REPORT TO THE COURT

Court Monitor
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July 24, 2007

Executive Summary

This tenth Report to the Court shows solid progress on many issues. There is measurable improvement on several of the required performance levels and demonstrated performance on one of the 19 criteria that warrants movement to inactive monitoring status. Two priority areas (DC CSA and Crisis Services planning) were cited in the January 2007 Report to the Court as needing concerted efforts; both of these efforts have moved forward significantly in the past six months – though neither are at final plan stages.

1. Implementation of Exit Criteria

   This Report shows data on all seventeen (17) of the quantifiable measures. Nine of these seventeen have been verified as to data integrity by both DMH and the Court Monitor. One measure (Newer Generation Medication) has demonstrated performance at a level sufficient to move to inactive monitoring status per the terms of the December 2003 Consent Order. There are nine additional criteria that have shown real progress but additional verification and/or performance elements are required before achievement of inactive monitoring status. Nine of the nineteen Exit Criteria have not met compliance levels. However, in each of these nine, there is concerted activity and renewed focused on data integrity and organizational efforts needed to achieve compliance.

2. Comprehensive Psychiatric Emergency Program (CPEP)

   There continue to be two major issues. The first is the development of a comprehensive plan for crisis/emergency services. There has been good progress on this via a workgroup chaired by the DMH Director. An initial internal draft has been presented for discussion – with the intent to have a draft ready for circulation by September, 2007.

   The relocation of CPEP to a suitable site is a more vexing problem. The uncertainties regarding the future of Greater Southeast have brought any concrete planning at that location to a stand still. There is no prospect of resolving this issue in the short-term. The only positive hope is that a comprehensive crisis plan, might allow for the co-location of a new CPEP and a new acute care setting as part of an existing acute care Hospital. Accordingly, it is important that the DMH move forward quickly with developing and implementing a comprehensive crisis plan.

3. St. Elizabeths Hospital

   The construction of the new 292 bed Hospital is fully underway – although weather and unexpected soil contamination have the project 45-60 days behind schedule. With an accelerated construction plan, the hope is still to achieve occupancy by the summer of 2009.

The other major development is the May 2007 Settlement Agreement with the Department of Justice (DOJ). This Settlement Agreement calls for a comprehensive multi-year set of actionable strategies that will be tracked by a new Compliance Officer at SEH. The Compliance Officer begins full time in July 2007and will serve as liaison among SEH, DMH, DC government and DOJ. The Compliance Officer will prepare semi-annual reports regarding progress. Overall, the new Hospital Director, Dr Patrick Canavan, has embraced the requirements of the DOJ Settlement Agreement and is actively organizing recruiting and deploying resources to meet the multiple challenges at hand.

4. Budgeting/Provider Payment Issues

   The FY 2007 budgeting issues for DMH have been addressed including the two major issues of $8.6 million in supplemental funding for SEH, and $13 million via the Medicaid Reserve Account to pay for uninsured MHRS services and other program shortfalls. The FY 2008 budget has gone to Congress. It appears that it will adequately address DMH's highest priorities.

   The DMH has continued its efforts to manage the billing process in a more timely way. There continue to be systemic issues (e.g. the adequacy of the existing eCura system) that will need to be addressed as a part of planning for a potential Administrative Services Organization (ASO). It is important that DMH find a way to address the inadequacy of the eCura system, whether through an ASO or otherwise.

5. KPMG

   The DMH has re-engaged KPMG to assist on several major projects – including the Medicaid claims recovery effort, movement of Medicaid claims to MAA, and the development of an RFP for a potential ASO contract. Each of these efforts is on track. The new target date for movement of Medicaid claims to MAA is October1, 2007. The DMH and MAA have persistently worked through the multiple unresolved issues that were detailed in the January 2007 Report to the Court. It now appears that a smooth transition can occur. The ASO development is at Stage 1 – with a Request for Information (RFI) having gone out to potential bidders on July 16, 2007. The nest step will be the development of a full Request for Proposals (RFP) and a projection of costs for an ASO model. If the ASO moves forward, the projected transition would begin in early 2008.

6. DC CSA

   A planning process for the desired service and organizational roles for DC CSA has begun. The DMH Director, the DC CSA Director and key leadership staff from both the Authority and DC CSA are meeting on a weekly basis to discuss issues and options for the future. Some short-term cost savings will be accomplished via the closing/consolidating of two existing sites.

The longer term resolution is still pending – with a target date for developing a plan of October 2007. The hard questions and critical issues are finally being addressed via this process. Support from the Mayor's office and Council will be crucial to developing and implementing a long-term resolution.

7. Acute Care Beds

   The development and use of alternative acute care beds have not moved forward; if anything there is reduced capacity at Greater Southeast due to having only one fulltime psychiatrist. The net result is continued high-demand for acute admissions at SEH (approximately 45 per month). This issue needs to find alternative solutions beyond those at Greater Southeast and should be considered as a complementary part of the comprehensive crisis plan.

Overall, the District/DMH have shown clear improvement on many fronts over the past six months. It is encouraging to see the hands-on leadership style of the DMH Director Steve Baron. Areas that have lagged are now beginning to move – including for example: focused attention to the long-standing issues at SEH; planning for DC CSA; development of a comprehensive crisis/emergency service plan; development of short and long range solutions for the billing, payment and collection system; and heightened attention on key performance areas (including the Dixon performance criteria). It is clear that DMH has a ways to go, but it now appears (for the first time) that there is concerted leadership, focus and support to achieve real progress on many fronts.

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

A. The District should continue to submit progress reports to the Court on high priority items. These should include (at a minimum): a) status of provider payments and development of relevant metrics to measure performance b) status of crisis/emergency services planning and planning for new CPEP location c) construction of new Hospital at SEH and status of quality of care issues – including hiring and retention of key staff d) status of KPMG issues – including payment movement to MAA and development of new ASO i.e. status of SEH discharge plan f) status of planning for alternative organizational and service options for DC CSA g) status of developing and utilizing alternative acute care beds. These reports should continue on a bi-monthly basis.
B. The DMH/District should intensify its efforts to locate a suitable long-term solution to the need for a co-located CPEP and acute inpatient facility. Past efforts to utilize Greater Southeast have proven unsuccessful. New strategies need to be developed in a timely way as a part of the overall crisis/emergency service planning.
C. The District/DMH should actively engage the District's Human Resource Director toward the goal of using its independent personnel authority to make needed changes to existing H.R. regulations. With outside consultant help, a prioritized plan needs to be developed as soon as possible.

I. Current Situation

In October 2006 the Federal Court approved the Monitoring Plan for October 1, 2006 through September 30, 2007. The Monitoring Plan included three primary areas for review during this period:

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

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

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

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

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

II. Findings Regarding Exit Criteria

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

As in the previous three Reports, Table I in IIC presents the current status of all nineteen (19) Exit Criteria and discusses specific progress and concerns.

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

The major issue for the Court Monitor continues to be the lack of DMH's capacity to demonstrate that the data collected are being considered and utilized to improve the availability and quality of care.

As discussed in the January 2007 Report to the Court, the DMH has finalized its 2006 annual Mental Health Statistics Improvement Program (MHSIP) consumer survey in March 2007. This survey – together with the supplemental Recovery-oriented System Indicators (ROSI) – provide a very rich set of opportunities for systemic quality improvement. However, it is unclear how this data is being communicated to providers and utilized in any discrete way to make changes. The DMH Quality Council has not met in over six months. As discussed in III

A1, the plan is to reactivate this group in September 2007 – with the Internal Quality Committee (IQC) serving as an Advisory Board to the Quality Council.

The DMH has contracted out for the MHSIP/ROSI survey for 2007 – as opposed to doing this through the Office of Consumer and Family Affairs. This contract ws awarded to the Gregory Project – a consumer-run organization. The target is to complete this survey, including the analysis, by Fall 2007. The DMH has completed its contracting process for a separate RFP that primarily focuses on grievance training and assistance. This contract also requires that there be conducted consumer satisfaction surveys (focus groups and convenience sampling only). The Consumer Action Network (CAN) was the successful bidder for this contract and this contract was signed on June 1, 2007. Given that this contract was just recently finalized, the specific timetables and methodology for the 2007 and 2008 convenience sampling and focus groups are not yet clear. One of the Co-Directors for CAN has left to take a position in SAMHSA, so it is likely there will be a period of transition as new leadership and staffing are employed.

The consumer functioning method(s) requirement has not seen any movement over the past three years. The DMH continues to require that providers complete the LOCUS instrument for adults and the CALOCUS for children/youth. However, the data is not aggregated and analyzed at the DMH level as a part of a demonstrated effort to utilize the results as part of a quality improvement process. Demonstrated utilization of the results as part of a quality improvement process is a precondition for satisfying these exit criteria.

It is hoped that – with the Quality improvement position now filled – there will be some concerted movement on both the Consumer Satisfaction and Consumer Functioning Review method(s). The Court Monitor will work with the DMH to identify how the DMH will demonstrate utilization of the Consumer Satisfaction and Consumer Functioning Review methods.

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

1. Summary of Children/Youth Findings

As in previous years, there was a stratified random sample of 162 youth who received services between July 1st and December 31st of 2006. Youth selected had to have received at least one billable service during this period. The number of youth served by DMH during this time period (per processed claims data as of January 8, 2007) was 1870. As in previous reviews, the target number of cases for in depth review was 54. This number ended up at 52 cases reviewed, due primarily to some parents or guardians choosing not to participate or due to difficulties in locating the parents/guardians to obtain consent.

The reviews were all conducted during a two week period in March 2007. All reviewers are trained to standard by Human Systems and Outcomes (HSO). Approximately half of the reviews were conducted by trained DMH staff and the other half by HSO reviewers. The logistical support – in terms of obtaining consents and arranging schedules – was performed by CAN. The hard work of CAN, DMH and HSO staff made the logistical part of this successful review possible. Interagency cooperation with CFSA was improved over previous years.

The findings for year 5 for children/youth were consistent with the trend from previous years. The overall child/youth status was 75% of cases in the acceptable range. This compares to 81% for year 4 and 73% for year 3. For systems performance – which is the Dixon Exit criterion measurement – the year 5 results were at 48% . At the Court Monitor's request, HSO did a five-year analysis of trends and themes for both children/youth and adults. For children, these results were very telling. It is clear that the current child-serving system performs certain functions at an adequate level e.g. safety of the child, health/physical well-being, culturally appropriate practice and medication management. The system tends to break down, however, in terms of school progress, transition progress, service team formation and functioning, and the adequacy of a long term guiding plan for the child/family. What is also very compelling from these trend data is that for lower functioning children/youth, the system is much less likely to work. There are high negative correlations between system performance and the child's level of functioning. For higher functioning children/youth, the system performed adequately at an 86% level. However, for lower functioning children, adequate systems performance was at 23%. This is obviously unacceptable. It is understood that more difficult children require more intense resources; however, it seems paradoxical that cross-agency service teams are less likely to happen for the most difficult cases. Clearly, this is an area that needs concerted and immediate attention if the system is going to improve for children/youth.

