UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

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

COURT MONITOR'S NOTICE OF SUBMISSION OF REPORT

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

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that copies of the foregoing COURT MONITOR'S NOTICE OF SUBMISSION OF REPORT and the Court Monitor's REPORT TO THE COURT were served by first class mail, postage prepaid, this 24th day of July 2006 upon:

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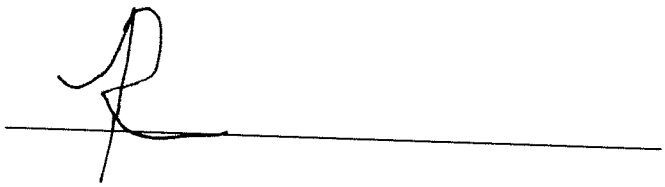

REPORT TO THE COURT

Court Monitor
Dennis R. Jones

July 24, 2006

Executive Summary

The eighth monitoring Report to the Court shows progress on several fronts but with many of the same issues dominating the agenda as in previous Reports to the Court. The following is a summary of the major areas:

1. Implementation of Exit Criteria

   The Court Monitor and DMH staff have been working collaboratively to put in place a verified process to collect and record data on the seventeen (17) Exit Criteria that require quantitative measures. As of this Report, data methods have been validated for 15 of the 17 measures and with first-time reporting of performance for 14 of the 17 measures. The next steps are to validate (audit) the numbers before any recommendations are made to the Court regarding compliance or non compliance with the performance levels agreed upon by the parties.

2. Comprehensive Psychiatric Emergency Program (CPEP)

   The DMH has developed an aggressive plan – per the January 2006 Report – to provide for an adequate physical location for CPEP. Until very recently, the plan was to upgrade the current location – lacking any viable Hospital-based alternatives. However, the option of a stand alone building at Greater Southeast Hospital has again opened up as a possibility. There are multiple advantages to the Greater Southeast site. The key will be to move as quickly as possible on this long overdue issue.

3. St. Elizabeths

   The two major issues at St. Elizabeths continue – namely the timely construction of the new 292-bed Hospital and the Authority's oversight and support of quality of care issues.

   As relates to the new Hospital, progress has clearly been demonstrated. The District has gone to bid for the construction of the new Hospital – with anticipated selection of the contractor in October, 2006. Assuming timely approval by the District Council, the 30 month construction phase will begin – with targeted occupancy in the spring of 2009. These timelines – already 3 years behind schedule – cannot slip any further. The quality of care concerns have been heightened by the release of the (DOJ) Department of Justice Report in May 2006. This report outlined a broad array of patient care issues, including problems with the physical plant and environment. The DMH is developing a plan to address the DOJ recommendations – many of which are consistent with the recommendations made by Dr. Richard Fields. The Court Monitor believes that DMH should organize an Authority-based team to deal with the multiple issues at play. This team needs clarity and urgency – working to intersect with the leadership efforts at St. Elizabeths.

4. Budgetary/Provider Payment Issues

Unfortunately, provider payment issues have continued to dominate the landscape with inordinate amounts of time and effort being spent by DMH leadership, the Mayor's office, District Council, providers, and the Court itself.

It would appear that progress has been made to resolve some of the major issues –mainly the outstanding claims for 2005 and the 2006 residential claims. The parties are negotiating the terms of a consent order regarding the remaining FY 05 claims. In addition, DMH is current through June 30, 2006 in payments to residential providers. With respect to FY 2006 MHRS services, DMH has developed a multi-faceted short-term strategy to expedite claims and work more collaboratively with providers to process and pay claims.

The KPMG has finished its Phase 2 report to the District. It contains numerous recommendations that impact planning, policy, structural design and organizational capacity to put a vastly improved system in place. The DMH - in conjunction with the District - needs to identify short term strategies (e.g. stabilization of the current system) at the same time that it seeks longer term fixes.

5. DC CSA

The District-run CSA is its largest provider – serving some 39% of all consumers. Despite major improvements over the past five years, it still does not represent a viable business entity. This is largely driven by its high cost structure and its limited capacity to improve productivity. The time has come to deal with alternative governance options outside of DC government. The Court Monitor recommends an independent review with recommended options back to DMH and the District.

6. Acute care beds

The new 20-bed unit at Greater Southeast has been renovated but still not occupied due to necessary DOH certifications and a final agreement with DMH. This unit – and the renovation of another 20 bed unit – are key to the DMH being able to provide most of its acute care outside of St. Elizabeths. Given all of the demands on St. Elizabeths, it is critical that this component move forward in a timely way.

In sum, it is clear that the same issues that have been reported in previous Reports to the Court still remain. Discernible progress has been incremental. Perhaps the most positive development is the approach of the new DMH Director. His tack has been to openly identify problem areas and seek consensus and support for solutions. The leadership task can be overwhelming – given the multiplicity of issues. The key will be to create a leadership team with realistic goals for both short term tasks and longer term redesign. This will take well – defined planning strategies, District support, and active engagement by the multiple stakeholders in the process.

I. Current Situation

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

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

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

C. Monitoring the occurrence of events which may significantly impact the implementation of the Court-ordered Plan and/or the achievement of the required performance levels for the Exit Criteria.

This Report provides updates on the status of each of the above-identified areas, highlights any barriers to progress, and makes recommendations for future actions.

The May 23, 2002 Court-approved Consent Order requires a Monitoring Report to the Court twice per year. This is the eighth formal Monitoring Report.

II. Findings Regarding Exit Criteria

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

This Report utilizes the format that was introduced in the January, 2006 Report to the Court. However in addition to the requisite development of policy and practice data verification, this Report also includes – for the first data – actual baseline data in all categories except two. A beginning analysis of this data – and its current verification status – is discussed in II C.

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

The DMH continues to contract with the Consumer Action Network (CAN) to conduct three different consumer satisfaction measures. These measures were all completed in 2005 and the findings were included in a February 2006 Report on Consumer/Family Member Perceptions of Mental Health Services. This Report summarizes the results of these three including 1) A convenience sampling survey

– targeting the level of understanding that consumers, families and staff have of the recovery model. 2) Focus groups – to understand for both adults and children the current level of satisfaction with services and recommendations for improvements; and 3) telephone satisfaction survey – a randomized survey of 1026 (complete surveys) to determine levels of satisfaction with services received.

From these various satisfaction methods the CAN Report identifies consistent themes in the mental health system's strengths and weaknesses. Included in these are: 1) Housing – the lack of access to affordable housing that is able to meet the unique needs of consumers. 2) Appropriate services – the inability to provide consistent individualized consumer-driven care. The issues of consumers having meaningful choices in their treatment and housing also came up as a consistent concern. 3) Access to information – the lack of coherent and acute information about mental health services and also other related services.

The Report made a series of recommendations in each of the identified areas. While some of these are broad in scope, it would seem that others could be translated into concrete ways to improve the system in the shorter term. It should also be noted that the DMH will again be conducting the annual MHSIP telephone survey in September 2006. The results of this survey will also be provided to the Quality Council for review and recommendation.

This Report has been referred on to the DMH Quality Council for review and potential action steps. The Quality Council has reviewed the CAN Report and made a series of recommendations as of a June 14 memo to the DMH Director. The Council recommended that issues of housing should be a top priority. The Court Monitor has expressed the view that the DMH – both directly and via contract – has developed the required methods to measure consumer satisfaction. The key issue that remains is to demonstrate (per the approved Exit Criteria) that "the consumer satisfaction data is being considered and utilized as appropriate to improve the availability and quality of care". As relates to consumer functioning method(s), the DMH has continued to mandate that providers complete the LOCUS instrument for adults and the CALOCUS for children/youth. However, the DMH has still not aggregated this data electronically. The principal reason appears to be that the limited information systems staff time has been spent on higher priority projects (e.g. provider billing issues). It is not clear when this project will get attention. From the Court Monitor's stand point, the same issue applies here as to consumer satisfaction; the LOCUS/CALOCUS is an acceptable method for measuring consumer functioning, but it is the demonstrated utilization of the data that still remains.

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

1. Summary of Child/Youth Findings

The overall sample was pulled from those children/youth who received a billed service between June 1 and October 31, 2005. The total pool for this survey was 1405 children/youth who were served by some 18 different agencies. The total sample of 162 cases was drawn proportionally from the child-serving agencies – with nine primary agencies included. The target for cases to be reviewed in depth was 54 (as in previous reviews). However, after attrition due to unforeseen cancellations, etc. the actual number of cases reviewed was 48. The review occurred during a 2-week period in late April, 2006. The child/youth cases are always the most difficult to coordinate – due to the major tasks of obtaining consent and coordinating multiple interviews, schedules, etc. Thanks to the diligent efforts of the Consumer Action Network (CAN), DMH staff and HSO staff, this child/youth review went more smoothly than any reviews to-date.

