UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

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

COURT MONITOR'S NOTICE OF SUBMISSION OF REPORT

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

Respectfully submitted,

/s/ Robert B. Duncan

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CERTIFICATE OF SERVICE

I certify that on July 28, 2010, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system, which will send notification to all counsel of record.

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REPORT TO THE COURT

Court Monitor
Dennis R. Jones

July 28, 2010

Executive Summary

The sixteenth Report to the Court shows important progress on several fronts. The DC CSA has completed its transition and phase-out with nearly 3100 consumers transitioned to private CSAs and the remainder of active consumers transferred to the DMH-operated Mental Health Services Division (MHSD). The new 293 bed hospital was opened and occupied in May 2010. The most recent DOJ visit reflects over all progress on many issues, but with continued concern about the pace. DMH is facing an additional 10% cut ($16 million in local funds) for its 2011 Budget. However, this cut was softened by allowing $9 million of the cuts to come from fixed costs savings leaving $7 million (4%) in true reductions. There is continued concern about additional cuts and the impact on Dixon services.

The major areas of note in this Report include:

1. Implementation of Exit Criteria

   Nine (9) of the nineteen (19) Exit Criteria are now in inactive status; this includes three (3) since the filing of the January 2010 Report to the Court (Child/Youth with SED (#6); Adults (#7) and; Children/Youth in Natural Settings (#14)). In addition, there are two (2) Exit Criteria for which DMH has written letters requesting inactive status (#1 & #15) that are currently under review by the Court Monitor. DMH's requests for inactive monitoring status for Child/Youth penetration (#5) and ACT (#11) were denied by the Court Monitor.

2. Transition and Closure of DC CSA

   The DC CSA successfully transitioned nearly 3100 consumers to private CSA's by March 31, 2010. The MHSD continues to provide an array of specialty services and provide psychiatric support to the private CSA's as requested. .

3. Budgetary Issues

   DMH has absorbed several major budget cuts in FY'09 and FY '10. The FY'10 Budget appears safe from any additional cuts and in fact, DMH will have some unanticipated one-time revenue from Medicaid recoupment and SEH payments from the Virgin Islands. The FY'11 Budget targets a $16 million cut in locals funds for DMH, but $9 million will come from savings in fixed costs. The $7 million in true cuts includes $2 million for SEH and a number of cuts to contracts that are not fully expended. While the overall revenue picture for the District has stabilized, there is lingering concern about additional FY'11 cuts and impact on Dixon issues.

4. St. Elizabeths Hospital

The new hospital was fully occupied as planned in May 2010 - marking a very historic milestone for the DMH and the District. The reduced census should allow all patients to be served in the new facility by no later than January 1, 2011. The DOJ visit in May 2010 showed a number of areas of progress; however, DOJ remains concerned about the overall pace of progress. DOJ will return in November, 2010.

4. Use of Local Hospitals to Provide Acute Care

The use of local hospitals to handle acute care has continued to be well managed. The most recent six months reflects a stable pattern with very limited acute care admissions directly to SEH. The District's recent decision to purchase the United Medical Center (UMC) will hopefully provide stability at that facility.

5. Community System Redesign

The larger Redesign Workgroup has divided into three (3) sub-committees which have intensified the overall effort. The April 2010 timeline for completion was not met; the lack of a definitive timeline for completion (and beginning implementation) is of concern.

6. Integrated Service Delivery for High Risk Children and Youth

DMH and other child-serving agencies have made some progress on this issue nevertheless; major gaps remain especially for non-Medicaid children/youth being admitted to PRTF's. The DMH has overall statutory responsibility for the SED population; it should be given explicit authority to oversee and manage all aspects of the PRTF program.

Based upon the findings in the Report and prior Reports to the Court, the Court Monitor makes the following recommendation:

A. The District must formally address in a timely way all of those system-of-care issues regarding PRTF's. Any solution(s) should recognize DMH's statutory responsibility for the SED population in general and oversight of PRTF's in particular.

I. Current Situation

In October 2009, the Federal Court approved the Monitoring Plan for October 1, 2009 through September 30, 2010. 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 sixteenth formal Monitoring Report.

II. Findings Regarding Exit Criteria

The Report utilizes the same format as previous Reports. Table 1 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 Eight 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 Methods(s)

DMH has continued its efforts to meet Court requirements on both of these Exit Criteria. On Exit Criteria #1 (Consumer Satisfaction), the DMH has submitted a letter to the Court Monitor requesting that this Criterion move to inactive status. This letter (and supporting exhibits) is currently under review by the Court Monitor and plaintiffs' counsel. In its letter, DMH has identified three (3) consumer satisfaction issues that have surfaced from a composite of consumer input methods: 1) the first is the utilization of the MHSIP survey itself. Based on

methodological concerns from prior MHSIP reviews, the 2009 MHSIP sought to improve consumer response via mail surveys (as needed) in addition to telephone only and the provision of a $10.00 incentive gift cards for participation. The result was a significant increase in participation (33% increase for adults and 27% for children/youth). The DMH, through the Internal Quality Council (IQC), has carefully analyzed the data and has identified four (4) specific areas that will be pursued to improve consumer services; 2) Consumer Participation in Treatment – this has been identified in focus groups conducted by the Consumer Action Network (CAN) as a persistent consumer concern. The Office of Accountability (OA) has developed a Quality Review tool designed to measure consumer involvement in treatment. As a part of the pilot phase for the Provider Scorecard (see III. A. 1.), the OA included this as a distinct measure. The FY 2010 rollout of the Provider Scorecard will include this element; the results will be made public for consumers to review as they make choices about which provider to select, and; 3) Medical Co-morbidity QI Initiative – The IQC identified the issue of coordination of care between physical and mental health as a high concern beginning in 2008. As a result, OA began a major initiative to identify the degree to which DMH consumers were linked to primary care. The first year of measuring the level of linkage showed a 12% improvement – from 70.2% at the baseline to 82% by the end of the fiscal year. This is an excellent example of DMH working through its Quality Wheel (Plan, Do, Study, Act) to achieve improvement.

DMH effort continues in the implementation of LOCUS/CALOCUS as a measure of consumer functioning. Despite the major training effort that DMH has completed on the web-based LOCUS/ CALOCUS application, the initial reports indicate that there is inconsistent utilization of the web-based system by DMH providers. The OA continues to monitor the requirement for completion of a LOCUS/CALOCUS every six months through the Quality Review process. OA reports that based upon the Quality Reviews there is evidence to suggest that LOCUS/CALOCUS is used more widely throughout the system than shown in the reports of utilization of the web-based system. Providers continue to use LOCUS/CALOCUS as required by policy with regard to requests for changes in levels of service (CBI, ACT), but apparently the manual scoring system remains the preferred method of conducting the assessment.

Parallel to the DMH compliance efforts, the Division of Organizational Development in consultation with the Division of Quality Improvement and DMH program staff have now finalized a set of Utilization Guidelines. These are intended to provide a crosswalk between LOCUS/CALOCUS scores and actual MHRS

service utilization. The overall thrust of this effort is to build some enthusiasm and capacity for providers to utilize the LOCUS/CALOCUS scores as an important internal measure that should strongly correlate with service utilization. It is evident that much work remains before DMH can begin to show "demonstrated utilization" – as required under Dixon.

B. Results of Year Eight (8) Consumer Service Reviews (CSR's) for Children/Youth and Adults

1. Summary of Children/Youth Findings

Following the well-developed protocol, the Child/Youth Review was conducted over a 2-week period in March 2010. The target size was set at 86; however, due to the lack of sufficient quantitative data and consent issues, 76 cases were included in the final case sample. HSO-affiliated reviewers conducted 52 reviews and DMH specially-trained staff completed 24. Since the 2008 review, HSO has provided a case judge to review all cases reviewed by DMH staff and as many cases as possible reviewed by HSO. The case-judging process has been an important factor in providing inter-rater reliability in case scoring.

As in 2009, a $25.00 gift card was provided to families who participated in the review. CFSA staff co-reviewed cases in which both DMH and CFSA were involved. There were sixteen (16) total DMH agencies reviewed; however, 9 of the 16 had 3 or fewer cases.

Year Eight (8) results ended in overall scores in a pattern very consistent with prior years. The overall status of acceptable reviews in terms of child/youth status was 70%. This is lower but in the range of 77% (2009) and 78% (2008). Areas that scored well were safety of the child (83%), and physical well-being (88%). Lower-scoring areas included stability (58%), functional status (59%), academic status (58%) and responsible social behavior (58%).

The Dixon criterion measures how well the system performs with a required acceptable standard of 80%. For FY 2010, the overall systems performance was 49%. This score is also very consistent with prior years – 36% (2008), and 48% (2009). Areas that have scored poorly in the past continue to lag well below the expectations; these include: service team formation

(45%), service team functioning (33%); functional assessment (39%) and; long-term guiding view (32%).

The one encouraging part of the 2010 results for children/youth is that the intensive follow-up work from the 2009 CSR review appears to have had demonstrable results. Two of the larger child/youth providers undertook an intensive staff training and organizational change effort (with DMH support) following last year's review. Both of these providers scored in the 70% range this year in systems performance. The Court Monitor recognizes that creating consistent cross-agency care plans for high-risk children is not easy; however, the positive results of targeted organizational training suggests that it can be done. The DMH efforts to follow (and expand) this process for FY 2010 (See III. A. 5.) is hopeful. It would appear, despite the years of flat (and poor) performance that the system is now looking more comprehensively at what it takes to improve the quality of care.

2. Summary of Adult Findings

The Adult CSR review for Year Eight (8) included 85 cases and was conducted during May 2010. As with the child/youth review, two-thirds of the cases were reviewed by HSO and one-third by DMH. Since the 2008 review, HSO has provided a case judge to review all cases reviewed by DMH staff and as many cases as possible reviewed by HSO. The case-judging process has been an important piece in providing inter-rater reliability.

The overall Year Eight (8) result for consumer status was 80%. This compares favorably to Year Seven (7) at 74% and Year Six (6) also at 74%. Areas of strength included: safety (89%), economic security (79%) and health/physical well-being (80%). Areas that continue to score low included: social network (49%), education/career preparation (49%), work (50%), and recovery activities (60%). These patterns of strengths and weaknesses are very consistent with prior years.

Year Eight results for the Dixon measure of systems performance was 77%. This also compares favorably to the 70% score for 2009 and 74% for 2008. Unfortunately it still does not meet the required 80% performance level. A breakdown of the data for 2010 shows that the larger providers tended to perform very well. Of the five (5) largest providers in the sample, the top three (3) scored at a systems performance

level of 93%. On the other end the twelve smallest providers in the sample had an aggregate systems score of 58%. This bifurcation of performance reflects a major challenge for DMH. Clearly the larger providers have moved to embrace the recovery principles inherent in CSR and have created internal systems to improve practice. The smaller agencies typically have less infrastructure capacity (e.g. staff training and quality improvement). DMH intends to use this CSR data to create targeted technical assistance interventions. Overall it is encouraging to see the adult system so close to the Dixon standards.

