO reviewers made special note of the exemplary participation of DC CSA leadership and staff in the 2005

reviews. The results of the year 3 reviews also show a very positive trend. Limited sample sizes (for a single CSA) preclude definitive conclusions; nevertheless the 2005 CSR results for the DC CSA (as compared to 2004) are impressive. DC CSA scores improved in all major areas of measurement, but probably the most telling were in the adult status scores – which improved from an overall rating of 53% positive in 2004 to 85% positive in 2005. It was evident to the reviewers that DC CSA staff (at all levels) had embraced the principles inherent in the CSR model and were actively working to implement these. Overall practice performance scores went from 32% for adults in 2004 to 65% in 2005.

The agency has also tackled frontally the whole issue of staff productivity. It has developed clear position descriptions and performance standards for all positions. Working through a labor/management work group, new understandings have been reached about billing expectations. A consistent policy for disciplinary action – as regards staff who are not meeting billing expectations – is being implemented. All teams (and individual staff) now understand expectations and the progressive discipline (up to and including termination) that will result from not meeting standards. The full impact of these new standards (in terms of individual staff) will be felt in the next six months. The DC CSA leadership is fully aware that these new standards (which require 50% of the total time toward billable services – or 1040 hours annually) is not the end goal. However, the management view is that clear and reasonable standards need to be set – and reinforced – before "raising the bar" any higher.

The overall financial picture is mixed. The measure of current MHRS billings (gross revenue) versus agency gross costs still shows a major gap (approximately $10 million). However, two factors are in play that should reduce this gap: 1) the DMH is planning an "early and easy out" this summer to help reduce overall personnel costs 2) the impact of the productivity/ enforcement policy should show some combination of increased billings and/or reduced personnel costs in the next six months. Additionally, the DMH – as part of the ongoing discussion about the D.C. CSA – points out that the DC CSA costs per consumer served are mid-range as compared to other CSA's.

The other major factor in evaluating the DC CSA is its role as a "safety net" CSA. In addition to being the largest CSA – with nearly 4000 active consumers at any point in time – the DC CSA also is required to carry out other "above and beyond" functions. These include 1) provide first response readiness for District residents in the event of a natural disaster 2) maintain a core of bilingual staff to meet needs of multi-cultural residents 3) ensure availability for consumers with unique or high risk needs e.g. individuals enrolled in or referred from the criminal justice system. While these factors are not totally unique to the DC CSA, there is an overall reality

that the DC CSA must accept consumers irrespective of their status (economic, legal, health, behavior, etc). The difficultly is in being able to quantify the additional "cost burden" associated with these safety net roles.

In sum, the DC CSA has made significant progress in the past year – clinically and organizationally. It has put together a strong leadership team that has a clear grasp of what it will take to move the agency to full performance. Clearly the DC CSA has proven that it is a critical component of the evolving DC community-based system. Many of the elements to the Dixon Exit Criteria are directly dependent on the performance of the D.C. CSA. Hence, the issues surrounding the DC CSA have shifted over the past several years. The question now is not whether the D.C. CSA is needed. It is rather one of what organizational structure and supports will best achieve the needed results. There remains, for example, an open question as to whether the inherent cost structure (e.g. personnel costs) can ever achieve a financial "break even' point: There also are ongoing questions as to the efficacy of certain services e.g. ACT and CBI. Given all of this, the Court Monitor believes that the DMH Authority – as with St. Elizabeths – should have clear annual performance expectations of the DC CSA. These should – at a minimum – speak to issues of productivity, gross billings, and fidelity measures for ACT and CBI. In addition, the DMH should attempt to quantify the cost of the incremental safety net functions. It should also provide a two year projection for costs and revenue based on current budgeting and management assumptions.

E. Review of FY 2005 Budget and Status of FY 2006 Budget

The FY 2005 DMH was essentially a flat line budget from FY 2004. The major complication for FY 2005 – as noted in the January 2005 Report to the Court – was the $11 million reserve amount. These reserves were not released to DMH until March 2005, which caused delays in being able to fully "load" the DMH budget and effectuate full Task orders with providers. In addition, there are numerous other factors that have complicated the budget situation for 2005 – including the funding of new CSA's the development of targeted community services (e.g. new ACT Teams) and the major growth in child/youth services (e.g. CFSA referrals) and the funding of new Juvenile Justice initiatives (see III B2). All of these are critical initiatives – many of which are in direct support of the Court-ordered Plan. The major problem has been the necessary reduction in MHRS – funded services to existing providers from over 45 million (final billings) in FY 2004 to approximately 38 million (budgeted) in FY 2005. Most major providers have experienced reductions of 25-30% for FY 2005 – primarily in area of day services. This has caused major upheaval in many of the CSA's – with the attendant concerns over ability to accept referrals and demonstrate fiscal viability (short and long term). Each agency has unique issues, but in general the climate continues to be one of uncertainty and at times acrimony between DMH and its provider community. All of this – in the mind of the Court Monitor – points to the critical importance of

developing a clear multi-year services and funding plan for DMH – which can then be communicated with individual providers to the degree possible. The DMH has begun this process and is planning a series of meetings with providers.