The results of year 4 for child/youth status were 81% in the acceptable range. This compares favorably to year 3 reviews which showed an overall child/youth status of 73% in the acceptable range. (Note: an acceptable case is 4 or higher on a 6 point scale). The child/youth status showed some very positive elements e.g. safety of the child at 85% and home and school placement at 92%. However, other measurement areas – as in previous years – scored low e.g. academic status at 53% and responsible social behavior at 58%. The Dixon Exit Criteria measures system performance. For year 4, the aggregate acceptable system performance was 54%. This compares to 47% in Year 3 and 43% in Year 2. This shows modest but incremental improvement in overall systems performance. The same strengths and weaknesses that were identified in previous reviews were again evident. Strengths include child and Family engagement (83%), culturally appropriate practice (94%), and functional assessment (79%). Weaknesses continue to be in areas of service team functioning (40%), individual resiliency plan (46%) and long-term guiding view (40%).

In general, the child/youth scores are not progressing as hoped. There are multiple contextual issues which continue to overshadow quality of care concerns. These have to do with ongoing delays in payment, authorization barriers and budget reductions for some child-serving agencies. There are also the continued perceived conflicts between the clinical practice model and the financial model (which puts a high premium on billable hours). While this tension is inevitable in any developing system, it does not appear that an appropriate balance has been reached. The HSO report summarizes the current status nicely (HSO Child/Youth Report p. 54): "Essentially the system change process has reached a plateau and the consistency in quality of services is not improving significantly". Until these issues are resolved (i.e. issues of process, payment, capacity,

workload and communication), "it is unlikely that this review and measurement process will find improved results and consistency." The report further suggests that now is an appropriate time to assess the overall use of HSO resources – with an eye to how to move the system forward more forcefully. The Court Monitor agrees with this assessment and will be facilitating conversations with Dr. Ivor Groves and Steve Baron, the new DMH Director. The DMH Director is in agreement that the major issue is stabilizing payment issues to allow greater focus on quality of care.

2. Summary of Adult Findings

The adult sampling process is consistent with that for child/youth. The review was completed during a 2-week period in February-March 2006. The total number of cases reviewed was 51 – with slightly over half reviewed by HSO external reviewers and the remainder by trained staff or DMH-assigned representatives.

Year 4 showed that 65% of the consumers were in the acceptable range for overall consumer status. This is very consistent with Year 3 results, which were 67%. Higher scores were evident in satisfaction with services (85%), safety (73%) and living arrangements (75%). Low scores showed up in numerous measures including: social network (39%), work (32%) and recovery activities (42%).

The Systems performance score – the Dixon measurement – was 69% for year 4. This shows a significant jump from year 3 which was at 51%. In general, the reviewers noted an improvement in the awareness and use of a recovery model by CSA's and improvement by many case managers – particularly in seeing consumers outside of offices and being available beyond typical office hours.

There were many areas noted for improvement including: 1) the need to develop longer-range natural supports for consumers, 2) the need for more work development – especially for consumers under age 40, 3) the need for continued focus on services access for persons with co-occurring mental illness and substance abuse, and 4) the same issues of delayed payment and lack of "flex" funds with which to do a full recovery model.

In general, the child/youth and adult reviews show some incremental progress. Clearly the systems of care philosophy has permeated the system to a much greater degree and this shows at the practice level. However, there is an overriding need to step back and look critically at how to help move the system toward greater focus on quality. Clearly, the ongoing payment instability has to be resolved. Beyond that, the new Director will have an opportunity to shape the role and priorities of the DMH Authority. It is hoped

that this new focus will include greater capacity to use, train, and reinforce the CSR model in more dynamic ways.

C. Implementation of Court-approved Performance Criteria

The January 2006 Report to the Court outlined the overall status of measuring and validating the nineteen (19) different Exit Criteria. This Report takes the status to a new level, in that it reports for the first time the actual performance levels of 16 of the 19 Exit Criteria.

Table 1
Exit Criteria
Current Status

July 2006

Exit Criteria	Policy in Place	Data Methods in Place	DMH Validated Data Methodology	Court Monitor Validated Data Methodology	Court Required Performance Level	Current Performance Level (Unverified)
1. Consumer Satisfaction Method(s)	Yes	N.A.	N.A.	N.A.	Methods + Demonstrated Utilization of Results	Methods Completed. Utilization in Process
2. Consumer Functioning Method(s)	Yes	N.A.	N.A.	N.A.	Methods + Demonstrated Utilization of Results	Methods Completed. Utilization in Process
3. Consumer Reviews (Adult)	Yes	Yes	Yes	Yes	80% for Systems Performance	69%
4. Consumer Reviews (C/Y)	Yes	Yes	Yes	Yes	80% for Systems Performance	54%
5. Penetration (C/Y 0-17 Years)	Yes	Yes	Yes	Yes	5%	2.16%
6. Penetration (C/Y with SED)	Yes	Yes	Yes	Yes	3%	1.15%
7. Penetration (Adults 18 + Years)	Yes	Yes	Yes	Yes	3%	1.96%
8. Penetration (Adults with SMI)	Yes	Yes	Yes	Yes	2%	1.62%

9. Supported Housing	Yes	Yes	Yes	Yes	70% Served Within 45 Days	53.56%
10. Supported Employment	Yes	Yes	Yes	Yes	70% Served Within 120 Days	76.78%
11. Assertive Community Treatment	In process Target: 8/31/06	Yes	Target: 8/31/06	Target: 9/30/06	85% Served Within 45 Days	Target: 12/1/06
12. Newer - Generation Medications	Yes	Yes	Yes	Yes	70% with Diagnosis of Schizophrenia	69.29%
13. Homeless (Adults)	Yes	Yes	Yes	Yes	150 Served + Comprehensive Strategy	331
14. C/Y in Natural Setting	Yes	Yes	Yes	Yes	75% of SED With Service in Natural Setting	64.52%
15. C/Y in own (or surrogate) home	Yes	Yes	Yes	Yes	85% of SED in Own Home or Surrogate Home	64.52%
16. Homeless C/Y	Yes	Yes	Yes	Yes	100 Served + Comprehensive Strategy	Target: 12/1/06
17. Continuity of Care a. Adults b. C/Y	Yes	In Process Target: 7/31/06	In Process Target: 8/31/06	Target: 9/30/06	80% of Inpatient Discharges Seen Within 7 Days	Target: 12/1/06
18. Community Resources	Yes	Yes	Yes	Yes	60% of DMH Expenses for Community Services	59%
19. Medicaid Utilization	Yes	Yes	Yes	Yes	49% of MHRS Billings Paid by Medicaid	30%

It is evident from a review of Table 1 that DMH has done considerable work since the January 2006 Report in developing and implementing a data collection and process validation system. DMH has designed a process by which each Exit Criteria will be generated in a systematic way. Constructing the data methodology involved:

1. Identifying a methodology for calculating each metric related to the exit criteria
2. Specifying data sources

3. Detailing a data collection process
4. Creating a data dictionary with definitions for each metric
5. Listing training requirements and resources, including user manuals where available
6. Designating a quality assurance process that will be used to assure that the data are collected accurately and are analyzed appropriately.

In review of Table 1, all of the policies are in place except for ACT, which requires a formal rule change. DMH indicates it expects to complete this process by September 2006. Basic data methods are in place for all the criteria except for continuity of care. This data piece is complicated by the fact that the local acute care hospitals that treat DMH patients need to be full participants in this data collection process. Three of the 17 data elements that require quantitive measures are still in process. Continuity of care (#17) awaits working out the data collection process as noted above. The ACT data system was recently put in place; the target date for actual data on the missing data elements is October 2006.

It is important to note that the current performance levels are enumerated but are untested except for the Consumer Service Reviews (#'s 3&4). Though not verified, it is interesting to note that DMH data indicate they are above or near compliance on several measures.

The next step is to conduct a structured review of the process steps to determine if the resulting calculations are correct. To validate the data collection and analysis processes, the Court Monitor will:

1. Review each step in the specified data collection method for each metric
2. Observe the calculation of the metric and assure its accurate construction
3. Verify that the collection process is actual as stated in the data methodology
4. Confirm that staff are trained in data collection
5. Determine that the quality assurance process associated with the metric is in fact being followed and results in accurate metric calculations.

If any exceptions to the data methodology are found, the Court Monitor will request that DMH resolve the issues within a given timeframe. Once he is notified of the resolution, he will repeat a structured review (as detailed above) of the exit criteria. In addition, the Court Monitor will be meeting with providers and advocates to discuss the preliminary data, data sources and validation methods.

It is important to note that DMH has an internal data project team that meets every week. This team has been very diligent in working through the multiple issues for each metric. The Court Monitor has engaged an outside consultant who has reviewed the internal DMH data methods and made suggestions for refinement. In all cases, the DMH staff has been very receptive to these

recommendations. Hence, there is now an orderly and cooperative process in place.