C. Implementation of Court-approved Performance Criteria

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

Table 1
Exit Criteria
Current Status

Aggregate Data for April 1, 2009 – March 31, 2010

Exit Criteria	Policy in Place	Data Methods in Place	DMH Validated Data System	Court Monitor Validated Data System	Court Required Performance Level	Current Performance Level
1. Consumer Satisfaction Method(s)	Yes	N.A.	N.A.	N.A.	Methods + Demonstrated Utilization of Results	Methods computed. Utilization in process.
2. Consumer Functioning Method(s)	Yes	N.A.	N.A.	N.A.	Methods + Demonstrated Utilization of Results	Methods computed. Utilization in process.
3. Consumer Reviews (Adult)	Yes	Yes	Yes	Yes	80% for Systems Performance	77%
4. Consumer Reviews (C/Y)	Yes	Yes	Yes	Yes	80% for Systems Performance	49%
5. Penetration (C/Y 0-17 Years)	Yes	Yes	Yes	Yes	5%	4.07%
6. Penetration (C/Y with SED)	Yes	Yes	Yes	Yes	3%	3.16% (inactive)

Exit Criteria	Policy in Place	Data Methods in Place	DMH Validated Data System	Court Monitor Validated Data System	Court Required Performance Level	Current Performance Level
7. Penetration (Adults 18 + Years)	Yes	Yes	Yes	Yes	3%	3.13% (inactive)
8. Penetration (Adults with SMI)	Yes	Yes	Yes	Yes	2%	2.97% (inactive)
9. Supported Housing	Yes	Yes	Yes	Yes	70% Served Within 45 Days of Referral	10.0%
10. Supported Employment	Yes	Yes	Yes	Yes	70% Served Within 120 Days of Referral	84.71%
11. Assertive Community Treatment (ACT)	Yes	Yes	Yes	Yes	85% Served Within 45 Days of Referral	85.47%
12. Newer - Generation Medications	Yes	Yes	Yes	Yes	70% of Adults with Schizophrenia Receive Atypical Medications	64% (inactive)
13. Homeless (Adults)	Yes	Yes	Yes	Yes	150 Served + Comprehensive Strategy	276 Served + 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%.	81.19% (inactive)
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%.	89.45%
16. Homeless C/Y	Yes	Yes	Yes	Yes	100 Served + Comprehensive Strategy	80 (inactive)
17. Continuity of Care a. Adults b. C/Y	Yes	Yes	Yes	Yes	80% of Inpatient Discharges Seen Within 7	a. 55.3% (adult) b. 48.4% (child)

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
					Days in Non-emergency Outpatient Setting.	
18. Community Resources	Yes	Yes	Yes	Yes	60% of DMH Expenses for Community Services	FY '07-59% FY '08-57% (inactive)
19. Medicaid Utilization	Yes	Yes	Yes	Yes	49% of MHRS Billings Paid by Medicaid	FY '09 - 51.8% (inactive)

The above data is for the four (4) quarters of April 1, 2009 – March 31, 2010. It should be noted that many of the Exit Criterion are calculated on data from MHRS claims that have been approved for payment. The run date for approved claims was June 24, 2010; given that providers have 90 days to submit claims, it is very likely that the MHRS-based performance levels will improve after all claims for services rendered during the reporting period are processed. It should also be noted that the data reported for Exit Criterion 5, 6, 7, and 8 includes both MHRS data and MCO data per the agreements of the Consent Order. This represents an unduplicated count of individuals served; however, the MCO data for this Report includes the third and fourth quarters of FY 2009 (April 1, 20009 – September 30, 2009) only. The DMH had requested and received, but not yet completed its analysis of MCO data for the first two (2) quarters of FY 2010 (October 1, 2009 – March 31, 2010) as of July 1, 2010; hence the total number of persons served and Exit Criteria percentages are understated.

The following four (4) categories describe the Court Monitor's assessment of current compliance:

1. Exit Criteria Met – Inactive Monitoring Status

There are now nine (9) Exit Criteria that have moved to inactive status including three (3) since the time of the January 2010 Report to the Court:

- Prescribing Newer Generation Medications (#12) – This criterion was moved to inactive status as of the July 2007 Report to the Court. It should be noted that this performance level has dropped below the Dixon standard. DMH officials indicate there has been no change in prescribing practices and believe that there may be some data entry issues affecting reporting. DMH is doing a

detailed review of the data to determine the cause of the apparent reduction.

- Medicaid Utilization (#19) and Community Resources (#18) moved to inactive status in January 2008; #19 was moved to inactive status in July 2008.

- Homeless Services for Adults (#13) and Children/Youth (#16) – These two criteria were moved to inactive status as of January 2009. The Child/Youth number served (80) has fallen below the Dixon standard of 100. This may in part be due to staffing turnover; DMH intends to broaden the responsibility for providing this service to multiple staff.

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

- Penetration – Child/Youth with SED (#6) and Adults (#7) – Following full review of DMH letters and supporting data, these two criterion move to inactive status as of this Report.

- Child/Youth in Natural Setting (#14) – Following full review of DMH letter and supporting data, this criterion moves to inactive status as of this Report.

2. Under Current Review for Inactive Status

    - There are two (2) Exit Criteria for which DMH has requested inactive status. These include: Consumer Satisfaction (#1), and Children/Youth in Own (or Surrogate) Home (#15). These two (2) Criteria are being reviewed by the Court Monitor with the parties before a recommendation is made to the Court.

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

    There are four (4) Exit Criteria that required improved performance and/or require additional verification to meet the Court-approved performance levels:

    - Consumer Service Reviews (CSR) for Adults (#3) – The May 2010 CSR results for adults was 77% - with the requirement at 80%. There is clear focus by DMH to move this into the acceptable range.

- Penetration Rate for Child/Youth (#5) – The overall penetration for children/youth for the four (4) quarter reporting period running from April 1, 2009 through March 31, 2010 stands at 4.07% with the inclusion of partial MCO data (April 1, 2009 – September 30, 2009). The DMH is working to obtain FY 2010 MCO data and with the Court Monitor to identify and verify data for non eCura-based child/youth services.

- Supported Employment (#10) – The continued issue is the verification that CSA's are in fact making appropriate referrals to this program per DMH policy. The eCura quarterly event screen went into place as of May 2010. DMH has developed a protocol to review data (by CSA) and develop agency interventions.

- Assertive Community Treatment – (ACT) - #11 – DMH has requested inactive status, which the Court Monitor has denied. DMH is implementing a number of strategies (see III C1d) in response and expects to submit another request for inactive monitoring status within the next few months.

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

   There are four (4) Exit Criteria that still require additional and concerted effort in order to achieve the required performance level:

   - Consumer Functioning Method (#2) – DMH has completed the requisite training for its web-based application of LOCUS/CALOCUS. However, there are major issues in ensuring that providers are complying with the required 6-months completion. The second step is for DMH to show that demonstrated use of the data is occurring.

   - Consumer Service Reviews (CSR) for Children/Youth (#4) – There were clear pockets of significant improvement in the 2010 CSR review; nevertheless the overall score was still at 49%. DMH intends to broaden its technical assistance efforts.

   - Supported Housing (#9) – DMH continues to believe that a different set of indicators to measure performance on this issue is needed. The Court Monitor has responded with a number of questions regarding the supported housing program. Discussions between DMH and the Court Monitor about the questions have been ongoing.

- Continuity of Care (#17) – The DMH has made progress both in analyzing the continuity of care data and in assigning specific staff to manage this for both adults and children/youth (see III. D. 4.for full discussion of programmatic efforts).

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 to build on its oversight role as regards DMH providers.

a. Claims Auditing of MHRS Providers

The OA Claims Auditing for FY 2008 has now been finished and work for FY 2009 has begun. This 3-member team completes at least one annual audit on all MHRS providers. If an agency has over a 15% claims failure rate, then a second audit is performed with a larger sample. The preliminary results for FY 2008 show that 17 of the 31 audited providers (or 55%) had a preliminary failure rate of 15% or more. This is consistent with FY 2007, when over 50% of providers exceeded the 15% threshold. Claims failure rates reflect a range of issues – but most often relates to missing or non-supporting treatment plans, or progress notes that do not match a claim. DMH has set up a Claims Review Committee made up of clinicians who were not part of the audit team; this group reviews and makes determinations about questionable claims.

DMH has continued its same practice for recoupment of failed claims to the Department of Health Care Finance (DHCF), and if DHCF agrees, then DHCF makes repayment to CMS. DMH and DHCF then jointly issue a demand letter to providers seeking recoupment for the dollar value of failed claims. FY 2009 will be used to set the boundaries for error rate methodology for a change in recoupment policy. Beginning with the FY 2010 claims audits (services delivered from October 1, 2009 and beyond), the percentage of failed claims for an agency will be extrapolated to the total dollar value of MHRS claims

for the period that was audited. This change in recoupment policy will obviously increase payback significantly for providers. However, DMH has been communicating this planned change to providers for several years, who have hopefully been strengthening their internal quality control systems to ensure compliance with federal and state requirements. DMH anticipates that audits of FY 2010 claims will begin in mid-FY 2011.

It should be noted that the Medicaid Integrity Group (MIG) of CMS has completed its review of the overall DC Medicaid program. In so doing it reviewed for both vulnerabilities and effective practices. The April 2010 Draft Report indicated that, while the District overall has many Medicaid issues, the DMH was singled out for both its comprehensive audit program and its mandatory annual Medicaid compliance training for all DMH providers. This is tangible outside recognition of DMH's work in this area.

b. Compliance Committee

The DMH Compliance Committee continues to meet on a quarterly basis. This committee looks at provider issues that cut across specific DMH functions; hence the committee has representatives from all major DMH functions i.e. OA, HR, Fiscal, Legal, Programs and Provider Relations. This committee would review, for example, issues of potential fraud by a provider and extrapolation of claims recoupment. One of the current issues for this committee is the promulgation of de-certification rules for MHRS providers. These rules will soon be revised due to the fact that the existing rules are unclear as to the conditions under which a certified provider can lose certification.

c. DC CSA Monitoring

The OA has continued its role in monitoring the transition of consumers from the DC CSA to their new MHRS provider. The specific components that continue for OA are: 1) consumer satisfaction survey and; 2) continuity of care monitoring. As relates to consumer satisfaction, the most recent report from OA indicates that – via a telephone survey of random consumers – 82% rated their overall experience as positive or very positive. Conversely 9% were in the negative category – with 9% neutral. OA will

continue to conduct this survey until a full year after the transition so the last survey will occur in the spring of 2011. In terms of continuity of care, the OA has audited a sample of 730 consumers of the 3,044 who had transferred as of March 31, 2010. The aggregate results show that 56.4% of consumers had an initial visit within 30 days of the transfer; this grew to 77.1% seen within 90 days of transfer. OA also attempted to measure whether the consumer appeared to be actively engaged with the new provider – using multiple face-to-face visits as the measure for "actively engaged." On this score, the aggregate percentages showed 6l.1% were actively engaged. It is difficult to assess this outcome without being able to compare it to the level of engagement that consumers had previously with the DC CSA.

d. Quality Improvement

The OA continues to lead the monthly meeting of the Internal Quality Council (IQC). This group has representatives (clinical, medical, programs and QI) from the Authority, MHSD and SEH. It has set as priorities for FY 2010 three major priorities: 1) the integration of successful primary health care for consumers with mental illness; 2) the documentation of clinical supervision by provider agencies and; 3) the continued review of high-end utilizers of community support services.

