UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

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

COURT MONITOR'S NOTICE OF SUBMISSION OF REPORT

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

Respectfully submitted,

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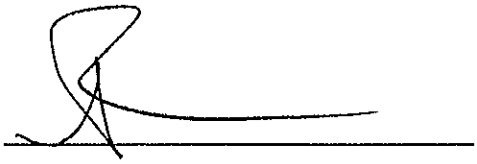
CERTIFICATE OF SERVICE

I certify that on July 29, 2009, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system, which will send notification to all counsel of record.



REPORT TO THE COURT

Court Monitor
Dennis R. Jones

July 28, 2009

Executive Summary

The fourteenth Report to the Court reflects continued progress despite the major challenges of the DC CSA transition and multiple budget cuts. The DC CSA is still targeted for closure as of March 31, 2010; over 2100 consumers have made their selection of a new provider. The new Hospital (292 beds) is planned for occupancy in March, 2010. DOJ progress is behind schedule but significant progress is noted. The DMH has absorbed FY'09 budget cuts of $3.7 million; for FY'10 there is an additional $18.1 million in proposed cuts in local funds (8.6%) due to overall revenue shortfalls.

The following areas should be highlighted:

1. Implementation of Exit Criteria

   Of the nineteen (19) Exit Criteria, six (6) are in inactive status. No additional criteria are recommended for movement to inactive in this Report. However, there are six (6) additional criteria that – with modest improvements in performance or additional verification – could move to inactive.

2. Implementation of Closure of DC CSA

   As of early July, 2009 over 2100 consumers had selected a new CSA and 52% of those have had at least one visit. There are major challenges for providers in ramping up capacity to absorb the new referrals. Consumers will continue to receive services from the DC CSA until such time as the new CSA can take the referral. The overall timeline remains the same – which is to complete the process by March 31, 2010.

3. Budget Issues

   The District has had to make major reductions due to the badly deteriorating revenue forecasts. DMH has absorbed a $3.7 million reduction in the FY'09 base and is looking at an additional $18.1 million reduction in local spending for FY'10 (8.6%). While every effort has been made to absorb cuts in non-direct service areas, it is evident that any further reductions will directly impact service areas. The unfortunate reality is that further cuts in FY'10 are a distinct possibility.

4. St. Elizabeth Hospital

   The new Hospital is now largely complete (95%) and will soon begin the final phase of inspections and furniture and equipment installation. The planned occupancy is now set for March, 2010.

The DOJ Settlement Agreement is clearly behind on its planned 3-year implementation schedule. The enormity of the task makes it unlikely that the District will be able to achieve substantial compliance within the 3-year window – which ends in May, 2010. Nevertheless, SEH has made progress in achieving at least partial compliance on 75% of the requirements in the Settlement Agreement (SA).

5. Use of Local Hospitals to Provide Acute Care

The DMH has made major progress on this issue due to the expanded availability of acute care beds under DMH contracts. Only one admission to SEH in a recent 4-month period occurred because of the lack of an acute care bed in the community. This is testament to the fact that DMH is – for the first time -- operating as intended under the Court-ordered Plan. This has taken many years of negotiation and work with local Hospitals; DMH is to be commended for this break through.

6. Community System Redesign

The DMH continues to work on the multiple broad issues of how to maximize access and revenue streams in the overall public mental health system. There is also the DMH-articulated need to create a more comprehensive service array among a limited number of CSA's. While this is of necessity a multi-year project, the Court Monitor believes that it is now time to articulate and share an overall vision and master plan for its redesign efforts.

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

A. The DMH should proceed with its full implementation of the DC CSA transition. The current policy of ensuring services at the DC CSA while new provider capacity develops should be protected – even if the timetable for transfer slips.

B. The DMH should proceed during FY'09 to invest in the Share Point Information Technology System. Multiple critical DMH functions are dependent upon upgraded IT access and support.

C. DMH should proceed as soon as possible to present an overall master plan for its redesign efforts. This master plan should invite comment and lay out incremental steps and timeframes.

I. Current Situation

In October 2008 the Federal Court approved the Monitoring Plan for October 1, 2008 through September 30, 2009. The Monitoring Plan included three primary areas for review during this period:

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

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

C. Events which may significantly impact the implementation of the Court-Ordered Plan and/or the achievement of the required performance levels for the Exit Criteria.

This Report provides updates on the status of each of the above-identified areas, highlights any barriers to progress, and makes recommendations for future actions. The May 23, 2002 Consent Order requires a Monitoring Report to the Court twice per year. This is the fourteenth formal Monitoring Report.

II. Findings Regarding Exit Criteria

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

The Exit Criteria fall into three categories: (1) review of demonstrated use of consumer satisfaction method(s) and consumer functioning review method(s); (2) the implementation of year seven Consumer Service Reviews (CSR's) for both adults and children/youth; and (3) the demonstrated implementation of data collection methods and performance levels for the fifteen (15) Exit Criteria.

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

There continues to be concerted effort and progress on both of these Exit Criteria. The first Exit Criterion related to consumer satisfaction calls for DMH to identify specific methods for measuring consumer satisfaction; DMH has had three identified methods for several years. The challenge has been to create a clear organizational process by which data from these three sources is aggregated and analyzed – followed by a process of prioritization, implementation and follow-up measurement of changes. The DMH, through its Office of Accountability (OA) and Internal Quality Council (IQC), has been scrutinizing the major methods to ensure that the tools are providing accurate and inclusive information

by which to inform the need for change. Progress is noted. For example, the Mental Health Statistics Improvement Program (MHSIP) has a consumer satisfaction survey that is required under the Federal Block Grant; this is one of the three adopted methods for DMH. However, there have been a number of problems associated with this annual survey – one of which has been the low response rate due to a telephone-only approach. For the 2009 MHSIP survey DMH is planning to change its contract requirements to include mail responses for unsuccessful telephone efforts. Additionally, a small cash incentive will be offered to participants. The goal is to sample approximately 1800 total individuals (adults and parents of children/youth). These changes are all due to recommendations of the IQC. There has also been progress on the information from focus groups – as conducted by CAN. In May, 2009, CAN presented the OA with a summary of focus group findings for the first quarter of calendar year 2009. CAN presented three priority concerns from the consumers who attended these focus groups; these included: 1) Improved education regarding psychotropic medications – including issues about side effects and any alternatives; 2) Housing – with specific concern about accessible and affordable housing; and 3) Coordination of care – with specific concerns about the level of sensitivity and responsiveness by case managers regarding consumer physical medical needs. The DMH has begun to formulate responses to these three areas – identifying the multiple interventions that might effect improvement. These examples of DMH responses are important first steps toward developing a response to consumer concerns that is formalized and integrated into the overall quality improvement process. Much work still remains but clearly there is now a process and consistent leadership on this issue. The new Director of Quality Improvement position in OA should also provide support in developing needed Quality Improvement Team(s) and processes.

As relates to Consumer Functioning Method(s), DMH has also shown progress. The implementation of the web-based LOCUS/CALOCUS application is on track. The DMH completed its "train the trainer" phase in November, 2008 and went live with its new web-based application on February 1, 2009. The next major task is to ensure that clinical staff in all of the provider agencies have completed the four-hour training that is required, so that each agency has qualified trainers on staff. The goal is to complete this by August 31, 2009. Effective May 8, 2009, DMH amended its policy regarding the completion of LOCUS/CALOCUS to require completion of the evaluation at least every 180 days (6 months) for consumers in continuing treatment. The requirements for completing the evaluation upon a proposed change in level of care (admission to CPEP, Saint Elizabeths, PRTFs) remain the same. DMH has clearly communicated to providers that LOCUS/CALOCUS must be completed on all consumers in accordance with DMH policy. OA has begun to review provider compliance with

LOCUS/CALOCUS as part of its auditing process. Compliance at less than an 85% level requires a corrective action plan. Thus far fifteen (15) providers have been required to submit corrective action plans. There remains the task of determining the "demonstrated use" of the LOCUS/CALOCUS data at both the system level and at the individual provider level. The Research and Clinical Informatics (RCI) section of the Division of Organizational Development has taken on the task of supporting a multi-faceted improvement plan. Beginning in the Fall of 2009, the RCI will facilitate the process of DMH and provider groups analyzing the data and creating quality improvement initiatives. RCI will help provide regular reports and provide training and technical support, in collaboration with the Training Institute.

B. Results of Year Seven (7) Consumer Service Reviews (CSR's) for Adults and Children/Youth

1. Summary of Children/Youth Findings

The Child/Youth Review was held from March 9 to 20, 2009. A total of 60 cases were reviewed. The original sample size was targeted at 86; however, due to the closing of the DC CSA, DC CSA cases were removed from the sample and this review was conducted as a "practice development opportunity". Forty two per cent (42%) of the cases (25 total) were also involved with CFSA. As in 2008, these child welfare cases were co-reviewed by DMH and CFSA by pairing up CFSA reviewers with HSO reviewers. Cases were selected from sixteen (16) different community providers; however, eight (8) of the 16 had two or fewer cases reviewed. An effort was made to put particular focus on the five (5) Choice Providers; hence 60% of cases reviewed were Choice Providers.

The overall results for year 7 are very much in line with prior years. The overall percentage of acceptable cases in terms of the child/youth status was 77%. This is very much in line with 2008 at 79% and 2007 at 75%. High acceptable ratings were achieved in several of the ten areas measured; these included safety of the child (83%), health/physical well-being (90%) and lawful behavior (86%). Those categories scoring less well included functional status (67%) and academic status (60%).

The Dixon measure is on systems performance – with a required performance level of 80% in the acceptable range. For 2009, the child/youth systems performance was at 48%. This compares to 36% in 2008 and 48% in 2007. Many of the same low-scoring areas that have presented in prior years are still at play

e.g. service team functioning (30%), long-term guiding view (18%), individual resiliency plan (32%) and service coordination and continuity (45%). The HSO Report that detailed the child/youth review recommended a primary focus on two areas to improve systems performance. The first is to work at improving the full understanding (assessment) of each child/youth – including a full picture of diagnosis and functional issues upon which to build a plan. The second major issue is the need to create functional teams that include families and cuts across organizational boundaries. This has been – and continues to be – a major challenge for the District.

As an outgrowth of this year's CSR review, DMH has undertaken a process that is intended to get at these core issues with its child/youth providers. One of the first steps is the development of a common practice model for all agencies and staff. The kickoff of these efforts was in late June, 2009. This very successful workshop was attended by 14 CSA's serving children/youth – with approximately 115 attendees. The DMH Team Formation and Team Functioning Practice Guideline was distributed and discussed at the session. The goal of the workshop was for each child/youth agency to develop its own action strategies to address the core performance issues that have persisted. The DMH Child/Youth Services Division and the DMH CSR Unit will follow up with agencies to provide technical support and coaching to assist with the implementation of action plan strategies. The Court Monitor is very pleased with this step. If sufficient and concerted focus can be brought to the quality of practice, evidence shows that the system can and will improve.

2. Summary of Adult Findings

The seventh adult Consumer Services Review (CSR) included a total of 88 consumers and was conducted from May 4 – 15, 2009. The total was right at the target set in order to have a statistically acceptable sample size from which to generalize about the adult system. The same basic protocols were followed as for children/youth and for the 2008 adult CSR. Fifty-three (53) of the reviewed cases were conducted with HSO as the lead reviewer and thirty-five (35) with DMH staff as lead reviewer. As was started in 2008, all DMH reviewers met with an HSO-assigned case judge to review relevant facts and information that would support ratings. This case-judging process is critical in assuring inter-rate reliability across reviewers.