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 organizational responsibility for quality improvement and provider oversight continues to be placed in the Office of Accountability (OA). The OA staff carries direct responsibility for the functions related to certification, licensure, policy development, and quality improvement. The OA Director role is being filled on an interim basis since the previous Director left in early 2006. The new DMH Director is recruiting for this key leadership position, but is also evaluating other ways to reorganize OA functions.

a. Division of Certification (DOC)

Since August 2005, the DOC has certified seventeen (17) new providers and recertified five (5) existing providers. There were thirteen (13) core service agencies that were either certified as new or recertified. The remainder of the providers certified were either as sub providers or specialty providers. There was also certification of one Residential Treatment Center (RTC) during FY 2006. During the past six months, there were 34 investigations of complaints which appear somewhat lower than previous years. The DOC has also begun participating in on-site claims audits since that function was transferred to OA. It is also significant to note that the DOC – as of March 1, 2006 – placed a moratorium on any new applications to become a MHRS provider. This was done with the knowledge that DMH already has 51 certified providers and another 13 applications before the March 1 cutoff. The intent is to conduct an overall assessment of community needs and provider capacity before any additional MHRS applications are permitted.

b. Division of Licensing (DOL)

Since October of 2005, the DOL has completed 310 license inspections of Mental Health Community Residence Facilities (MHCRF's). They have granted 75 renewals to date and 5 initial licenses. It is noteworthy that during this period there have been 19 investigations. During calendar year 2005, there were 20 CRF closures – primarily for financial or other business-related reasons.

c. Policy Support Division

The Policy Support Division continues to be very active in the development and coordination of new DMH policies. The policy development process often has significant involvement of attorneys, DMH managers and local providers. Among the major policies developed during FY 2006 are ones regarding major and unusual incident reporting procedures, mandatory drug and alcohol testing policy, and continuity of care guidelines for both adults and child/youth. The MUI reporting policy changes came as a direct result of recommendations provided by the quality council. DMH staff indicates there have been at least eight (8) major policies under development or issued in FY 2006.

d. Division of Quality Improvement (DQI)

The DQI, beginning in December 2005, assumed the primary responsibility for auditing claims of certified providers. The function was previously performed by the DMH internal auditor. The claims audit function involves an onsite audit of each new provider and then desk audits of provider claims on a quarterly basis. Audit results (together with any corrective action) are given to individual providers and appropriate DMH staff.

The DQI also implemented during this period a formal mortality review of consumer deaths. The DMH has re-established a formal workgroup to review the mortality report and review death determination reports. This DMH workgroup (which is composed of representatives from multiple DMH divisions) intends to provide quarterly reports to the clinical directors of provider agencies.

The DQI Director position has been vacant for some time. Despite this fact, the OA Director continued to support the DMH Quality Council. The Council is composed of provider representatives as well as DMH staff. The Council has formed two subcommittees – one on outcomes and one on utilization system-wide. Each subcommittee meets monthly and the full council meets quarterly. The Outcomes Subcommittee has included in its priorities the task of reviewing the DMH Satisfaction Survey. As noted in II A, this process of review and utilization of consumer satisfaction data will be a key component of the Court Monitor's review.

Overall, it appears that the Office of Accountability continues to carry out its key functions. Key vacancies (especially that of the OA Director) will be critical to fill as soon as possible. This leadership

position is vital to the overall ability of the DMH to carry out its mandates under the Court-ordered Plan.

2. Consumer and Family Affairs

The Office of Consumer and Family Affairs (OCFA) has continued to make important strides to create a true "consumer driven" system as envisioned in the Court-ordered Plan. In addition to its formal role of overseeing the grievance process and Periodic Psychiatric Evaluations (PRE's), the OCFA has a critical role in engaging consumers, modeling consumer-focused services and helping to shape DMH policy and practice. The following are examples of OCFA activities that demonstrate these efforts:

- Sponsored a three part Recovery Day Series for consumers focusing on recovery and employment – with over 221 in attendance.

- Deployed 15 consumers who were trained as Peer Specialists to provide off-hours activities at St. Elizabeths.

- Planned and coordinated a seminar for consumers, case managers, and families on the new Medicare Part D Prescription Drug program. Established a hotline at DMH to answer questions on Part D.

- Coordinated the peer specialist certification program to create new professional work opportunities for consumers. This program involves formal training plus an internship and exam. Ten consumers have completed the internship. The DMH is also evaluating other peer specialist training models from across the country.

- Created a Job Fair Committee and conducted a Job Fair for mental health consumers at the Disabled American Veterans Conference Center.

- Employed and contracted with over 13 consumers to work at DMH – performing various duties in different departments at hourly rates exceeding minimum wage.

- Established a work group to implement WRAP at St. Elizabeths

- Created an Advisory Council of 15 consumers and family members to assist in the resolution of any grievances against the DMH Authority and also to advise the OCFA Director.

- Conducted and trained consumers to do the annual MHSIP Federally-required survey on consumer satisfaction.

- Represented DMH on the mayoral task force to end homelessness.

It appears to the Court Monitor that the OCFA has not only worked to give consumers voice, but has also taken a leadership role in creating real opportunities for consumers. The emphasis on "real pay for real work" is not lost. While the peer specialist is still new (and small in numbers) it is exactly the kind of opportunity that some consumers want and need. The key will be for the provider community to embrace this concept as an important element of an overall recovery philosophy. It is also hoped that the DMH will explore ways to include peer specialist services as an eligible service under MHRS. These are the kinds of specific things that will add meaning and impetus to the overall consumer-driven efforts.

3. Enforcement of Consumer Rights

The OCFA continues to have organizational responsibility for all consumer grievances. The final consumer Grievance Procedure rule has been in place since October 2003. As of April 2006, there was a cumulative total of 125 grievances that had been received since the inception of the program. Of that number, 85 were filed between April, 1, 2005 and March 31, 2006. This represented a significant increase over the prior year (28 grievances). This increase might well be explainable by the fact that the grievance process has matured and consumers are more likely to know about and utilize the grievance system as a way to resolve concerns. Of the 125 total grievances, 107 of those were resolved at the local level; eighteen (18) went to an "external" review process at the DMH Authority level. Twelve (12) of the eighteen (18) consumers chose to go through the mediation process – one of the options available to consumers.

The OCFA continues to be active in providing training regarding the grievance rule and process to both providers and consumers directly. The OCFA has made some progress in the design and implementation of its computerized data management system. The contract with Calhoun Computer Services has resulted in a web-based Data Entry and Response function – which is now completed and being fully implemented. OCFA is providing hands-on training to all of the local grievance managers about the new data reporting requirements. The next phase of the data management project is the External Review and Reporting function – for which the

design is to be completed by summer of 2006. The data management system has been slow in coming but now appears to be close to reality.

The OCFA also continues to track complaints – which are typically less serious matters that can be resolved without extensive review. There were 80 complaints for the period of April 1, 2005 to March 31, 2006. This compares to 57 complaints for the same period in the previous year. It is important to note that the DMH still does not have an integrated process (across divisions) for tracking complaints. It would appear that most consumer complaints go to OCFA while other complaints (e.g. certifications-related) go to the Office of Accountability. In any event, the DMH is aware that it needs an integrated process in order to collect accurate data, track trends and effect meaningful systems follow-up.

The OCFA also continues to monitor the system in terms of the timely performance of Periodic Psychiatric Exams (PRE's). The DMH's compliance in this regard was highlighted in an April 2005 audit report done by the D.C. Office of the Inspector General – which found that there was not adequate tracking of the 90 day examination requirement for all involuntarily committed patients. Since that time, OCFA staff has been working consistently with providers to ensure compliance. The DMH completes a compliance report each month, broken down by agency and compliance level. As of this Report, only one CSA is not meeting the 80% minimum compliance threshold.

It is also noteworthy that the number of committed persons in the system has dropped from 568 to approximately 125. Given that most of these were out patient commitments, this drop may simply reflect the reality that most consumers no longer meet the legal standard for commitment. However, it is not clear as to the full reasons for this significant conversion to voluntary status. This issue bears watching given the Superior Court's concern about recidivism and premature movement from involuntary to voluntary status.

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 continues to articulate and implement a systems of care philosophy for adults. The systems of care concept relies heavily on the belief that persons with serious mental illness (who come with multiple life needs) can only access the necessary human delivery services if those systems actively collaborate to remove barriers. Research is clear that collaboration at the individual service level is

very difficult unless there is strong inter-agency work at the systems level.

In addition to the work in housing, employment and Assertive Community Treatment (ACT) – as detailed below, the DMH has also continued to work on other critical cross agency services, which include:

- Jail Diversion – The DMH Jail Diversion Program initiative (DC Linkage Plus) was developed in FY2006 in an attempt to engage and connect individuals with severe mental illness who come in contact with the criminal justice system to mental health services. The program is managed by the Forensic Coordinator in the Office of Programs and Policy. Services focus on pre-booking, post-booking and continuity of care for inmates with mental illness leaving the DC jail and returning from the Bureau of Prisons. In addition, N Street Village provides a 21 bed substance abuse treatment and housing program to women referred pre and post arrest for services. In July 2005, DMH began an outpatient competency restoration training program in conjunction with DC Community Services Agency and St. Elizabeths Hospital Forensic Legal Services that provides competency restoration training in the least restrictive environment. Provision of these services reduces the utilization of inpatient hospital beds for competency evaluations DMH is working closely with criminal justice agencies to strengthen cooperation in providing services to individuals in the criminal justice system. The Homeless Outreach Program (HOP) contributes to this effort through their involvement at the pre-booking stage of the program.

  DMH has introduced to the Metropolitan Police Department (MPD) the need to implement a proven program to train MPD officers on how best to respond to calls involving individuals with a psychiatric illness. Successful programs in other jurisdictions have shown decreases in officer injury, civilian injuries, police downtime and unnecessary incarceration of individuals with a mental illness. DMH arranged for Major Sam Cochrane from the nationally acclaimed Memphis Police Department's Crisis Intervention Teams (CIT) to meet with Chief Ramsey and his senior staff. The initial meeting was very well received by Chief Ramsey. In addition, DMH is working with the DC Criminal Justice Coordinating Council as they implement a contract with Georgetown's Department of Psychiatry to do a gap analysis of the mental health/criminal justice system.