2. Summary of Adult Findings

The adult sampling process and protocols are consistent with those for children. The adult review was completed during a 2 week period in April 2007. The total number of cases was 55, with approximately half of the reviews done by DMH staff and half by HSO reviewers.

The year 5 results indicate that 69% of the persons reviewed were in the acceptable range for overall individual status. This shows a very steady pattern with previous years; year 4 was at 65% acceptable and year 3 was at 67% acceptable. Year 5 showed continued progress on many factors impacting the person's status, e.g. safety (82% acceptable), living

arrangements (78%), and overall satisfaction (90%). Other key factors – while improved from prior years – did not score as well, e.g. social network (53%) education/career preparations (50%), and work (54%).

Year five results for systems performance was at 80%. This compares very favorably to year 4 which was 69% and year 3 at 51%. System performance indicators in key areas likewise reflected a consistent upward trend e.g. goodness-of-service fit went from 55% (year 3) to 69% (year 4) to 76% (year 5). These positive improvements reflect that the larger CSA's (most notably the DC CSA) have put considerable energy into understanding and implementing a recovery-based model.

It should be noted that while the 80% score technically meets the Dixon performance target, the Court Monitor is not ready to certify that the District should move to inactive monitoring. There are at least three issues that must be addressed in planning for the 2008 adult review: 1) the sample size needs to increase to provide more appropriate levels of confidence in the outcomes. The 54 sample size was agreed to as a start point while the DMH was still in a developmental state. 2) there needs to be greater attention to the final sample that is reviewed. The voluntary nature of this process raises the potential that more engaged clients are more likely to participate and alternatively that persons who are marginally engaged will not. 3) inter rater reliability between DMH and HSO reviewers needs to be carefully examined. Internal reviewers tend to rate higher. A careful case-scoring process could help correct for potential variability – as well as ensuring that DMH reviewers are fully trained. None of these factors should subtract from the fact that on the adult side the DMH has made consistent and measurable improvement over the past three years, but each must be addressed before the Court Monitor can certify that the District should move to inactive monitoring.

One of the most noteworthy outcomes of this year's review was the five-year analysis. The DMH Director and Senior Staff asked the Court Monitor and HSO to present themes, trends, and data points over the past five years. These findings were discussed extensively with senior leaders as part of an initiative that DMH has undertaken via the Institute for Healthcare Improvement (IHI). The overall goal is to identify specific practice or system performance areas in which DMH can make a real impact. For example, the lack of consistent team formation and functioning is clearly a consistent theme in the child/youth area. The DMH is formalizing its overall priorities for the next year in terms of CSR and will be sharing these with the Court Monitor and the provider/advocacy community. This focused sense of priority on the practice side is precisely what has been missing up to until this point. Hence, this is a very encouraging development – particularly as it relates

to the more complex practice requirements for children, youth, and families.

C. Implementation of Court-approved Performance Criteria

Table 1 July 2007
Exit Criteria
Current Status

Aggregate data for April 1, 2006 – March 31, 2007

Exit Criteria	Policy in Place	Data Methods in Place	DMH Validated Data System	Court Monitor Validated Data System	Court Required Performance Level	Current Performance Level
1. Consumer Satisfaction Method(s)	Yes	N.A.	N.A.	N.A.	Methods + Demonstrated Utilization of Results	Methods Completed. Utilization in Process
2. Consumer Functioning Method(s)	Yes	N.A.	N.A.	N.A.	Methods + Demonstrated Utilization of Results	Methods Completed. No Evidence of Utilization
3. Consumer Reviews (Adult)	Yes	Yes	Yes	Yes	80% for Systems Performance	80%
4. Consumer Reviews (C/Y)	Yes	Yes	Yes	Yes	80% for Systems Performance	48%
5. Penetration (C/Y 0-17 Years)	Yes	Yes	Yes	Yes	5%	2.63%
6. Penetration (C/Y with SED)	Yes	Yes	Yes	Yes	3%	1.56%
7. Penetration (Adults 18 + Years)	Yes	Yes	Yes	Yes	3%	2.10%
8. Penetration (Adults with SMI)	Yes	Yes	Yes	Yes	2%	1.80%
9. Supported Housing	Yes	Yes	Yes	Yes	70% Served Within 45 Days of Referral	32.90%
10. Supported Employment	Yes	Yes	Yes	Yes	70% Served Within 120 Days of Referral	97.10%

11. Assertive Community Treatment (ACT)	In Process	Yes	Yes	In Process Through the Monitor's Consultant	85% Served Within 45 Days of Referral	51.52%
12. Newer - Generation Medications	Yes	Yes	Yes	Yes	70% of Adults with Schizophrenia Receive Atypical Medications	84.37%
13. Homeless (Adults)	Yes	Yes	Yes	In Process Through the Monitor's Consultant	150 Served + Comprehensive Strategy	117 Comprehensive Strategy to be Developed
14. C/Y in Natural Setting	Yes	Yes	Yes	Yes	75% of SED With Service in Natural Setting. Must Have SED Penetration Rate of 2.5%.	73.71%
15. C/Y in own (or surrogate) home	Yes	Yes	Yes	Yes	85% of SED in Own Home or Surrogate Home. Must Have SED Penetration Rate of 2.5%.	92.27%
16. Homeless C/Y	Yes	Yes	No	No	100 Served + Comprehensive Strategy	145 Comprehensive Strategy to be Developed
17. Continuity of Care a. Adults b. C/Y	Yes	Yes	No	No	80% of Inpatient Discharges Seen Within 7 Days in Non-emergency Outpatient Setting.	 a. 71% b. 51%
18. Community Resources	Yes	Yes	In Process	In Process Through the Monitor	60% of DMH Expenses for Community Services	FY 06: 67%
19. Medicaid Utilization	Yes	Yes	In Process	In Process Through the Monitor	49% of MHRS Billings Paid by Medicaid	FY 06: 50%

Table 1 again reflects the current status of District performance on all of the nineteen (19) Court – approved Exit Criteria. With few exceptions, the time period measured for each criterion is for on full year (April 1, 2006 – March 31, 2007). The DMH has made good progress in validating its internal data collection methods. Thirteen of the seventeen quantifiable measures have been internally validated. The remaining four are still being developed and tested for validity

(Exit Criteria 16 – 19). The Court Monitor has validated (via an outside consultant) seven Exit Criterion since the time of the January 2007 Report to the Court. There are eight remaining Exit Criteria to be verified by the Court Monitor. However, there is concerted activity on all of this and a continued high degree of cooperation by DMH program and data analysis staff.

The following categories reflect the overall status of compliance as it relates to the nineteen Exit Criteria:

1) Exit Criteria Met – Recommended for Inactive Monitoring Status

   In an April 11, 2007 letter to the Court Monitor, the DMH indicated that it has met the performance requirement for Exit Criteria #12 (Prescribing Newer Generation Medications). The Court Monitor finds that the data methodology used to verify this performance level is accurate. Hence, under the terms of the November 2003 Consent Order, the Court Monitor will cease active monitoring. It should be noted, however, that DMH is required to continue collecting and presenting data on this Exit Criteria.

2) Significant progress, but Exit Criteria Not Met – Not Recommended for Inactive Status

   There are nine (9) Exit Criteria that have additional verification and/or performance elements required before achievement of inactive monitoring status. These nine – and the remaining issues involved – are summarized as follows:

   - Consumer Satisfaction and Consumer Functioning Methods(s) – (Criteria #1 and 2)

     As detailed in II A, both of these measures have approved methods; however, the DMH has not demonstrated that the results have been utilized per the requirements of the Consent Order that approved the Exit Criteria.

   - Consumer Service Review (CSR) for Adults (Criteria #3)

     The year five results for systems performance is at 80% - the required level. However, this was based on a sample size that does not provide reasonable confidence levels (95%/+/-10%). The required sample size (approximately 88 cases versus 54) has been shared with DMH in May 2007. Planning and budgeting for the 2008 Adult CSR review will include this higher number.

   - Supported Employment (Criteria #10)

The data collection method has been validated by the Court Monitor. The DMH indicates that 97.1% of referred individuals are placed into Supported Employment within 120 days. The issue is that DMH does not have in place – per the consent order – "any methods utilized for verifying the degree to which relevant policy and practice is being followed by providers". The Court Monitor will work with DMH to develop a method to see if the Supported Housing policy is being followed. The same issues will also relate to Supported Housing and ACT services.

- Children/Youth in Natural Settings and in Own (or Surrogate) Home (Criteria # 14 and 15)

  Both of these criteria have had data methods verified and exceed the Court –approved levels. However, in both cases, the Consent Order requires that the penetration level for SED children (#6) be at 2.5% or greater before these measures can be fairly reflected. The current penetration rate is at 1.39% so it is premature to count these measures as acceptable.

- Homeless Children/Youth (Criteria # 16)

  The data for this measure has not been validated by either the DMH or the Court Monitor. There is also a requirement for DMH to develop a comprehensive strategy for homeless children, youth and families, which has not yet been done. DMH has developed an overall planning framework – which needs additional development and formal agency approval.

- Community Resources (Criteria # 18)

  The data methods for this measure have not been validated by either the DMH or the Court Monitor. A process for seeking verification through an independent accounting firm has been mutually agreed to by the DMH and Court Monitor. The next step is to complete this independent review before formal presentation to the Court Monitor.

- Medicaid Utilization (Exit Criteria # 19)

  The 50% Medicaid percentage has not been verified by either DMH or the Court Monitor. The percentage clearly reflects all of the effort to date on collections. However, the data as reported is largely missing both payments and receipts from DC CSA. These and other issues will be addressed in the months ahead.