Year seven (7) results for individual consumer status was at 74%. This matches the 2008 results – also at 74%. Areas that scored well in terms of consumer status included: safety (85%); economic security (85%); living arrangements (83%); and satisfaction with services (91%). Areas that scored low included: social network (60%); education/career preparations (41%); work (57%); and recovery activities (58%). This data continues to indicate that basic needs are being met but that consumers are still not consistently engaged in a recovery-focused model of care.

Year seven (7) results for system performance – which is the Dixon measure – was at 70%. This compares to a score of 74% for 2008. The adult system continues to score well in terms of engagement efforts by staff (85%) and culturally appropriate practice (93%). However, the areas where it continues to lag are in service team functioning (49%), personal recovery goals (63%), and individualized recovery plan (55%). The HSO Report on the adult CSR review pointed to many of the themes that have been identified in previous years – i.e. lack of adequate communication between and among caregivers. HSO "strongly recommended that the DMH and provider leadership make client-centered planning and teaming the top priority for refinement this year. If this is done successfully, it is anticipated that DMH should meet the Dixon Exit Criteria for CSR reviews in the next review cycle" (HSO Report, p.66). The Court Monitor concurs with this assessment.

C. Implementation of Court-Approved Performance Criteria

Table 1 reflects the current status on all nineteen (19) Exit Criteria.

Table 1 July 2009
Exit Criteria
Current Status

Aggregate Data for April 1, 2008 Through March 31, 2009

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. Utilization in Process
3. Consumer Reviews (Adult)	Yes	Yes	Yes	Yes	80% for Systems Performance	70%
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%	2.96%
6. Penetration (C/Y with SED)	Yes	Yes	Yes	Yes	3%	2.42%
7. Penetration (Adults 18 + Years)	Yes	Yes	Yes	Yes	3%	2.51%
8. Penetration (Adults with SMI)	Yes	Yes	Yes	Yes	2%	2.38% (Inactive)
9. Supported Housing	Yes	Yes	Yes	Yes	70% Served Within 45 Days of Referral	10.61%
10. Supported Employment	Yes	Yes	Yes	Yes	70% Served Within 120 Days of Referral	90.4%
11. Assertive Community Treatment (ACT)	Yes	Yes	Yes	In Process via Consultant for Court Monitor	85% Served Within 45 Days of Referral	64.95% (Fy08)

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
12. Newer - Generation Medications	Yes	Yes	Yes	Yes	70% of Adults with Schizophrenia Receive Atypical Medications	86.69% (Inactive)
13. Homeless (Adults)	Yes	Yes	Yes	Yes	150 Served + Comprehensive Strategy	190 + Strategy (Inactive)
14. C/Y in Natural Setting	Yes	Yes	Yes	Yes	75% of SED With Service in Natural Setting. Must Have SED Penetration Rate of 2.5%.	44.36%
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%.	94.2%
16. Homeless C/Y	Yes	Yes	Yes	Yes	100 Served + Comprehensive Strategy	185 + Strategy (Inactive)
17. Continuity of Care a. Adults b. C/Y	Yes	Yes	Yes	Yes	80% of Inpatient Discharges Seen Within 7 Days in Non-emergency Outpatient Setting.	Adults: 54.17% Youth: 50.49% Total: 53.8% (FY08)
18. Community Resources	Yes	Yes	Yes	Yes	60% of DMH Expenses for Community Services	60.45% (FY'06) (Inactive)
19. Medicaid Utilization	Yes	Yes	Yes	Yes	49% of MHRS Billings Paid by Medicaid	47.8% (FY'08) (Inactive)

The standard time period for Table 1 is April 1, 2008 – March 31, 2009. The exceptions are #18 and #19. For #18 (Community Resources) the data reflects full FY'07 data; for #19 (Medicaid Utilization) the percentage reported is for FY'08 claims that have been fully processed as

of June 10, 2009. Due to the lag in claim processing and final payment to DMH, this percentage will likely increase. The one remaining validation issue is still #11 (ACT). An unexpected staff loss at DMH has delayed the necessary verification by the consultant to the Court Monitor. Data reported for #11 and #17 is for FY'08, because additional work is needed to validate the data for both Exit Criteria. There is ongoing work by DMH in attempting to obtain and validate MCO data. The potential inclusion of this data could have a positive impact on penetration rates. There is ongoing discussion between DMH and the Court Monitor about the metrics for #9 (Supported Housing). The issues have to do with full data capture (via CSA's who have independent housing programs) and re-evaluating the most significant performance metrics.

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

1. Exit Criteria Met – Inactive Monitoring Status

There are six (6) Exit Criterion that have moved to inactive status:

- Prescribing New Generation Medications (#12) – This Criterion was moved to inactive status as of the July 2007 Report to the Court.
- Medicaid Utilization (#19) and Community Resources (#18) – #19 was moved to inactive status in January, 2008; #18 in July, 2008.
- Penetration – Adults with SMI (#8) – This Criterion was moved to inactive status as of January 2009.
- Homeless Services for Adults and Children/Youth (#13 and #16) – These two Exit Criteria were moved to inactive status as of January 2009.

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

There are six (6) Exit Criteria that require improved performance, are dependent upon meeting certain thresholds and/or require additional verification:

- Consumer Service Reviews (CSR) for Adults (#3) – The June 2009 CSR systems performance results were at 70%; the requirement is 80%. With concerted effort in select areas, this target is within reach.
- Penetration Rates (#5 - #7) – The key issue is still obtaining and scrubbing the MCO data for potential inclusion. This should happen in the next few months.
- Supported Employment (#10) – The outstanding issue continues to be the lack of verification that CSA's are in

fact making appropriate referrals to Supported Employment per DMH policy. The potential use of the eCura quarterly event screen to document facts could prove useful.

- Children/Youth in own (or Surrogate) Home (#15) – Performance continues to be above the Dixon requirement; however, DMH must first achieve penetration levels for SED children/youth of 2.5%.

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

There continue to be seven (7) Exit Criteria that still need significant effort to achieve the required performance level. It should be noted that each of these has had concerted effort over the past six (6) months:

- Consumer Satisfaction Method(s) – DMH has taken steps to improve the data sources on two of its three consumer methods. This should allow for the development of an overall quality improvement plan that can be implemented and measured.
- Consumer Functioning Method (#2) – The LOCUS/CALOCUS has been implemented and the comprehensive training of all staff is underway. DMH is monitoring compliance with utilization. The issue of "demonstrated use" still remains.
- Consumer Service Reviews (CSR) for Children/Youth – The 2009 systems performance score of 48% has prompted DMH to develop a targeted strategy for improvement via the child/youth providers. The new internal CSR unit, together with the overall leadership of the Child/Youth Director, should bring continued emphasis and hopefully improvement in CSR scores.
- Supported Housing (#9) – The DMH continues to work on data collection and recommendations of ways to best measure performance in this low-scoring area.
- ACT (#11) – DMH has significantly improved capacity and referrals to ACT over the past year. In spite of the loss of the DC CSA ACT teams, DMH has engaged three (3) new providers to develop ACT teams.
- Children/Youth in Natural Settings (#14) – Scores in this area continue to be low, but this may well be because of the data system problem due to the roll-up of claims – which does not capture same-day services provided in the home. DMH will need to find a solution to this problem.
- Continuity of Care (#17) – The overall Integrated Care Division is a major step forward as it relates to diverting

and out-placing patients at SEH. One of the remaining tasks for this unit is to intensify its efforts toward ensuring the timely out-patient connection for adults and children/youth who are leaving inpatient settings.

While there have not been any new Exit Criteria recommended for inactive status (for this 6-month period), it is evident that considerable work continues. Each Criterion has not only an "owner" but in many cases a team that is working to develop needed solutions/improvements. Hopefully, the January 2010 Report will see additional recommendations for movement to inactive status.

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 Office of Accountability (OA) has continued its strong efforts to build consistent and quantifiable oversight as it relates to the MHRS providers. Highlighted areas include:

a. Claims Auditing of MHRS Providers

As noted in the July, 2008 Report to the Court, the OA staff caught up with past years claims auditing (FY'05, FY'06 and FY'07) by the time of the July 2008 Report. OA staff is currently working on FY'08 claims, which they hope to have finished by late Fall of 2009. The auditing of individual providers is done on a tiered basis so that providers with greater claims get audited first and larger agencies will also have a second audit for a given fiscal year. Even small agencies will have at least one claims audit per fiscal year. If agencies have error rates over 15%, then a follow-up audit is conducted. It is noted that for FY'07, over 50% of the providers had error rates over 15%. It is too early to know what FY'08 percentages will be. Error rates can include a number of things – including missing or nonsupporting treatment plans and progress notes that do not support a claim.

The recoupment process has been the same for the past fiscal year as it was in FY'08. DMH delivers failed claims to the Department of Health Care Finance (DHCF).

DHCF reviews failed claims and if it is in agreement, makes repayment to CMS. DMH and DHCF then issue a demand letter to individual letters seeking recoupment only for those failed claims that were audited. A major change in recoupment policy is planned starting in FY'10. Beginning with dates of service on October 1, 2009 and beyond, all audited claims that fail will be extrapolated to the entirety of billed claims for this period. This will increase potential provider paybacks by an exponential factor. While this practice is consistent with Federal payback approaches, it heightens the need for DMH and its providers to tighten internal quality systems in order to avoid large financial penalties. It is noteworthy that CMS is doing a Medicaid Integrity Review for major DC Medicaid agencies in late June, 2009. While this is not an audit – depending on findings – it could lead to an audit. It is a credit to DMH that it has moved forward aggressively with its own internal auditing functions.

b. Compliance Committee

The Compliance Committee of DMH continues to meet – but currently just on a quarterly basis (as apposed to monthly initially). The Compliance Committee is intended to have a cross-section of all DMH functions (e.g. OA, HR, Fiscal, Legal, Programs and Provider Relations) in order to look at cross-cutting compliance issues and make recommendations as needed to the OA Director or the DMH Director. DMH has continued to have mandatory annual compliance training for all staff. The Compliance Hot Line continues to be in place and is run by an independent vendor. The Compliance Hot Line is intended for callers to maintain anonymity if wanting to report on any suspected fraud, abuse or unethical behavior by DMH staff or providers. There have only been a few calls made to the Hot Line, but its existence has been widely published within DMH and to the community providers.

c. DC CSA Monitoring

As noted in the May 8, 2009 Supplemental Report to the Court, the OA has taken on a major new task in monitoring the process of consumers transitioning to new CSA's. The specific elements of this monitoring include: 1) Consumer Satisfaction Survey – with a minimum of 526 consumers who have transitioned to be randomly sampled;

2) Continuity of Care monitoring – involving a record review at 90 days of the same 526 consumers to track issues of timeliness of service and service continuity; 3) Consumer Transition Voucher (CTV) Claims Audit – to track the provision of services necessary to draw down CTV claims; 4) Provider capacity monitoring – to review providers throughout the process on issues such as DC CSA consumers referred, staff-to-consumer ratings, etc.

This additional task for OA should be a time-limited one but demonstrates the importance DMH is placing on ensuring the transition of consumers from the DC CSA is a successful one. This task clearly adds to the overall work loads for OA and potentially diverts resources from claims auditing and other critical functions. This is not unique to OA; the DC CSA project has added demands, stress, and tight timelines on virtually all areas of the Authority.

d. Quality Improvement

The Internal Quality Council (IQC) continues to meet on a monthly basis. Its membership includes leadership (clinical, medical, programs and QI) from the Authority, DC CSA and SEH. It has continued its focus on priority areas – including: major unusual incidents; mortality reviews; review of the MHSIP survey; review of high-end utilization of community support services; and review of the current treatment plan format.