- The Homeless Outreach Program - The HOP (in addition to Jail Diversion) provides a wide array of services through its ten member team to persons with mental illnesses in shelters or on the streets. This ongoing effort involves assessments, referrals, traveler's assistance and brief intervention.

- Interagency Initiative with Mental Retardation and Development Disabilities Administration (MRDDA) – The DMH and MRDDA have entered into an agreement that is intended to target services for individuals who are both mentally ill and mentally retarded. This pilot project now has 61 individuals and a specific ACT Team to deal with this population.

- Interagency Initiative with the Addiction Prevention and Recovery Administration (APRA) – As a part of its overall efforts to impact persons with co-occurring disorders (mental illness and substance abuse), DMH is actively involved on several fronts with APRA. The Co-occurring Systems Change Initiative Grant (COSIG) was awarded by SAMHSA in September 2005. The ultimate goal of this grant is to create a service system that integrates assessment and treatment for persons with co-occurring disorders. In the near term, the DMH is mandated under the 2006 Budget Support Act to make available $900,000 in substance abuse vouchers to APRA-certified providers under the Choice In Drug Treatment Program and an additional $100,000 for mental health services at the detoxification center. The DMH and APRA are hoping to utilize this mandate to strengthen interagency collaboration.

All of these examples suggest an ongoing commitment to develop true systems of care for adults. It is the strength and depth of these interagency efforts that will ultimately make the difference. Many of these efforts are relatively new and hence it is too early to assess their full impact. However, it does appear that DMH leadership is strongly committed to finding new and effective ways to grow partnerships.

b. Housing Capability

The DMH continues its efforts to provide adequate, affordable and timely supported housing to individuals with serious mental illness.

It is clearly an uphill struggle given the cuts in Federal housing dollars and the high cost of rental units in the District.

The DMH sites the following among the positive developments the past year:

- Finalizing the Housing Business Plan with financing strategies for over 200 new affordable housing units
- Ongoing work with developers and land lords to identify sites for affordable housing for DMH consumers.
- Providing housing options to over 1000 DMH consumers utilizing local and federal subsidies.
- Accessed 85 of the 108 project-based Federal subsides available through the HUD Partnerships affordable Housing Program.
- Opened 32 new single room occupancy (SRO) housing units.
- Expedited the placement of over 125 indigent consumers at St. Elizabeths into community housing utilization bridge funding dollars.
- Worked with over 127 licensed community Residential Facilities (CRF's) who provide supervised settings for over 700 individuals. It is noteworthy that in calendar year 2005 22 CRF's closed and the majority of persons moved into less restrictive housing.

All of these efforts are commendable. However, there are many barriers still to be overcome if the District is to reach its goal of adequate and affordable housing for persons with serious mental illness. Housing affordability is a serious issue. The current SSI payment is $603 per month; this represents the total income for most DMH consumers with serious mental illness. At this level, most consumers cannot afford to rent even a modest efficiency apartment. Hence, the pressure on DMH housing subsidies grows. Compounding this pressure is staff concern that the FY 2007 DMH budget will mean a cut of 1.2 million in housing subsidies – which will translate into a loss of approximately 125 housing subsidy slots. There is also a parallel reduction in capital funding for new housing development – with a targeted cut of $3.5 million. With only $2 million in capital funds, DMH estimates that it will only be able to produce 40-50 new units – versus the original goal of 300 new units.

The Federal housing cuts are also having a very negative impact locally. The D.C. Housing Authority is considering closing off its waiting list for public housing due to the fact it is now at 28,000 and

growing. They are simply unable to support enough low income housing to meet the community's needs. There are also 37,000 persons (according to the D.C. Housing Authority) who are waiting for a Housing Choice Voucher. It is small wonder, then, that it is very difficult for DMH consumers to access the Housing Choice Voucher Program (HCVP) - which could provide consumers with longer term housing subsidies. The lack of access to this Federal program puts undue burden on local subsides via the DMH budget. The previously promised 500 slots for DMH consumers did not materialize – apparently because the timelines for this project could not be met. Recently the DCHA Director has indicated an interest in revisiting this initiative. DMH officials will meet with the DCHA Director to pursue this and any other housing options.

All of this suggests that the housing crisis is likely to grow and it will continue to disproportionately impact persons with serious mental illness who are almost always indigent. It is time – with new DMH leadership – to critically look at issues of DMH access to the Housing Choice Vouchers Program. It will also be incumbent on DMH to advocate in its 2007 budget to protect its existing subsidy program. There may well be other creative solutions to the housing dilemma that will need to be explored in the year ahead.

c. Supported Employment Capability

The DMH has continued to evolve its supported employment program. During the past year the DMH has finalized its supported employment policy and also developed a memorandum of understanding (MOU) with the DC Rehabilitation Services Administration. The DMH has continued its participation in the Dartmouth/Johnson and Johnson Evidence-Based Practice Project, which continues to provide consultation on the supported employment project.

The DMH continues to contract with six (6) providers who during the past year provided services to 388 consumers. The DMH would like to add an additional provider and diversify its services for transition-age youth.

While DMH data indicates that it is exceeding the Court-approved target (see IIC) there remains a serious underlying question as to whether supported employment is truly known and available to both consumers and referring providers. On the face of it, 388 consumers out of 8715 active adult consumers is a low percentage by any reasonable measure. This is particularly true given that employment is one of the areas consumers most often discuss as an unmet system

need. DMH staff argue that these numbers are comparable to other states who are participating in the Dartmouth project. Hence, the overall issue of system capacity, knowledge of the program, referral patterns, and consumer choice will need to be explored in the months ahead before Court compliance can be determined.

d. Assertive Community Treatment (ACT) Services

The ACT program is very much in a state of review from an overall DMH standpoint. An ACT coordinator was finally identified in February 2006. This person, an experienced member of the Access/Care Coordinator Team is working hard to get a handle on the various aspects of the ACT program overall. The issues that have been raised in previous Court Monitor Reports are now very much in play – namely overall ACT capacity, under-referral to ACT teams, questions of fidelity to the ACT model and apparent lack of transfer out of ACT for individuals who no longer need this level of service. The preliminary analysis, for example, shows that there is a current enrollment in ACT of 397 consumers; this compares unfavorably to an overall caseload of 495 in July 2003. This drop in numbers served is in spite of the fact that there are more Act Teams now (7.5) than there were in July 2003 (6.0). It would appear there is significant under utilization/under referrals to ACT teams – with an estimated referral rate of 4-5 per month. The reasons are not clear, although DMH staff speculate that part of the answer may be the misperception by community providers that ACT teams are at full capacity. In fact, quite the opposite is true – with an estimated overall capacity of 617 persons – versus the 397 currently enrolled. The DMH indicates that one of the structural barriers to clients accessing ACT services has been the requirement that for those ACT providers that are specialty providers in the DMH network a Core Service Agency (CSA) must do an assessment, enroll the client and make the referral. A number of clients eligible for ACT are not able to handle these requirements. DMH's MHRS committee is currently addressing this issue and plans to recommend changes that will allow ACT specialty providers to directly admit clients.

The DMH acknowledges that there are many basic issues that it does not currently have a handle on. The ACT coordinator intends to put together a work plan aimed at addressing all of these issues. As noted in previous Reports to the Court, the DMH still does not have a final ACT policy in place-given that this will require an official change in MHRS rules and hence a change in the State Medicaid Plan. While these delays are of concern, the timing may now be good in that the new DMH Director has considerable experience

with ACT and definite ideas as to how to improve the overall program – including the issue of payment for ACT services.

In sum, the multiple historic issues for ACT remain. The point of encouragement is that these issues are being addressed in a frontal way. The Court Monitor would encourage this process to move as quickly as possible but also in a very transparent way. It has been suggested, for example, that an ACT Advisory Board be appointed to help advise on critical issues. The DMH staff appear open to this option – with strong agreement that there needs to be a process that involves consumers, advocates and providers in the analysis and revamping of this critical service area.

2. Review of Child/Youth Systems of Care Development

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

   One of the most significant events in terms of the child/youth systems of care development has been the changes relative to the federal SAMHSA systems of care grant – DC Children Inspired Now Gain Strength (CINGS). As a result of multiple discussions within the District and with SAMHSA, it was agreed that DMH would not reapply for year 5 of this 6-year grant. Instead, the District would use the next 18 months to create a different structure for managing and integrating systems of care – hopefully then reapplying for federal funding in 2008.

   One of the key elements of the new structure is to move the overall leadership for systems of care development to the office of the Deputy Mayor for Children, Youth, Families and Elders. The Executive Committee of this Interagency Collaboration is chaired by the Deputy Major – with the Director of all District child-serving agencies at the table. While this interagency structure has existed for several years, it has now been formalized and given visible importance under the Deputy Mayors leadership. The five guiding principles include:

   1) One family = one plan. The family team meeting model will replace the current agency-level decision-making process.