The externally-constituted Quality Council (QC) is made up of approximately 30 community providers who meet quarterly. In addition to the review of the MHSIP data and LOCUS/CALOCUS (see II. A. for discussion), the QC has continued to discuss the rollout of the provider scorecard. OA successfully completed its pilot of the scorecard for FY 2009. The intent of the scorecard is to measure provider performance for a variety of domains in three overall areas: quality, financial, and compliance. The quality component is done via an on-site quality review of a random selection of records; the sample size for both children/youth and adults ranges from 15 to 25 depending on the size of the agency. The pilot phase included an in-person review with agency leadership to discuss the results of the scorecard and any recommended action steps. The plan is for the FY 2010 results to be made public via the DMH website. Overall scores will be converted into a star ranking from zero stars (74 or under aggregate score) to 5-star (95 or

over). It will be interesting to see the impact of the scorecard on both provider behavior but also on consumer choice of individual CSA's.

e. Integration of Data Bases

The OA staff have done some internal work in utilizing a Microsoft Access Data Base to load some of the OA data. This has been an improvement over the previous Excel spreadsheet in that it allows multiple people to enter data and OA can now do some trending of data. However, the auditing function is still on Excel and OA overall still has need for upgraded ability for a fully integrated and interactive data base.

Overall, OA has continued on a solid path. The MIG review demonstrates that the auditing function is highly reflective of federal expectations. The new provider scorecard should provide providers with clear feedback on performance in multiple compliance-related areas and should help to spur providers to strengthen their internal quality control systems. The role of the Quality Council will hopefully continue to grow as systems issues (e.g. LOCUS/CALOCUS) take hold at the provider level.

2. Consumer and Family Affairs

The Office of Consumer and Family Affairs (OCFA) has maintained its role in advocating for and directly engaging consumers in multiple aspects of service planning and service delivery. The following represent key activities from the past year:

- Olmstead Conference – The DMH/OCFA, in collaboration with the D.C. Office of Disability Rights, sponsored the second annual Olmstead Conference on December 18, 2009. The overall topic of "Social Inclusion and Community Living" was well-received by the approximately 250 people in attendance. The conference was largely organized, planned and attended by consumers. Planning has already begun for the third conference in October 2010.

- Consumer-run Organizations – The DMH continues to fund two (2) consumer-run organizations – the Consumer Action Network (CAN) and the Ida Mae Campbell Wellness and Resource Center (WRC). DMH has contracted with CAN

for several years – providing advocacy, consumer feedback, training and outreach to consumers. CAN has also provided logistical support for the CSR process via a separate contract with the Court Monitor.

The WRC has now completed its second year as a self-help center – providing targeted supports for consumers that include computer training, self-advocacy training, and "Double Trouble" – a program for dealing with both mental illness and addiction issues. The WRC has continued its community education and outreach efforts – as witnessed by a recent Mental Health Day for consumers that focused on issues of HIV/AIDS. The enrollment of the WRC was at 850 as of April 2010 – as compared to 245 in April 2009. By all reports, the WRC is doing an excellent job of engaging consumers in meaningful educational and self-help activities.

- Employment Opportunities – The OCFA provided direct assistance in the training and the hiring of over 12 consumers who worked as Peer Support Partners during the DC CSA transition. These consumer peers participated in all aspects of the transition – providing information, outreach, follow-up and advocacy when needed. As a result of this successful effort, the DMH Division of Integrated Care began to contract in March 2010 for ten (10) Peer Transition Specialists to assist consumers leaving SEH and transitioning into the community. Some of the Peer Partners from the DC CSA transition have moved into these new roles.

- Certified Peer Specialists – The DMH has convened a workgroup to develop a peer specialist program. The workgroup is developing a training curriculum and supervisory protocol for all peer specialists. The OCFA is collaborating with the DMH Office of Strategic Planning, Policy and Evaluation to accomplish this task. The hope is to be able to "grandfather" current peer specialists who have been through prior DMH training for peers. After rules are developed and the training curriculum and supervisory protocol are finalized, DMH will work with DHCF to obtain CMS approval. This means that the new support billing code will not be in place until early 2011. Once accomplished, this will open up major new opportunities for employment by peer specialists.

- Advisory Council – The OCFA Advisory Council has been largely inactive for the past year. It is not entirely clear as to the reasons, but the OCFA leadership intends to re-activate this group – perhaps with a tighter focus as to its role.

  Overall, the OCFA has continued to provide visible support for consumers in the DMH system. The development and support of consumer-run organizations is a vital step forward; the inclusion of Medicaid billing for peer specialists will provide a major new opportunity for consumer employment in CSA's.

3. Enforcement of Consumer Rights

   Both the July 2008 and July 2009 Reports to the Court highlighted concerns about the existing Mental Health Consumer Rights Protection Act of 2001. The DMH had proposed clarifying language in this statute that would limit a grievance to issues which relate "to the provision of mental health services or mental health supports." The backdrop to this proposed change was the use of the grievance system for issues that could be considered frivolous or outside of DMH control. This legislation has not moved forward in the past year. Through grievance trainings to provider staff, the Office of Consumer and Family Affairs has encouraged mental health providers to voluntarily develop an informal complaint process that will give the consumer a more expedient mechanism for resolution of their complaints. This complaint system does not preclude consumers from filing formal grievances. It is intended to promote more options for the consumer and family members. This option is addressed in the new consumer and families link on the DMH website. DMH staff report that they believe the informal complaint process appears to be addressing the most immediate needs of consumers. However, DMH may still proceed to seek an amendment to the Mental Health Consumer Rights Act of 2001.

   The OFCA shows that for the 14-month period of April 2009 – May 2010, there were a total of 138 grievances. Of this total, 115 (83%) were from SEH. The remaining 23 (17%) were from numerous CSA's. The preponderance of grievances from SEH is not unusual. It should be noted that five (5) consumers at SEH filed 30 grievances with one consumer accounting for twelve (12) grievances. The grievance process allows for consumers to go to an external review if they are not satisfied with the agency's response. Thirteen (13) of the total grievances ended up in an

external review with a hearing officer. OCFA staff indicate that there are continued issues of timeliness of reporting to OFCA (24 hours) – particularly at SEH. This issue at SEH was apparently tied to a new staff person handling grievances and the complications of the move to the new Hospital.

The last issue for the grievance system is also an ongoing one – namely the lack of an adequate database management system. OCFA has had multiple conversations internally at DMH and with the Office of the Chief Technology Officer (OCTO). The ongoing message is that there are other higher priorities and – given limited resources – this issue is not likely to get attention. The broad-based development of Share Point technology within DMH could be a solution (See III A4). In the meantime, OCFA will continue to use a manual system with limited capacity to produce reports and accurately monitor grievances that have been filed.

4. Information System Development

In the July 2009 Report to the Court, the Court Monitor reviewed the ongoing challenges that DMH has had in creating a viable and accessible IT system for all DMH departments and sub-departments. DMH IT leadership was hopeful that SharePoint (a Microsoft product) could be the vehicle to build a common data platform throughout DMH. DMH purchased, developed, trained and installed SharePoint, although not at the level envisioned in July 2009, due in part to the loss of a Senior Developer in the IT department.

Currently, DMH has an active SharePoint site that supports the entire hospital and is their central portal for all common, shared information including policies, application links, announcements, procedures, video and photo archives, etc. SharePoint is used in IT and some other areas of the agency outside of the hospital as well – namely as management site for tracking software, licenses, remote access, purchases, etc. Recently, DMH launched an addition to the IT site that allows users to request the generation or creation of canned reports. Also, Contracts and Procurement uses SharePoint to track the status of contracts (although this will change once the PASS modules are fully operational).

IT leadership remain very interested in expanding the use of SharePoint if the Senior Developer position can be successfully recruited and if the requisite funds (approximately $300,000) can be found in the FY 2010 Budget that would allow for the purchase, development, training and installation of Share Point. The DMH

belief is that both the Senior Developer position needs to be filled and the funds sequestered to make this a viable proposal. The enthusiasm for Share Point to meet managers' needs continues. It should provide a) access to multiple databases; b) automation of operational workflow; c) versatility to meet unique team needs and; d) low IT maintenance once installed.

The Court Monitor continues to believe that this investment of funds would greatly help to meet the longstanding demands for IT support within DMH.

5. Organizational Development

The Division of Organizational Development (DOD) has continued to take on major challenges in the areas of training, building internal CSR proficiency and providing system-wide program evaluation and performance management expertise. The following represents a summation of activities and challenges in each of these three (3) areas:

a. DMH Training Institute

In January 2010, DMH/DOD was successful in hiring a very experienced and energetic Director for the Training Institute. This has accelerated and intensified the overall development of the Training Institute. It is clear from the current (and planned) offerings of the Institute that DMH is committed to the Court-ordered Plan vision for the Institute as "a continuous learning environment for consumers, community stakeholders, staff and providers."

The fall of 2009 and FY 2010 offerings of the Institute reflect a diverse array of training opportunities for consumers, DMH staff and community providers. The training includes both basic training (e.g. DMH 101: Overview of Services and Supports Offered through the DC Department of Mental Health) to more advanced (e.g. Using the Ohio Scales to Inform Case Conceptualization and Ongoing Treatment Planning) training. The Court Monitor counted some 75 different training opportunities that have occurred or are planned during this one year period. This is an impressive array – particularly given that the Training Institute is largely dependent upon staff within the DMH system to provide the individual training.

During the spring of 2010, the Training Institute will offer a 5-session series on Disaster Mental Health. The target group for this training will include DMH staff, DMH providers, the disaster response partners and volunteers. The series will include: basic concepts in disaster mental health; Psychological First Aid (PFA's); issues of grief, loss and suicide in the wake of disasters; and ethical and legal issues in disaster mental health.

The DOD has also continued to be the point of coordination for the successful Crisis Intervention Officer (CIO) initiative. As detailed in the July 2009 Report to the Court, this initiative is a joint effort among DMH, Metropolitan Police Department (MPD) and the local office of the National Alliance on Mental Illness (NAMI). The goal is to provide intensive 40-hour training to select MPD officers – who learn specific symptoms of mental illness, de-escalation techniques and knowledge of local mental heath resources. Since its inception in the spring of 2009, there have been seven (7) 40-hour training sessions for 154 MPD officers, who are now fully certified. After the initial round of training, all officers who now enroll do so on a voluntary basis. DMH staff report that this change has significantly improved the receptivity and engagement of the officers. The goal is to eventually train 15%-20% of the MPD officer contingent. Based on the estimate of 4,000 MPD officers, this goal will take several years to accomplish.

One of the next major tasks for DMH/MPD is to look at the differential outcomes of CIO-trained responses versus non-CIO trained. Based on MPD incident reports, DMH staff will begin to analyze key outcomes, i.e. disposition of cases, officer time spent, injuries, etc. Some initial data should be available by summer of 2010. There is also the question of the degree to which people with mental illness are referred to CIO-trained officers.

b. CSR Unit

The Division of Organizational Development continues to oversee the small (two staff) internal CSR unit. This unit has taken on a major role in the formal Dixon CSR reviews – providing logistical support for DMH reviewers and helping to provide reviewer training. This CSR unit was also heavily involved in the targeted interventions to two large child/youth providers following the 2009 child/youth

reviews. It is very noteworthy that both of these agencies made major improvements in the 2010 CSR reviews for child/youth. Based on this experience, DMH has developed an overall systems improvement strategy that will focus on up to six CSA's whose CSR scores are in the low range. The intent is to both identify these CSA's and develop with them specific action plans by August 30, 2010.