The Quality Council (QC) also continues to meet on a quarterly basis. The QC includes representatives from provider agencies. In addition to the priority areas identified above for the IQC, the QC has also focused on the implementation of the web-based LOCUS/CALOCUS application and the new provider "score card". The score card will be piloted during the remainder of FY'09, but eventually the results of the score card will be made public for each provider. The score card tracks a number of quality-related, process-related, and financial-related performance indicators for each provider. OA has conducted a quality review at each agency and selected 30 records randomly (15 for adults and 15 for children/youth). From these record reviews, OA completed the pilot score card. The intent then is for OA to sit down at least annually with each provider (CEO and QI Directors) to discuss the score card and recommend provider action steps.

It should also be noted that OA has had a turnover in the Director of Quality Improvement. The new QI Director comes from SEH and has had considerable experience with the IQC and quality improvement systems in general. OA has also recently added two nursing positions to its overall audit team – which will help greatly as it provides more focus on the coordination of care between mental health and physical health.

e. Integration of Data Bases

There continues to be a critical need for OA to build an interactive database that can support the multiple strands of information (e.g. licensure, certification, investigation, audits, etc). These data sites continue to be maintained as stand-alones in Excel spreadsheet format. It appears that the solution to the issue will rise and fall on DMH's ability to solve this problem more broadly. The Share Point technology (and its application and versatility) is discussed in III A4 (Information System Development). The OA dilemma serves as a concrete example of the need for DMH to move forward on this initiative.

Overall, the Court Monitor continues to be pleased with the progress in OA over the past year. While the fiscal auditing function has continued to be the primary focus, OA is moving forward with notable quality-related efforts as well. The new score card should be a useful way of aggregating compliance-related expectations and giving providers clear and timely feedback. There is still considerable work to be done in building provider compliance infrastructure. The information system upgrade is overdue and needs to be addressed in the near-term (i.e. six months).

2. Consumer and Family Affairs

The Office of Consumer and Family Affairs (OCFA) has had a full year towards the goal of re-invigorating the role of consumers in the DMH system. In addition to significant work on revisions to the grievance rules (as discussed in III A3 below) the OCFA has played a leadership role in the following initiatives:

- Olmstead Conference – in September 2008, DMH/OCFA sponsored the first District-wide Olmstead Conference in collaboration with the Office of Disability Rights. The

entire conference was planned by consumers and was well-attended by both consumers at SEH and those living in the community. A second conference is planned for the fall of 2009.

- Consumer-run Organizations – DMH funds two (2) consumer run organizations – the Consumer Action Network (CAN) and the Ida Mae Campbell Wellness and Resource Center (WRC). CAN has played a vital role in providing advocacy, training and outreach to consumers for several years. It continues to expand its efforts and has, for example, been very active in the DC CSA transition.

  The WRC has recently celebrated its one-year anniversary. As a self-help activity center, it provides a variety of services targeted toward mutual support, advocacy, and education and referral for interested consumers. It would appear from recent monthly data that the WRC is on a strong growth pattern in terms of consumers involved; it grew from 142 consumers in December, 2008 to 245 in April, 2009. The Center has developed a number of community outreach efforts – which is apparently paying off with increased consumer enrollment.

- Peer Specialists – The OCFA is working with its consumer-based partners to enhance the training and role of peer specialists. One of the leading national consumer training groups (the Appalachian Community Group) will be providing consultation to the OCFA that is targeted – among other things – toward strengthening the training curriculum for peer specialists and creating a peer support service definition that is Medicaid-billable.

  It is noteworthy that the OCFA took the lead in the training and hiring of the twelve (12) consumers who are working as Peer Support Partners (PCP) on the Continuity of Care Transition Teams (CCTT) as part of the DC CSA Transition. These consumers are proving to be a key component in helping DC CSA consumers understand their options and make a solid connection to their new CSA.

- Advisory Council – The OCFA has formalized regular meetings with an Advisory Council – which is broadly composed of individuals and groups who are knowledgeable and invested in promoting full consumer

involvement at DMH. The plan is for this group to meet quarterly.

Overall, the OCFA has made significant progress over the past year. The potential for Medicaid support for peer support specialists could create enhanced opportunities for consumers to work directly as providers. The positive contributions of consumers on the DC CSA transition is another example of the growing role consumers can and must play in the system.

3. Enforcement of Consumer Rights

As noted in the July 2008 Report to the Court, there has been ongoing concern that the current grievance system for consumers is "too protracted and legalistic" and is open to grievances that are outside of the control of DMH or should more appropriately be handled via a complaint process. DMH has proposed changes in both statute and regulation to make more explicit the definition of a grievance. The key proposed change is to limit a grievance to those issues which pertain "to the provision of mental health services or mental health supports". The DMH must first seek changes to the existing District of Columbia Mental Health Consumers' Rights Protection Act of 2001. If the statutory changes are made then DMH can duly promulgate regulatory changes. It is unclear as to how quickly the statutory changes can be accomplished.

The Court Monitor is in agreement that the grievance statute and regulations need to be tightened and clarified. Grievances that are frivolous (e.g. grievance that a flag is flying outside of a providers building) or outside of the DMH's control (e.g. legal status of a patient) simply serve to dilute and frustrate the intent of the grievance process. There are clearly legitimate grievances – which need to be handled expeditiously and with all due-process protections.

There are two related issues that also need attention. The first is the complaint process. As part of the public discussion about the grievance system, several advocates indicated that there needs to be a streamlined process for consumers to make complaints with providers without having to utilize the formal grievance procedures. DMH agreed and is in the process of developing a system-wide complaint process that would also require a response within ten (10) business days.

The second issue is the ongoing lack of a viable database and reporting system for the grievance system. Despite several years of work with outside contractors, DMH still does not have a data system that can be inputted, tracked and reported in an electronic format. OCFA has met with a representative from the Office of Chief Technology Officer (OCTO) to pursue a web-based system that would achieve the multiple goals of timely tracking, provider access to input data, and regular report generation. It is unclear how quickly OCTO can pursue the application; since a similar project was recently completed for the DC CSA transition, hopefully the work can be expedited. The issue of an adequate database for grievance reporting has been there for many years. It is time for this issue to be resolved.

4. Information System Development

The IT plans, as discussed in the July 2008 Report to the Court, have been directly impacted by the budget reduction that occurred in FY'09. The planned rollout of a separate Business Intelligence Unit (within the newly structured IT Department) did not happen as result of positions that had to be eliminated. While this has slowed down movement, it has not dissuaded DMH leadership from the conviction that building IT capacity is still a critical priority.

One of the key IT strategies is to build an enterprise-wide data platform that would serve as a common IT base for all DMH departments and sub-departments. The belief is that Share Point – a Microsoft product – could provide this support. The plusses of Share Point are: it is interactive; it is capable of holding and accessing multiple data bases; it is linked to Microsoft Outlook software; it can provide necessary timeline reminders for key tasks (e.g. contract renewals); it can be used to automate operational workflow that is today done manually; it is versatile enough to allow different units to meet their unique needs and; once it is set up it does not need IT maintenance or intervention unless there are changes.

The major issue in accomplishing this task is the constraints of the FY'09 budget. However, given the critical IT needs across DMH, it would appear that the approximate cost of $300,000 necessary to purchase, develop, train and implement this system would be well worth the expense. If this were to move forward, DMH officials estimate that Share Pont could be up and running by the end of the calendar year at the latest. The Court Monitor has heard the repeated calls for IT data support over many

years. While Share Point will not solve all of the IT issues, it can go a long way toward creating a common data platform for all areas. The Court Monitor strongly encourages the DMH to find the necessary funds to move this effort forward.

5. Organizational Development

The Division of Organizational Development (DOD) has moved forward in very significant ways over the past year – tackling multiple initiatives in the areas of training, implementation of an internal CSR unit and providing evaluation and performance management expertise to DMH's leadership. A summary of these activities include:

a. DMH Training Institute

The Training Institute has undertaken an ambitious effort to make the Training Institute a dynamic entity that would – as envisioned in the Court-Ordered Plan – "provide a continuous learning environment for consumers, community stakeholders, staff and providers".

One of the major undertakings of the past year has been the Crisis Intervention Collaborative – an initiative jointly developed by DMH, Metropolitan Police Department (MPD) and the local Office of the National Alliance on Mental Illness (NAMI). The goal of this effort is to improve the ability of police officers to interact with and hopefully divert persons with mental illness into the mental health system. As often happens, the immediate impetus for this initiative came from several unfortunate shootings of persons with mental illness over the past year. The most intensive form of the overall collaboration is the Crisis Intervention Officer (CIO) training. While built on national models, the DC model is uniquely tailored to meet local needs. The key element is a 40-hour intensive training program for designated law enforcement officers. Officers learn signs and symptoms of mental illness, engagement and de-escalation techniques and specific knowledge of local mental health resources. The training is provided by mental health professionals and consumers and family members. NAMI serves as the primary coordinating point for consumer and family involvement. Upon completion of the 40-hour training, officers receive a formal certification. The CIOs will be identified in the MPD data base so that a qualified CIO can be dispatched as

requested to handle more complicated mental illness-related calls. As of this Report, two classes of CIO officers have graduated a total of 40 officers. This is a remarkable effort by all involved – taking a community crisis and turning it into a true community resource. DMH leadership and the organizational development leadership and staff should be commended for the speed and quality with which this training has been put in place.

The Training Institute has also sponsored or co-sponsored a variety of ongoing training opportunities. Examples of these include:

- LOCUS/CALOCUS Train the Trainer initiative
- ACT workforce development initiatives
- Consumer Service Review (CSR) Adult and Child Review Training
- DMH 101 – For a variety of stakeholders regarding how to access mental health services
- Systems of Care 101 – an overview of SOC philosophy and values
- Supported Employment – training for consumers and providers

The Training Institute plans additional training initiatives in the months ahead – including clinical supervision, trauma-informed services and cultural and linguistic competence. Overall, the Training Institute has done an excellent job of creating meaningful curricula and outreaching to target audiences.

b. CSR Unit

The Division of Organizational Development has taken on the task of developing and supporting the first internal CSR unit. Over the past six (6) months this small team has been actively involved with the formal Dixon reviews – seeking to learn the requisite skills in logistics, training, facilitating and reviewing the cases. The next steps are to establish the guidelines for how the unit will function, develop priority areas for review, support the child/youth practice model targeted toward improvement in team formation and functioning, and develop formal and informal agreements. Overall, this team is off to a good start; the next six (6) months should see the start of actual internal CSR reviews and the beginning of a network of

providers committed to improving practice performance.

c. Research and Clinical Informatics (RCI)

The RCI is the newest unit within Organizational Development. The plan is for this unit to serve as a hub for evaluation and performance management activities within the Office of Programs. This team of evaluation and data support staff will pose evaluative questions to explore, develop methodology, and assist program staff in the analysis of data and results. This team will develop necessary reports and present findings to diverse audiences – including program managers and staff and external stakeholders. This unit brings another rich opportunity for DMH to create the kind of data-driven culture to which it aspires. The program units have lacked strong data-gathering capacity but also have often lacked the time and analytic skills needed to use data effectively in making decisions. The RCI can help to bridge both of these gaps.

B. Review of Independent Authority for Key Functions

1. Independent Personnel Authority

As reflected in the January, 2009 Report to the Court, DMH has completed – via KPMG – a comprehensive analysis of all HR functions, policies and processes. The fundamental goals of this effort remain the same – to create a more stream-lined, consistent and less costly HR system. An essential component is to implement a fully electronic HR system versus the current system which is part electronic and part paper.