   2) A coordinated structure will support coordinated outcomes.

   3) Healthy tension among providers, agencies and community members will drive change.

4) Evidence will drive implementation and practice.

5) All services will utilize the concept of community services first before more restrictive services are provided.

As a part of this reconfiguration, SAMHSA agreed to let the District use carryover funds from the grant to support infrastructure-building activities. SAMHSA also agreed to provide technical assistance via the Technical Assistance Partnership (TAP). As a result of all of these discussions, the new structure was officially transitioned in January 2006 – with the Deputy Mayors office now in a lead role. The underlying assumption is that the Deputy Mayor will have a much stronger voice in providing the needed cross-agency collaboration that is critical to a systems of care model.

b. School-based Services

The School Mental Health Program (SMHP) continues to be a vital part of the overall child/youth program in the District. The SMHP continues to operate directly as a part of the DMH Authority.

It provides an array of prevention clinical services in 29 different schools in the District – with active plans to serve one additional school. These include 20 DC PS schools and 10 charter schools. For the most current school year, SMHP saw 458 students who were formally referred and 2544 who were seen on a "walk-in" basis. In addition, SMHP staff provided 1,510 consultations to parents, 4,446 consultations to teachers and staff and conducted 116 in service training sensors for school staff. All of these numbers represent growth from the previous year and indicate that the SMHP is very actively utilized by the schools in which it operates.

The SMHP recently completed a SMHP Progress Report for the five years of its existence (2000-2005). It is a comprehensive and detailed review of all elements of the program –services, partnership, results and future planning. Perhaps most impressive in this Report is the attention to a critical evaluation of the outcomes of this program. It attempts to measure, for example behavioral outcomes (e.g. truancy, suspensions, school climate, and drop out rates) as well as satisfaction measures by principals. While each of these represents difficult evaluative areas it is unique to find this level of outcomes – oriented focus. SMHP leadership indicate that a full time evaluator has been hired – which should strengthen capacity going forward. The overall evidence is clear that "school-based mental health

services can effectively enhance supportive and coping mechanisms, thereby mitigating the effects of these extreme stressors on the lives of D.C. youth" (Progress Report, p.15).

For the future, the District Council has funded this program to allow expansions into 11 additional schools in FY 2006. This will include 9 DCPS schools and 2 charter schools. This will put the total number of schools impacted at 41- out of a total of 199 schools (147 DCPS and 52 charters). Hence it is clear that if the goal is to have school-based mental health in all schools (or even all of the neediest schools) there is a long way to go. It would appear that now is the time to reevaluate organizational and financing strategies to achieve sustained growth for this program. The placement of this unit at the Authority (which is not itself a provider) precludes the use of Medicaid and delimits the ability to raise outside funds via Foundations, for example. On the other hand, it is clear that many of the activities of the SMHP are not Medicaid reimbursable (e.g. staff and teacher consultation) and will need a dedicated source of funding to be sustained. The new DMH Director is committed to the school-based model but would like to explore alternative strategies of contracting (and growing) this successful program. This scenario would leave the DMH Authority with the rightful role of overseeing, leveraging and funding a program which can well serve as a national model for school-based mental health services.

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

As a part of the transitioning process, the previous Multi-Agency Planning Team (MAPT) process will be replaced by a family team meeting model. This model is still an interagency model, but it differs in some important respects. First the meeting itself occurs at a location of the family's choosing. Second, the thrust is to have the family (and its needs) driving the process – as opposed to the agencies. Third, the agencies (to every degree possible) need to bring their individual and collective resources to bear to meet the families identified needs.

The intent is for DMH to pilot this new model in May-June 2006 and then move into full implementation in July 2006. It is important to note that the CFSA has already fully implemented this approach and DYRS is also planning to implement the family-centered approach. Hence, three of the major child-giving agencies will soon be operating from a common approach.

DMH data (as of 2005) indicates that 77.8% of the 1082 MAPT cases reviewed were diverted to community-based services. However, several critical policy and practice gaps have been identified; including:

1) Assignment of all children/youth to a CSA – This issue has been addressed so that all children/youth are assigned to a CSA before the interagency planning meeting and the CSA representative is included in the planning meeting.

2) Follow-up on children/youth
As of Oct 1, 2005, all children youth who go through the interagency review process are tracked via the DMH care coordinators. Follow-up prior to this time was, by DMH's own admission, inconsistent and sometimes incomplete. Still missing, however, is a data system that allows DMH a systematic way to track and evaluate children/youth who are diverted from residential care. The previous Harmony Information System did not perform needed functions. The DMH Federal carryover funds show $80,000 to create and implement an adequate software system. It is unclear when this will be accomplished. The lack of adequate data is a long standing issue that is way past due for resolution. It is positive to note that DMH is attempting to hire an Evaluation and Quality Coordinator, whose job will be to collect, analyze and report on evaluative data.

3) Residential Treatment Center (RTC) Re-Investment Project – As of March 1, 2006, this new DMH unit became operational. The goal is to collaborate actively with CFSA on all child/youth placements and perform a concurrent review of treatment planning of CFSA youth who are placed in RTC's. This new unit is still being fully staffed. The current RTC placement census (CFSA only) is 126 – as of May 4, 2006. This team will be charged with personally visiting all RTC's to participate in the planned treatment and discharge for all D.C. youth. Approximately 50% of the RTC's are non-Medicaid facilities and thus are paid entirely with local dollars. As with other areas, a reliable data system will be an essential component.

This is an absolutely essential component if the District is to meet the Court-approved target that 85% of all children/youth with Serious Emotional Disturbance (SED) will live in their own home or surrogate home. At this point, the DMH staff does not have a handle on the total number of children/youth in residential care (across child-serving agencies) or the costs associated with these youth. It is hoped that this unit will serve as an organizational first step toward creating the needed cross-agencies policies, services and data management to achieve the desired goal of redirecting expensive residential care dollars into alternate community-based services.

4) Flex Funds – One of the critical elements of a system of care model is to have earmarked funds that can be used for special purposes that are not covered by other funding streams e.g. Medicaid. The DMH has budgeted $100,000 in flex funds as a part of its federal funds carryover strategy. In addition, it is noteworthy that District Council member Kathy Patterson has proposed legislation that would pool 1% of the budgets of each of the District's child serving agencies into an Integrated Services Fund. It is not clear at the time of this Report what support this initiative will get, but it appears to be an effort to further stimulate the kind of cross-agency and family-centered planning that DMH and CFSA, and DYRS are embracing.

d. Juvenile Justice

The DMH will be re-organizing its Juvenile Justice programs in FY '07, in part to comply with the requirements of a corrective action plan negotiated between the parties in the Jerry M. case. There were four significant programs that DMH ran in FY '06 that intersected directly with the Juvenile Justice system:

1) Front End Assessment Team (FEAT) – This team of five staff was started in January 2005 with the goal of providing mental health screening for all youth who are detained by the Metropolitan Police Department (MPD) and then whenever appropriate – to divert these youth into community-based mental health alternatives. The program was developed to comply

with the requirements of a corrective action plan negotiated by the District with the plaintiffs in the Jerry M. case.

Over the past six months, this team has assessed nearly 300 youth per month. The FEAT staff uses a standardized instrument to conduct its screenings (MAYSI-2). It is noteworthy that some 58% of youth assessed do exhibit identifiable mental health concerns. The goal of front-end diversion is commendable but does not happen in most cases. According to the data, approximately 18% of youth are diverted at the front end by the MPD. The remainder goes through the Central Processing Unit (CPU) where a more detailed evaluation is done. However it is noteworthy that at least five youth were taken directly to a psychiatric hospital since the program started – often because of suicidal ideation.

Overall this program has had limited impact and DMH has decided to close the FEAT in FY '07. There is no evidence that the information obtained by the FEAT staff is unique from information gleaned in the risk assessments conducted by Court Social Services, and during the Initial Mental Health Evaluation and Risk Assessment conducted at Oak Hill/YSC within twenty-four hours of the youth being detained. Step Down Program – For youth who are processed and detained or committed, there is a second level of diversion opportunity. Once a more thorough evaluation is completed, some youth are then released to an identified CSA within the DMH system. For the first nine months of 2005; 121 youth were diverted via the Step Down Program. In many cases, these youth were previously connected to a CSA prior to their arrest.

Initially, DMH detailed a staff member specifically to coordinate the step-down process. DMH is re-organizing this process in order that the step-down referrals go directly through the AHL.

2) Assessment Center - The DMH continues to run an Assessment Center to do comprehensive evaluations for both the Juvenile Justice system and foster care youth (typically in regard to placement issues). The major issue for the Assessment Center has been

response time. This has been a significant issue in the Jerry M. case. Reduction of response time is one of the deliverables negotiated by the District with the plaintiffs in the Jerry M. case. The DMH indicates that the number of referrals to the Assessment Center is 92 over the past 12 months. The average total time to complete reports to the Court is 6.6 weeks. Both the Superior Courts and DMH consider this an unacceptable level of performance, but the DMH has struggled – given current staffing levels and the overall volume – to reduce this time period.