The Court Monitor is pleased with the overall DMH commitment to the CSR model. It now appears that quality of care issues are getting focused leadership attention at the DMH and in local CSA's. The recent success of targeted agency interventions shows the progress that can be achieved with focused effort. The major issue for DMH will be to ensure that adequate resources are directed to the quality improvement task. The large number of providers (39) in the DMH system makes this a formidable task. The Court Monitor supports the model of training/ technical assistance to targeted agencies as a next step. However, at some point, the DMH will need to create the capacity to do CSR reviews on a system-wide basis (ala the current Dixon model) and/or on a targeted agency basis. Alternatively, DMH could require internal CSR reviews as a part of the CSA quality improvement program. Whichever model is selected will require a clear DMH staff commitment that is equal to the task.

c. Applied Research and Evaluation

The Applied Research and Evaluation (ARE) unit was formerly referred to as the Research and Clinical Informatics Unit. The basic function for this six-member team, however, remains the same. The goal is to enhance the DMH's ability to analyze and report on data for use in program and system-level planning and decision-making. Hence the primary customers of this unit are DMH program managers, data managers and local providers. Among the 35 different time-limited and ongoing projects that this unit is handling are specific efforts to work with providers on the utilization of LOCUS/CALOCUS (see II C) data. The unit manages the federal Data Infrastructure Grant (DIG). It works closely with the School Mental Health Program in providing multiple evaluative/outcome tools, and provides ongoing data analysis and reporting support to the following program areas: Forensic Services,

CBI, CFSA initiatives, Systems of Care, and Child Wraparound. It certainly appears that this unit is beginning to fill a historic gap at DMH – namely the ability to bring systematic analytic tools to program review and outcomes-based thinking.

B. Review of Independent Authority for Key Functions

1. Independent Personnel Authority

The DMH has largely completed its Phase 2 Human Resources realignment as discussed in both the July 2009 and January 2010 Reports to the Court. Phase 2 is the realignment and integration of core H.R. functions between the Authority and SEH. The basic conceptual design is to have a single and fully integrated Human Resources Division – with the policy development functions to be housed at the Authority and the basic operations (e.g. recruitment staff) to be housed at SEH. This staff realignment happened in February 2010, although there continues to be specific elements that are still being addressed e.g. where to house employee benefits staff.

Phase 3 is the planned implementation of the 2008 KPMG Report to modernize and streamline the H.R. system. This Phase 3 has been pushed back due to the DC CSA transition and the Phase 2 realignment. DMH officials indicate they are now ready to move forward with Phase 3 and have set March 31, 2011 as the target date for completion of Phase 3. DMH has established priority areas for Phase 3 and will be phasing these in over the coming year.

2. Independent Procurement Authority

The DMH Office of Contracts and Procurement (OCP) has continued its concerted efforts to refine and improve its procurement system. The highlights of the past year are as follows:

- The ongoing search for improved IT capability appears to now be on track. The District has purchased the Contract and Sourcing Modules for its software system PASS, that are specifically designed for contracts management. These modules are now be available to DMH. This new software should be fully implemented by September 30, 2010. It will provide many of the tools OCP has wanted, e.g. current online status of contracts and prompts to contract

managers regarding renewal. OCP leadership is very hopeful this new system will assist both OCP staff and Contracting Officers Technical Representative (COTR).

- OCP has continued its emphasis on training of DMH management in general and COTR's in particular. Specific presentations have been targeted to senior management (e.g. contract management for cross-year contracts) and to program managers (e.g. understanding of different kinds of contracts and requisite steps for each). There continues to be a mandatory annual half-day training for all COTR's.

- OCP has strongly encouraged its seven (7) contract specialists to pursue national certification as Certified Professional Purchasing Buyer (CPPB). In this past year, two (2) additional staff achieved this milestone, bringing the total with their CPPB to four (4).This certification adds professional credibility to the OCP office and demonstrates a breadth of knowledge and skills.

- For the past two years, DMH has has not been cited in the District-wide "yellow book", which is an independent audit of all agencies that identifies any significant contracting or procurement issues. Three (3) years ago, DMH was included but only for one small technical omission.

Overall, the OCP continues to perform at a high level. The new IT upgrade should provide further capability. The number of contract specialists (7) has not increased but the level of expertise has gone up. There is discussion among the District agencies about moving to a more centralized model for procurement and the Council is currently considering city-wide centralization as part of a larger procurement reform legislation called the Procurement Reform Act. It is unclear how the centralization will affect DMH, since the legislation is still under consideration by the Council. DMH indicates that it has addressed the need to ensure that the final legislation allows DMH to continue to exercise independent procurement authority with the Mayor's Office. The Court Monitor will track this issue to ensure that the progress DMH has made in contracts and procurement is not in any way impeded.

C. Review of Systems of Care Development

1. Review of Adult Systems of Care

a. Organizational Efforts to Develop Adult Systems of Care

The DMH has continued its broad-based efforts to develop multiple and coordinated services as part of its adult Systems of Care (SOC) philosophy. It is commendable that DMH has created and filled the position of Adult Systems of Care Manager. The very experienced manager has been able to provide additional depth and perspective to the adult SOC development. The specific adult services that are directly linked to an Exit Criterion (i.e. Supported Housing, Supported Employment, Assertive Community Treatment (ACT), and Services to the Homeless) will be discussed below in III. C. 1. b.-e.). However, DMH also continues to put resources and emphasis on special populations that also are involved with other DC agencies as follows:

1) Forensics – Under the leadership of the Adult SOC manager, the 6-member forensics team has further refined the Sequential Intercept Model. The goal is to provide the earliest possible linkage (or re-linkage) to the mental health system for persons with serious mental illness and/or co-occurring substance abuse who are involved in the criminal justice system. The DMH has conceptualized the Sequential Intercept into five (5) levels of mental health intervention.

- Intercept 1 – Pre-booking Interventions – This would include the CIO Training (as discussed in III. A. 5.), the Homeless Outreach Program (III. C. 1. e.) and Mobile Crisis Services (see January 2010 Report to the Court).

- Intercept 2 – Initial Hearings and Detention (Post-booking) – This phase of intervention is a very active one for DMH. It includes: 1) Court Urgent Care Clinic, which is contracted to PIW and provides immediate access to services at the Superior Court. This pre-trial service saw 190 individuals from October 2009 through March 2010. It has recently expanded to provide interventions for children/families as well as adults. 2) Court Liaison – This full-time

DMH person is also co-located at the court and works closely with the Pre-trial Services Agency (PSA) to gather information on court-referred individuals, provide screenings, and make referrals for needed mental health and/or other services. From October 2009 – March 2010, 597 screenings were conducted by this person. 3) Options Program – This program is contracted to a provider (Community Corrections) and provides immediate services for persons with mental illness who are not linked and have a history of non-compliance. Options has access for temporary housing for up to 5 males and 5 females. For FY 2009, 76 individuals were served via Options.

- Intercept 3 – Jails, Prisons, Courts (Post Initial Hearings) – DMH also provides intensive interventions at this level. A full-time Jail Liaison Coordinator identifies and tracks all persons with a serious mental illness who are admitted to the DC jail. For persons in jail, there is direct coordination with Unity Healthcare, who provides the overall health care and mental health care during incarceration. The Jail Liaison Coordinator also works with CSA's and local advocates while persons are in jail. The DC Linkage Plus Program (DCLP) has been funded by DMH since 2005. DMH (as of Fall 2009) now has two (2) providers (Green Door and Volunteers of America) that provide intensive community-based services for persons coming out of jail with misdemeanor/felony charges who are not actively linked to the mental health system. These providers must meet with consumers within 48 hours of the referral and help facilitate release into the community. There were 203 persons served under the DCLP from October 2009 – March 2010.

- Intercept 4 – Re-entry from Forensic Hospitals, Jails and Prisons – DMH has a Re-entry Liaison Coordinator that is co-

located at the DC Department of Employment Services. The Re-entry Coordinator does mental health screenings for referrals from the Court Services and Supervision Agency (CSOSA), the Mayor's Office of Ex-offender Affairs, legal clinics and the Bureau of Prisons. The goal is to provide linkage and support for persons who have been in jail or prison for some time. For FY 2009, 309 persons were evaluated and assisted as part of the re-entry program.

- Intercept 5 - Community Corrections and Community Supports. This phase includes: 1) Outpatient Competency Restoration – as provided as part of the MHSD and discussed in III. D. 5. 2. Streicher Cases – DMH Forensic Services has responsibility for monitoring the Periodic Psychiatric Exam (PPE's) for committed patients. The timeliness of these exams has been an issue in the past but now appears to be under control with an overall 95% compliance rate. As of July 19, 2010, there were 191 committed patients in the DMH system – of which 137 were outpatients and; 3) Collaboration with SEH Forensic Services- The DMH Forensic Services staff meet on a regular basis with SEH to coordinate efforts and share linkage information for patients at John Howard.

  Overall, DMH has continued to evolve and refine its forensic services. Among its challenges for the next year are efforts to optimize forensic reporting, develop practice guidelines, expand CSA expertise in forensic services and evaluate the need for specialized forensic ACT Teams.

2) Co-occurring Mental Illness and Substance Abuse – DMH finished its federal 4-year grant for co-occurring disorders (COD) on August 31, 2009. Since that time, there has not been any full-time designated staff to work on the COD challenge within DMH and its provider system. However, the

DMH Chief Clinical Officer continues to oversee and champion the necessary steps to achieving COD competency throughout the system. It is clear that there continue to be pockets of demonstrated use in this regard:

- All clinical staff (and all new employees) at SEH are trained in COD, and SEH uses a standard COD assessment tool.
- A comprehensive training manual was completed during the grant period. There are five individuals within the DMH system who can train on the 14 modules.
- Five (5) DMH providers continue to be designated by DMH as COD competent.
- There is active discussion between the alcohol prevention and rehabilitation agency (APRA) and DMH about creating a fully integrated mental health/drug and alcohol clinic at the Court Urgent Care Clinic (CUCC). This behavioral health clinic could be a model program for service integration.

In terms of planning for this whole area, DMH officials indicate that this is one of the topics of discussion in the redesign effort (see IV. B.). Ideally, all DMH providers should be COD competent – given the significant percentage of consumers who have both mental health and drug/alcohol issues. The DMH 2003 policy on COD directly requires a standard of COD capability; however, this policy is not currently enforced. It also appears that focused priorities in training (via the Training Institute) will be critical to growing an ever increasing percentage of the workforce who

understand and practice COD principles.