The planned timeline for implementing the needed HR changes has had to be modified somewhat due to the unanticipated HR demands due to the DC CSA transition and budget shortfalls. These events have necessarily consumed HR staff with the immediate tasks of handling RIF's, explaining benefits, communicating policies, etc. Nevertheless, DMH officials remain committed to the necessary restructuring of the HR system consistent with KPMG recommendations. The next major step is for the policy-related staff at DMH to go through all of the KPMG policies, prioritize those that can and should move forward and develop the necessary processes to make this happen. This effort will begin in July 2009 and will likely take 2-3 months to complete. It appears that DMH can work within its existing Independent Personnel Authority to accomplish this – without

having to promulgate new HR rules. The other major task is to review the overall HR structure – including SEH – to determine the most efficient and effective structure to carry DMH into the future. DMH officials indicate the target date for any needed restructuring should be the Fall of 2009.

It appears that, despite the HR demands for this year, DMH is committed to making significant progress on the HR front by the end of calendar year 2009. The Court Monitor will continue to track progress.

2. Independent Procurement Authority

The DMH has shown significant progress in its contracts and procurement functions. The July 2008 Report detailed a number of areas that needed concerted attention. DMH, through its Director of Contracts and Procurement, has moved aggressively on many of these. Among the major accomplishments of the past year are:

- Augmenting the number of contract specialists (currently at full complement of seven (7)) to handle the work demands.
- Conducted a series of training events for program managers and Contracting Officers Technical Representative (COTR). Training has emphasized the specific legal and organizational responsibilities of the COTR. Training also has focused on the front-end task of creating an effective Statement of Work (SOW).
- Streamlined the procurement process by creating a clear base year plus annual options concept. This has created a much easier process for managers and helped avoid discontinuity between contract periods.
- Created an expedited review process for contracts in excess of $1million that need District Council approval. This involved working on an expedited basis with the OAG to obtain legal sufficiency so that Council could exercise its authority to passively approve contracts.
- Worked extensively with SEH to restructure the contract process to provide timely processing and needed Council approvals.
- The streamlined procurement process has resulted in cost savings, including a savings of $1.8 million on a three-year contract (base year with two option years).

The COTR communication and training has been pointed to as a District model by the Chairman of the Health Committee for the District Council. As a result, the DMH Director of Contracts

has been called upon to provide technical assistance to other District agencies. Clearly much progress has been made over the past year on multiple fronts. Among the remaining issues is the need for IT support – e.g. creating prompts to COTR's prior to end of contract periods. As discussed in III A4, the implementation of Share Point should go a long way toward resolving this problem. It is very encouraging to see that DMH has moved from being an agency with a very poor procurement record to one that is now being looked to as a model.

C. Review of Systems of Care Development

1. Review of Adult Systems of Care

a. Organizational Efforts to Develop Adult Systems of Care

The adult Systems of Care (SOC) philosophy and organizational efforts continue to be robust. The specific areas that are tied directly to an Exit Criterion will be discussed in III C 1 b-e; these include Supported Housing, Supported Employment, Assertive Community Treatment (ACT) and Services to the Homeless. Beyond these services, DMH continues to provide specialized services that cross agency boundaries as follows:

1) Forensics – The DMH continues to frame all of its forensic efforts around the Sequential Intercept Model, which attempts to both connect, and divert when possible, persons with mental illness and /or co-occurring substance abuse who have also become involved in the criminal justice system.

A major component of the overall Sequential Intercept effort is the DC Linkage Plus. This program was started in 2005 with targeted efforts at critical points of "intercept". These include; a) Pre-booking – Pre-booking is handled by CPEP, the Mobile Crisis Teams (adult), and the Homeless Outreach Program (HOP). The new MPD/DMH collaboration to train MPD officers (see III A 5) should also provide a major new opportunity for the program identification, intervention and diversion of persons with serious mental illness. b) Post-booking – DMH provides mental health screenings at the DC Superior Court for the Pre-trial Services Agency (PSA). The screenings may result in a recommendation for

services via the Specialized Services Unit of the PSA, the DMH-contracted Court Urgent Care Clinic for further evaluation or a direct referral to the Options Program. The Options Program is also contracted to a private CSA who provides immediate mental health and other support services, including access to temporary housing (five female and five male beds). c) Jail-bound Linkage – DMH has a full-time Jail Liaison Coordinator who tracks all individuals with serious mental illness who are identified and referred by the mental health staff at the jail. The liaison saw 318 inmates at the jail for the period of April 1, 2008-March 31, 2009 and provided linkage for 159 of these individuals to the four designated CSA's. These CSA's are required to meet with referred inmates within 48 hours to ensure a smooth linkage upon release. Since its inception in 2005, a total of 579 inmates/consumers have been linked via this component of the Linkage Plus program. d) Re-entry – DMH also has a mental health coordinator on site at the Project Employment Plus program. This coordinator does screening/assessments for referrals from Court Services and Supervision Agency (CSOSA), the Office of Ex-offender Affairs and the Bureau of Prisons. Of the 686 total referrals in FY '08, 206 were identified as having mental illness and an additional 199 with co-morbid mental illness/substance abuse.

The Forensic Services program of DMH has taken on the responsibility of the Periodic Psychiatric Exams (PPEs) for committed patients. As of May, 2009 there were a total of 184 consumers under mental commitment; 103 were out patients and 81 at SEH. This total of 184 consumers under commitment compares to 168 as of May 2008. The DMH forensic psychiatrist provided specific training to providers in the Spring of 2009 regarding the requirements for the Certificate of Physician form which must be completed 90 days ahead if there is clinical determination that the individual needs to be re-committed. This training was reportedly well-received.

The DMH has continued to run the community-based Outpatient Competency Restoration Program (OCRP) that began in July 2005. This program has been a collaboration between the Authority and the DC CSA. The services will transfer to the Authority with the phase-out of the DC CSA. The OCRP clinic operates twice per week and provides psycho-educational groups to defendants court ordered for out-patient competency restoration. There have been a total of 104 referrals to the program since its inception. At the end of April 2009 a total of 41 (41%) of the 99 referrals to the program were eventually determined competent to stand trial.

The DMH continues to look for ways to expand its forensic efforts. For example it has two grants in process that, if successful, would expand available mental health services for women prisoners who are diverted or released from incarceration. DMH is also collaborating with the Criminal Justice Coordinating Council in the establishment of a work group to evaluate needed mental health services for veterans involved with the criminal justice system.

2) Co-occurring Mental Illness and Substance Abuse – DMH is concluding its 4-year COSIG grant for co-occurring disorders (COD) as of August 31, 2009. DMH officials point to a number of organizational and service delivery changes that have occurred as a result of this grant. These include:

- The development of a 72-hour intensive training program in COD with over 120 clinicians who have completed it. Over 300 other staff have received elements of the COD training.
- All clinical staff at SEH have been trained in COD and SEH has included a standard assessment tool for COD in its disciplinary assessments.
- A fully comprehensive training manual on COD has been completed and five individuals in the system are prepared to conduct COD training after the grant expires.
- Five (5) DMH providers have been designated as competent to do COD treatment.

Once the grant expires, the plan is for the training for COD to be fully included in the Training Institute. While it does not appear that there will be any designated COD staff, it is evident that the knowledge base and awareness level have begun to permeate the system. It will be critical for DMH leadership to keep this issue alive and moving – given the known high levels of COD in the population.

3) Co-occurring Mental Illness and Mental Retardation – DMH and the Department of Disability Services (DDS) have had a cross-agency memorandum of understanding (MOU) since October, 2004. The DMH/DDS Joint Project continues to serve approximately 73 consumers who are both developmentally disabled and have an Axis 1 diagnosis. This joint effort has waxed and waned over time; in FY'09 there were only two accepted referrals – which is certainly not reflective of the need for this population.

Recently, there have been regular meetings between DMH, DDS and the Department of Health Care Financing (DHCF) to develop strategies to best serve 15 – 20 eligible individuals who are now at Saint Elizabeths Hospital. The goal for FY 2009 is to have 5 individuals move successfully into the community with intensive individualized services. DDS has agreed to assume responsibility for coordination of services for consumers jointly served by both systems. DHCF is also exploring the possibility of DMH (the public system) becoming a DDS waiver provider. There is agreement by all that there are additional individuals in the respective DMH and DDS systems who need a mix of services as part of a cross-agency effort.

Additionally, DMH's Integrated Care Division is working closely with DDS to affect the discharge of 11 consumers who have co-occurring Mental Illness and Mental Retardation with significant maladaptive behaviors. These consumers are currently inpatient at St Elizabeths Hospital. Months of careful planning and co-ordination of services between DMH and DDS will result in the

discharge of four consumers in the month of July 2009.

Hopefully, the next few months will result in further progress.

b. Supported Housing Capability

The DMH has continued its efforts to provide Permanent Supportive Housing (PSH) to consumers with Serious Mental Illness (SMI). The key elements in the PSH philosophy are that consumers live in community-integrated settings (not in mental health residential settings), receive flexible services and supports matched to their needs, and have housing supports that are not contingent upon their service choices. DMH provides supported housing via a scattered-site model. The goal is to help people both obtain and maintain stable, safe and affordable housing. Most of the consumers in the DMH Supported Housing Program have histories of institutional care, incarceration, homelessness and/or substandard housing.

The DMH has a formal process of application for persons seeking housing subsidies via the limited DMH appropriations (currently at $6.1 million) – which provides housing subsidy capacity to 1211 consumers; this includes 750 persons via the Bridge Rental Subsidy Program and 461 through the Supported Independent Living program. In addition DMH administers 384 HUD-supported slots that are set-a-sides for DMH. Hence the total DMH capacity is currently at 1595; this compares to a total capacity of 1584 as of May 2008. In addition to the housing capacity that DMH has direct control over, there are also housing slots that are available to several of the CSA's. DMH is in the process of collecting this information so that it can be counted as part of the overall systems capacity. DMH keeps a formal waiting list of persons who have been approved but not yet funded. DMH housing staff indicates that this wait list is at 603 as of June 1, 2009. The average current wait time on the Housing Waiting List (HWL) is 2.5 years; this is the overall average for all persons currently on the approved DMH HWL.

DMH has continued its partnership with the DC Department of Housing and Community Development to develop 300 additional housing units – with a DMH-appropriated $14 million in capital funds transferred to support this effort. The original completion timeline of September 2009 has been extended to September 2010 due to developer-related slowdowns in applications for these funds. There are currently 219 new units in the pipeline with targeted completion dates on or before September 2009. In addition to the capital costs for these new units, it appears that most of the rent subsidies will be paid for by the Local Rent Subsidy Program (LSRP). These new units should help to meet some of the unmet need for supported housing for consumers with SMI. The Dunbar, developed by Open Arms Housing, is one example of innovation among the new capital projects. The approach of this project is "housing first", a philosophy that people should be housed before being required to get more help. The project will house 16 chronically homeless women who will pay 30% of their income for rent and they will be encouraged to attend weekly meetings with staff and other residents. This project is also funded under the LRSP.

There have been ongoing discussions between DMH and the Court Monitor regarding Exit Criterion #9, which requires that 70% of approved supported housing referrals be served within 45 days. DMH currently reports only data regarding the Home First II program subsidies. The average time from approved application to lease-up is 130 days. As a result, DMH continues to score very low in this measure.