3) Exit Criteria Not Met

The remaining nine Exit Criteria are ones that the Court Monitor believes face additional issues. In some cases, this reflects the overall resources/capacity of the current system, e.g., supported housing and ACT. The penetration number (criteria 5 and 6) for children are clearly low due to the non-inclusion of the Managed Care Organization (MCO) clients. As reflected in the January 2007 Report to the Court, additional work is needed to gather and validate the MCO data; this process is underway – with regular meetings between DMH and MCO staff. The second (and larger) issue is reflected in the Court-approved Consent order – which states that the inclusion of persons outside of the DMH mental health system will be assessed by the Court Monitor based on the level of "DMH authority, the nature of services provided, the oversight of providers and other relevant issues". These relevant issues are still to be addressed.

Specific progress on these Criteria can be summarized:

- Penetration Rates (Exit Criteria 5 – 8)

  The data collection metrics for these performance measures have been validated by the Court Monitor. DMH has obtained data about services provided by the Medicaid MCOs for FY 2006 and FY 2007 and is in the process of validating the data for inclusion in the reporting to the Court Monitor.

- Supported Housing (Exit Criteria 9)

  The data collection metric for this performance measure has been reviewed and validated by the Court Monitor. There are significant resource and practice issues to be addressed – as well as verification of DMH policy.

- ACT (Exit Criteria 11)

  The data collection metric for this performance measure has been reviewed by the Court Monitor's consultant. A process to conduct a final review and validation of this data collection metric is underway. Issues relating to compliance with DMH policy also need to be addressed.

- Homeless Adults (Exit Criteria 13)

  The data collection metric for this performance measure has been submitted to the Court Monitor for validation. DMH has agreed to

report only those consumers receiving Housing First services through Pathways to Housing for this particular measure. If the planned discharges from Saint Elizabeths Hospital occur as expected, DMH should reach this target by the end of 2007.

- Continuity of Care (Exit Criteria 17)

  DMH has been working diligently on the reporting of data regarding services provided in the community after discharge from an acute care setting.

Overall, there is notable progress on both the accurate measurement of the Exit Criteria and on the programmatic focus that will be required to achieve the Court-approved targets. It is noteworthy that the new Administration is beginning to implement an accountability tool called CAP STAT. The overall goal is put in place identified performance measures for each District agency. These measures will have a clear focus on the mutually-agreed mission and priorities for each agency and will build data bases against which to measure performance. This data-driven model will set the tone for regular discussions with the City Administrator and the Mayor's office directly. This overall process may include Dixon-specific measures; the process is still in its formative stages. No mater how the specifics get addressed, it is the presence of meaningful and objective priorities (with measurable outcomes) that will help to reinforce the process that has gone on with the Exit Criteria over the past several years.

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 is fixed in the Office of Accountability (OA). The DMH Director successfully recruited (as of November 2006) a highly qualified person for this position – with advanced degrees in both law (J.D.) and social work (M.S.W.) The Office of Accountability is undergoing major changes under new leadership and new challenges.

The OA Director has identified six near-term objectives – with targeted progress for each by October 1, 2007. These six initiatives can be summarized as follows:

1) Build interactive data bases for all key OA functions. Key functions will include licensure, certification, major unusual incidents (MUI's), complaints, investigations, audits, and corrective action plans. The current data system is ad hoc and does

not allow OA to sort data by consumer or provider. This is a major project that will require support from DMH's Chief Information Officer (CIO) and the Office of the Chief Technology Officer (OCTO).

2) Revise the claims-auditing process and protocols. The OA – since December 2005 – has had responsibility for conducting Financial Data Validity Audits (FDVA's) for its MHRS providers. The OA Director believes that the existing process and protocols need revisiting. This will include a review of sample size, eligibility thresholds for each claim that is audited, and the adequacy of the audit tool that is currently utilized. The whole area of claims auditing has taken on high priority given the increased degree of Federal scrutiny regarding mental health payments via Medicare and Medicaid. This issue will require careful coordination and planning with the new DMH Office of Strategic Planning, Policy and Evaluation and also with the D.C. Medicaid office (MAA). The OA has engaged a consultant to assist in this critical area. Among other things, policies regarding recoupment of funds need to be developed.

3) Ensure adequate training for OA staff. A good example is the need for several OA staff to be certified in Advanced Investigation Training. This has already been accomplished for three staff.

4) Create quality improvement infrastructure – both internally (for DMH-run entities) and for the overall system. The OA Director has filled the Quality Improvement Director position, which had been vacant for over two years. The first priority is to create an Internal Quality Committee (IQC) which will serve as a way to coalesce direction, analysis and oversight of QI functions for the two DMH-run facilities (DC CSA and SEH). The IQC has begun meeting and includes key clinical, medical and QI leadership from the Authority, SEH and DC CSA. The plan is to reconstitute the overall Quality Improvement Council by September 2007 with representatives from most providers and DMH. It will focus on system-wide issues such as mortality reviews, clinical fidelity and qualitative data on clinical outcomes. The development of an effective data system will be an important prerequisite to the effectiveness of this new council.

5) Build a small but effective Investigative Unit within OA. The DMH – as it has grown in size and complexity – finds itself increasingly needing to do full-scale investigations on unusual deaths or major unusual incidents. It needs the capacity to do this effectively. An existing DMH employee has been identified to

head up this unit and an additional FTE has been requested in the '08 budget. The target date to begin is October 2007.

6) Develop a comprehensive work plan for FY 2008. The intent is to look comprehensively at OA requirements once some of the immediate needs have been met. This '08 plan will include defined success measures.

Overall, the Court Monitor is pleased to see the level of energy and focused activity that is now occurring in the Office of Accountability. New leadership and the filling of key vacant positions (i.e. the Quality Improvement Director) provide beginning capacity to move forward on critical initiatives. The key will be to balance QI priorities directed toward DMH-run programs with those of the system overall. Hopefully, the next six months will see significant progress in this area.

2. Consumer and Family Affairs

The Office of Consumer and Family Affairs has had significant personnel changes which has affected its overall viability. The OCFA Director went on Administrative leave in early 2007 and has now officially left this position. In addition, the senior staff person handling all grievances took early retirement in August 2006 – which meant that this position could not be filled. As a result of these losses, the current Acting Director for OCFA is also handling the grievance process. The DMH Director is in the process of recruiting for a new OCFA Director.

Despite these staff shortages, OCFA continues to pursue its mission of promoting a recovery-based model of care for consumers throughout the DMH System. It continues to have organizational responsibility for managing the grievance process and monitoring the Periodic Psychiatric Evaluations (PRE's) process. The following are illustrative of the activities OCFA has developed or continued over the past 12 months:

- Employment – The DMH has successfully employed over 20 consumers in short and longer term contract employment assignments in various offices at the Authority. Several of these persons have gone on to obtain full time permanent employment at DMH or the DC CSA.

- Consumer Choice – The OCFA has worked closely with other DMH offices to ensure that consumers are successfully transitioned out of closing programs. The OCFA has been present to ensure that consumers receive adequate information and individual assistance to make an informed choice about a new provider.

- Consumer Advocacy – The OCFA actively assisted in the creation of a Patient Advisory Council at the John Howard forensic facility at SEH. Consumers from each unit participate on this Council and a consumer is elected to chair the meeting. The goal is to openly communicate with Administrative staff on issues of both patient rights and patient responsibilities.

- Wellness Recovery Action Plan (WRAP) – The OCFA has continued its leadership role in promoting WRAP. In addition to ongoing groups at John Howard, OCFA contracted with the Copeland center to provide a 3-day introduction to WRAP for 16 consumers. Fourteen of these consumers went on to additional training and are now official WRAP facilitators trained by the Copeland Center. The future goal is to train 20 WRAP facilitators per year with dedicated funding to achieve this support.

- Consumer Rights Training – The OCFA continues to provide consumer rights training to consumers, providers, DMH staff and community organizations. For example, over 200 Community Residential Facility (CRF) staff and owners were recently trained.

3. Enforcement of Consumer Rights

   The OCFA continues to manage the grievance process. The number of grievances being filed continues to increase – most likely due to the fact that consumers are more aware of their rights and are actively assisted throughout the grievance process. For the period of April 1, 2006 through April 30, 2007 (13 months) there were a total of 106 grievances filed. This compares to a total of 85 grievances for the 12 month period of April 1, 2005 – March 31, 2006. The largest single reason (by far) for filing a grievance related to treatment rights – either about the kinds of services provided or the way consumers were treated by staff. Of the 106 grievances filed during this period, 74 were closed – meaning the consumer was satisfied or chose not to pursue the grievance process. Thirteen consumers had taken their grievances to the external review process at the DMH Authority level. Four of these have been satisfactorily resolved, four are still pending and the other five have either been withdrawn or are not scheduled due to consumer's status (e.g. discharged from care or in jail).

   Consumer Action Network (CAN) continues to provide consumer advocacy and assistance during the grievance process. Clients approach CAN because of a referral from an agency or professionals working with the client, through references from fellow consumers, or from contact with CAN staff in outreach and training efforts. As with OCFA, the number of

consumers contacting and working with CAN has also increased, probably due to the fact that consumers are more aware of their rights and have used CAN's assistance throughout the grievance process.

The OCFA interim leadership believes that additional ongoing training is needed for both consumers and staff. The OCFA staff continue to struggle with the development of an adequate data management system. The OCFA staff is able to enter grievance information into a separate data base. However, there are multiple issues regarding needed programming, maintenance and report generation that are lacking. The shortage of staff, coupled with an inadequate data system, makes it difficult for OCFA staff to hold providers to prescribed time lines, schedule grievance appeals in a timely way and track grievance resolutions and external review recommendations. All of these functional concerns run the risk of lost confidence in the process. It is hoped that there will soon be resolution to the OCFA leadership issue so that the OCFA can once again take on its full responsibility to help lead the charge for a recovery-oriented and consumer-driven system. The DMH will also need to address staffing and data system issues in the OCFA to support a functioning grievance process. The Court Monitor expects to address the grievance process in more detail in future Reports to the Court.

The OCFA continues to monitor providers to ensure the timely filing of Periodic Psychiatric Exams (PRE's). The OCFA completes a monthly report to identify compliance by each provider. Performance is very comparable to last year; eight of the nine CSA's with committed patients meet the threshold of 80% positive compliance.

There is high concern by the Superior Court Judges that the number of committed persons in the system has dropped so precipitously – from a high of approximately 591 in 2003 to 129 currently. As noted in the July 2006 Report to the Court, this issue warrants a more in depth review. There is wide speculation that the changes in the Ervin Act (PL 21-545) requiring the physician's appearance in Court may be a major factor. There is also concern regarding the number of consumer commitments that expired simply because providers failed to complete the necessary paperwork for commitment renewal. The Office of the Attorney General has asked DMH to notify providers regarding the potential negative consequences if consumers representing a real danger are not recommitted. In general, the DMH has made progress in tracking and monitoring, but obviously more analysis and work needs to be done.