3) Co-occurring Mental Illness and Retardation - One of the major cross-agency efforts between DMH and the Department of Disability Services (DDS) has been the effort to locate in the community those developmentally disabled consumers who have been at SEH. During FY 2009 eleven (11) dually diagnosed individuals were moved. For FY 2010, there is a target of ten (10) additional individuals. These are very challenging placements given the array of services needed. These ten (10) will need to be placed by September 30, 2010 in order to meet SEH census and budgetary goals. DMH has transferred a total of $500,000 to support services for this group of individuals ($300,000 to DDS and $200,000 to DHCF). DMH staff indicate that DDS has been collaborative throughout this effort.

The other major DMH effort for this population is the special team that exists within the DMH-run Mental Health Services Division (MHSD). This team specializes in services to this dually diagnosed population and has apparently established a good working relationship with DDS. MHSD currently has a total of 124 consumers who are dually diagnosed (MI/MR). Of these, 114 are enrolled in the DDS system. MHSD staff report that they regularly attend cross-agency planning meetings regarding individual consumers.

In the next year, DMH officials indicate they would like to meet with new leadership at DDS to explore several issues. These include: 1) whether it would make sense for DMH (MHSD) to become a provider through the DDS Medicaid waiver program; 2) strengthen the relationships among DMH providers and DD providers and; 3) explore the potential for DMH to develop specialized crisis/emergency services for the DD population.

(b) Supported Housing Capability

The DMH continues to support the philosophy of Permanent Supportive Housing (PSH) for consumers with serious mental illness. The fundamental tenets of PSH remain – namely that consumers have choice in living in community-integrated settings, have flexible services matched to their needs, and have permanence in housing supports that are not contingent upon their service choices.

The DMH has operationally defined its Supported Housing model as including those consumers for whom there are housing subsidies from local dollars and federal dollars, where DMH controls access to the housing. The Bridge Rental Subsidy Program (Home First) budget is currently $6.1 million (local dollars) providing monthly housing subsidies to 717 persons. The Supported Independent Living program is also funded with local dollars. Fifty-one (51) of the 406 individuals in the Supported Independent Living Program receive Home First housing subsidies. DMH also has 363 HUD-supported slots that have been set aside for DMH consumers and 58 consumers supported via the Local Rent Subsidy Program (LRSP). The current total capacity of directly-controlled DMH supported housing is 1,653 – – Home First (750); SIL (461); Federal Vouchers (384); LRSP (58). This compares to 1,595 as of May 2009, and 1,584 as of May 2008. In addition to the DMH directly controlled housing, it should be noted that some of the CSA's have direct access to supported housing slots. Based on a survey of CSA's, DMH has determined that there are an additional 683 supported housing slots created by the CSA's. Hence, the overall capacity of supported housing is currently at 1,659 directly controlled by DMH and 683 available via CSA's (total of 2342).

DMH has continued its ongoing partnership with the DC Department of Housing and Community Development (DHCD) to create an additional 300 housing units – utilizing the $14 million in capital funds that was appropriated to DMH and later transferred to DHCD. The timeline for the full completion of this 3-year project is now 2011. Rent subsidies for these new units will be paid for through a mix of programs, including the Local Rent Subsidy Program (LRSP), Housing Choice Voucher Program (HCVP), Permanent Supportive Housing vouchers and Shelter Plus Care Program.

As part of the discussion among the parties regarding Exit Criteria #9, the Court Monitor raised a number of questions to DMH regarding consumers on the DMH waiting list. DMH has responded with several important facts:

- The current waiting list for supported housing (as of May 31, 2010) is 1,113. DMH indicates that this number is considerably higher than prior years due to the full inclusion of consumers who were actively looking for housing but not finding it (and previously not counted); persons in CRF's who have applied for PSH; and more than 400 new applications that have been received since June 2009. This number of 1,113 contrasts to the 603 number as of June 1, 2009.

- DMH is in the process of finalizing rules for its Home First Subsidy program. This proposed rule codifies the overall process of application for the housing subsidy and clearly identifies the priority categories (e.g. persons discharged from SEH, homeless, consumers with critical health care needs, and consumer with emergency situations regarding health or safety).

- The average time that all consumers on the waiting list have been there is 28 months.

- DMH attempts (via the CSA's) to re-validate each quarter the continued need for supported housing for all consumers. This has recently become a standing agenda items for DMH meetings with CSA Clinical Directors.

- DMH is working (with the active help of the Corporation for Supportive Housing) to develop a new Housing Plan. Part of this plan will be to attempt to quantify the need for supported housing in the District for persons with serious mental illness.

- DMH continues to look for ways to augment its supported housing capacity. For example, there is hope that a recent HUD initiative for the non-elderly disabled that might provide an additional 100 slots. It is not clear that DMH has looked

seriously at the potential for moving resources from the more expensive CRF program to supported housing; DMH currently spends $8.6 million on payment to CRF providers to serve 225 individuals. This per person annual cost of over $38,000 is considerably higher than the average cost of supported housing.

The Court Monitor is pleased to see the level of activity on PSH. It is clear that rules are needed. Likewise the need for an updated and reasonably comprehensive plan is recognized by all. The large jump in the numbers on the waiting list represents an effort to reflect all categories of persons who are waiting. DMH needs to look comprehensively at the issue of consumer need and resource allocation. The national movement is clearly away from group homes (CRF's) and toward more independent living arrangements coupled with flexible supports. DMH currently has a workgroup reviewing the various ways of organizing this service. It is clear that much work remains in this critical area.

c. Supported Employment Capability

DMH continues its evidence-based supported employment program – with the goal of supporting consumers with serious mental illness to obtain a competitive part-time or full-time job. With the closure of the DC CSA, DMH now funds six (6) different CSA's to provide specialized supported employment services. The core DMH capacity continues at 550 and DMH has a census of 475 (as of April 1, 2010). DMH has finalized its agreement with the Department on Disability Services/Rehabilitation Services Administration (DDS/RSA) regarding the expansion of the supported employment program through DDS/RSA funding. DDS/RSA has entered into contracts with the six (6) DMH supported employment providers which will cover expansion of the supported employment program by 150 slots. Hence, the new total capacity now stands at 700. These expanded contracts with the CSA's (including RSA dollars) began on October 1, 2009, but the details of referrals and funds flow were worked out in January-March 2010. RSA dollars pay for the upfront costs of supported employment – including intake and assessment, job development and placement, job coaching and the first 90

days of successful employment. DMH dollars can now be directed to the ongoing costs associated with helping consumers maintain successful part or full-time employment.

The DMH Supported Employment Program manager is also in discussions with the Department of Human Services, Income Maintenance Administration (IMA) about the development of supported employment services for individuals with SMI who currently receive Temporary Assistance for Needy Families (TANF). If successful, this interagency memorandum of understanding would go into effect October 1, 2 010, and would provide 100 additional supported employment slots. There is also beginning discussion with the Department of Employment Services about potential partnerships with DMH and its supported employment program.

One of the ongoing questions about the supported employment program has been verification of the degree to which DMH providers are following DMH policy in both identifying and referring consumers to this program. One of the strands of this discussion has been the volume and source of referrals. For April 1, 2009 – March 31, 2010, there were a total of 242 referrals to the supported employment program; this compares to 181 for April 1, 2008 – March 31, 2009. There remains the specific question as to the degree to which CSA's without a Supported Employment Program are making referrals. The other major verification strand has been the inclusion of a quarterly event such that must be completed by providers every quarter. This event screen went live on May 1, 2010, and should begin to provide specific data as to which CSA's are appropriately referring to supported employment and which are not. The Supported Employment manager has developed a follow-up protocol to analyze the data and conduct targeted technical assistance to low-referring or non-referring CSA's. The first full quarter of Event Screen data will be available in August 2010.

d. Assertive Community Treatment (ACT) Capability

DMH continues to show strong progress in the development of an ACT program that meets the test for capacity and quality. As of May 27, 2010, there was an overall ACT census of 866; this contrasts with 523 as of

May 31, 2009. There are now twelve approved ACT providers in the system – with a total capacity of 1,060. There has also been dramatic increase in the number of referrals over the past year. From April 1, 2009 to March 31, 2010, there were a total of 418 ACT referrals – as compared to 217 total referrals for the previous year (April 1, 2009 – March 31, 2009). It is also noteworthy that out of the 418 referrals, 137 came from referral sources that can be considered 'high risk" i.e. high utilizer groups, CPEP, St. Elizabeths and Homeless Outreach. This data reflects that DMH is now reaching those programs that have historically not been referral pathways to ACT e.g. SEH.

As a part of the DMH effort to ensure the consistency and quality of ACT services, DMH has undertaken a multi-pronged ACT Performance Improvement Workplan for FY 2010. As a major component of this effort, DMH has (via DMH policy of December 9, 2009) committed itself to the utilization of the Dartmouth Fidelity Scale for ACT; this is the first time this has been an explicit expectation for ACT service providers. To operationalize this DMH has trained 12 staff who can now function as fidelity reviewers. DMH has now completed fidelity assessment reviews for 11 of the 12 ACT teams (one ACT team in the start-up phase was not reviewed during this cycle and will be reviewed in the next fidelity assessment cycle). All reviewed ACT teams received final scores on July 13, 2010. Of the 28 different areas that are scored, any score of 3 or below (on a 5 point Likert Scale) will prompt a follow-up plan for improvement. DMH reserves the right to suspend referrals or create a probationary status for an ACT team that does not show adequate overall quality or demonstrate a lack of responsiveness to make needed improvements. The intent is to conduct fidelity assessments on an annual basis.

In addition to the fidelity assessments, the DMH ACT staff will also: 1) review and update the ACT Organizational Plan for each ACT team that is required under the December 9, 2009 DMH policy; 2) implement a monthly reporting process for all teams; 3) develop a single spreadsheet on current priority cases; 4) attend all ACT team monitoring meetings on at least a quarterly basis; and 5) formally track and report on referrals (including referral sources) to ACT services on a semi-annual basis.

The Court Monitor is pleased with the depth and breadth of the ACT monitoring that is now being developed and implemented. While there have been pieces of this in the past, it has not been brought together as an integrated and ongoing effort. The clear commitment to the utilization of the Dartmouth Fidelity Scale will provide a consistent measuring stick for performance and the ability to track improvements over time. The ACT education and outreach efforts to targeted programs (e.g. CPEP, SEH and Homeless) are clearly showing results in the increased number of referrals from the programs. Overall, ACT appears to be on a very positive trajectory on all fronts.

e. Services to the Homeless

The Homeless Outreach Program (HOP) continues to provide a wide array of services to persons who are both homeless and also have significant mental health and/or addictions problems. The HOP went through a major organizational change in the fall of 2009 (see January 2010 Report to the Court) – moving from a more independent status to becoming a part of CPEP. Indications from DMH leadership (and from HOP staff directly) are that this change, while difficult on the front end, has now been worked through. The DMH hired a new HOP manger as of the end of February 2010 – who has worked to develop a clearer program direction and team centered approach to homeless services. The DMH also discontinued the Sobering Station at the end of FY 2009 due to budget reductions. The intent was for the Alcohol Prevention and Recovery Administration (APRA) to absorb this service; however, it is unclear if this has happened.