3) Oak Hill Youth Center (OHYC) – DMH has historically provided mental health service staff at the OHYC (as run by DYRS). For a variety of reasons, this has not proven to be an acceptable arrangement. Hence, the DMH and DYRS, at the urging of the plaintiffs and the special arbiter in the Jerry M. case, (with the approval of the District Council) have agreed that DYRS will assume full responsibility for the provision of mental health services at OHYC directly as of September 1, 2006. This involves the transfer of funds from the DMH budget to DYRS. To date, DMH has transferred $150,000 in funds created from staff vacancies, and has offered to provide $120,000 in bridge funding to assist DYRS in the smooth transition of the mental health service. DMH plans to transfer the prorated funds that are available as a result of the additional vacancies over the next few weeks. DMH initially had a complement of 13 staff in the mental health service at OHYC. To date, five have left OHYC for other competitive positions and two more have accepted other positions. This leaves a DMH program assistant, psychiatrist, and four mental health specialist at OHYC.

e. Child Welfare/Foster Care Initiative

The July 2005 Report to the Court detailed five DMH services that were funded as a part of the special federal initiative for the D.C. foster care system. The plan was that three of these grant-funded initiatives (multi-systemic therapy, intensive home and community-based services and mobile response and stabilization services) would transition to an MHRS-funded (fee-for-service) model once the federal grant funds ran out (Oct 1, 2005). Unfortunately, there has not been a smooth transition to the new fee-for-service model. There

were several factors that came into play – most notably: 1) lack of adequate up front transition planning by DMH and the local providers delivering these services 2) changes in DMH authorization levels as of Oct 1, 2005 – which created confusion and reduced funding for some services e.g. mobile response and 3) the overall crisis in mental health providers payments –as detailed in III C.

These issues are all being addressed frontally by DMH and CFSA staff. Compromises have been reached which will hopefully avoid the closure of local services (e.g. DMH has agreed to continue its 6-week authorizations for mobile response and stabilization until September 30, 2006 – allowing time to evaluate the efficacy of this policy). DMH and CFSA staff are meeting regularly to work out these issues – which is a testament to the leadership and staff of these two agencies to work collaboratively on behalf of D.C. children, youth and families.

An overall evaluation of the child/youth system is difficult to do at this point. The overall philosophy and sense of direction is excellent. However, the capacity to carry it out is a question mark. For example, the positioning of the Deputy Mayors office to provide leadership makes eminent sense. The real issue is the consistency and continuity of leadership. The current Deputy Mayor has a strong commitment to children, youth and family systems. In a mayoral election year, however, there is the open question of future leadership. The D.C. system has many of the components necessary to create a very strong child/youth system of care. However, it will take several years of consistent and strong leadership, political will and infrastructure development to make this a reality.

C. Review of DMH's Role as a Provider

1. Evolving Role of St. Elizabeths

The DMH has made some progress over the past 12 months in terms of the role envisioned in the Court-ordered plan i.e. functioning as a tertiary care Hospital for civil patients and as a forensic Hospital. The key elements in achieving this goal are detailed in other sections of this Report III C3 and III C 4 – namely the construction of the new 292 bed Hospital and progress in using local acute care units. While progress on both of these issues has been delayed, it is hoped that both are now on track to resolution. As noted in previous Reports to the Court, virtually all voluntary admissions go to local acute care Hospitals and some involuntaries go to Greater Southeast. DMH indicates that for the past 6 months, there have been approximately 43 admissions per month to St. Elizabeth's. This compares to 50 per month a year ago and over 100 per

month two years ago, so clearly progress has been made. Once both inpatient units at Greater Southeast are finished, the number of admissions at St. Elizabeths should drop to a small number i.e. most difficult cases. The other developmental factor that is critical is the rehabilitation and staffing of an adequate number of observation beds in the rehabbed CPEP (see IV B).

Of some concern is the fact that the census at St. Elizabeths has been creeping back up. While it was at 413 at June 30, 2005 it is currently averaging 425 – 430. The DMH, together with staff at St. Elizabeths are attempting to analyze this increase and develop appropriate strategies. One of the identified issues are geriatric patients whose primary management needs are more physical than mental illness-related. Hence, these patients may more appropriately be served in an alternative setting e.g. Nursing Home. This could involve as many as 30 patients. There is also concern that some of the previous DMH efforts toward assessing community readiness and placement have gotten lost in the leadership changes and competing priorities. It is also clear that CSA's – with their focus on payment issues – are not incentivized currently to pursue community placement for patients who are ready to be discharged.

In sum, the DMH still has major steps to take before the rightful role of St. Elizabeths can be achieved. It is hoped that the next 6 months will see progress – especially as it relates to alternative acute care beds.

2. Quality of Care Initiatives at St. Elizabeths

St. Elizabeths continues to have external bodies critically reviewing quality of care concerns. The most recent and notable was the May 23, 2006 Department of Justice (DOJ) report of its investigation pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). The DOJ Report outlines a series of serious concerns that include:

- Assaults , Elopements and Suicide Risks – with particular focus on staff availability and supervision
- Seclusion and Restraints – while noting an overall decrease in seclusion and restraint, there was great concern about the pattern of seclusion and restraint in the forensic unit
- Risk Management – the lack of an adequate system to investigate follow-up, and remediate instances of risk to patients e.g. abuse
- Environmental Health and Safety Issues – noting the serious deterioration and unsanitary conditions of the living and cooking areas

- Inadequate Behavioral Treatment Progress – while commending the treatment mall concept, the report notes a lack of connection of treatment plans to mall programs
- Inappropriate Medication Management and Monitoring – with concern about the clinical justification for medications prescribed and the lack of adequate monitoring for side effects e.g. tardive dyskenisia
- Nursing Care and Treatment – with noted concern about the overall numbers of nursing staff available and the lack of standard nurse protocols e.g. monitoring of patients who return from acute Hospitals or emergency rooms with unstable medical conditions
- Discharge Planning and Placement in the Most Integrated Setting – with notation of the lack of rehabilitation goals and transition planning for patients to re-enter community programs

The District has responded to this investigation with an initial letter of June 5, 2006 that speaks to the District's intent to work with the DOJ to resolve the issues of concern. The letter points to the fact that a number of changes and improvements have occurred since June 2005 – pointing to areas of staffing, training, overall management, and the credentialing and privileging of clinical staff.

Obviously, the DOJ report provides a major challenge for the DMH to resolve. To its credit, the DMH leadership has acknowledged that there are real issues of quality care and would – if possible – like to work collaboratively with the DOJ to resolve them. The DMH is actively working to develop a plan to address the DOJ recommendations. This plan – once completed – will serve as a basis of discussion with DOJ in the months ahead. It is also important to note that many of the areas identified in the DOJ Report overlap very directly with the review and recommendations made by Dr. Richard Fields (see July 2005 and January 2006 Reports to the Court). For example, Dr. Fields notes in his most recent report of March 2, 2006 that there is a "Needs Improvement" status in areas of:

1) Active Treatment- noting the need for appropriateness of treatment as reflected in the medical record.
2) Training and Staff Effectiveness – noting good progress overall but with work needed on the credentialing/privileging of Physicians
3) Use of Seclusion and Restraint – with note that despite a "relatively low reported frequency of use, there continues to be concern about the appropriateness of restraint, its documentation and related medication use (Fields Report of March 2, 2006 – page 4).

4) Quality Improvement Status – with note of "outstanding progress" in 2005, but need for greater integration, coordination and communication.
5) Patient Advocacy – with emphasis on the need to fully implement the patient grievance process.

Fields had two areas of "Needs Considerable Improvement." These included:

1) Staffing Status – with need for an effective nurse recruitment/retention plan and less reliance on costly nurse contracting. There is also the remaining issue of an overall staffing model for the Hospital
2) Hospital management – with commendation for the development of annual goals and the restructuring of the executive committee, but noting the lack of a multi-year strategic plan. Dr. Fields will complete his next review in June 2006 – with an anticipated Report in late July 2006.

Another development of note at St. Elizabeths is planning for an electronic information system. The DMH has developed an overall project plan for this effort and has formed a Business Team to review and make decisions. The goal is to create an integrated information system which today does not exist. This will include all of the clinical and business functions. This project will need approval by the District's technology office (OCTO) and by the District Council. The target date for completing the planned approval phase is November 2006. Needless to say, many of the oversight and monitoring needs identified by the Hospital, DMH and DOJ will depend upon an adequate information system. Today there is minimal data support – with much of the work being done manually.

Despite all of the above it should be noted that the Hospital has made progress on many fronts. Of particular note are:

1) The creation of an office for Clinical Planning, Development and Implementation – to help bridge the gap between clinical departments and provide needed cross-functional planning.

2) Developed and implemented a Violence and Aggression Work Plan.

3) Established 4 interdisciplinary mock survey teams which have done 16 mock surveys.

4) Developed a behavior management program in the treatment mall.

5) Revised the nursing staffing standards to increase coverage.

6) Put a Peer Review process in place to assess the quality of nursing compliance.

7) Implemented a 4 week intensive training for new direct care employees.

8) Revised the seclusion and restraint policy.

9) Significantly improved compliance for psychiatrist completion of medical records.

10) Established liaison with the Authority and all CSA's for social work involvement in discharge planning.

11) Developed a hospital-wide Risk Assessment Alert Program based on unusual incident categories.