B. Review of Independent Authority for Key Functions

The 2001 Establishment Act for the Department of Mental Health created Independent Authority for this new agency for both personnel and procurement

functions. This was consistent with the language and intent of the Court-ordered Plan – which anticipated that DMH would have maximum ability to manage its human and capitol resources consistent with overall District laws and good public management practices. The Court Monitor for this Report has had several interviews to determine the degree to which this independent authority has been utilized or plans to be utilized. Several findings are of note from this review:

1) The Establishment Act of 2001 that sets up the independent authority also requires consistency with the overall personnel and procurement statutes. In review of these statutes, it would appear that there are reasonable parameters that, for example, any good human resources system would need to address. The real issue is in the underlying regulations that govern implementation of these broad areas.

2) DMH has chosen not to fully utilize its independent authority to promulgate regulations for its unique needs. Rather it has attempted to follow the layered and often convoluted regulations that have evolved for DC government. It is unclear as to why DMH has not taken advantage of its authority.

3) The new District Administration recognizes there is a tremendous need to realign and reform the existing personnel and procurement systems for the District overall. With this goal, the City Administrator is highly supportive of DMH working with the District's Department of Human Resources to create meaningful changes that could potentially also apply to other agencies. The general philosophy is to create centralized policy and decentralized authority for operations.

4) Personnel/human resources would appear to be the place to begin. DMH acknowledges that it does not have the internal capability to evaluate the existing set of personnel regulations and determine priorities for needed changes. Hence, outside consultation will be needed.

The Court Monitor is encouraged with the general willingness of the new Administration to tackle this arcane system. It is also encouraging that DMH could serve as an agency model for this process. The key will be for the DMH to engage – with the help of the District's Director of Human Resources – outside consultation to jump start this effort. There are competing views as to how broadly or narrowly to take this on; it is clearly a major project and will take concerted effort. The critical issue is that concrete steps begin. The Court Monitor will track these efforts in future Reports to the Court.

C. Review of Systems of Care Development

1. Review of Adult Systems of Care

a. Organizational Efforts to Develop Adult Systems of Care

The DMH continues to broaden and deepen its commitment to a systems of care philosophy for adults with serious mental illness. The areas of housing, employment and Assertive Community Treatment have a specific focus because of unique Exit Criteria for each. Hence they will be detailed below. However, other areas of active cross-agency work are likewise noteworthy. These include:

- Forensic – The DMH has developed a multi-faceted approach to its forensic services program. The overall philosophy that is developing is built around a Sequential Intercept model. This approach requires the mental health and law enforcement/criminal justice systems to connect at each critical point in terms of penetration of persons with mental illness into the criminal justice system – from initial officer contact for persons with mental illness to post incarceration placement. The obvious goal is to redirect/divert people with mental illness whenever possible. When not legally possible, the goal is to work with the agency providing mental health care while persons are incarcerated and provide linkage to the mental health system upon release. The DMH (along with the Criminal Justice Coordination Council) received a $50,000 Bureau of Justice Assistance Grant to develop an overall strategic plan for persons with serious mental illness or co-occurring conditions who are involved with the criminal justice system. This plan will be built on the Sequential Intercept approach. The goal is to have this plan completed by September 2007.

  The DMH has continued to grow its Outpatient Competency Restoration Program (OCRP). The goal of this program is to provide competency restoration outside of an inpatient setting (St. Elizabeths) for select individuals. The DC CSA is the outpatient component. The program seems to be working well and has had a total of 46 referrals.

  The DC Linkage Plus program began in 2005. This program is very consistent with the Sequential Intercept model and attempts to intervene with persons with serious mental illness who are at risk of or come in contact with the Criminal Justice System. Specific diversion initiatives are being developed as part of this overall effort. This program serves approximately 300 individuals and includes specific services at four points of interception or linkage:

1) Pre-booking – The DMH Homeless Outreach Program and CPEP work with Metropolitan Police Department (MPD) to do assessments and facilitate linkage to mental health services.

2) Post-booking – DMH provides screenings for the Pre-trial Services Agency (PSA), which then recommends release conditions and makes referrals to mental health services. DMH has a fulltime staff person physically at the Superior Courts to do these screenings. Referrals can be made to one of the 6 CSA's who are under contract as part of the Linkage Plus program. DMH has also funded the Options program with capacity for 35 consumers. Options provides intensive case management, medication management and housing for 10 consumers; it also provides regular reports to PSA regarding status and compliance with release conditions.

3) Jail-based Linkage – DMH has a fulltime Jail Liaison coordinator. This individual tracks all individuals with a serious and persistent mental illness, collaborating with Unity Mental Health staff regarding discharge planning and needed linkage. The intent is to connect consumers back to a CSA if they have one. For those who do not, the goal is to connect them to one of the 6 CSA's that are part of the Linkage Plus program.

4) Re-Entry – The DMH has a Mental Health Coordinator on site to provide mental health services and accepts Linkage Plus referrals from both the Court Services Office and Supervision Agency (CSOSA) and the Bureau of Prisons.

It is certainly a reality that persons with mental illness are a major part of the criminal justice system – often to the dismay of both systems – and to consumers and families. Given this hard reality, however, it is commendable that DMH has committed to a dynamic model of collaboration at all levels. There is also beginning discussion of developing an urgent care mental health clinic at the Superior Court via potential funding from the Department

of Human Services. This could include a part-time psychiatrist.

- Homeless Outreach Program (HOP)

  The HOP continues to provide outreach services to individuals who are both homeless and dealing with a mental illness. Such individuals reside in low barrier shelters, on street corners, transitional programs, abandoned vehicles and other temporary residences. The HOP has ten staff positions, including a psychiatrist. The HOP team has also gotten heavily involved in the Linkage Plus program – particularly targeting individuals at high risk who meet the Linkage criteria. Three staff are assigned to this effort, each of whom carries a specific caseload of individuals

  The HOP also provides a winter Sobering Station for co-occurring individuals who need a bed, shower, food and referrals. The HOP continues to be the primary team to do adult mobile crisis; this was previously done by CPEP. The future locus of this service will be decided as a part of the comprehensive crisis services planning.

- Co-occurring Mental Illness and Mental Retardation

  This cross agency initiative began in 2004 and was targeted toward individuals in both DMH and the Department of Disability Services (DDS) – formerly the Mental Retardation and Developmental Disabilities Administration. An effective cross agency tracking system was working in 2005 and 2006. However, staff and organizational changes at DDS significantly impacted the pilot effort. DMH staff indicate the program is now getting back on track – with referrals and regular meetings. Currently there are 66 consumers in this program – 28 of whom are in ACT services.

- Co-occurring Mental Illness and Substance Abuse.

  The DMH is the recipient of a 3 year Federal SAMHSA grant for systems change for persons with co-occurring mental illness and substance abuse. The DMH has put together an impressive array of cross-agency initiatives in the past 1 1/2 years as part of this COSIG grant. The overall goal is to create a "no wrong door" integrated

service response in both the mental health and addiction service systems. There have been high levels of cooperation between DMH and the Addiction Prevention and Recovery Administration (APRA). DMH staff who are leading this effort have adopted a Continuous Quality Improvement (CQI) approach in tackling needed systems changes. Four major teams have been created – each targeted at specific junctions of care (e.g. high risk youth who are discharged from inpatient psychiatric care).

The COSIG initiative also has a major training component. A first class of 32 different clinical staff is approximately half way through this intensive training effort (100 hours for certification). The goal is to train 150 different individuals by the end of the grant period. The Court Monitor had an opportunity to talk to several of the trainees at St. Elizabeths Hospital – all of whom were very excited about the training and the opportunity to put new skills to work at SEH.

Given the high percentage of persons with mental illness who also have had substance problems, this major effort is both timely and critical. The Court Monitor views the overall approach as very much in the fore front of national best practices. The use of CQI teams will hopefully allow this effort to continue even after the grant ends.

b. Housing Capability

The DMH continues its efforts to provide safe and affordable housing for persons with serious mental illness. The scarcity of Federal housing dollars and the continued high cost of rental units in the District make this effort an ongoing challenge. Complicating the resource issue farther was the fact that the original FY 2007 DMH budget for rental subsides was cut by $1 million. While these funds were eventually restored, it caused initial reductions in housing supports and further reduced the DMH's Exit Criteria performance – which requires that 70% of adults with serious mental illness receive supported housing services within 45 days of referral.

The DMH continues its practice of prioritizing housing supports for persons who are homeless, discharge-ready from SEH, released from jail or other institutions, living in a CRF, living in substandard housing, or who require special needs assistance. The basic eligibility requirements are enrollment in a CSA, registered

for a voucher with the D.C. Housing Authority, and willingness to pay 30% of income. The DMH maintains a formal application process – working through DMH housing liaisons of the individual referring CSA's. Qualified applications are either approved or placed on a waiting list. The DMH Housing Program maintains a housing vacancy list to assist in the housing search. The demand for housing is one of the highest priorities for consumers.

The District has received a legal opinion from bond counsel regarding the use of capital funds via general revenue bond sales. This legal opinion should facilitate the release of funds that have been transferred to the DC Housing Finance Agency to make capital grants specifically for the creation of housing units for people with serious mental illness. This contract process (targeted toward the creation of 100 new units per year) has been held up pending legal resolution. Hopefully, with this legal resolution, the funding process will begin very soon.

From the Court Monitor's viewpoint, there are at least two other major issues that must be confronted in order to meet the 70% mark. The first (and most obvious) is for the District to provide adequate housing resources for persons with serious mental illness. The restoration of the rental subsidy cuts is certainly a good start. The DMH is currently paying $500 - $600 per person per month in approved rental subsidies. If one assumes that the Federal voucher program is maxed out, then the question is what would it take in local dollars to meet established targets. Alternatively, the District could make further efforts to leverage additional "set asides" for DMH via the Housing Choice Voucher Program (HCVP).