The Homeless Outreach Program (HOP) continues to provide outreach, engagement, linkage, psychiatric treatment and follow-up services to persons who are homeless. The outreach is both to adults and to children/youth and families. As part of a community collaboration, HOP staff continue to coordinate the monthly "Emergency Rounds" and "Hot List" meetings – which focuses on high-risk consumers. The outreach by HOP staff is to homeless persons wherever they are – streets, abandoned vehicles and building, temporary residences, low-barrier shelters and transitional programs. The ten (10)-person staff includes eight (8) staff who are devoted to the traditional homeless services and two staff

for the stimulus funded-Supported Homeless Prevention and Rapid Re-Housing Program (HPRP). The HPRP started in December 2009; DMH (via HOP) does all of the homeless outreach for the District-wide effort. HOP assessed 297 people during its first five (5) months of the HPRP grant.

The core HOP program served a total of 1,331 (unduplicated) persons from April 1, 2009 – March 31, 2010. Out of this total, 1,139 were adults and 292 were children/youth/families. A total of 4,659 contacts were made with these 1,331 individuals – of which 3,067 were face-to-face. It is noteworthy that these contacts resulted in 58 FD 12's, 12 voluntary visits to CPEP, and 21 cases of connecting persons to Emergency Rooms for medical assistance. All of this points to the complexity and severity of psychiatric and medical problems for this population.

The Psychiatry residency rotation has historically placed third year residents at homeless shelters, soup kitchens, and street outreach. This has been a very successful part of the overall homeless program. One of the problems, though, has been that most third year residents have not yet met the DC requirement for 3-year residency for foreign medical graduates. Hence they do not have a DC license to prescribe, which limits efficacy with this rotation. Therefore, the decision has been made to suspend this program for one year (July 2010 – June 2011) and then reactivate it for 4th year residents.

The HOP continues its active involvement with the Community Partnership for the Prevention of Homelessness (TCP). As part of this effort, HOP staff collect data that feeds into the Homeless Management Information System (HMIS) – which is required for all HUD-supported programs.

Overall, it appears that HOP is through its organizational change phase and is in fact becoming a more integrated part of the overall crisis/emergency services mission of CPEP. HOP appears very focused in its unique task of outreach to a difficult-to-engage population and to the continued partnership with DC agencies that are part of the homeless network.

2. Review of Child/Youth Systems of Care

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

The major organizational effort currently underway is the development of a comprehensive 3-5 year plan. A broadly-based group of 35 people has been at work since late 2009. DMH has made a concerted effort to engage youth and parents directly in this planning process. The larger group has created four (4) targeted work groups: 1) Service Delivery – Evidenced Based Practices; 2) Early Identification and Family Engagement; 3) Accountability and Systems Integration and; 4) Financial Strategies and Workforce Development. The intent is for each of these work groups to submit findings, broad recommendations and specific actionable strategies. The timeline is to have a draft of the overall plan by September 30, 2010. The issue of potential restructuring of child/youth services in the District is also on the table but will be discussed as part of a parallel process. The overall thrust of the planning is to create a true implementation plan that will deal with the full spectrum of mental health issues for children/youth – ranging from early intervention to children/youth with the most serious forms of emotional illness. The Court Monitor commends this effort highly. While considerable good work has been done in the child/youth area over the past couple of years, there has never been a comprehensive and integrated plan developed for this population. As with all issues for children/youth, the key will be to get true cross-agency and advocacy commitment to the specific recommendations. The Court Monitor will be anxious to review this plan and will discuss it in the January 2011 Report to the Court.

b. School-Based Mental Health Services and Prevention/Early Intervention Programs

The School Mental Health Program continues to be a critical component of the overall Child and Youth Services Division of DMH. In the past year, the School Mental Health Program (SMHP) has provided on-site services in 58 different schools (47 DCPS and 11 charter). The legislative requirement to expand into 10 additional schools in FY 2008/2009 – without any additional staff – required the development of a 2-tiered staffing model. Tier 1 schools have a full-time clinician and Tier 2 schools have a

part-time clinician (20 hours/week). During the 2008/2009 school year, there were 37 Tier 1 schools and 21 Tier 2. DMH evaluations of the Tier 1 vs. Tier 2 schools indicates that, while there are some differences in specific services provided, the overall service delivery pattern for Tier 1 vs. Tier 2 was not discernibly different. Hence this same model has been continued for the 2009/2010 school year. Overall referrals for service in the 58 schools appear to be pretty consistent from 2008/2009 to 2009/2010. Areas of notable services growth are in individual sessions – which grew from 3,736 (2008/2009) to 5,592 (2009/2010) for the comparable September-March period; this major growth is also seen in family therapy (53% increase). The SMHP staff continues to provide a wide array of interventions, including prevention services, training presentations, parent consultations, teacher consultations and classroom observations.

The SMHP continues to measure clinical outcomes and satisfaction with its services through the use of the Ohio Scales. The Ohio Scales is a measurement tool with established reliability and validity which measures problem severity and functioning from intake to discharge for three (3) cohorts of youth (12 years of age and older), parent and worker. It has been used for the past three (3) school years. Outcome data from 2008-2009 indicated statistically significant changes in both problem severity and functioning scores across all cohorts. SMHP also measures satisfaction from a range of school-based customers – including school administrators, teachers, parents, school nurses and children/youth who received services. There are consistently high scores from all groups.

FY 2009 saw the beginnings of DMH efforts to bill for eligible treatment services for children/youth who are enrolled through the District's MCO's. This has created significant changes in the SMHP – in that clinical staff must now provide a diagnosis and meet productivity standards for billable units. This has created a level of tension with staff, schools and parents – which is still in the process of being understood and hopefully resolved. Due to delays in working out all the billing issues, it appears that the amount collected for school year 2009/2010 will be significantly less than the $500,000 which was originally projected; as of the end of March 2010, there were $117,000 in payables for the September 2009-March 2010

period. All indications are that there is significant work still to be done in implementing the billing component for SMHP.

During FY 2009, DMH received a one-year grant via the Deputy Mayor of Education to implement a new program. The Primary Project is an early intervention program intended to increase school-related competencies; the target group is kindergarten through third grade. By the use of specific screening tools, identified children (with parental consent) are paired with specially trained Child Associates. Over a period of 12-15 sessions, the child-led play interventions are intended to improve child/youth readiness for learning. During its first year, 164 students participated – with positive results on all measured domains. The success of year one prompted continued funding for FY 2010 – with expansion from the original 12 schools to 16.

DMH/SMHP was also awarded approximately $750,000 for FY 2010 (from a combination of the Department of Health, through their SAMHSA Project Launch Grant, DMH Block Grant funds and ICSIC dollars) to develop an early childhood mental health consultation program for 28 Child Development Centers and Head Start programs. This program was officially launched in May 2010. This initiative (called Healthy Future) will provide an array of site-based interventions – including consultants to work with staff on issues of behavior management, crisis intervention, accessing mental health resources and promoting team-building and staff support.

Overall, it is evident that the DMH/SMHP has not only created a solid place in existing schools; it has also expanded to areas of early childhood intervention. This is an exciting development given the preponderance of research that children/youth with significant behavioral issues are clearly identifiable at an early age and can also be helped to make changes that greatly enhance their readiness to learn. It is telling that other areas of District government can now turn to DMH to develop and implement these early childhood models that have proven successful in other locales.

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

The DMH, through its CYSD, has continued to provide positive leadership and energy toward the goal of providing maximal supports for children/youth in their home communities so as to prevent out-of-home residential care or shorten lengths of stay when residential care is required. The DMH points to the D.C. Wraparound program as a prime example of its effort to divert from residential placement. This program, administered by Choices, Inc. – served a total of 144 youth for the period of October 1, 2009 – March 31, 2010. D.C. Wraparound program is really two (2) different initiatives with a common philosophy of intensive community services. 102 of the total 144 served are part of the DCPS School Wraparouond effort – largely intended to improve school functioning for special needs children/youth. The Community Wrap component serves the remainder and is a smaller program focused on youth who are at highest risk of Psychiatric Residential Treatment Facility (PRTF) placement. Choices has implemented a comprehensive assessment of outcomes for both programs; in general the results show a positive trajectory for both populations in terms of community permanency planning, school function, truancy, etc. The intent is to grow the Wraparound program capacity by an additional 30 slots for the coming year.

Since the July 2008 Report to the Court, the Court Monitor has consistently written and recommended that there needs to be a truly integrated system of care for children with serious emotional disturbance (SED) who are in (or at risk of entering) one of the PRTF's. The Court Monitor has laid out five (5) core elements that should frame such a system: 1) a common database for all out-of-home PRTF placements; 2) common standards and a single protocol for placement decisions; 3) common standards and practices for monitoring children who are placed in PRTF's; 4) the creation of financial incentives for alternative community placements and; 5) the creation of specialized community capacity for high-needs children and youth.

The Court Monitor notes some progress in this whole area. For example, the Department of Health Care Finance (DHCF) enacted rules effective February 26, 2010, designating DMH as the Level of Care Agent with the responsibility of making the medical necessity determination for all requests for fee-for-service Medicaid Psychiatric Residential Placements in the District of

Columbia. This includes approving continued stays for MCO eligible consumers when their Medicaid eligibility becomes based on the Family of One designations (30 – 59 days after placement by the MCO). DMH is currently conducting medical necessity reviews for all Medicaid PRTF placements for District agencies (DMH,CFSA, DYRS, Court Social Services or DCPS) as well as continuing stay medical necessity reviews for youth remaining in a PRTF that is covered through the District's Medicaid program (including DMH, CFSA and MCO placed children and youth). DMH is also monitoring all Medicaid-funded PRTF placements as further described in Subsection d. below. Hence, DYRS and DCPS now have a clear incentive (if they want 70% Medicaid support) to obtain a medical necessity determination from DMH in order to place a child in a PRFT.

It should be noted that CYSD leadership staff have continued to work towards a cross-agency process that would address many of the five (5) areas identified above. DMH has developed Psychiatric Residential Treatment Facility Criteria and a referral form which will be used by all child serving agencies seeking a PRTF Level of Care (LOC) from DMH. DMH's Associate Chief Clinical Officer has been responsible for coordinating medical necessity (LOC) determinations since late September 2009. She has been tracking LOC referrals since October 2009. As of July 8, 2010, she has received 47 LOC requests of which 29 have been approved.

In addition, a standard monitoring tool for PRTF was created and piloted by DMH and the Office of the State Superintendent of Education (OSSE) from October 2009 – March 2010. The monitoring protocol is currently being modified based upon the data gathered through the pilot effort. It is anticipated that the changes will be incorporated into the document and will be forwarded to the directors of the child/youth serving agencies for their review and approval prior to the conclusion of FY 2010 for implementation in 2011.

A central database has been created to contain all of the monitoring reports completed as a result of the PRTF site visits conducted by all of the District' child-serving agencies. DMH will maintain this database. The centralized database will allow information gathered on

PRTF's commonly used by all child serving District agencies to be shared immediately and considered a part of the placement process, among other things.

Despite these efforts, the Court Monitor still has concerns and is looking for additional progress that includes the following:

1) A District-wide database for tracking all PRTF children/youth, regardless of the placing agency, does not currently exist. DHCF maintains complete data about Medicaid placements. However, information about non-Medicaid placements is not consistently submitted. In December 2008, OSSE was charged with maintaining a comprehensive database to track school placements, including PRTF placements. Although DMH also provides reporting to OSSE about PRTF placements, OSSE has reportedly been unwilling to provide reporting about PRTF placements back to DMH because of concerns about privacy and compliance with FERPA. Hence, no one in the District knows how many children/youth are in PRTF's at a given point in time. The recently enacted Jacks Fogle bill may facilitate information sharing between District agencies about PRTF placements.