12) Development and approval of more than 40 new Hospital policies.

13) Successfully completed 5 performance improvement teams.

It is clear to the Court Monitor that an even more intense period of external monitoring is at hand. It is also clear that the Hospital and DMH are making great effort to remediate decades of neglect to both physical conditions and adequate clinical care. The main challenge will be to integrate and prioritize these activities in a fashion that is urgent but orderly. There is a real risk of even higher levels of demoralization among staff. To that end, the Court Monitor would like to build upon the recommendation in the January 2006 Report to the Court, which called for "an organizational structure and process that creates clear accountability and support" for the multiple issues at St. Elizabeths. The DMH has identified Ella Thomas as the liaison between the Authority and the hospital. While the Court Monitor is supportive of this designation, it would appear that there is need for more of an integrated team (perhaps SWAT Team) at the Authority level to deal with the multiple issues at play. Team members should include personnel, procurement, office of accountability, IS and other support functions. This team should obviously intersect and coordinate with the leadership efforts at the Hospital. There needs to be both clarity and urgency. The Authority needs to have the capacity to know what the care and conditions are at St. Elizabeths; it should not have to hear this from outside sources. The Authority also needs to help break down the bureaucratic barriers to solving many of the underlying problems e.g. inability to hire nurses and psychiatrists in a timely way. The next several months will be critical for

DMH in developing an overall strategy for St. Elizabeths. Faced with the DOJ report, it is critical that positive forces be aligned and that key issues be addresses in a timely way.

It should be noted that DMH has put together a small work group including representatives from the Hospital and DMH to work on staffing issues. The workgroup is conducting an assessment of staffing needs that includes all levels of the hospital to determine how many positions they have, where the gaps are by discipline, what additional positions will need to be requested. The OCFO and HR have also been involved in this process. The goal is to determine total staffing needs and cost in this area.

Also the hospital is working on a plan for discharge planning in conjunction with DMH. Ms. Thomas expects to have a plan for discharging Hospital patients by the end of July 2006, which will require serious steps to work with the providers, consumers and families around appropriate discharging to the community.

3. Panning for New/Consolidated Hospital

The District has – as of June 6 2006 – released the Invitation for Bid (IFB) for the new Hospital. It is anticipated that there will be a 90 – 120 period to select and award this contract. This will need to include legal sufficiency review by the Office of the Attorney General (OAG) and final approval by the District Council. Hence, barring any further delays the work for the new facility should begin in the fall of 2006. That timeframe would target toward completion and patient occupancy of the new Hospital in the spring of 2009 – assuming a 30 month construction phase. The overall construction project will last approximately 36 months – the last 6 months involving the abatement and demolition of the existing John Howard Pavilion.

The other immediate and positive development is that the new furniture has arrived for the existing inpatient units RMB CT 7& 8 (approximately 184 patient rooms). This furniture was ordered by DMH given the poor condition of many existing furnishings. This new furniture includes new beds, wardrobes, chairs and dayroom furniture.

The District appears to be moving forward to get the new Hospital built. The Court Monitor does not anticipate any additional barriers despite the 3 years worth of delays already experienced. As indicated in previous Reports to the Court, these timelines cannot tolerate any further delays. The District is continuing to spend millions of dollars per year patching together HVAC systems, building structures, and living units that have far

exceeded any useful life. It is also true that it is exceedingly difficult – if not impossible – to provide quality patient care in such environments.

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

The DMH has not yet finalized either of its acute care agreements with local hospitals. The renovations for the new 20-bed unit at Greater Southeast are complete. However, there are two remaining hurdles prior to this unit being occupied: 1) necessary certifications via the Dept of Health and 2) a final Human Care Agreement with DMH. It is not clear how long these remaining steps will take, but the hope is that it will be in a relatively short period. The understanding is that the financial agreement (as previously worked out with DMH) will begin as soon as the new unit is occupied. This new unit was designed with the clear intent of handling involuntary patients so it should provide some additional relief for St. Elizabeths (estimated at 9-10 involuntary admissions per month that could be redirected to Greater Southeast)

Once the new unit is opened, the existing 20-bed unit at Greater Southeast will also be rehabbed – with an additional $240,000 capital grant from DMH. The rehab will be relatively modest, so that timeframe for completion is approximately 4 months from the date of the signed agreement (June 28, 2006). This second unit will then provide an additional 20 beds – which should fully meet the DMH demand for acute care beds – and allow St. Elizabeths to deal only with those acute patients who are most difficult to manage.

There has been no discernible progress regarding the 4 involuntary beds at GWU Hospital since the time of the January 2006 Report to the Court. While there are no remaining substantive concerns that are known to DMH staff, the final contract has not been signed. The reasons are unclear.

Overall, there is some progress to be noted, but no definitive date for occupancy of the new unit. There also still remains the open question as to the longer turn organizational and financial viability of Greater Southeast. The Court Monitor thus cannot conclude that the requirement to process acute inpatient services in local hospital has been met. This issue will continue to be reviewed in each Report to the Court.

5. Management and Role of DMH-operated CSA

The DMH continues to operate the largest CSA in the system – the DC CSA; it serves approximately 39% of the total enrollees in the DMH system. One of the major ongoing challenges for this entity has been the lack of an electronic information system. The DC CSA has purchased a

comprehensive I.S. system with 3 modules. The first two (billing and scheduling) have been fully implemented. The third (assessments and treatment planning) has been fully designed and is now being implemented. Three teams have been trained to date. The target date for all teams to have initial training is July 2006 with full training and implementation by the Fall of 2006. Staff have generally been responsive and positive – in spite of the fact that the I.S. (especially the clinical module) will cause major changes in how people record, track and access information. The clinical module – once fully implemented – will give staff and managers the data tools to begin reporting on key performance areas e.g. a regular report on continuity of care for patients at St. Elizabeths. Heretofore, all of this information has had to be generated manually in a very labor-intensive, delayed and often inaccurate mode.

The DC CSA has also put considerable energy into the quality improvement of key clinical service areas –specifically Community-Based Intervention (CBI) Services for children/youth and ACT services for adults. In both instances there is a process to assess the degree of fidelity of current services (utilizing standardized fidelity measures) and then to create an action plan to ensure that overall fidelity targets are at established levels (85% compliance for CBI and 90% for ACT).

The DC CSA has also demonstrated improvements in the past year in key areas including:

- Acceptance as a panel provider of all local MCO's
- Successful phase-out of its primary medical care clinics – which were a carryover of its clinics at St. Elizabeths. These consumers were successfully transitioned to local primary medical care clinics
- Developed and implemented a process to comply with the Ervin Act. This effort resulted in the conversion of some 128 consumers from involuntary to voluntary status
- Enrolled over 100 consumers in the DMH's Jail Diversion Program. The DC CSA is the largest provider for this initiative. The DC CSA has successfully contacted over 80% of diverted individuals within 48 hours and has demonstrated to-date very low rates of reoffending by the consumers involved
- Actively participated in the Co-occurring Disorder Initiative. The DC CSA is scheduled to be a pilot site for the COSIG grant on Outcomes-Informed Care.
- Improved the percentage of consumers seen within 7 days (post discharge from SEH) to 84%
- Worked with the relevant labor unions and employees on several major initiatives – including an early retirement offer, the new IT initiative and a comprehensive employee recognition program.

An ongoing issue for the DC CSA has been that of staff productivity. The leadership at DC CSA has continued to track and enforce an overall productivity policy for all clinical staff. The overall agency target is 50% (i.e. 50% of available time will be spent producing billable units - which applies at the team level and individual staff level. The minimum threshold for individual staff is 35% for this year (versus 30% for last year). Anyone below this level is subject to progressive discipline. The actual performance for October 1, 2005 – April 30, 2006 shows that child/youth teams were at 39% and adult teams at 40%. While this represents some improvement over a year ago, it is clear there is still a major gap between current agency-wide expectations and current performance. The introduction of mandatory training for the new I.S. has, according to DC CSA leadership, caused some dips in recent productivity levels.

The issue of overall financial viability for the DC CSA remains. Previous Reports to the Court have highlighted the fact that the gross expenses for MHRS services (roughly $23.7 million) far exceeds its performance in generating gross revenue. This gap for the current year is estimated at $11 million. This major gap does not measure revenue received – only revenue generated. It also does not include the expenses associated with programs that are not tied to MHRS services e.g. pharmacy, supported employment and emergency response services. These "safety net" functions (including administrative overhead) total to approximately $10 million per year.

The July 2005 Report to the Court recommended that DMH undertake a detailed review of the DC CSA – examining issues of costs, revenue and alternative governance options. There is no indication that this was done; the same issues remain. Despite strong and stable leadership at the DC CSA level (with increased productivity and decreased expenses), it would appear that the inherent cost structure will never achieve a breakeven point – even at the gross revenue level. DC CSA leadership estimates that staff would have to be at an 80% productivity level to even approach breakeven. This does not seem feasible. Hence, after five years of incremental gains, it is now time to look at alternative governance models. The existence of a new DMH Director and a respected DC CSA Director makes this an opportune time to look at new models. The Court Monitor recognizes that there are legitimate District – wide functions that need to be maintained e.g. emergency response. It is also as true as ever that the capacity of DC CSA is needed. The challenge is to find a model that can achieve the dual goals of maintaining capacity and continuing to improve quality – but to do so in a business model that also achieves cost-efficiencies. The Court Monitor believes the District should begin

aggressively to detail alternative governance options, transition issues, future roles for the DC CSA, and program/financial implications.