The second issue is perhaps less obvious. The current DMH process for tracking Dixon compliance is entirely based upon the securing of <u>new</u> housing for applicants. While this is the likely outcome in most cases, it is important to note that the Exit Criterion for supported housing also allows for an individual to be <u>maintained</u> (with site-based supports) in existing housing. The key issue is the supports required to live successfully in "safe, decent, affordable and permanent housing that is their home". The DMH would be well served to look at its existing capacity to provide (and measure) housing-based supports for referred individuals. While this might normally require new or different housing, in some cases it may simply mean additional site-based service supports that could be MHRS billable. Either scenario (new or maintained housing) should yield the same end result – adequate housing and needed site-based supports.

c. Supported Employment Capability

The DMH continues to contract with six CSA's to carry out the array of services that are a part of the supported employment program. The DMH indicates that these six agencies are at maximum service capacity – which at this point is 402 consumers. In order to grow capacity and referrals, the DMH has undertaken a four-part strategy: 1) Increase the current hourly rate to providers from $45 to $65. This will cover costs and allow some additional agency staff. 2) Develop a plan to draw down Medicaid for specific work-related support services. This will help leverage local dollars. 3) Add two additional providers in FY 2008 and 2009, plus add a supported employment specialist to the existing ACT teams. This will allow the program to grow in a significant way. 4) Collaborate with the DMH Training Institute to help educate staff and consumers about the availability and value of supported employment. This is a critical piece because – as noted in the III C discussion of performance criteria – the supported employment program appears to have a suppressed level of referrals due to lack of knowledge and limited capacity. 402 consumers out of 8691 persons with SMI represents only 4.6%. This stands in stark contrast to the consumer message that employment is one of the most desired services from a recovery-based system.

The Supported Employment Program is targeting the need to develop supported employment services to transition age youth (ages 18-24). The DMH is soliciting proposals for this new initiative – with the goal to serve 20 youth initially in obtaining part or full jobs and/ or enrolling in college or technical schools.

The Supported Employment Program has – as a part of its strategic planning – set a goal of doubling the number of consumers able to be served at any point from approximately 400 to 800 over the next two fiscal years, representing a service level closer to 10% of persons with serious mental illness. The DMH further projects that at least 60% of persons receiving services will be gainfully employed.

The Supported Employment Program has)on an annual basis) done fidelity assessments for each of its contracted providers. These scores indicate that all providers are in the fair or good range in overall fidelity. The Court Monitor is pleased with the energy, planning and direction of the Supported Employment Program. The next 12 months should see significant growth in both the awareness of this program and its overall capacity to serve.

d. Assertive Community Treatment (ACT) Services

The past 12 months have been very active for the ACT coordinator, but much work remains to be done. Perhaps for the first time, the DMH has a handle on many of the core elements necessary to manage this program at the Authority level. These include having a single point to collect and analyze ACT data, provide information to ACT providers and provide consistent guidelines and procedures for all ACT teams. As noted in II C, DMH is now able to generate ACT data per the Dixon criteria. The ACT coordinator has also done considerable education to key stakeholders – including CPEP, SEH staff, Mental Health Commission members and DC Superior Court Judges. Each of these are key points of referral to the ACT program. The DMH has – as a part of its SEH discharge plan – targeted 50 consumers at SEH who will move (by August 2007) into an ACT program run by Pathways to Housing.

Despite all of the work on ACT, there are still major issues to be resolved. These include:

1) The DMH has still not finalized its ACT policy, although it is now in final draft form. This policy is the obvious precursor to many other issues. It is not yet clear if this policy will trigger changes to MHRS rules and a potential Medicaid State Plan Amendment.

2) There does not appear to be any process by which DMH measures fidelity for the ACT teams. The lack of external measures reinforces the already existing concerns about whether ACT Teams are truly functioning according to national standards for ACT services.

3) The referral patterns to ACT continue to be low. From April 1, 2006 – March 31, 2007, there were a total of 61 valid referrals to one of the ACT teams. This average of five referrals per month seems very low given the array of high-need individuals in the system.

4) The current census of ACT consumers remains well below the defined capacity of the system. April 2007 data from DMH show 396 consumers enrolled in ACT as compared to capacity of 520 (76%). This excess capacity may reflect ongoing structural barriers in the system, negative perceptions of ACT teams or the continued misperception

that ACT teams are at full capacity. Pathways to Housing has been a good example of very targeted use of ACT services – both to persons who are homeless and at SEH. The DMH has also made it possible for ACT referrals to go directly to Pathways, thus eliminating one of the structural barriers.

5) Overlaying all of this is also the concern that the person who is the ACT coordinator will be leaving DMH due to the elimination of contracted positions via the Public Health Service. This critical vacancy raises concerns about the potential loss of the progress that has been made. Hopefully, DMH will move aggressively to fill this key position. It is clear that a great deal of work still remains for DMH to meet the Dixon criteria for ACT services.

2. Review of Child/Youth Systems of Care

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

The organizational context for systems of care development for children/youth has continued to change in the District. As noted in the July 2006 Report to the Court, the District agreed with SAMHSA not to reapply for years 5&6 of the original systems of care grant. SAMHSA also agreed that the District would be able to apply for a future systems of care grant. Instead the District committed to a different structure for managing and integrating Systems of Care for children, youth and their families. The Deputy Mayor for Children, Youth, Families and Elders was integral to this decision making. SAMHSA agreed to let the District use carryover funds to support key infrastructure-building activities that would further development of a children's system of care. With this carryover money, DMH contracted with the District's Child/Youth Investment Trust to manage a sub-grant process, whereby five community organizations were awarded seven grants, totaling over $900,000, to provide family education, supports and social marketing to support development of the system of care and services for the population of focus.

The new Mayor has chosen not to establish a position of Deputy Mayor. While the Mayor's office continues to be involved in key finance and policy issues, it is no longer the epicenter for coordinated planning and cross-agency participation. Despite this fact, DMH and its sister agencies (especially CFSA) have forged ahead with implementing the basic tenets of the new plan. Central to this is the implementation of family team meetings as the

organizing structure for planning and coordinating all services and supports needed to meet the needs of multi-agency involved children and youth. The model for these meetings requires that agency workers involved with the youth be present at the meeting, thus supporting an interagency rather than a unilateral approach for planning and decision making. DMH, CFSA and DYRS have embraced the model and it serves as the sole mechanism for reviewing cases under consideration for psychiatric residential treatment facility (PRTF) placement. As of the time of this Report, 118 children and youth are enrolled in the DC system of care. The target population is children/youth who are seriously emotionally disturbed (SED), at risk of out of home placement, and eligible for MHRS through fee-for-service Medicaid.

Another contextual element is that DMH and CFSA have accelerated the degree to which they are planning and implementing in a joint fashion. This has certainly been driven by at least three major factors: 1) A genuine commitment to a family-centered approach 2) the recognition that many families are connected to both systems and 3) the combined interest of the LaShawn and Dixon Court Monitors to work collaboratively on issues involving mental health services. The details of this will be discussed below.

Another significant reality in terms of systems of care planning is that the large majority of children/youth who need/receive mental health services in the District are enrolled in either the Health Services for Children with Special Needs (HSCSN) or one of the other three privately run Managed Care Organizations (MCO's) that serve the TANF population. According to the data provided by the MCO's to DMH, there were a total of 2763 children/youth who received services from an MCO during the period from October 1, 2005 through September 30, 2007, that did not receive an MHRS-funded service. In addition, there were over 700 children/youth who received services funded by both DMH and an MCO during that same period. DMH is in the process of validating the MCO data.

However, representatives from the MCO's attend the bi-monthly Children's Roundtable and actively participate in the discussions with CFSA and DMH about the service array and coordination of services. The Roundtable has created the opportunity for the DMH, CFSA, the MCO's and providers to discuss issues of mutual concern (e.g. MHRS referrals and transition planning for discharged youth).

b. School-based Services

The School Mental Health Program (SMHP) continues to be a dynamic part of the child/youth system. It is operated directly by the DMH Authority. The SMHP has grown significantly over the past year – providing an array of prevention, crisis, treatment and consultative services in 42 schools. This compares to 29 schools in July 2006. The number of students seen has likewise grown from 525 in 2006 (12 months) to 685 (YTD for 2007). The overall growth of 40% created the need to establish key infrastructure positions – including an evaluation coordinator, crisis coordinator, program manager and program specialist.

The SMHP continues to evaluate multiple aspects of both the student's and the school's satisfaction with the program. It also continues to evaluate clinical outcomes e.g. depression, anger, disruptive behavior and school level performance outcomes including truancy, suspensions, and school climate, etc. Individual schools have been highly appreciative of the consistency and quality of the SMHP services as indicated by teacher and administrative surveys.

The District Council has recognized the value of the SMHP and has continued to increase program funding. The intent for FY 2008 is to add an additional four schools (total of 46). The major issues for the future are 2-fold: 1) There is a critical need to develop an electronic data system (web-based) that is accessible to all clinicians. Currently data sheets are filled out manually by each individual clinician, then re-entered into an excel spreadsheet. This expressed need – along with others in DMH – relates to the information systems capacity of the CIO's office. 2) The issue of potential Medicaid support for SMHP is now beginning to be addressed. The current plan is to pilot this concept in four schools for next year. The DMH would fund the full amount for the first year while it evaluates the potential for Medicaid revenue. Clearly, many of the SMHP services are not MHRS reimbursable. The plan is to collect Federal dollars for those services, such as treatment services, that are billable. This then could be a way to leverage local dollars so as to grow the SMHP even further. The Court Monitor feels strongly that the potential for Medicaid support for SMHP should be vigorously pursued. The projected 46 schools to be served in FY 08 is still only about one-fourth of all the public and charter schools in the District.

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

The DMH child/youth leadership shared data regarding the number of referrals for residential placement from October 2006 through April 2007. These cases are now all reviewed via the cross-agency family team meeting model – which has been fully in place since October 2006. The seven-month data indicate that there were 99 referrals for residential placement – of which 50 were diverted to alternative community programs. While the 51% diversion rate appears to be significantly lower than the rates from previous years, changes in counting methodology in part explain the difference. Additionally, there is indication now that youth being presented to the SOC are youth with serious deep-end treatment needs and that diversion from a PRTF placement represents a marked improvement in the capability of the community system.

To bolster its capability to keep children/youth in the community, the DMH has initiated a new pilot effort to serve children/youth who are most difficult to serve in the community through a true wraparound model. The pilot will be supported by blended local funds in a way that supports a single, cross-agency, family-driven care plan. The initial target is 25 children and families and the goal is to have the pilot up and running by early in calendar year 2008. The DMH is working closely with the Medical Assistance Administration (MAA) to determine what waiver or combination of waivers would optimize federal support in order to make wraparound available to a broader population.