DMH continues to work with the Corporation for Supportive Housing (CSH) toward the goal of recommending alternative Exit Criterion measures for this issue. As discussed earlier, DMH is also in the process of gathering data from CSA's regarding supported housing slots directly controlled by the CSA and not currently known to DMH. The Court Monitor continues to express openness to looking at alternative measurement points – provided that the issue of access to housing remains as a required point of measurement.

c. Supported Employment Capability

The supported employment program at DMH continues to provide an evidence-based service – with the goal of actively helping consumers with SMI to obtain a competitive part-time or full-time job earning at least minimum wage. The supported employment model provides vocational assessments, job development and placement, job coaching, job-related interventions and the development of ongoing natural supports to help ensure job sustainability.

DMH continues to fund seven (7) CSA's with a total capacity of 550 supported employment slots. As of May, 2009, the enrollment stood at 512. One of the seven providers (DC CSA) is in the process of phasing out its program as part of the overall DC CSA phase-out. This SE capacity, however, is being shifted to the other six (6) providers. DMH is collaborating with the Department on Disability Services/Rehabilitation Services Administration (DDS/RSA) towards the allocation of $500,000 in federal stimulus funds to DMH to expand the supported employment program by 150 slots. While the stimulus money ends as of December 31, 2010, the DDS/RSA has committed to build this funding into its ongoing annual budget. DMH is intending to complete its RFP process for these new funds by July 30, 2009. Hence, DMH should be able to increase its overall capacity to 700 persons as of September, 2009. The planned approach is that each of the six providers will add at least one new employment specialist with a caseload of 25 consumers each (total of 150).

The Supported Employment program has taken on the task of phasing out and transitioning the Work Adjustment Training Program (WATP) which has operated for many years at the DC CSA, SEH and Deaf Reach. The end of FY'09 (October 1, 2009) is the target date to transition 84 consumers from this sheltered work program into a supported employment model. This task has put additional demands on the SE manager of DMH, but the plan is to add a full-time position plus a time-limited contract position to assist in the transition of the WATP plus the ongoing demands for technical assistance, monitoring and social marketing. The SE manager has continued to engage in education and outreach to clinicians, case workers and consumers directly about the availability of supported employment. For the one year period of April

1, 2009 – March 31, 2009, there were a total of 181 referrals; this compares very favorably to past periods. However, it still appears that the large majority of referrals come from CSA's that have SE programs. The Court Monitor could only identify 10 referrals for the period that came from a CSA that does not run a SE program. This continues to raise questions about full access, as discussed below.

The SE program is also piloting two initiatives that can hopefully expand knowledge for all. The first is a collaboration with the DDS and Department of Labor, Office of Disability Employment Policy to train two SE programs regarding new protocols and practices for individuals with the most challenging disabilities. The second pilot is in collaboration with GWU and will train staff at two SE programs regarding detailed understanding of consumers' ability to manage their Social Security benefits.

The Court Monitor continues to be impressed with the breadth and quality of the overall SE program. It is encouraging to see the planned expansion to a capacity of 700. The question of Dixon compliance in this Exit Criterion is still unresolved. The continued issue is DMH's ability to determine whether DMH providers are following approved policy on supported employment. Efforts-to-date to answer this question have not proven successful. The most recent discussion has been to possibly add a required reporting on the quarterly event screen for all adult consumers. This strikes the Court Monitor as a more fruitful approach than past efforts. Much discussion remains as to the viability of the option.

d. Assertive Community Treatment (ACT) Capability

The DMH has made significant progress in the past year in terms of its capacity to provide ACT services. As of May 31, 2009, there were 523 consumers receiving ACT services with a total capacity of 625. Even with the phase out of the three DC CSA ACT teams over the next several months, the DMH has still significantly increased its ACT capacity by adding two new providers – with a third new provider scheduled to start in July, 2009. This will bring the total number of ACT teams to nine (9), the total number of providers to five (not counting the DC CSA), and the

total capacity to 700. This growth in ACT census (523 as of June 1, 2009 vs. 351 as of March 31, 2008) can be directly tracked to referral patterns. For the period of April 1, 2008 to March 31, 2009, there were a total of 217 referrals; this compares to 78 total referrals for the same period in the prior year. Clearly ACT is now being utilized as the appropriate service for persons with the highest service needs. An indication of this is that 13 persons in the past year were referred directly from SEH to ACT.

There are likely multiple reasons for this increased capacity. The most notable include: 1) Consistent leadership and focus by the DMH ACT manager; 2) Improved ACT rates as of November 1, 2008; 3) Improved education and understanding of ACT services by DMH providers; 4) Increased coordination with the Homeless Outreach Team to identify homeless consumers in need of this service; 5) Clear organizational commitment to grow ACT as an evidence-based practice; and 6) Willingness of key DMH providers to develop and/or expand ACT teams. All of this has created a positive dynamic for ACT services that has not been there previously.

The DMH has also continued its efforts to grow quality in its ACT services. A two-day core training was offered in May, 2009, targeting newly certified ACT teams and staff. The training was modeled after the SAMHSA toolkit for ACT as an evidenced-based practice. This same two-day training will be repeated in June and September, 2009. There will also be on-site consultations provided to each ACT team and a baseline fidelity assessment for all startup ACT teams – utilizing the Dartmouth Fidelity Scale. Startup teams will receive written documentation and recommendations for action. DMH also plans to conduct an annual team leader retreat to help ACT team leaders build leadership and supervisory skills. The final date for this is pending but should occur before September 30, 2009. The Pathways Technical Assistance Center will provide this training.

It is very encouraging to see ACT on a positive trajectory. For the first time, it now appears that there is clear organizational commitment, leadership and specific supports to develop ACT services within the District. The number of new teams will require continued attention and focus. The Court Monitor would hope that the next year

will also see resolution on two major development issues. The first is the issue of specialization for ACT teams. There has been ongoing discussion about the need to create ACT teams that would provide specialized support to certain high-risk populations e.g. forensic consumers. This issue needs to be fully discussed and resolved. The second issue relates to fidelity standards. While DMH has done baseline fidelity reviews, it has not formally adopted a set of ACT fidelity standards as clear expectations for all providers. There is also the need to formalize at least annual fidelity reviews for all teams. It would appear that, with capacity issues being addressed, DMH can now take the next steps in assuring consistent quality across all providers.

e. Services to the Homeless

The DMH Homeless Services Program has continued to provide comprehensive services for persons who are homeless and also have significant mental health problems. The Homeless Services Program includes the following array of services:

- Homeless Outreach Program (HOP)

The mobile crisis team at CPEP has fully assumed all mobile crisis responsibility for adults who are not homeless; the exception is that HOP continues to provide some crisis services to persons who have a history of chronic homelessness. HOP has thus been able to target its eight (8) FTE's toward homeless outreach, engagement, linkage, treatment, follow-ups and consultation to providers serving the homeless. For the period April 1, 2008 to March 31, 2009, the HOP provided services to 1330 different adults and 185 different children. There were a total of 3465 face-to-face contacts for this period. The HOP has begun working with The Community Partnership (TCP) to collect data using the Homeless Management Information System (HMIS) – a nationally recognized data base that is required for all HUD-supported programs.

- Psychiatry Residency Training

As part of the psychiatry Residency rotation at SEH, third year residents are placed at homeless shelters, soup kitchens and street outreach programs. This training

opportunity provides insight into the unique needs of persons with mental illness who are temporarily or chronically homeless. Residents in this rotation see approximately 150 homeless individuals in a given quarter.

- Hermano Pedro Drop-In Center

  This program is contracted with Anchor Mental Health and provides basic supports for homeless drop-ins (e.g. laundry, showers, food and clothing) as well case management and groups for men and women with co-occurring illnesses. For the first six months of FY'09, 138 different individuals were served by the program and 3288 face-to-face contacts.

- Sobering Station

  The Homeless Services Program directly operates this service during hypothermia season. It is utilized by men and women who are intoxicated and unwilling or unable to handle the structure of a traditional homeless shelter. For the past hypothermia season (12/2/08-03/31/09) there were a total of 261 persons served via the sobering station (253 men and 8 women).

The DMH has continued to be an active partner in the Interagency Coordinating Committee on Homeless Services. All policy and program issues related to the homeless are discussed in this forum. One of the new District-wide efforts of the past year was the Housing First Initiative. Under the leadership of the Department of Human Services (DHS), a targeted outreach was conducted towards those individuals who were prioritized with the highest special needs. To date over 400 individuals who were homeless have been placed through this effort. The HOP staff has been present for all housing placements and has helped to coordinate needed services and provide training.

Overall, the DMH Homeless Services Program continues its role as a vital element in overall District services to the homeless. The advent of the mobile crisis team has allowed the HOP to focus its efforts specifically on the homeless population and those agencies that are part of the homeless network. The HMIS is providing more accurate data on services. The Housing First Initiative is

reflective of a best-practice approach to persons with chronic homelessness and significant other problems as well.

2. Review of Child/Youth Systems of Care

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

In September, 2008 DMH formally entitled its Child and Youth services as the Child and Youth Services Division (CYSD) as one of the major service divisions of the Office of Programs. The restructuring occurring shortly after DMH was successful in recruiting a CYSD Director who comes with a very strong background in planning and implementing an urban-based system of care model. Under new leadership, the CYSD has undertaken an ambitious cross-agency agenda. It appears that the four (4) major DC child-serving agencies (DMH, CFSA, DYRS and DCPS) are working in a much more collaborative manner that at any time since DMH was created. These efforts will be detailed in the specific sections that follow. There continues to be a shared philosophy to a family-centered and community-integrated approach to care. The continuing challenge is to make this philosophy come alive in a consistent way at the practice level. The CSR systems performance score of 48% acceptable for year seven (7) suggests there is still great need to build in and reinforce common practice expectations as discussed in II B1.

The CYSD has begun the process of creating a 3-5 year comprehensive mental health plan for children and youth. The process for this planning effort is currently being finalized. The intent is to develop a plan that speaks to the entire gamut of child/youth issues and challenges. Other agencies, child advocates and children, youth and families will be included in the process. The Children's Round Table, which is a broadly-based composite of child-serving providers and advocates, was informed of this effort and was strongly supportive. The goal is to have a working draft of this plan by the fall of 2009.

b. School-Based Mental Health Services

The School Mental Health Program (SMHP) continues to focus on the social and emotional development

of students via a variety of prevention, early intervention and treatment services to youth, families, teachers and school staff. The major change in the past year has been the requirement to provide services in ten (10) additional schools without any additional staff (total of 58 schools). This has led to the need to have a 2-tiered system with tier 1 (37 schools) having full-time staff and tier 2 (21 schools) having part-time staff. The SMHP Director indicates that the decision regarding which level of support a school gets is based on a combination of school size, history of mental health service demand and overall readiness for the program. It is too early yet to know whether there are discernible trends in the types of services being utilized as a result of this 2-tiered system.

The overall volume of services provided by SMHP continues to grow. As of the end of March, 2009, the SMHP had already seen 1086 students for this school year; this compares to 968 for the entire SY 2007-2008. There appears to be a steady volume (or growth in some areas) of other school-based services e.g. conflict resolution sessions, parent consultations, teacher consultations and walk-ins for immediate services. The SMHP has also developed a Joint Crisis Protocol with DCPS, ChAMPS and MPD for all public schools to address day to day crisis interventions. Trained SMHP clinicians work in close collaboration with DCPS staff and in the past year have responded to 28 different crises and spoken to approximately 4600 students. These crises often involve issues such as a shooting or student death.

The SMHP continues to utilize a variety of tools to measure quality. These include specific clinical outcomes tools (e.g. Ohio Scales Problem Severity Score from Intake to Discharge), satisfaction surveys, clinical record reviews and community and staff focus groups. It is noteworthy that satisfaction scores from all four major respondents (students, parents, teachers/staff and administrators) are consistently at 90% or above.