D. Review of FY 2006 Budget and Status of FY 2007 Budget

The FY 2006 budget period has been one full of major surprises. As detailed in the January 2006 Report to the Court, the first set of major issues had to do with unpaid claims for FY '03, '04 and '05. After a lengthy and laborious ratification process, the District has paid $15.283 million (out of District reserve funds) to providers for prior periods. Unfortunately, the issue of payments for prior periods is still unresolved. There is still approximately $1.74 million in play – the majority of which is in MHRS claims for '05 that were denied by DMH. (See DMH Status Report of May 12, 2006 – p.2) The unresolved issue is the degree to which these claims are legitimate and due for payment. It is the DMH's presumption that any valid claims for '05 will once again trigger the whole ratification process. It is unclear how quickly this will happen.

In addition to the reserve allocations for previous years, the District Council – upon request of DMH and with support from the deputy mayor – approved supplemental funding for FY '06 of $10.985 million in early June 2006. These funds include $8.541 million in community service funds, of which $6.2 million will go to non-Medicaid eligible MHRS services. These dollars should certainly help to alleviate the resource concerns for FY '06 – although it is not yet clear how all of this will play out. There are still major issues (as noted in IVB&C) that relate to eCura upgrades, Medicaid eligibility, and the timely resolution of submitted claims. All of these directly relate to the sources and uses of funds for FY '06.

There is also uncertainty about the adequacy of the submitted DMH budget for FY '07. The '07 proposed budget is $2.1 million less than the base budget for '06. It is reasonable to assume that prior year payments ('03 to '05) will be fully reconciled this fiscal year; hence there should not be the carryover problem in the '07 budget year. However, there are multiple other spending pressures for '07 that do not appear to be addressed in the '07 budget. Notable examples are:

- the $1.2 million loss in supported housing subsidies
- potential capital and operating costs at St. Elizabeths in resolving quality of care concerns
- non-Medicaid expenses for MHRS Services
- rapidly escalating telecommunications costs
- loss of CFSA matching funds to pay for new child/youth providers

These and other '07 budgeting concerns suggest that if the '07 budget is approved as submitted, the DMH will once again be facing the need for supplemental funds in '07. The Court Monitor will continue to track this issue – with particular focus on those areas that relate directly to Dixon.

IV. Follow-up on Previously Identified Recommendations

The January 2006 Report to the Court made four recommendations. Two of those that related to St. Elizabeths have been addressed in III C 2 and III C 3 of this Report. This section will provide updates on CPEP, the KPMG assessment, and also provider payment issues.

A. CPEP

The District initially made a determination to rehabilitate the existing CPEP building. As detailed by the District in status reports to the Court, other Hospital-connected alternatives proved not to be viable within the timeframe required for affirmative action. The DMH has engaged McKissack and McKissack a private firm of architects and engineers, to conduct an inspection of the current location and based on those findings to prepare a report on conditions and preliminary design. The Court Monitor has not seen this report as of the filing of this Report to the Court.

From the Court Monitors standpoint, there are several issues that will need to be reviewed and discussed as part of this project: 1) the ability to rehab this building while still providing services 2) the longer-term planning (3-5 years) of the D.C. General grounds 3) the ability to improve triage/access to acute medical services for consumers who require it and 4) the overall design and adequacy of space to accomplish the mission of this critical program.

More recently the option of a stand alone building at Greater Southeast Hospital has been introduced. Given the proximity to the inpatient unit this option would have real advantages.

Thus, while it is encouraging to see that CPEP is now a front-burner issue, there are still many questions that need to be addressed. Hopefully this can be done in a concentrated timeframe.

B. KPMG

The District received and commented on the Phase 2 KPMG management review during June 2006. The Court monitor and plaintiff's Counsel were briefed on July 13, 2006 on this Phase 2 Report.

The Phase 2 Report contains numerous recommendations as relates to program design, population-based needs assessment, management roles and responsibilities at DMH, legal questions as to Medicaid contractual agreements with providers, IT processes and resources, and alignment of budget planning with agreed upon policy and strategic decisions. The report is comprehensive and somewhat daunting in its scope. It is clear that there needs to be a comprehensive and well-articulated plan. It is also clear that DMH will need to commit both internal and external resources to

this effort to provide any sense of continuity, accountability for progress and integration of the multiple moving parts.

The DMH Director clearly understands that there are fundamental planning/systems design issues that need to be tackled. These will take a dedicated workgroup and some time to accomplish. The DMH Director intends to begin a planning process that will look in detail at the core issues of priority populations, number of persons who need service, range of services, and funding strategies. This process will result in a 3-year plan. At the same time there are more immediate issues that need to be addressed simply to stabilize the funding and claims processing system as it exists. In addition to the issues identified in IV C, it appears to the Court Monitor that the legal issues regarding the Medicaid contract form must be resolved sooner and not later. Currently DMH pays for MHRS (Medicaid) services via the Human Care Agreement – even for those persons and services that are fully Medicaid eligible. This is in direct contrast to how the District pays for all other Medicaid services as a federally-approved entitlement program. The DMH has sought a legal opinion from the Office of the Attorney General (July 6, 2006) on this issue. The matter is deeper than simple contractual formats. The current method not only caps payments to the limits of contracts but it places DMH in an untenable legal and administrative position under the anti-deficiency laws of the District. One of the end results is the endless hoops that ultimately make payments to providers so difficult. The recent round of ratification bears out how impossible it is to work within the current model. Even when dollars are available, the current system requires Herculean efforts to actually get dollars paid to providers.

It appears to the Court Monitor that this issue – and perhaps a few others of like kind – need to be fixed in the short term to avoid further implosion with providers. The DMH – out of all the KPMG recommendations – needs to be clear about those issues that need immediate attention in order to stabilize the system while it concurrently looks to address longer-term issues.

C. Provider Payments

The issue of provider payments has been one of enormous focus, activity, analysis and frustration at all levels. Clearly this was a central reason for the KPMG review as discussed above. Beyond the mid range to longer term solutions, the DMH has undertaken several short-term activities to help ameliorate the problem:

1) The DMH is warranting claims more frequently and the OCFO is working to expedite payment for approved warrants within 7 – 10 business days.

2) DMH is working actively with Info MC to rework the eCura System – particularly as it relates to the rejection of claims that then go into the exceptions report – meaning these are claims not being paid. The exceptions category is consistently running at about 25% of total claims submitted. DMH is also working on those claims that are denied due to,

e.g., entry errors, unauthorized services, etc. This amount (in total) is almost 20% of total claims submitted. Hence the total percentage of claims in exceptions or denials is at 45% of total.

3) DMH is meeting with all of its providers on an individual basis to determine unique issues

4) DMH is meeting regularly with all providers to share progress and discuss problems. DMH is preparing a draft of a work plan with providers – with the intent to engage providers as partners in this process. The intent is to have this work plan in place by July 10, 2006.

5) DMH has sought and received additional funding. As noted in III D, the 2006 DMH budget for community services has been augmented by $8.541 million – of which $6.2 million will go to non-Medicaid MHRS services and the reminder as match for Medicaid-eligible services.

6) DMH is working – with the additional funds in hand – to redo task orders for providers whose total support is under $1 million. DMH has obtained Council approval for the 12 providers over $1 million and the four residential providers whose payments have been delayed for many months. For all providers, necessary adjustments to Medicaid and non-Medicaid allocations will be done.

7) DMH is actively evaluating individual providers who are not billing or are under billing significantly on a year-to-date basis; the DMH will seek to de-obligate funds and shift these dollars to providers who are most in need of additional financial support.

All of these efforts have resulted in a more positive climate with providers. It has been significantly impacted by the message of the new Director that providers can and should be viewed as partners in the process – as opposed to antagonists. It is clear that the current system has many systemic flaws (per the KPMG report) and any short-term solutions will take considerable staff effort to make work. Nevertheless, an open approach to communication and problem-solving bodes well for the future.

V. Recommendations

Based upon the findings in this Report and previous Reports to the Court, the Court Monitor makes recommendations as follows.

A. The District should submit monthly progress reports to the Court on high priority topics. These should include (at a minimum): a) status of provider payments b) planning for CPEP c) construction status for new Hospital at St. Elizabeths d)

quality of care issues at St. Elizabeths e) implementation status of KPMG recommendations f) status of utilizing acute care beds as alternatives to St. Elizabeths

These monthly reports should extend through December 2006 – to be reassessed at the time of the January 2007 Report to the Court.

B. The DMH should develop an Authority-based team with the goal of assessing and improving the care and conditions at St. Elizabeths. One clear outcome should be the development and measurement of key performance indicators. This team should have high level visibility and priority at the Authority level. The structure and plan for these efforts should be presented to the Court Monitor and plaintiffs' counsel for review.

C. The District/DMH should commission an independent review to examine alternative governance options for the DC CSA. This review should include – in addition to governance – issues of the future role of the DC CSA, expense and revenue models, and transition issues (including employee issues).