The FY 2006 District Budget was passed by the District Council on July 6, 2005. As it stands (awaiting final congressional approval) it will increase the overall DMH budget by $10 million to $229.5 million. It also includes an increase of $15.5 million in local funds as compared to FY 2005 (once the $11 million reserve allocation is included). There are multiple mandates, approvals and funding reallocations imbedded in the 2006 Budget which have direct effect on the DMH's ability to meet Court-ordered requirements including:

- A waiver from Certificate of Need (CON) requirements for any hospital supporting the DMH's Acute Care Initiative and Council approval for seeking a State Plan Amendment (SPA) to allow rate increases for hospitals accepting involuntary patients.

- Language that requires DMH, CFSA and DYRS to contract for and authorize (via DMH) all residential placements for children and youth with emotional or mental disorders. The language also requires joint contracting for effective community alternatives to residential treatment centers.

- Transfer of funds from CFSA to DHM to pay for the local share of funding for mental health services for children under the jurisdiction of CFSA.

- Increase the DMH's school-based mental health program in order to expand into 15 new schools (an additional $1.3 million).

- Add $1.5 million to support jail diversion programs provide mental health services at the D.C. jail, and provide follow-up services for persons released from the D.C. jail.

- Support for a DMH initiative to provide Early and Easy out for individuals who meet early retirement eligibility. This will allow the DMH to reduce its workforce while maintaining the ability to hire critical positions as needed.

- Provide $2.5 million in local match to support the continuation of mental health services begun via the Congressional allocation for the foster care initiative.

- Provide replacement funds ($5.5 million) for lost Medicaid/Medicare due to the downsizing of St. Elizabeths. This will allow needed budgetary support at St. Elizabeths.

All of these initiatives represent strong and persuasive leadership by DMH – with the full support of the Mayor. The Chairman of the Health Committee for the D.C. Council has also been a visible and active force in the shaping of the overall 2006

DMH budget. This budget should enable DMH to move forward on multiple fronts – while also maintaining core funding in critical areas. The Court Monitor will continue to track the FY 2006 Budget through the Congressional approval process.

IV. Follow-up on Previously Identified Recommendations

A. CPEP

The reorganization of CPEP (as detailed in the January 2005 Report to the Court) continues – with apparent positive success. CPEP continues to be very active in the process of front-end triage for consumers in crisis. DMH indicates that admissions to St. Elizabeths for FY 2005 have decreased approximately 50% as compared to FY 2004. This is a direct result of the continued aggressive front end work done by CPEP and DMH Authority staff. CPEP has hired a new Director – an individual with strong crisis and community-based experience.

There now appears to be a solid plan in place to move CPEP to a rehabbed floor of the old D.C. General Hospital. Capital dollars ($4 million) to do the necessary rehab have been identified and it appears that all of the needed approvals for this relocation have been obtained. A detailed space plan has been developed that will involve expanded bed capacity for the Extended Observation Unit and much improved office and waiting space. The DMH indicates that the rehab should be completed before the end of calendar year 2005.

The Court Monitor is very pleased to see concrete progress as regards the CPEP site. After multiple previous efforts that did not materialize, it appears that this current plan is going to happen. It should provide CPEP with much more suitable space (in terms of design, furnishings, and functionality) with which to carry out its critical mission. The Court Monitor will continue to track developments in each Report to the Court.

B. Claims Processing and Payment

The January 2005 Report detailed and made recommendations for DMH to develop specific operating standards and performance reports for each of the major tasks in the process of adjudicating and paying claims. The Court Monitor – after several months of effort – has now obtained both DMH standards and initial performance measures. The two major standards involve 1) the percentage of "clean" claims that are received by the 10th of the month and are subsequently warranted for payment by the 30th of the month. The DMH has set this performance standard at 90% 2) the percentage of warrants that are paid within 17 days of receipt from Accounts Payable. This standard is also set at 90%.

DMH has provided the Court Monitor with performance data for the months of March, April, and May 2005. These data show that the DMH is clearly exceeding its standards for the warranting part of the process. These percentages went from 92% in March to 100% in May 2005. However, in terms of actual payment to providers, the percentages fall below the mark, but show steady improvement – ranging from 52% (April payments) to 60% (May payments) to 78% (June payments). The Court Monitor recognizes these data are very recent. Nevertheless, the goal is for DMH to analyze its performance (as against its own standards) as a tool to improve performance. Clearly, the payment part of the process lags; the reasons are not yet clear – at least to the Court Monitor. It is hoped that DMH will continue its efforts to look at the entire process (and each of the component steps) with the clear intent of improving processes and ultimate performance. As noted in this Report (and previous Reports to the Court), consistent performance in this area is critical to the overall success of DMH vis a vis the provider community. The Court Monitor will continue to track this whole process and report results to the Court.

V. Recommendations

Based on the findings in this Report, the Court Monitor makes the following recommendations:

A. The DMH should continue to analyze its performance for each of the steps in the claims processing system. Results and performance improvement efforts should be articulated internally and with the provider community.

B. The DMH should continue and intensify efforts toward a clear services and funding plan for FY 2006. This overall plan should articulate policy priorities, service changes and funding implications. As soon as practicable, the DMH should meet with individual providers to discuss key service and financial assumptions for FY 2006.

C. The DMH should continue its intensive efforts to ensure that St. Elizabeths meets the multiple Dixon objectives of providing quality care in a quality environment. The documented and specific efforts should be shared with the Court Monitor on a regular (monthly) basis.

D. The DMH should undertake a detailed review of the DC CSA. The review should identify the remaining issues as relates to costs (variable and fixed), organizational/governance structure, revenue, and the inherent costs associated with its safety net role. This review should articulate future performance objectives and identify remaining issues (and options) for future actions.