As part of the Blackman Jones settlement agreement with the District regarding special education, there was $1 million transferred from the Office of the State Superintendent of Education (OSSE) to DMH. These funds are to provide intense wraparound services for up to 100 students in eight DCPS model schools that have been

targeted as "full service schools" – intending to combine academics, mental health, Positive Behavior Intervention (PBIS) and an intensive wraparound component for the highest-need students. DMH contracted with Choices, Inc. to manage this effort. As of May 2009, there were 72 students served through the wraparound program. Indications are that this initiative is gaining momentum via increased common understanding of the program and positive outcomes for students referred. The intent is to expand this program for SY 2009/2010 to 135 students in eleven (11) middle schools. Each of the targeted schools also has a full-time mental health clinician assigned as part of the overall SMHP program.

During the next school year, the SMHP plans to stabilize and evaluate its 2-tiered model. It has also taken on a primary intervention project that is funded via the Deputy Mayor for Education. This initiative screens for school adjustment issues for kindergarten and first graders in 12 schools. Thus far 991 children have been screened – with 168 referred for active intervention. The last major initiative for SMHP is to evaluate the financial and program impact of Medicaid funding for the SMHP – which began in January 2008. In addition to two outside contractors who provide school-based services, DMH is now eligible to bill via the Authority for its direct clinical services in schools. Given the high percentage of students who are MCO enrollees (approximately 80%), this billing happens via the MCO's. Revenues for this new Medicaid effort have been built into the FY 2010 DMH budget – one of the ways DMH has been able to expand revenue and soften the budget cuts.

Overall the SMHP continues to be a very positive and well-supported effort. Beyond the current budget crisis, it will be important to look for ways to expand these critical services into all District schools. (Note: There are 170 total schools in the District – with 123 DCPS and 47 Charters. DMH serves 58 of this total or 34%). DMH is working collaboratively with the DCPS and the Office of the Deputy Mayor of Education to develop a common service delivery model for School Mental Health, which would include the SMHP, DCPS social workers and DC Start social workers, as well as a common supervisory structure to ensure seamless mental health services in all of

the schools, regardless of the program delivering the services.

c. Capacity for Children/Youth to live in own home or surrogate home.

The DMH has made significant effort toward creating cross-agency mechanisms by which high-risk children and youth can be diverted whenever possible. When residential services are necessary there should be common mechanisms for assessment, and common standards for placement and monitoring. The District is far from having these issues resolved but is clearly working at it under the overall auspices for the Interagency Collaboration and Services Integration Commission (ICSIC). The Subcommittee on Residential Placement (SRP) is a standing subcommittee of ICSIC; it is made up of all the child-serving agencies in the District and is chaired by DMH. The SRP is charged with all of the necessary functions to manage this District-wide challenge. Key functions include: maintaining a central data base, developing standards and joint decisions for placement, facilitating the coordination of monitoring of residential facilities, developing financial incentives for alternative placements and creating community-based alternative capacity. Hence there is now a single District-wide entity responsible, which did not exist at the time of the July 2008 Report to the Court.

This Report will utilize the major functions of the SRP framework to evaluate current status.

1) Central Data Base

It does appear that the District via SRP is beginning to get a handle on how many youth are in out-of-home placements – not counting children/youth that are in foster care. As of March 2009, there were 526 District children/youth in all types of residential settings. Of this total, 235 were in Psychiatric Residential Treatment Facilities (PRTF's) which by definition would be only for children/youth with a diagnosis of Serious Emotional Disturbance (SED). There were an additional thirteen (13) who were in a Residential Treatment Center (RTC). Of the 235 PRFT placements, DMH is directly involved in the

monitoring of 92, since these are children/youth referred by CFSA or DMH.

2) Common Standards for Placement Discussions

A subcommittee of the SRP is in the process of developing common standards and a single protocol for all agencies to use in making decisions regarding residential placement. A draft of this effort has been completed but has not yet been approved. The intent is to create a process that: 1) ensures that all SED children/youth being considered for PRTF placements have first had the opportunity to receive intensive community-based services; 2) that the family team review model has been followed; and 3) a local coordinating council would be appointed as a standing group to review all PRTF applications. These elements are congruent with the Court Monitor's recommendation in the July 2008 and January 2009 Reports that there needs to be a "common pathway" for all children/youth referred to PRTF's. Clearly there is not a common pathway today except for DMH and CFSA referrals. The SRP will review and approve the common standards and protocol in conjunction with the approval of a Memorandum of Understanding between the child serving agencies about the placement process. The target date for the SRP to approve both documents is September, 2009.

3) Coordination of Monitoring Activities

There is considerable work to be done in this area as well. Each of the multiple child-placing agencies has its own standards and monitoring process – the exception being DMH and CFSA. There is great variability in the frequency of monitoring, the attention to lengths of stay and the facility and clinical standards by which monitoring occurs. The beginning steps by DMH are to develop a common database (via OCTO) that all agencies can at least report monitoring activities in a timely way. This common database is currently a work-in-process. It would seem logical that the next phase should (as per the placement process) to develop common monitoring standards and a common process for conducting monitoring visits

and reviewing cases at specific time intervals (e.g. children/youth who have been in a PRTF over 12 months). A common monitoring tool has been developed by an interdisciplinary team which included the MCOs. All District agencies that monitor children will use this common monitoring tool. This same interdisciplinary team is currently meeting to develop common standards of practice for PRTF/RTC for the District, including criteria for admission, monitoring length of stay and evaluation of the facilities.

4) Creating Financial Incentives for Alternative Placements

Successful diversion programs across the country have found ways to incentivize alternative programs. One model is to create a capitated risk-based funding approach for high-risk children/youth, such that core management organizations are at full or partial risk for whatever level of care is delivered. This obviously creates incentives for low-cost community alternatives. Another approach is to simply take a "money follows the client" model so that dollars which are budgeted for residential care are redirected to community-based services based on actual or planned diversion. If DMH and other child-serving agencies are to be successful, ICSIC must develop models for incentivizing intensive community-based alternatives.

5) Creation of Specialized Community Capacity for High-Need Children and Youth

The CYSD has continued to evolve and refine its Systems of Care (SOC) model for all children who are fee-for-service Medicaid with complex needs and being considered for out-of-home placement. This model has been in place since October 1, 2006. As a baseline for diversion, FY'07 saw 87 children diverted out of 160 total served by the SOC process (54% diversion rate). This approximate 50% diversion rate has been the norm for the past several years. However, for the period of January through March 2009 the diversion rate – based on 72 referrals – was at 92%. While this very high percentage will not likely stand, it

does point to a couple of important improvements in the SOC. First the way Family Team Meetings (FTM's) have been re-organized so as to be more inclusive and productive in finding alternative resources. The Care Coordinators in the SOC unit follow each case for a maximum of 90 days to ensure full implementation of the treatment recommendations and assign continued care coordination to a member of the FTM team for on-going teaming. Second is the continued development of the first DC Wraparound program – which has the capacity to serve 24 children/youth who are diverted from residential care. This program – administered by Choices, Inc. – has a current census of 14. It would be hoped that this program would continue to grow to both divert children and to help shorten lengths of stay (see III C2 for discussion of PRTF's length of stay).

As part of a DC-wide effort to find incentives, there is also the reality that not all children/youth who end up in PRTF's go through the SOC process. There are multiple reasons, but the ICSIC goal should be for 100% of children/youth to have a team-based process and consideration of alternative community services.

d. RTC Reinvestment Program/Assessment Center

The Reinvestment Program of the CYSD provides clinical monitoring to all CFSA, DMH and fee-for-services Medicaid youth who are placed into PRTF's. DMH has staff capacity to monitor up to 125 children, so has agreed to take on MCO PRTF placements up to its 125 capacity. The total number of DMH/CFSA placements being monitored was 92 as of May 14, 2009. This compares to 109 as of the July 2008 Report to the Court. The 7 month period from October 1, 2008 – April, 2009 shows 60 more discharges then admissions for this period. There is also a slight downward trend in the total length of stay for children/youth discharged. From October 2008 – April 2009, the ALOS is 18.6 months versus approximately 20 months for prior periods. DMH staff recognizes that these numbers are still inordinately high and reflect the need for increased community capacity and greater attention to the

reasons why youth remain in PRTF's as long as they do.

The CYSD also continues to manage the Assessment Center – which provides comprehensive mental health evaluations for Juvenile Justice youth and CFSA youth plus any DMH youth being considered for PRTF placement. In FY 2008, a total of 643 assessments were performed. The turnaround time for completion of assessments continues to improve. The standard under the Jerry M case is 15 days. The current average is 15.2 days. If one outlier (38 days due to scheduling difficulties with the family) is eliminated from the sample, the average would be 12.4 days – significantly under the target for the Jerry M. case.

e. Choice Providers

The DMH has moved forward with the concept of Choice Providers – with five (5) child/youth providers designated. The original intent was that Choice Providers would be more comprehensive in scope and would be the exclusive source of referrals for all CFSA children/youth who need mental health services. That concept is not yet a reality as there is a desire to broaden the existing network of providers by at least a couple more in the next several months via a new RFP process which closed as of mid-May, 2009. Hence, Choice Providers can perhaps be thought of as preferred but certainly not exclusive as of this point in time. The CYSD is tracking a variety of performance data via the Choice Providers and will be working with them intensively on efforts to improve the CSR scores for children and youth.

CYSD, in partnership with the Office of Crime Victim Services, provided training to 70 clinicians on Trauma-Focused Cognitive Behavioral Therapy. The clinicians participating in the training included 50 representatives from the Choice Providers. In addition, CYSD is developing a plan to provide training on three additional evidence-based practices that will create better clinical capacity within the Choice Providers to meet the complex needs of children and youth in the District. It remains to be seen how this concept will play out over time.

f. Child Welfare/Foster Care

The framework for the DMH/CFSA efforts is the Amended Implementation Plan (AIP) in the LaShawn case. As part of the CYSD structure, one of the five (5) operating units is the CFSA Mental Health Initiative – Child and Youth Clinical Practice. DMH has placed at CFSA a Mental health Program Manager, a Home and Community-Based Services Coordinator, a Program Analyst and three (3) clinical co-located positions. The goal of these staff is to assure that needed mental health screenings and referrals occur for children/youth in the child welfare system. There is capacity in the clinical team to screen over 500 children/youth per year.

In addition to the clinical team process, the overall AIP also speaks to many of the other major initiatives in the CYSD. These include: a) the new Child and Adolescent Mobile Psychiatric Service (ChAMPS), which began operating in October 2008 and was discussed in the January 2009 Report to the Court; b) the Wraparound initiative which started in the fall of 2008 and has capacity for 24 children/youth and c) Choice Providers – as discussed in III C2e. The composite of DMH/CFSA efforts indicates a strong and growing collaboration.

Overall, the Court Monitor finds that the CYSD is at a very key juncture. It has put in place over the past year several key initiatives – e.g. crisis mobile, Wraparound and the Choice Provider model. It has taken a lead role in out-of-home placement and monitoring challenges. There is now stable and strong leadership in place – with a CYSD team that appears to be working very well together. The new efforts to improve clinical practice are both timely and necessary – given the continued low system performance scores. The next year will include the challenge of putting all of these pieces together in an integrated and functioning way. The development of a multi-year plan should help.