The DMH – through the Child/Youth Services Division – continues to manage the Residential Treatment Center (RTC) Reinvestment Project. The front-end part of this effort is to complete comprehensive assessments for youth who are being considered for residential placement. As of November 2006, the DMH Child/Youth Assessment Center was organizationally placed under the Reinvestment Program Administrator. The Assessment Center continues to complete psychiatric evaluations for Juvenile Justice youth and child welfare-involved youth. The issue of turnaround times continues to be of concern to DMH, the referring agencies and to the Courts. The Jerry M. case mandates completion time for psychiatric assessments. The DMH indicates that the average turnaround time—from Court-ordered assessment to report completed for the Court—is 47 days for FY ’07 (down from 58 days for FY ‘06). The transition of mental health treatment assessment for CFSA-involved youth to community providers, which will occur over the next year, will decrease Assessment Center volume and thus reduce turnaround time.

The RTC Reinvestment Program is staffing up in order to do in-depth tracking and monitoring of CFSA children/youth who are in psychiatric RTC's. This number averages around 100 at any given point in time. 38% are paid for entirely with local funds. 87% of the children/youth are in RTC's over 100 miles from D.C. – which makes family visiting and DMH staff oversight that much more difficult. The RTC unit is also tracking the average length of stay – which is running at nearly 19 months, considerably higher than systems with active wraparound services. The DMH still does not have full access to data for the total number of children/youth (from all child-serving agencies) who are in residential placement, as well as the full costs associated with those placements. However, it does seem that the RTC unit is developing good monitoring and oversight capacity. The remaining step is to create full participation across child-serving agencies (including the public schools) as a part of creating consistent and reliable alternatives to expensive residential care for most children. The Court Monitor feels strongly that the possibility of potential Medicaid support for SMHP must be seriously explored. The other goal – as witnessed across the country – is to significantly shorten the length of stay for children/youth who are placed into RTC's.

d. Child Welfare/Foster Care

As noted earlier in this Report, the DMH and CFSA have been actively collaborating at many levels. In fact, the degree of cooperation between the two agencies is perhaps higher than it has ever been. One of the major frameworks for this joint effort has been the Amended Implementation Plan (AIP) in the LaShawn case.

The AIP was approved by U.S. District Court Judge Thomas Hogan on February 27, 2007. It sets specific outcomes and strategies to meet these outcomes by December 31, 2008. One of the specific subsections of the goal to promote child well-being speaks to action steps required by the DMH and its provider system. There are nine distinct strategies and DMH has the lead on six. These identified issues include (as primary examples): a comprehensive needs assessment of mental health needs of CFSA-involved children/youth; a Request for Proposals for a limited number of Core Services Agencies to meet access standards and provide a specialized array of services for CFSA Youth; development of a community wraparound service for youth who are at risk of placement in a psychiatric residential treatment facility or have experienced multiple inpatient hospitalizations;

adding key additional staffing at DMH to support the DMH/CFSA interface; and issuance of an RFP for the currently closed Hurt Home for children ages 6-12. DMH submits a biweekly report to CFSA tracking progress on the AIP deliverables. As of the July 6 report, all deliverables were on track except the needs assessment (CFSA is the lead on this deliverable). Though completed in April 2007, the report does not outline the steps for meeting childrens' needs based on the assessment. Both agencies are working on completing a next-steps document and CFSA has retained a consultant to spearhead the process. DMH has selected applicants for the new positions and hire dates have established for all but one. That position will be covered temporarily by an internal detail while a final recruitment decision is made.

Overall, progress on the child/youth systems of care development is still very mixed. The amount of cross-agency work between DMH and CFSA is very encouraging. The Court Monitor continues to support the philosophy and the direction; the challenge is to put the pieces together and make it work on a consistent basis. The 48% positive score of the CSR systems performance clearly suggests there is a long way to go. Hopefully, the inter and intra-agency work will begin to show payoff over the next year.

D. Review of DMH's Role as Provider

1. Planning for New/Consolidated Hospital

The construction of the new 292 bed Hospital has had some unexpected delays – primarily due to weather and contaminated soil in two different locations. These factors have put the project 45-60 days behind the original schedule. However, Tompkins (the builder) is hoping to make these days up by working on Saturdays.

The overall timeframe for completion remains at 36 months, which includes the demolition of the John Howard Pavilion and the construction of an exercise yard and new parking lot. The planned occupancy of the new Hospital would occur at approximately 30 months. Given the current status, this occupancy would occur during the summer of 2009.

Another critical piece is the successful contracting of phase one for the renovation of RMB, CT7 and CT8. The phase one element includes the consolidation of utilities onto the East campus. This project has OAG approval and was approved by the D.C. Council on June 18, 2007. The notice to Proceed was issued to Forney-Manhattan the week of June 25, 2007. The target to complete phase 1 of the renovation of RMB, CT 7 &

CT8 is eighteen to twenty-four months, due to seasonal switchovers for heat and air conditioning. This is a complex project because much of the work will take place in occupied buildings. The construction team has devised a way to assure adequate power to the building, so as not to affect occupancy. This is a critical path issue for the overall Hospital project to stay on timeline. Any further delays will risk overall delays on completion and occupancy of the Hospital. This cannot be tolerated.

2. Quality of Care Issues at SEH

The most significant development since the January 2007 Report to the Court has been the Department of Justice (DOJ) Settlement Agreement which was signed by the parties on May 10, 2007 and approved by the Court on June 25, 2007. This Settlement Agreement outlines a comprehensive set of actionable strategies and timelines to achieve them. The parties also signed a Strategic Action Plan (SAP) which supplements the original settlement. The SAP provides greater detail in certain areas and was signed by the parties on May 22, 2007. The settlement tracks very closely to the issues raised in the original May 2006 DOJ report.

In direct response to the Settlement Agreement, the Hospital has put together an ambitious Reform Plan, which has been shared with the Court Monitor in draft form. This Reform Plan delineates specific actions, responsible person, target date and current status in each of the following areas:

- Integrated Treatment Planning
- Mental Health Assessments
- Discharge Planning and Community Integration
- Specialized Treatment Services
- Protection from Harm
- Incident Management
- Quality Improvement
- Environmental Conditions
- Training
- Staffing
- Equipment/Infrastructure/IT needs

The complete list contains at least 94 different actions that need to be accomplished and monitored. While this is a daunting list, it clearly tracks to the Settlement Agreement and reflects the scope of tasks that need to be accomplished concurrently. It is organized in a way that will provide a clear division of labor and provide for ongoing review as to current status. In reviewing this document with Dr. Patrick Canavan, the new Director at SEH, the Court Monitor was impressed not only with the breadth of the planning, but also with the level of integration and attention to detail.

One of the key elements of the Settlement Agreement is the hiring of a Compliance Officer. This position has been filled, with the selected individual on staff full time as of July 2007. The Compliance Officer will report directly to the Hospital Director and will serve as liaison among SEH, DMH, DC government, and DOJ. This key position will monitor the District's compliance with all of the provisions of the Settlement Agreement and will prepare semi-annual reports regarding compliance.

The Court Monitor has updated and reviewed specific items that – while imbedded in the overall Settlement Agreement – bear special focus. These include:

- Leadership/Accountability

  The SEH Director has taken aggressive steps to reorganize leadership roles within the Hospital. This has involved the reassignment of several key individuals. The goal is to match skill sets with the critical need to focus leadership tasks. This effort has also led to revitalizing the Treatment Mall. Professional and Staff are now located in the Mall – along with treatment charts. The intent is to make the mall the epicenter of treatment activity – which was the original concept. Inherent in all of the reorganizing and planning is the fundamental concept of holding people at all levels accountability – starting with those in leadership roles. Building this "culture of accountability" will be a key predictor of future progress. It is clearly off to a good start.

- Staffing

  The DMH 2007 budget was increased $8.6 million for SEH. OF this amount, $5.4 was to add additional staff – primarily in areas of clinical care (psychiatry, nursing, psychology, pharmacy and nutritional services). Nearly 120 new positions have been added. In addition, the 2008 requested budget includes an additional $4.1 million (75 FTE's). This requested amount stands as the District's overall budget went to Congress for approval. Clearly, additional dollars and staff resources have been made available – with more to come.

  The major continuing challenges are the ability to recruit and retain qualified staff. The DMH HR Director continues to make this a top priority and some discernable progress is noted. As of July 9, 2007 the DMH has successfully filled 102 positions since October 1, 2006. This includes a number of key clinical positions, including 44 nursing personnel (RN's and nursing paraprofessional) and 6 psychiatrists. Nevertheless, there are still

79 vacancies as of July 9, 2007 so the ongoing task of aggressive recruitment still remains. Of these 79 vacancies, 23 are in the areas of nursing personnel.

As recruitment efforts have intensified, the issue of retention continues to be of concern. Since October 1, 2006 a total of 78 employees have terminated from SEH – including 49 who were in clinical positions. Hence, the challenge is a dual one of both recruitment and retention of qualified individuals.

The DMH is in the process of developing a multi-pronged approach to both recruitment and retention. There are two recent developments that should help. First, the DC Council passed legislation on July 10, 2007 that will provide salary increases for non-union employees. Part of the overall 6.25% in increase will be retroactive to Feb 18, 2007 and the remainder will be effective October 1, 2007. This will put DMH non-union employees on the District pay scale. The issue of non-union pay has been outstanding many years. The Council action will allow for increased pay scales for nurses, and allied medical interns; it also created three new pay scales for Supervisory Wage Service Rates, Supervisory Medical Officers and Medical Technologists. The other major element of the Resolution is to allow DMH to fully implement the Management Supervisory Service Pay Schedule as the basic pay schedule for eligible management/supervisory employees. This MSS system has been in place in most DC agencies for several years; it provides a varying pay-for-performance compensation system that should provide increased flexibility and accountability for performance.

The other significant development is the creation of a fully staffed H.R satellite office at SEH. This will include additional staffing targeted toward nurse recruitment, classification specialist and employee relations. This should help to improve both recruitment and retention efforts.

The DMH Human Resources Director indicates that over the next 6 months additional strategies will be developed to intensify both recruitment and retention. Some of these are targeted strategies for hard-to-recruit professionals e.g. psychiatrists. Hopefully, these additional efforts can be detailed in the January 2008 Report to the Court.

- Environmental Conditions

During the 2-year period before the new Hospital is occupied, the hospital understands that it needs to meet reasonable standards to ensure that any environmental hazards are corrected and that any unsanitary conditions (especially in housing units and kitchen areas) are promptly addressed. It has taken several steps toward this end, including a monthly building inspection of all occupied areas. These reports funnel up through the Risk Management and Safety Committee – which is overseen by the Hospital's Risk Manager. The Risk Manager will also monitor any complaints that come in via the consumer complaint log.