2) While all Medicaid-supported referrals must go through DMH, District agencies may place children in a non-Medicaid PRTF without going through the established LOC process.

3) Children/youth who are placed in PRTF's by District agencies such as DYRS or DCPS may not have received mental health services through the DMH system of care.

   The Court Monitor believes that DMH has clear statutory authority for the SED population in general and for the regulation and oversight of PRTF's in particular. It is fundamental to a systems of care approach that DMH must exercise its authority for the highest risk population. The Court Monitor in the January

2010 Report to the Court recommended legislation as a solution; subsequent conversations suggest that DMH-promulgated rules could be faster and perhaps more effective. The intent of this Report is to indicate that a solution needs to be developed and implemented in the very near future. The Court Monitor finds that the current status does not meet the definition of compliance with systems of care philosophy and is hence not in compliance with the Court-ordered Plan.

d. RTC Reinvestment Program and Assessment Center

The RTC Reinvestment Program of CYSD continues to do the monitoring for PRTF placements that originate from CFSA, DMH and any fee-for-service Medicaid referral. Effective March 2010, DMH is also now managing and overseeing all MCO children/youth who are placed into PRTF's after the first 30 days. As of April 1, 2010, the total number of DMH monitored children/youth was at 74. This number reflects the continued downward trend and compares to 92 as of May 14, 2009, and 109 as of the July 2008 Report to the Court. This downward trend is a direct result of two (2) facts: 1) the number of discharges continues to exceed the number of admissions. For FY 2009 there were 47 discharges versus 45 admissions, and in FY 2008 there were 58 discharges versus 37 admissions; 2) the average length of stay (ALOS) in PRTF's has continued to drop over the past 2 years. For FY 2009, the ALOS for discharges was 12.3 months versus 14.2 months for FY 2007. Currently, the ALOS for FY 2010 is 7.5 months. CYSD is also now tracking those children/youth who have been in PRTF's over 18 months. While this constitutes only 18 out of the 74 total, it clearly represents a group of youth for whom concerted work will be needed to effectuate community placement. The fact that nearly 96% of all PRTF placements are over 100 miles away adds the challenge in keeping families and other caregivers invested in a return to the community.

The CYSD continues to manage the Assessment Center – which performs comprehensive mental health evaluations as requested for Juvenile Justice and CFSA youth plus any DMH, CFSA or Medicaid fee-for-service youth being considered for PRTF placement. There has been a decline

in the number of neglect assessments for FY 2010 year-to-date as compared to prior years. CYSD staff believe this may be due to the fact some children/youth have already been assessed via one of the CSA providers and hence Courts do not need to request another assessment. Conversely, the number of domestic relations referrals has increased over the past year. All told, the Assessment Center completed 969 assessments for FY 2009 (238 domestic relations, 146 juvenile assessments, and 585 neglect). This compares to 872 assessments for FY 2008 – obviously a significant jump in overall demand. It should also be noted that DMH is looking at the issue of whether it can put in place a fee schedule for families and/or Medicaid for the assessment components. The timeline for completing this review is October 1, 2010.

e. Choice Providers

DMH continues to evolve the concept of Choice providers. In the past year, DMH has added two (2) new Choice providers (Hillcrest and Maryland Family Resource) and has also lost one Choice provider (Progressive Life) so there are now a total of six (6) Choice providers. Each of the choice providers receive additional contractual dollars (from $90,000 - $300,000 each) to provide more comprehensive and timely services – especially for CFSA referrals who need mental health services. This $1.0 million dollars in total local funding is intended to provide additional non-Medicaid services that can be used for traditional services (e.g. flex funds, summer camps, etc.). Choice providers are also expected to provide additional staff training as needed. The original concept of Choice providers becoming the exclusive set of providers for CFSA referrals is still far from a reality; while most of the CFSA referrals that go through DMH get referred to a Choice provider, CFSA continues to directly refer approximately 40% of its children/youth who need mental health services to non-Choice providers (at a total cost of approximately $3.0 million). The reasons for this are not entirely clear, although one reason is the large number of DC CFSA children/youth who are in foster care in Maryland. While DMH has added a Maryland choice provider, this is apparently not enough to meet demand. DMH is working with CFSA to explore this issue further. The original intent of CFSA utilizing the DMH system to meet the mental health needs of CFSA children/youth is

still the goal but it is evident there is still work to be done to make this a reality.

f. Child Welfare/Foster Care

The Amended Implementation Plan (AIP) of the LaShawn case continues to provide the overall framework for DMH/CFSA collaboration and program development. As a critical part of the AIP, CYSD continues to place clinical staff at CFSA's Child Protective Services (CPS) unit. Altogether the Child and Youth Clinical Protective Unit (CYCPU) has seven staff – including a program manager, a home and community-based coordinator, two co-located clinical staff, a psychologist and a program analyst. These staff assure that timely mental health screenings are conducted for children and youth who are removed from their homes and are entering the child welfare system. The co-located staff saw 179 different families during FY 2009.

The AIP has also been the framework for the continued development of ChAMPS (as discussed in the January 2010 Report to the Court), the community-based wraparound initiative (see III. C. 2. c. of this Report) and the choice providers (see III. C. 2. e.). Overall, the working relationship with CFSA appears to be solid. The AIP framework has been helpful in developing much-needed services on the mental health side.

Overall the Court Monitor finds that the CYSD is on a very positive trajectory. It continues to add both depth (e.g. increased wraparound capacity) and breadth (e.g. expansion into prevention and early childhood intervention). CYSD has had success in targeted improvements in CSR scores for a few providers; nevertheless overall systems performance scores for children/youth remain low (49%), which reflects that concerted additional work remains. There is a compelling need for DMH to assert its policy and practice leadership over the admissions, monitoring and utilization of PRTF's; this is a long-standing systems issue. The active development of a cross-systems 3-5 year plan is seen as a very healthy effort and should provide clear focus on the remaining tasks and needed structures and resources.

D. DMH's Role as Provider

1. Planning for New/Consolidated Hospital

The new 293-bed Hospital was fully occupied in May 2010 – following a major community-wide event celebrating this historic milestone. There have been the usual array of post-move issues, but it appears that these are resolved or are being resolved.

DMH is now into Phase 3 – which includes: the asbestos abatement and demolition of the old John Howard building; the building of a new recreation yard for forensic (intensive) patients and; additional surface parking and landscaping. The cost for Phase 3 should not exceed $13.0 million – even with contingencies. The timeframe is approximately 12 months for completion (June 2011). The general contractor for Phase 3 has been selected (Forney) following an RFP process. There continue to be water pressure concerns for the overall campus. While the new Hospital itself is fine, the rest of the campus may need water line enhancements. An RFP is being developed for the engagement of a contractor to resolve the campus fire suppression issues, e.g. hydrants and water lines to hydrants.

DMH still intends to provide overflow bed capacity in the RMB building. This will involve the renovation of two units of 25 beds each (total of 50 beds). This modest level of enhancement to patient rooms should cost approximately $1.0 million. No timeframe has been set for this project.

2. Quality of Care Issues at SEH

The Department of Justice (DOJ) review team visited for the fifth time since the June 2007 Settlement Agreement (SA). The visit by DOJ attorneys and their consultants occurred during the latter part of May 2010. DOJ has not yet submitted its official report on this visit. However, DMH/SEH staff did provide the Court Monitor with detailed notes from the Exit Conference on May 24, 2010 which are summarized below:

a. Overall – DOJ noted in an overall sense that there has been much progress in the environment of care with the move into the new Hospital. They also noted some progress in the quality of care, although the belief is that progress is still too incremental.

b. Areas of Noted Progress – The following areas are examples of progress that was noted:

- Progress in nursing services regarding medication administration, scheduling (all units had an RN on all shifts) and nursing participation in the IRP.

- Clinical administrators are doing well at facilitating and structuring IRP conferences.

- The IRP process monitoring tool is working well – providing useful data for teams and supervisors.

- Clinical teams are doing a better job in identifying and using an individual's strengths, life goals and cultural preferences.

- Improved medical services and medical policies.

- Noted decrease in some high-risk medication practices.

- Progress was noted in the Positive Behavioral Support program with hiring of a team leader and the initial training of staff that has begun.

- Rehabilitation services are providing very good assessments and specific recommendations – although most are not being included in the IRP plans.

- Therapeutic Learning Center (TLC's) – (formerly known as treatment malls) are making good progress on both the civil (transition) and forensic (intensive) side. Groups are well organized and engaging of individuals.

- The Unusual Incident system (including investigations) is now using the correct standards. This system is capable of providing the data to monitor and improve services.

c. Areas that need improvement – The following are examples of areas that need further work:

- The IRP's tend to focus too much on present symptoms and not enough on other factors (i.e. functional status and results of evaluations).

- IRP's need to focus more on discharge (i.e. barriers to discharge).

- Need to develop and implement clinical chart audit tools.

- AVATAR IT system must be fixed immediately to allow physicians to track medication changes on a single report.

- Nursing staff is still of concern and the quality of nursing assessments needs improvement.

- Documented rationale (by physician) for high risk practices (three or more antipsychotics) is often missing or inadequate.

- Need to improve the linkages between the TLC's and the IRP's.

- Need greater clarity in the IRP's on community integration and community needs for successful transition.

Overall, the general feedback seems to reflect a clear message of progress on DOJ issues – albeit still not as quickly as DOJ would like and as the 2007 Settlement Agreement contemplated. The DOJ will be back for its next visit the first week of November 2010. The required self-evaluation Report by the DMH liaison to DOJ will be done by the last week of September. The Court Monitor will carefully evaluate the DOJ report once it is completed to ensure that the official report matches both the content and tone of the exit conference. The Court Monitor would observe that the occupying of the new building – while a major plus in the larger sense – has also taken large amounts of SEH staff time and focus in the past six months. The other observation is that there is now a strong cadre of leadership in most key positions; this is clearly reflected in the progress that is noted and

should well be a predictor for accelerated improvement into the future.

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

The DMH use of local hospitals to provide acute care has continued for the six-month period of October 2009 through March 2010. There were 40 total acute care admissions to SEH; this matches exactly with the number for the previous months (April-September 2009). It is also very noteworthy that from October 2009 – March 2010, there were only four (4) occasions when a person was not admitted to an acute hospital due to the lack of an available bed. United Medical Center (UMC), with 30 available beds has averaged 33 acute admissions per/month over the October 2009 – March 2010 period, while Providence (with 15 beds) has averaged 31 admissions per month. The total number of admissions to SEH for this period was slightly under 21 per month; this is very comparable to the prior six months which was at 22 admissions per month. The data suggests that the overall management of acute care admissions is in a continued stable pattern. The number of acute care admissions to SEH is probably approaching its low point. The major continued concern is the financial status of UMC. In early July 2010, the District took full control of the Hospital. The DMH Director has been appointed by the Mayor as a member of the UMC Board of Directors. Indications are that the hospital is losing about $1.0 million per month. UMC officials indicate this loss is due to the lack of full reimbursement for Medicaid patients. The District appears committed to maintaining UMC – having invested nearly $100 million in funds over the past several years. Nevertheless, it still leaves DMH in a tenuous position in terms of bed-planning for the future. The Court Monitor continues to encourage the development of alternative acute care capacity beyond UMC.