D. DMH's Role as Provider

1. Planning for New/Consolidated Hospital

As of June, 2009, the new Hospital is nearing the stage of substantial completion – approximately 95%. The remaining work includes the installation of finishes and flooring, exterior

landscaping and related utility and road work. The "commissioning" of the Hospital will occur from September to December, 2009. This involves a contracted commissioning agent who will thoroughly test all of the Hospital systems. It is uncertain when the new furniture will arrive. The Fall of 2009 and early 2010 will also see the final punchlist and necessary external inspections. The target date for occupancy is March, 2010. The one remaining issue is the need to ensure that there is adequate water supply and water pressure for the new sprinkler system and fire hoses. This is an issue directly involving the DC Fire Marshall. Alternative options are being explored and hopefully an adequate solution will be found that does not cause a delay in Hospital occupancy.

The electrical work on RMB (Phase 1) is completed and the utility consolidation is almost complete. Phase 2 work on RMB ($4 million obligated) has been pared back to only include the re-configuration of the lobby and provide an additional dental suite in support of the Hospital. The Phase 3 for RMB ($3million capital in FY'10 Budget) will provide some additional infrastructure work (e.g. IT) but will primarily be focused on basic painting and cosmetic improvements. RMB has up to 100 beds and will service as an overflow to the 292 bed new Hospital.

The other remaining project still outstanding ($19.8 million capital in FY'09 budget) is for the demolition of the John Howard Pavilion after the move to the new Hospital. This project will also involve the creation of a new activities courtyard for forensic patients and additional surface parking and landscaping. This project will take approximately one year to complete but will not be started until after the John Howard Pavilion is vacated.

2. Quality of Care Issues at SEH

The DOJ Settlement Agreement (SA) continues to be the template for monitoring quality of care progress at SEH. DOJ conducted its third visit on March 30 – April 3, 2009 and issued its findings and a summary letter on May 27, 2009. The recent visit noted continued progress on many fronts but also stated in strong terms that SEH is significantly behind the three year schedule on its overall compliance efforts. The letter noted that SEH was to be in compliance with 74 provisions as of December, 2008 but was only in compliance with six (6). DOJ outlined priority concerns to be completed before the next DOJ visit – likely in September, 2009. These priority concerns can be summarized as follows:

- Protection From Harm and Risk Management

  The recent hirings of a Director of Performance Improvement and a Risk Manager were noted as positives as was the annual competency-based training on recognizing and reporting abuse and neglect. Among the highlighted priorities in this area are:

  1) Apply the use of the preponderance of evidence standard in policies written by the Performance Improvement Department. This is particularly critical in abuse and neglect investigations – which need to be tightened to ensure all witnesses are interviewed and investigations are more comprehensive.

  2) Take necessary steps to reduce incidents on RMB-3 and RMB-6. Reviewers noted an unusually high degree of incidents on these units. They further recommend that RMB-3 should be reconfigured. RMB-3 is the behavioral unit for SEH and as such contains some of the most behaviorally difficult patients. The DOJ reviewer argues that placing these patients together limits the potential normalizing constraints of peers on other units.

  3) Assess the Hospital environment to identify areas where air vents could potentially be used for suicide attempts.

  4) SEH remains in non-compliance on the overall category of restraints, seclusion and emergency involuntary psychotropic medications. However, SEH reviewers noted significant progress in this area – noting there has been an overall reduction in both the number and hours of seclusion and restraint. There is a need to move forward in the next 6 months to implement new policies and requisite staff training. There was specific mention of training on nursing procedures for seclusion/restraint – with focus on those procedures regarding side rails and medical protective devices.

- Nursing Care

The DOJ team identified progress in filling nursing positions – with a 7% vacancy rate as of February 2009. However, SEH remains in non-compliance for the overall category of nursing and has not yet been able "to translate numbers of nursing staff into quality and competent nursing care". Some of the identified priority tasks include:

1) Provide competency training for all nursing staff.

2) Streamline disparate policies and procedures so as to provide a consistent approach to nursing policy in terms of actions required, by whom and in what timeframe.

3) Implement a Comprehensive Nursing Assessment as part of the overall hospital policy.

4) Revise policies, procedures and training regarding nursing's role in providing care as part of the overall treatment planning.

5) Review and clarify specific nursing interventions in key areas e.g. assessments for choking/swallowing and protocols for insulin administration to patients with diabetes.

6) Implement a workable infection control program – with concern expressed about the vacancy in the Infection Control Director position in October 2008 and delays in progress as a result.

7) Provide assurances that an RN is on duty on all units on all shifts. This is currently not the case – as documented by the DOJ team.

- Treatment Planning and Psychiatric Care

In the whole area of integrated treatment planning and psychiatric care, SEH continues to be in non-compliance according to the DOJ report. DOJ noted progress in this area as a whole, but still much work is required in terms of implementation and training. Some of the priority areas include:

1) Ensure that the IRP has clear expectations of both the process and outcomes of engagement as part of

the IRP meetings.

2) Develop a program of interventions to ensure that patient's receive a minimum of 20 hours per week of clinically appropriate treatment and rehabilitation services.

3) Develop and implement policies and processes that ensure increased diagnostic accuracy in psychiatric assessments.

4) Develop and implement increased system-wide monitoring of appropriate use of psychotropic medications. There is concern about the long-term use of certain medications and/or polypharmacy that are not clinically justified in light of patient risks.

- Behavioral Management and Psychological Care

The DOJ team found improvements in the overall area of behavioral management and psychological care, including discharge planning and community integration. SEH was commended for achieving substantial compliance with five (5) different sub provisions. Of particular note were improvements in the Behavioral Intervention Program and a specific state-of-the-art manual for implementing Positive Behavior Supports (PBS). Some of the priority issues in this area are:

1) Implement a training effort to support the team leader/facilitator in treatment planning conferences.

2) Develop a staffing and recruitment plan to ensure that there are adequate numbers of rehabilitation therapy staff to complete Rehabilitation Service Assessments in a timely way.

3) Develop an auditing method regarding social work documentation of barriers to discharge.

4) Discontinue the process of transferring patients with behavioral intervention needs to RMB-3 and instead provide that service in an integrated manner on the unit.

The above-summarized priority concerns of the DOJ visit need to be put into the context of overall compliance efforts. There are a total of 208 findings that DOJ has reviewed and scored to-date (out of a total maximum of 224 requirements per the SA). Of the current total of 208, SEH has achieved substantial compliance on 11 (5%), partial compliance on 157 (75%) and noncompliance on 40 (20%). This 80% score on partial and substantial compliance scores combined compares to a 55% level as of the September, 2008 DOJ visit. Clearly progress in being made although not at the pace that was originally agreed upon. Other key areas for SEH can be summarized as follows:

1) Human Resources

SEH has continued its positive performance in reducing vacancies. The most recent weekly snapshot of vacancies is reflective of the overall pattern for the past 6 months. It shows an overall vacancy rate of 6.17% (62 vacancies out of 1005 positions). The actual vacancy rate was 5.67% (vacancies minus the 5 committed positions). These percentages contrast to historic vacancy rates of 10 – 12% – so obviously significant hiring progress has been achieved. Nursing vacancies are also at reduced levels – with 5.44% vacancy rate as of June 15, 2009 (24 vacancies out of 441 total nursing positions).

SEH has made a change in the Nursing Chief Executive position – adding someone who can bring stronger leadership to the multiple nursing challenges. SEH has also hired four (4) new psychiatrists as of July, 2009. This will provide for full staffing of psychiatrists to provide 24 hour coverage. Leadership vacancies exist for the following critical vacancies: the Performance Improvement Director (PID), the Psychology Director and the Risk Manager. All of these positions are critical to the areas cited by DOJ for priority improvement.

2) Contracts and Procurements

This is an area that has seen marked improvement over the past year. As discussed in III B2, the contracts staff at DMH have worked very closely with SEH to anticipate and manage procurement needs and timeframes. The major challenge has been to prioritize existing contracts in order to meet budgetary constraints. This has been handled in a very collaborative way without any discernible interruption of core services.

3) Information Technology

Phase 2 of the new AVATAR system is well under way. Phase 2 is the clinical workstation module, which includes patient assessments, treatment planning and care notes. The electronic medical record is the key step in creating a single clinical and demographic database. As with Phase 1, there is a major training component in bringing up Phase 2. The plan for Phase 2 is to "go live" in incremental steps. Training began on May 28, 2009 – with 88 clinicians trained as of mid-June and additional training planned for social workers, rehabilitation services staff and nurses during July and August. It is hoped that Phase 2 training and implementation will be completed by October, 2009 – with requisite follow-up to ensure that both the IT systems and clinical staff are fully working. Phase 3 will begin in the Fall of '09 and will deal – among other things – with the need to do historical imaging of old manual records with necessary IT linkages.

4) Budgetary Issues

As discussed in various sections of this Report, the '09 and '10 budget constraints have had widespread implications for SEH. Thirty one (31) SEH staff were RIF'd – all in non-clinical areas. The revised FY"10 budget will reduce an additional 27.1 FTE's. One of the major challenges has been the management of overtime. SEH spent $6.5 million in overtime on FY'08; it was budgeted in '09 for $1.9 million – which obviously is inadequate. SEH and the Authority have been in constant dialogue about this issue – with close monitoring and accountability systems now in place. FY'09 trend lines are positive (as compared to FY'08) but it appears that there will still be overtime expenditures for FY'09 in excess of $4.5 million. Funds from other DMH sources have had to be reprogrammed to cover this budget shortfall. Hopefully, the combination of tight controls and positive clinical recruitment will obviate excessive overtime expenses going forward. The additional $400,000 in reduced overtime in the revised FY'10 budget will put additional pressure on the overtime issue.

5) Internal Customer Service

SEH is in the process of implementing an innovative approach to handling all internal customer needs. Called the Solution Center, it will consolidate the multiple streams for complaints/help that currently exist

(e.g. AVATAR, Help Desk, Trouble Desk, Communications and the Security Call Center) into an integrated and single-number process. The goal is to streamline the process, increase collaboration among support areas and use available resources more effectively. SEH staff can access the new Solution Center by email, phone or by intranet. It began operations as of June 15, 2009 and will be in pilot phase for two months to smooth out start-up issues.

SEH has had to deal with an incredible number of organizational, facility-related, clinical and IT, budgetary and staff issues all at once. Any one of these would normally consume an organization's agenda. The Court Monitor's overall assessment is that the basic foundation for change is clearly in place. The new IT system and new Hospital should help create a true state-of-art environment within which to work. Leadership in key positions is the strongest it has ever been. The major task for the District is to continue providing support, communication and a modicum of patience. DMH senior staff should also be commended for their collaborative support on key issues e.g. budget, IT, facilities, and procurement.

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

The DMH has shown dramatic progress in this area. For the four months of February, 2009 – May, 2009, DMH had only 12 acute admissions to SEH, an average of three per month. By contrast, for the 4 months of October, 2008 – January, 2009, the average of acute admissions was 18 per month. The key has been the additional acute care beds that DMH now has available per service contracts with United Medical Center and Providence. There are now a total of 54 beds that are potentially available – the highest it has ever been (34 at UMC and 20 at Providence). The fact that acute bed capacity is no longer the problem is borne out by the fact that over the past 4 months (February – May, 2009) there was only one acute admission to SEH due to the lack of an available community bed.

SEH continues to get transfers after a patient has not stabilized within 14 days. These admissions are averaging about 11 per month. The net effect of this is that civil-side admissions to SEH are now averaging approximately 20/month (all reasons). This compares to recent year patterns which have had approximately 45 total civil admissions per month. This takes bed

pressure off of SEH, shortens acute lengths of stay, and allows for consumers to remain connected with families and current living situations.

This lack of acute bed capacity has been a repeated theme since the time of the Court-Ordered Plan. The Court Monitor is pleased to find that DMH now is in compliance with the Court-Ordered Plan. Its efforts on this front are noted and commended.