The Court Monitor, in a walk through several of the buildings, noted that the units looked cleaner in general – with several areas having been freshly painted. Clearly the maintenance of horribly outdated buildings is a challenge, but timely attention to basic issues of cleanliness and repair can go a long way. It appears these efforts have begun.

- Internal Quality of Care Monitoring

  The Hospital has restructured its Performance Improvement Department (PID) to focus on four key areas. These include Active Treatment, Environmental Conditions, Infection Control, and Discharge Planning. Quarterly self-assessments are done in each of these areas – with follow-up actions as noted.

  The whole area of active treatment is a major one. As noted earlier, the refocusing of staff into the Treatment Mall is a major step. It should be noted that CMS has in recent months recertified 96 beds under the Medicare certification program. Active treatment has been a major issue in prior CMS reports. Dr. Richard Fields continues his consultative work at SEH. Given the DOJ settlement as a framework for action, Dr. Fields will assist Hospital leadership in building an integrated clinical path. He will also help to reactivate many of the Quality Improvement Teams that previously existed. It is obvious that – as noted in previous Reports to the Court – there is a high degree of consistency in all of the findings from outside reviewers/consultants. The task is how to organize, structure and monitor internal efforts to achieve incremental (but measurable) results.

  It should also be noted that the Hospital has now committed itself to pursuing accreditation by the Joint Commissions on Accreditation of Healthcare Organizations (JCAHO). Accreditation by this national body should also help to serve as a focal point for staff efforts. The target date to achieve

accreditation is late 2009 – assuming the new Hospital is occupied by then.

- New Information Technology System

  The planning for a new IT system at SEH has made solid progress. The District Council has approved a contract with Net Smart to develop and install a new information system (AVATAR). A dedicated project manager from Net Smart has been working intensively with a work Team made up of the DMH Chief Information Officer (CIO) and dedicated staff (administrative and clinical) from SEH. The overall project has three phases – with core data (admissions, discharges, patient demographics, billing, pharmacy and lab) a part of Phase 1. The target date for completion of Phase 1 is January 2008. Phase 2 (clinical information) and phase 3 (Incident Tracking) will begun in early 2008 – with the goal to complete the entire implementation by early to mid – 2009. The AVATAR system will be an essential component of the Hospital's ability to track and manage on all fronts. It is encouraging to see this project finally moving forward.

- Alternative Community Care

  The DMH has shown progress in implementing its Discharge Plan. The original target list was 108 patients who had been at SEH for over 30 days. The goal was to outplace 55-65 persons by July 2007. In reality, as of June 19, 2007, 80 persons had been discharged from SEH. 72 have been discharged into community settings and 8 into nursing homes. The DMH Project Team Leader for this effort has worked intensively with staff at the Authority, SEH and CSA's. While the target numbers have been exceeded, the census at SEH has not changed appreciably because patients from the acute units at SEH are moving into the longer-stay units. Hence, the focus is now being broadened to look both at new admissions (less than 30 days) and those who have been there over 30 days.

  This project has highlighted several facts:

  1) There is still not tight coordination/discharge planning between SEH and local CSA'S for new admissions. The Project leader and SEH staff are looking at specific ways to improve this collaboration and hopefully shorten stays for new admissions.
  2) There are at least 24 patients who need nursing home care. Of these, only 8 have been transferred. Further progress

will depend on developing stronger psychiatric consultation and support to willing nursing homes

3) There are identified clusters of patients at SEH with specialty needs. These include persons with co-occurring mental retardation, medical problems and predatory behavioral histories. Successful community planning will need to ensure that local providers have services/programs that are uniquely responsive to these higher-risk patients.
4) The Pathways initiative has not moved as quickly as planned – with only five individuals moved to date. It is hoped that the barriers have been worked out and the original plan for up to 50 people can still be realized.

Overall, the discharge planning process is working. However, there will need to be more work on new admissions if the ultimate goal of reduced census at SEH is to be achieved.

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

Progress on the development and use of acute care beds has largely stalemated. If anything, the situation has deteriorated due to the uncertainly regarding the future of Greater Southeast Community Hospital (GSCH). The psychiatric staffing (as provided by PIW) is at one psychiatrist – which effectively limits the number of acute beds to fifteen maximum. Thus not only is the new 20-bed unit not being rehabbed, but the existing 20 bed unit is not able to be maximally utilized. There is concern that Greater Southeast might further curtail its operations or even go out of business altogether. The District Council has held several recent public hearings regarding the ownership, financing and conditions at GSCH. The potential change in ownership has not moved forward and it is unclear when (or if) it will.

The DMH has developed a contingency plan for acute admissions if GSCH is no longer an option. This would involve the use of PIW – which has plenty of available beds and has in the immediate past had a contract with DMH to handle acute care. The problem with PIW is a financial one; PIW is considered an IMD for Medicaid purposes. Hence it cannot bill for patients age 22-64, which would be the large majority of patients. This option – though it might become a necessary temporary solution – is not a viable longer-term solution.

The DMH leadership continues to explore other options with local Hospitals – with limited interest to date. The potential collapse of GSCH might create greater political attention to the use of other D.C. Hospitals for general acute care. This could create opportunities for DMH to leverage acute psychiatric beds. The other point of opportunity is the

development of the comprehensive crisis plan. In an ideal scenario, the future home of CPEP could (and should) be connected to acute psychiatric beds – as a part of an existing acute general hospital. The District will obviously need to work at assuring any Hospital as to longer term financial and organizational commitment on the District's part.

In the meantime, the number of acute admissions to SEH continues to average 45 per month and SEH continues to operate two acute care units (45 beds). This further compounds the issues at SEH and forces the District to unnecessarily spend 100% local dollars on acute care. As noted in previous Reports, the District is clearly not in compliance with the Court-ordered Plan on this issue.

4. Management and Role of DMH-operated CSA

For the past two years (beginning with the July 2005 Report to the Court) the Court Monitor has pushed for a serious review of the role, cost efficiencies, and governance of the existing DC CSA. This process is finally happening with a team including the DMH Director, DC CSA Director, the DMH Chief Clinical Officer and other senior leadership staff at the DC CSA meeting on a weekly basis. At the time of this Report, there are no final recommended actions or resolutions on any of the major issues under discussion. However, there does appear to be an emerging consensus on several issues, as follows:

a) There are opportunities for additional short-term reductions in fixed expenses. The primary focus has been on closing out two existing sites and consolidating these programs into other locations. These include the two sites on N street – which could be relocated by as early as the fall of 2007.

b) The DC CSA has made solid gains over the past five years on both the administrative and clinical side of the operations. Major accomplishments include:

- The reduction of actual FTE's at DC CSA from 591 in 2001 to 290 currently. These numbers mirror the reductions in overall expenses.

- Implementation of an entirely new electronic information system. All three modules of this multi-year effort have been installed – with 89% of clinical staff demonstrating competency in the new system. This new IT system sets the stage for overall efficiency and productivity enhancements.

- Implemented productivity standards for all clinical staff. The overall expectation is for staff to be at 50% of available hours to be billed. The DC CSA overall is currently at 40%. Approximately 1/3 of the staff are below 35% - which triggers a corrective action plan and progressive discipline up to and including termination.

- Consistently scored well on the annual Consumer Service Review (CSR's). The DC CSA has embraced the CSR model and has incorporated it into its internal training and care model. As a result, the DC CSA has been one of the CSA's that has shown the highest scores for both children/youth and adults. While recognizing that sample sizes are limited, this is nevertheless an impressive organizational accomplishment.

- Implemented a comprehensive CQI Program to measure and manage with quality and performance indicators. Issues that are routinely tracked include, for example, mortality reviews, major unusual incidents, provision of clinical supervision, and completion of health assessments.

c) There are a critical set of District-wide specialty services that the DC CSA currently provides. Some of these are true "safety net" functions e.g. services to the uninsured; others are specialized services/roles that the DC CSA has taken on in response to DC government or due to gaps in the privately run CSA's. Services/functions that have been discussed include (as examples): pharmacy services, ADHD clinic, emergency services, medical co-occurring disorders, first response for disasters, geriatric services, cross-cultural clinic, and competency restoration services. While any of these services could in theory be developed in the marketplace, there is a reality that many of these specialty services only need to be done by one provider in a manner that is highly responsive to the DMH Authority and D.C. government.

d) Despite productivity gains and cost reductions, the DC CSA does not generate revenue that is anywhere near its costs. If the MHRS revenue-generating part of the DC CSA is separated out, its projected expenses for FY 2006 were in excess of $23 million. Its gross revenue for the same time period was $9.2 million – a $14 million gap between gross revenue and actual costs. The $9.2 million does not represent realized revenue – which is considerably less. Normally a not-for-profit organization would want to show gross revenue at least equal to gross cost. Hence, as reflected in past Reports to the Court, this "subsidy gap" of $14 million

continues to show the magnitude of the current business model. In simple terms, the problem is still the combination of high personnel and fixed costs and relatively low staff productivity.

The overall issues regarding the DC CSA have not changed. What offers some encouragement is that the DMH Director and key DC CSA leadership are asking the hard questions and looking at critical facts. The issues continue to revolve around: a) overall community capacity (if some or all of the DC CSA went away) b) clear identification of specialty/safety net functions c) determining criteria for decisions as to what services can be delivered via private sector agencies d) evaluating the need and capacity for the DC CSA (or a successor quasi-public agency) to provide specific services to target populations. The overall target date for completing the review and developing a plan is October 2007. While this process of review is long overdue, this timeline strikes the Court Monitor as a reasonable one. The critical step, once a plan is developed, will be to gain the necessary support of key players – including the Mayor's office, DC Council, advocates and impacted personnel. The Court Monitor will continue to closely track this process.

E. Review of FY 2007 Budget Issues and Status of FY 2008 Budget

The outstanding budgeting issues for FY 2007 appear to have been addressed. The $8.6 million for SEH was approved – with $5.4 million to go for additional staff. The Medicaid Reserve Account has also provided an additional $13 million for persons who are uninsured but in need of MHRS services. $3 million of this total was allocated for funding shortfalls in the Juvenile Assessment Center and the multi-systemic therapy (MST) program. The remaining $10 million has been budgeted as a separate contract with individual CSA's. Given the overall reductions in provider claims submissions year-to-date (as discussed in IVC, this $10 million for the uninsured appears to be adequate.