4. Development and Implementation of the Integrated Care Initiative

The Integrated Care Division (ICD) at the Authority continues in its role of intensive care management and care coordination for the most difficult-to-place patients at SEH. This unit also takes on direct responsibility for tracking and monitoring consumers who are at high risk, i.e. individuals who are discharged from inpatient settings back to the community.

The Washington Hospital Center (New Directions) has been contracted to serve 27 difficult-to-place individuals coming from SEH; as of July 7, 2010, twenty-seven (27) are currently enrolled and sixteen (16) have actually been placed in the community. DMH and New Directions continue to find that it takes 4-6 months of intensive work to actually place individuals – most of whom have been as SEH for many years. The hope is to increase the capacity of this contract to 30 as of March 2011.

In addition, the ICD has been the ongoing leadership unit for working with DDS to place individuals with mental retardation into the community. Via a contract, DMH will transfer $500,000.00 to DDS and DHCF to support services for ten (10) individuals to be served through the Medicaid 1915(c) waiver for the developmentally disabled. The goal is to accomplish these placements by September 30, 2010, so that SEH and DMH can meet the target of moving all patients into the new Hospital by then.

As a critical part of Exit Criterion #17 (Continuity of Care), the ICD has intensified its efforts to monitor individual Hospital and CSA's collaboration for individuals moving from Hospitals to community care. On the adult side, ICD has started its intensive efforts with SEH and Providence – with UMC to come on line in mid-July. ICD staff have begun to sit in on treatment team meetings to help ensure that DMH consumers are appropriately referred and connected to the assigned CSA.
ICD is now tracking the percentages (by discharging Hospital) of those who are seen within seven (7) days, within 30 days, after 30 days, or not at all. On the child/youth side, there has also been a detailed review of all children/youth who were discharged from acute psychiatric units from April 1, 2009 to March 31, 2010. The DMH is in the process of analyzing the reasons for those children/youth who do not connect to the mental health system at all post-discharge (approximately 25% based on claims data). It is clear that there are valid reasons for some of this shortfall, e.g. child went to a PRTF or child was seen but claim was rejected. It is also true, however, that there is some level of discontinuity between inpatient and outpatient that needs greater attention. There is hope that an additional staff position can be added in the FY 2011 budget to focus on child/youth continuity of care – similar to what has been done for adults. While the overall percentages of connectivity within seven (7) days remains low in this report (55.3% for adults and 48.4% for child/youth), performance should improve with the recent focus on this issue. The Court Monitor is pleased to see detailed data collection and

analysis plus clinical staff interventions via the ICD. The new child/youth position appears to be critical in moving forward on the child/youth side. This position can accelerate efforts and allow for continued cross-training with other ICD staff.

5. Phase-out of DC CSA and Implementation of the Mental Health Services Division (MHSD)

DMH successfully completed the transition and phase-out of the DC CSA on March 31, 2010. Nearly 3,100 individuals were transitioned to a private CSA; the remainder of persons (from the original total of 4,100) are being served by the MHSD or have disenrolled or refused services. The OA (as discussed in III. A. 1.) will continue to monitor consumer satisfaction and continuity of care until April 2011. The CSR unit of the Division of Organizational Development also did an in-depth review of seventeen (17) of the twenty-six (26) adult DC CSA consumers who participated in the May 2010 Dixon CSR reviews. Fifteen (15) of the seventeen (17) consumers indicated they were generally satisfied with services from their new provider. Consumers who transitioned to the MHSD had significantly higher system performance scores than those who transitioned to a private CSA – which may reflect the reduced level of changes for MHSD consumers. The majority of consumers have received the same or more services, although the mix of services has shifted to more community support and less medication management.

The Mental Health Services Division (MHSD) continues to be functioning out of two (2) sites – 35 K Street for all adult services and 821 Howard Road, SE, for all child and youth services. The MHSD was very successful in its effort to be certified as a MHRS provider; as of April 30, 2010, the MHSD was certified for two years to serve both adults and children/youth.

The MHSD continues to provide the same array of specialized services as described in the January 2010 Report to the Court. For the first three quarters of FY 2010, the MHSD has averaged 1,619 consumers (unduplicated) per quarter. The practice group for psychiatrists is at 13 – 9 adults and 4 child/youth; however, the FTE equivalent for adult psychiatrists is at 7.8 with one psychiatrist who is now part-time and one who is on leave. The psychiatric support of the private CSA's is now up to 14 days per week – roughly 3 FTE's; this support has been well-received. One of the critical services that the MHSD provides is Same-Day Service. While individuals can be seen on an as needed basis at

CPEP, the Urgent Care Clinic at Superior Court and by the mobile crisis teams, the MHSD same day service is one of the few places individuals can be seen in a stand-alone ambulatory setting. Consumers can walk in and receive services on an unscheduled basis. This issue is being discussed as part of the overall urgent care need for redesign; in today's DMH system this is a unique service. In the most recent quarter, 358 consumers were seen for same-day service.

The MHSD is beginning to look at its business model, including its overall expenses to revenue ratios. Prominent on the revenue side is the issue of staff productivity. Each of the teams within MHSD is expected to bill for a minimum of 60% of total annual hours paid and 65% for psychiatrists. However, the last MHSD-wide productivity report covering the period 10/1/09 – 4/30/10 indicates a year to date productivity of 41%. A total cost vs. total revenue analysis also shows a major gap. If you subtract out the expenses that are not productivity-based (i.e. pharmacy and competency restoration) the total annual cost for MHSD is $6,788,211. The projected revenue for 2010 based upon billing through May 31, 2010 is $2,914,551 – showing a gap of $3,873,660. While it is probably not realistic to achieve a break-even point for MHSD (given its unique service mission), the Court Monitor agrees with DMH officials that the goal should be to get as close as possible. It is clear there is a long way to go on this front.

Overall, the DC CSA transition has gone extremely well. The DMH continues to provide follow-up monitoring as originally planned. The MHSD has done a good job of developing its unique array of services and reaching out to consumers and CSA to meet needs. One of the major tasks remaining is to sharpen expectations for staff (including productivity), reduce expenses where needed, and continue to evaluate the MHSD mission in light of the evolving system (e.g. need for urgent care).

E. Review of Development of DMH FY 2010 Budget and Status of 2011 Budget

In addition to earlier reductions to the FY 2010 Budget (as detailed in the July 2009 Report to the Court, the DMH absorbed a $9.0 million reduction (4.5%) in July 2009. These cuts affected SEH, the Authority and contracted services. While there has been talk of additional cuts for the FY 2010 Budget cycle, DMH has managed to avoid additional reductions. DMH has had two (2) positive revenue developments for FY 2010 that will help significantly. The first is the recoupment of local funds from providers due to the successful retrospective data

match for Medicaid eligible consumers who were originally paid for by DMH with 100% local funds. As DMH recoups the 70% Federal share, it will add back approximately $2.83 million to the FY 2010 Budget. The second positive revenue piece is the anticipated payment by the Virgin Islands for care provided to residents of the Virgin Islands at SEH. This is a long-standing issue of approximately $2.0 million that now appears likely to be resolved. Both of these are one-time revenue infusions; hence DMH is wisely looking at one-time expenditures to utilize at least some of these dollars in FY 2010. DMH is prioritizing needs but this could provide a revenue source for critical needs, e.g. IT software like Share Point. DMH will also need to obtain additional spending authority from the DC Council to make additional expenditures.

For FY 2011, DMH, along with other District agencies, was directed to produce a budget that would provide for additional reductions. The original DMH target was approximately 10% or $16 million in local dollars. However, the agreement reached was to allow DMH to utilize nearly $9.0 million in fixed cost savings as part of the FY 2011 reductions – leaving a true reduction of approximately $7.0 million or 4% from the baseline budget for FY 2010. Indications are that about $2.0 million of the planned reductions will be at SEH due to the consolidation into the new Hospital and the planned census reduction to 285 by January 1, 2011. DMH has looked at all of its contracts and intends to trim approximately $1.0 million from a variety of contracts – hopefully without major programmatic impact. The Medicaid recoupment project will also help in FY 2011 – with ongoing higher rates of Medicaid-eligible consumers to help take pressure off of local dollars.

The FY 2011 Budget Request Act was approved by Council on May 26, 2010. It was signed by the Mayor on June 28, 2010, and will now move to Congress for approval. The overall revenue forecasts for the District are looking somewhat improved – so it is hoped that the recurring rounds of cuts is over. Overall, the District and DMH have been careful to target cuts into areas with the least amount of direct services impact. The Court Monitor will continue to tract the FY 2011 Budget to ensure that Dixon-related services stay on target.

IV. Follow-up on Other Previously Identified Recommendations

A. Crisis Services Planning

DMH has continued to monitor the implementation of the Crisis/Emergency Services Plan that was developed in late 2007. The original work group continues to meet on a quarterly basis to review

components of the plan that have been put in place. These include: 1) the mobile crisis teams for children/youth and adults; 2) the eight (8) Extended Observation Beds at CPEP; 3) the utilization of crisis/respite beds for adults; 4) the functioning (and data) of the Court Urgent Care Clinic (CUCC) and; 5) the Crisis Intervention Officer (CIO) training that began in May 2009 (see III. A. 5. of this Report for current status).

DMH has stayed true to its commitment to implement comprehensive crisis/emergency services and also to continue the inter-agency workgroup as a way of monitoring performance.

The issue of same-day/urgent care capability throughout the system still remains to be addressed – hopefully through the redesign efforts.

B. Status of Community System Redesign

The Mental Health System Redesign Workgroup has been meeting (currently on a bi-monthly basis) since October 2009. The seven (7) original redesign principles continue to guide the group. In January 2010, three (3) sub-committees were formed to help move the larger workgroup forward and with specific findings and recommendations. These three (3) sub-committees include: 1) child/youth services – with an emphasis on services to children under five (5) as well as the need for expressive therapies; 2) free-standing mental health clinics – with an emphasis on Co-Occurring Disorders (COD) and; 3) Health Information Technology – with an emphasis on the high-level needs for the public mental health system. A fourth subcommittee focusing on provider restructuring was formed in April 2010. These sub-committees have been meeting in the alternate months and reporting to the larger group on issues/progress.

The original timeline was that the workgroup would have an initial draft of recommendations by April 2010; this has not happened. At this point there is no revised timeline for completion of the task. The Court Monitor notes that the work of sub-committees appears to have added depth to some of the issues but has broadened the number of issues. Overall there seems to be good process and energy. However, the Court Monitor would recommend that this process have clear timelines and urgency so that the system can begin to take on the multi-year tasks associated with implementation.

V. Recommendations

1. The District must formally address in a timely way all of those system-of-care issues regarding PRTF's. Any solution(s) should recognize DMH's

statutory responsibility for the SED population in general and oversight of PRTF's in particular.