4. Development and Implementation of the Integrated Care Initiative

The Integrated Care Division (ICD) began in the Fall of 2008 – with a targeted focus on consumers at SEH who need intensive care management if they are to successfully transition to the community. The ICD also seeks to avoid unnecessary admissions and re-admissions to SEH by providing care management monitoring for those at highest risk.

DMH initiated a planning process in April 2009 with District nursing homes to develop the system capacity to accept and care for consumers who are currently receiving inpatient services from Saint Elizabeths Hospital, but who could live in the community at the nursing home level of care. Several areas of policy and service development and support are being identified in this process that should result in real solutions to increase availability of nursing home beds for this population.

One of the specific projects for this unit is to manage a new Integrated Community Care Project – which has been contracted to the CSA at the Washington Hospital Center. The goal of this effort is to out-place 30 consumers from SEH who have had histories of inability to maintain successful community placements. The goal is to place five (5) individuals per month over a 6-month period. The first placements began in late May, 2009. The Integrated Care Project delivered by WHC's New Directions will also be engaging and discharging some forensic inpatients from SEH.

As of May, 2009, there were a total of 64 persons at SEH who had been targeted for needing the special assistance of the ICD in order to achieve successful discharge. Of this number, seventeen (17) were scheduled for discharge within the next 30 days. Hence, in any given month, the ICD is assisting in the discharge of 1/3 to 1/2 of total discharges. It is fair to say that these consumers would otherwise remain at SEH or face a very tenuous community placement. The ICD is encountering special

populations (e.g. mental retarded/mentally ill and medically infirmed) for whom concerted efforts are needed to achieve an appropriate placement.

The ICD also provides follow-ups for consumers once placed. The total "caseload" for the ICD as of May, 2009 was 136 – but this number will likely increase in the months ahead. Consumers receive periodic reviews by ICD (weekly, monthly or quarterly) based upon their level of need/stability.

The ICD currently has a direct staff complement of five – counting the Director. The hope is to add a fifth staff position in the coming months. This new person would focus on the Continuity of Care issue for acute care admissions – one of the outstanding Dixon measures. This person would provide concerted engagement not only during the hospital admission and the 7 day outpatient follow-up requirements, but would also stay involved for at least 30 days.

In addition to everything else the ICD is doing, it also is a key player in the DC CSA transition. The protocol is that the Care Management Unit of the ICD will engage with a consumer if they have not made a clear connection to the new CSA. Original estimates were that perhaps 10% of the total 2500 consumers to be transferred by September, 2009 could need special intervention.

The Court Monitor continues to be very pleased with the role and beginning efforts of the ICD. The focus on this highest risk population should help to not only reduce the census at SEH but provide greater assurances of successful community tenure.

5. Transition of DC CSA

The May, 2009 Supplemental Report to the Court identified the issues and plans for this major undertaking. This Report will provide a brief update on key developments as follows:

- The total number of consumers who have selected a new CSA is 2136 as of July 8, 2009. At the current pace of selection, DMH may not have to go through the auto-assignment process. This issue continues to be evaluated by the Implementation Team.
- The DMH is working with the Office of Property Management (OPM) regarding potential space availability. The plan is for OPM to issue solicitations for both government operated and available commercial space that DMH occupies and will no longer need. DMH vacated the

Alabama Ave. location as of July 7, 2009 and plans to use its 35 K Street and Howard Road sites to house ongoing government-operated services. There is still an open question as to the need for the U Street site, which will be addressed in the OPM solicitation.

- There is an ongoing and major issue regarding provider capacity. The DMH has completed its survey request to providers and is analyzing the results. The DMH Director and Deputy Director for Programs are meeting with the CEO's of each CSA to better understand concerns. Consumers who have selected a new CSA can continue to receive services via the DC CSA until such time as intake capacity opens up. It should be noted that several of the major CSA's have requested permission to periodically close intakes due to volumes they cannot currently accommodate. DMH is notified of this fact and is closely tracking CSA closure status.
- DMH has changed its CTV policy to provide 50% of full payment to CSA's at the time of consumer selection. The hope is to expedite cash-flow to CSA's and hence encourage needed hiring and provide funding for other expansion-related efforts.

Overall the DC CSA process is moving forward in a positive way. The DMH has the delicate task of maintaining capacity at the DC CSA until such time or private provider capacity develops. This will likely take several months to accomplish. DMH has appropriately put its focus on those individuals who have already made a new provider selection. The government-run services are in the planning stages and are still scheduled to start in the Fall of 2009. This will include the psychiatric practice group, which will see some consumers directly for medication management and also be available to provide psychiatric support for CSA's. The Court Monitor will continue to closely track progress on the overall transition.

E. Review of FY 2009 Budget Issues and Status of 2010 Budget

The DMH has already absorbed $3.349 million in reductions to its 2009 approved budget of $231.8 million. These reductions occurred in the Fall of 2008 and were discussed in the January, 2009 Report to the Court. Based on recent revenue forecasts, the District is looking to reduce its 2009 spending even further. The initial approach was to require agencies to revert any unencumbered funds or provide justification. The dollars in question are all for Non-Personnel Services (NPS). Of the $2.6 million in

unencumbered funds for '09, DMH has argued that the majority of these dollars are needed for SEH and the acute care contract. Hence, as of June 24, 2009, DMH has indicated that only $345,000 additional dollars can be reverted without serious jeopardy to service areas. The indication to-date is that there is agreement with the City Administrator and the OCFO on this target.

The original FY 2010 Budget status was discussed in detail in the May 8, 2009 Supplemental Report to the Court. The major change since that time is the continued erosion of overall projected revenue for the District. The severity of the revenue shortfalls has prompted the Mayor to re-open the FY'10 budget. On July 17, 2009, the Mayor presented a reduced expenditure plan that effects local budgeted revenue for all District agencies, including DMH. DMH is recommended to take an additional cut of $9.0 million in local revenue (4.5%). A major thrust of these latest cuts assumes the planned cost efficiencies of the new Hospital and the closure of the DC CSA. The following cuts are tied to the assumption of improved efficiencies:

- $1million in savings due to consolidation of facilities as DC CSA closes
- $1.87 million in savings due to reduced projections for DC CSA staff needed from October 1, 2009-March 31, 2010. Half of this $1.87 million ($938,000) would be reinvested in the MHRS program for expanded community services
- $630,000 reduction in contracted security services at SEH due to consolidation
- $600,000 reduction in pharmacy services at SEH due to projected lower census

In addition to these reductions of $3.168 million, there are significant other cuts also planned for SEH to include:

- $90,000 in security costs due to one gate closure at SEH
- $215,000 due to outsourcing of laboratory services at SEH
- $400,000 reduction in planned overtime at SEH
- $1.64 million due to 27.1 FTE reductions at SEH
- $350,000 reduction in contractual services at SEH

The Mental Health Authority (MHA) would also absorb major additional cuts:

- $440,000 due to reduction of six psychiatrists (out of 14) who were planned to be part of the Physician Practice Group.
- $691,000 due to 6.5 additional FTE reductions at the MHA

- $2million reductions in targeted DMH contracts e.g. a school-based contract that serves 6 schools ($575,000) and a 4% reduction in Community Residential Facilities (CRF's) ($360,000).

It appears that the District has continued its efforts to focus cuts in areas that do not directly affect consumer services; however, that is not entirely true in this go-round e.g. school-based contract. It should be noted that the original budgetary discussions were in the range of 10% cuts, so obviously a 4.5% is much better. Nevertheless, there is now the hard reality that the savings due to consolidations and efficiency measures have been used and any further cuts will inevitably impact direct services. The Court Monitor is very concerned that this may not be the end of budget reductions and that further cuts could directly impact the Dixon-related progress that has been made. The Court Monitor will continue to track this issue closely.

IV. Follow-up on Other Previously Identified Recommendations

A. Crisis Services Planning

DMH completed its comprehensive Crisis/Emergency Services Plan in late 2007. The original work group that helped develop the plan has continued to meet on a quarterly basis. The plan that was developed continues to serve as the framework for priority actions. Among the major accomplishments since early 2008 are:

1) The full implementation of the adult Mobile Crisis Team as of November, 2008 – providing services 16 hour/day and 365 day/year.
2) The ChAMPS contract with Catholic Charities to provide mobile crisis services for children, youth and families. This program began in late October, 2008.
3) The opening of the eight (8) Extended Observation Beds at CPEP on February 17, 2009.
4) The complete renovation of CPEP as of December 18, 2008.
5) The opening of a new Court Urgent Care Clinic (CUCC) as of June 23, 2008. The Psychiatric Institute of Washington (PIW) provides onsite evaluations and referrals for the Superior Court.
6) The Crisis Intervention Officer (CIO) program as discussed fully in III A5 of this Report – with a start point of May 1, 2009.

Overall, DMH has not only developed a comprehensive plan but has consistently followed through to make sure it is implemented. The past year has seen major accomplishments in this area. The major remaining issue is the overall availability of urgent care/walk-in capacity. DMH has begun to address this issue via CPEP, the CUCC and the

Residents Clinic; however, wide-spread availability of urgent care capacity will need to be addressed as part of the redesign efforts.

B. Community System Redesign

The basic principles regarding a redesigned community system were laid out in the initial DMH Report to the Council of October 1, 2008 and were summarized (with full support) by the Court Monitor in the October 17, 2008 Supplemental Report to the Court. These basic principles center around the overall need for the system to: 1) define and support a limited number of comprehensive mental health providers; 2) transfer from DHCF to DMH the full authority to manage and fund all Free-Standing Mental Health Clinics (FSMHC's); 3) require the new comprehensive providers to offer both Medicaid Rehabilitation Option (MHRS) and Medicaid Clinic Option Services. The goal is to maximize and rationalize the use of these two funding streams; and 4) establish an integrated medical records system for all providers.

There are multiple policy issues at play in a redesigned system. One of the major issues is the degree to which mental health benefits (and dollars) are "carved in" as part of an overall health plan or "carved out" – with separate mental health management. The District today has a mixed model – with the MCO's providing limited mental health benefits and DMH managing the more extensive services via MHRS. This mixed model (while typical across the county) often leads to confusion about what services should be billed first, differential rates for similar services and underutilization of the clinic option. DMH would like to see the development of an overall plan that weaves together consumer needs, clear coordination of benefits and consistent management.

Another major development since 2008 has been the opportunity to use some of the District's tobacco settlement money to look at best options for redesign. DMH (via the Department of Health) has awarded the Rand Corporation $406,000 to analyze the behavioral health needs of District residents, review current service delivery and financing and develop specific recommendations for improvements. This work has begun and is required to be fully completed by September 30, 2010. This work gives DMH and the District a unique opportunity to do a comprehensive review of the publicly-financed behavioral health system.

Given the complexity of the issues at hand, DMH conceptualizes this redesign as an incremental and multi-year project; the Court Monitor agrees. It would appear, however, that DMH is at a point of needing to outline an overall strategy or master plan that begins to detail the incremental steps that can and should be taken in the near-term versus those that should wait for the Rand study. An example of the near-term

might be the development of the clinic option for the District. The Court Monitor believes that now is the time to frame the overall redesign effort, communicate this to all shareholders and begin the task of implementation.

V. Recommendations

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

A. The DMH should proceed with its full implementation of the DC CSA transition. The current policy of ensuring services at the DC CSA while new provider capacity develops should be protected – even if the timetable for transfer slips.

B. The DMH should proceed during FY'09 to invest in the Share Point Information Technology System. Multiple critical DMH functions are dependent upon upgraded IT access and support.

C. DMH should proceed as soon as possible to present an overall master plan for its redesign efforts. This master plan should invite comment and lay out incremental steps and timeframes.