The proposed FY 2008 Budget for DMH stands at $249 million – of which $210 million is local funds. This budget (as part of the overall District Budget) has passed the Council and been approved by the Mayor. It has now gone to Congress for approval. It would appear that the major initiatives for DMH have been addressed in this budget, including:

- An additional $4.1 million for SEH to cover 75 additional staff in compliance with the DOJ agreement
- The full inclusion of supplemental dollars from 2007
- An increase in contract dollars to support safe and affordable housing
- $4.6 million to cover costs associated with union and non-union salaries
- An increase of $1.2 million (12.0 FTE's) to increase the capacity for the extended observation unit at CPEP

- An inctease of $3.1 million to cover costs associated with meeting the mental health needs of CFSA children/youth per the LaShawn AIP.

Overall, this appears to be the strongest base budget that DMH has had. Hopefully, it reflects growing confidence in the agency and a true commitment to meet the District's mental health needs as expressed in the Dixon case.

IV. Follow-up on Other Previously Identified Recommendations

A. Crisis Services Planning and Relocation of CPEP

The January 2007 Report to the Court recommended that the DMH "develop a comprehensive plan for crisis/emergency services". The DMH has, in fact, set about to do this. The DMH Director has personally chaired a Crisis/Emergency Services Planning Workgroup that has met on a biweekly basis since February 2007. This workgroup is very broadly inclusive of DMH staff, local providers, consumers, advocates, law enforcement and the Courts. The Court Monitor – in review of the minutes of these meetings – finds that the workgroup has undertaken a thorough analysis of current gaps in the system and interviewed other jurisdictions with comprehensive crisis/emergency systems. The overall components of a crisis/emergency system have been identified. These include (at a minimum): a 24/7 crisis/emergency services hotline, mobile crisis services, crisis observation beds, and crisis/respite beds. All of these services need to be carefully planned with law enforcement so as to ensure clear understanding of roles and the appropriate diversion of people into the mental health system.

A draft Interim Report was circulated to the workgroup in early July 2007. DMH anticipates that 4 or 5 more meetings will be required to address the remaining open issues, including the organizational structure and funding strategies. A draft plan is expected to be circulated in early September 2007. The Court Monitor is pleased with the process and the progress to date. The comprehensive and integrated model is highly consistent with the Court-ordered Plan. It is anticipated that the Draft Plan will be widely reviewed for comment. It will be critical that all of the key stakeholders support this plan and help to move it forward to full implementation. The Court Monitor will continue to track progress.

The relocation of CPEP has not moved at all. The long-running uncertainty regarding the ownership and viability of Greater Southwest Hospital (as discussed in III D 4 of this Report) is the major factor. As noted in the May bimonthly District Report to the Court, the DMH has sought clarification as to potential interest in the land lease at GSCH. No response has been received as of the date of this Report. Hence, the unfortunate reality is that this issue will likely continue unresolved until both there is clarity about both the future ownership of GSCH and its viability as an acute care hospital. The DC Council, in partial response to this uncertainty, has enacted permanent legislation about CPEP during the July

10, 2007 legislative session. The permanent legislation authorized the District to enter into a ground lease for CPEP at an unspecified location, rather than requiring the negotiation of terms with Greater Southeast Community Hospital. This new crisis/emergency services plan will need to incorporate planning as to the size, role and desired location for a new CPEP.

B. KPMG

The District originally engaged KPMG to do an overall assessment of DMH's administration of Mental Health Rehabilitation Services (MHRS). This August 4, 2006 Report detailed numerous ways for DMH to improve its MHRS programs. Many of these initiatives are underway. To assist DMH with some of its priority objectives, DMH contracted with KPMG again in early 2007 to provide help in four areas. These efforts (and current status) are summarized below:

1) Project Management of MHRS Improvement Initiates

KPMG has worked with DMH in establishing a Steering Committee to oversee all of the improvement initiatives. The intent is – via this group – to oversee time-specific tasks that are both linear and linked. As of June 2007, the DMH has contracted for an experienced project manager who will work on these tasks and timelines. Progress is updated on a weekly basis. DMH staff report that the structure and discipline of this effort has been very helpful – although it is not entirely clear how this process will be maintained once the KPMG contract ends.

2) Support for Medicaid- denied Claims Recovery

The KPMG has helped DMH to track its overall efforts to collect potential Federal Medicaid Dollars going back as far as FY 2002. There are multiple issues that have been identified and analyzed as areas for priority focus. These include; issues of same-day-service (clients being seen more than once in the same day); eligibility determination, name format (different names in the respective data bases); and claims that have been submitted by DMH but not paid. Value Options has also worked with DMH to identify specific areas for recovery. It appears that these efforts are having real payoff. To date, $7 million in Federal Financial Participation (FFP) has been paid by the Medical Assistance Administration (MAA). An additional $7.5 million is still in play. The MAA has worked very cooperatively with DMH in all of these efforts. The hope is to not only resolve the majority of potential past claims but to establish clear policy and information system interfaces so as to minimize disparities going forward.

It is worth noting that DMH tracks its overall FFP collection percentage year to year. With 100% as the ultimate goal, the system is at 77% for FY

2007. This compares to only 60% for FY 2006, so clearly progress is being made.

3) Movement of Medicaid Claims Payment to MAA

The Court Monitor expressed concern in the January 2007 Report to the Court about the importance of working out all of the needed coordination, role, and interface points before this transition occurred. It appears that this has in fact happened. A single workplan has been developed with clear tasks, timelines and accountability. Monthly meetings with MAA are happening to discus status and any unresolved issues. The revised target date for the transition is for provider claims beginning October 1, 2007. Thirty days prior to the official switchover there will be a "testing" of the new system to ensure planned systems are working.

Post the transition, DMH will continue to do the front end authorizations and initial determinations that claims are valid and eligible for Medicaid payment. DMH will also continue to authorize warrants for non-Medicaid eligible services. It is anticipated that common reports will be generated for both agencies so that any disparities can be identified early and resolved.

The Court Monitor appreciates the way in which DMH and MAA (with KPMG's help) have slowed down their timeline so as to ensure a successful transition. While there will undoubtedly still be issues, it does now appear that the major ones have been addressed. It will be critical that DMH and MAA staff continue to have regular communication and meetings to continue their problem-solving approach.

4) Development of an Administrative Services Organization (ASO) Request for Proposal.

DMH is actively considering the contracting out of key functions within its overall authorizations and claims system. Specifically, the functions in question would include: provider relations, service authorizations, claims processing, data and management reporting and quality controls. The KPMG has developed – with DMH input – a request for information (RFI), which went to potential contractors on July 17, 2007. This is the first step in the process. Following review of comments from the RFI (and review of anticipated cost) DMH will need to make a determination as to proceeding with a Request for Proposal – which KPMG will also draft as a part of its contract.

The ASO model is a relatively common one across the country. Hence there are vendors with considerable experience in the public sector. The major issues are likely to be cost and the needed DMH structure to

manage such an outsourced contract. Experience across the country is clear that DMH needs to maintain policy control and the ability to actively oversee and interact with any successful vendor.

The timeline target – assuming this project moves forward – is early calendar year 2008 to begin transition. In the meantime much work remains in reviewing potential vendors, assessing the implications for existing DMH staff and working on a readiness plan for providers. The overall belief is that this pathway still makes sense to pursue – given the tremendous amount of development and maintenance effort these systems take. The Court Monitor would concur with this view and will continue to track progress.

C. Provider Payments

The DMH has continued to show solid progress in its ability to make timely payments to providers. The DMH has effectively closed out FY 2006 claims. It ended FY 2006 with a total of $38.1 million in unduplicated claims – of which $32.7 was paid. The gap represented claims which were reviewed and denied for a variety of reasons. This $32.7 in final payment is 80% of the full allocation of $40.8 million for FY 2006. It should be noted that there is one agency that has submitted 2006 claims of $583,762 that are in excess of its FY 2006 Task Orders. The facts surrounding this submission are still under review, although it is now clear to all providers that the approved Task Order limits the Districts ability to pay claims.

For FY 2007, as of July 13, 2007, the DMH had received unduplicated claims in the amount of $22,165,536 and has warranted $17,326,493 for payment. Actual payments have been made in the amount of $15,077,076. One of the major concerns for FY 2007 is the significant number of approved providers who – as of May 31, 2007 – have still not billed at all for this fiscal year, which is now eight months in. The Court Monitor notes that 21 out of the 47 providers with approved Task Orders have not submitted claims for FY 2007. While many of these are smaller agencies, it nevertheless raises serious questions as to the ability of these agencies to carry out the requisite business functions necessary to operate in a Medicaid fee-for-service environment. The DMH is working with these agencies to understand their individual limitations. The Court Monitor will follow this issue in future Reports to the Court.

It is also noteworthy that – at two thirds of the way through the Fiscal Year – the DMH has only expended 36% of its full allocation of $35.8 Million. While there are always lags in claims submission, the low percentage year-to-date raises questions as to whether the MHRS system will even approach its FY 2006 level. The DMH does plan to continue to reallocate dollars to those providers who are approaching the limits of their FY 2007 Task Orders. All of this points to the

need for DMH to "raise the bar" for entry into the MHRS system – both clinically and in terms of an adequate business structure.

Despite these developmental concerns, DMH has continued its consistent willingness and ability to reduce barriers to timely payment. It has continued all of the internal actions that were noted in the January 2007 Report to the Court – including regular communication with providers.

The DMH still intends to develop a clear set of metrics to measure billing and payment performance. However, as of the time of this Report, this RFP was still in the procurement Office of DMH. This process needs to move forward on an expedited basis.

Providers have regained a level of trust in the process, although there is understandable anxiety about both the movement of claims payment to MAA and the potential impact of an ASO model.

V. Recommendations

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

A. The District should continue to submit progress reports to the Court on high priority items. These should include (at a minimum): a) status of provider payments and development of relevant metrics to measure performance b) status of crisis/emergency services planning and planning for new CPEP location c) construction of new Hospital at SEH and status of quality of care issues – including hiring and retention of key staff d) status of KPMG issues – including payment movement to MAA and development of new ASO i.e. status of SEH discharge plan f) status of planning for alternative organizational and service options for DC CSA g) status of developing and utilizing alternative acute care beds. These reports should continue on a bi-monthly basis.

B. The DMH/District should intensify its efforts to locate a suitable long-term solution to the need for a co-located CPEP and acute inpatient facility. Past efforts to utilize Greater Southeast have proven unsuccessful. New strategies need to be developed in a timely way as a part of the overall crisis/emergency service planning.

C. The District/DMH should actively engage the Districts Human Resource Director toward the goal of using its independent personnel authority to make needed changes to existing H.R. regulations. With outside consultant help, a prioritized plan needs to be developed as soon as possible.