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 26, 2011, 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 26, 2011

Executive Summary

The eighteenth Report to the Court shows continued progress in meeting Dixon performance standards on the nineteen (19) Exit Criteria; the District has now met fourteen (14) of the nineteen (19) with one additional Criterion met in the past 6 months. Progress in meeting DOJ requirements at SEH continues. Budget cuts for DMH in FY'11 and projected cuts for FY'12 are of high concern.

A brief summary of the key issues in this Report is as follows:

1. Implementation of Exit Criteria

   The District has achieved compliance (& inactive status) on fourteen (14) of the Nineteen (19) Exit Criteria. Since the January 2011 Report to the Court, Exit Criteria #2 (Consumer Functioning Method(s)) has been reviewed and recommended by the Court Monitor to move to inactive status.

2. Budget Issues

   For FY'11, DMH was forced to absorb budget reductions of $25 million (14%) in local funds – which has resulted in service rate cuts to providers and reduced funding for many programs. For FY'12, DMH could potentially lose an additional $8.7 million as compared to the FY'11 approved budget. However, DMH has been included in a supplemental local funding bill that would provide an additional $3.5 million – to be utilized for community service contracts and MHRS budgets.

3. St. Elizabeth Hospital

   The seventh DOJ visit in May 2011 continued the very positive trajectory that was reflected in the January 2011 Report to the Court. The progress is significant enough that DOJ has recommended that the focus should now be in four (4) areas.

4. Community System Redesign

   The formal process of Redesign Workgroup has ended. There are, however, multiple spinoff efforts from the Redesign planning. For example, DMH, DHCF and DOH are working on a planning grant request to CMS that would fund a planning project to determine the feasibility of implementing a "health home" model for an identified group of District residents. The "health home" is an expanded version of the "medical home" model and includes primary healthcare services, mental health services, substance use disorder treatment and possibly

some specialty health services. If feasible, the "health home" would be included in the District's state Medicaid plan.

5. Management of PRTF's

DMH and the other child-serving agencies in the District have come together to implement a single assessment process for all PRTF admissions. DMH is centralized manager of this process and is also now receiving data on all PRTF placements. DMH has begun to develop an Executive Order by the Mayor that would memorialize these voluntary cross-agency efforts.

Based on the findings in this Report and prior Reports to the Court, the Court Monitor does not make any additional recommendations.

I. Current Situation

In October 2010, the Federal Court approved the Monitoring Plan for October 1, 2010 through September 30, 2011. 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 eighteenth 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 Nine 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 to show strong effort on both of these Exit Criteria. For Consumer Satisfaction (EC #1), the DMH officially moved to inactive status as of the January 2011 Report to the Court. The Court Monitor is pleased to see the continued work of the DMH on this issue, noting in particular the continued refinements and utilization of the MHSIP annual consumer satisfaction method. The DMH continued to improve the sample size for the fall 2010 MHSIP and has published key results – including a breakout of responses by individual CSA's. For Consumer Functioning (EC #2), on June 9, 2011, DMH submitted a letter requesting

that this Exit Criterion move to inactive status. DMH points to the considerable work it has done in implementing the LOCUS/CALOCUS at both a systems level and at the individual agency level. The Court Monitor reviewed this letter for compliance with the court requirements and issued a letter dated July 19, 2011 approving inactive monitoring status.

B. Results of Year Nine (9) Consumer Service Reviews (CSR's) for Children/Youth and Adults

1. Summary of Children/Youth Findings

The Child/Youth CSR was completed in May 2011 – with a total of 87 cases reviewed. Trained DMH staff reviewed 33% of the cases. HSO provided case judging for most of the cases reviewed, including all of the cases that were reviewed by DMH staff to ensure inter-rater reliability.

In terms of child status, DMH scored at a 77% level, which is highly consistent with past reviews. Areas of strength continued to be child safety (82%), appropriate home and school placement 91% and physical well-being (97%).

The Dixon performance standard measures system performance – with a requirement for an 80% positive rating. For year nine, DMH scored at a level of 59%, which is considerable improvement over prior years – 49% (2010) and 48% (2009). Some of the major areas of weakness in past child/youth reviews showed marked improvement, including service team formation (59% vs. 45% for last year), service team functioning (49% vs. 33%) and long-term guiding view (48% vs. 32%).

As in prior years, there is large variability in scores across the individual CSA's. It is clear that the targeted training interventions have had a positive impact on lower-performing CSA's, but the issue of consistency continues to be elusive – particularly for the smaller CSA's. Staff turnover is a vexing issue, which serves to underscore the DMH efforts to create a certification process for the CSW positions within CSA's. Turnover also argues for the continued emphasis on clinical supervision and feedback to CSW's and therapists. Overall, the child review is an encouraging one – but with continued efforts needed.

2. Summary of Adult Findings

The Adult CSR Review was conducted in February 2011 and included intensive reviews of 78 adult consumers of mental health services. HSO continued to oversee the quality and integrity of individual reviews via the case judging process.

The overall year nine (9) result for consumer status was that 80% of the cases had an acceptable rating for consumer status - which was exactly the same as last year. There were three areas that continued to show high marks in the measurement of consumer status – with safety at 88%, living arrangements at 83%, and satisfaction with services at 91%. Areas of social network (65%), education/work (46% and 61% respectively) and economic security (69%) were identified as areas that need continued improvement.

Year nine (9) result for system performance was at 78% - also very consistent with last year's performance of 77% and slightly below the Court requirement of 80% for system performance. The overall functioning of service teams was up somewhat from last year (63% vs. 60%); Individualized Recovery Plans (IRP's) were acceptable in 78% of the cases – an increase of 4% from 2010. As in 2010, the larger agencies (with a larger sample size) were much more likely to score well. Green Door and Community Connections were singled out as providing "considerable amounts of quality services." The key factor to success appears to be internal CSR commitment and capacity to measure and improve quality practice. HSO made an important finding in noting that for the first time, the problem issues that were frequently identified were more unique to a given CSA as opposed to the system as a whole.

C. Implementation of Court-approved Performance Criteria

Table 1
Exit Criteria
Current Status

Aggregate Data for April 1, 2010 – March 31, 2011

Exit Criteria	Policy in Place	Data Methods in Place	DMH Validated Data System	Court Monitor Validated Data System	Court Required Performance Level	Current Performance Level
1. Consumer Satisfaction Method(s)	Yes	N.A.	N.A.	N.A.	Methods + Demonstrated Utilization of Results	Methods completed. Utilization implemented. (inactive)
2. Consumer Functioning Method(s)	Yes	N.A.	N.A.	N.A.	Methods + Demonstrated Utilization of Results	Methods completed. Utilization in process.

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
3. Consumer Reviews (Adult)	Yes	Yes	Yes	Yes	80% for Systems Performance	78%
4. Consumer Reviews (C/Y)	Yes	Yes	Yes	Yes	80% for Systems Performance	59%
5. Penetration (C/Y 0-17 Years)	Yes	Yes	Yes	Yes	5%	5.48%
6. Penetration (C/Y with SED)	Yes	Yes	Yes	Yes	3%	3.04%
7. Penetration (Adults 18 + Years)	Yes	Yes	Yes	Yes	3%	3.49%
8. Penetration (Adults with SMI)	Yes	Yes	Yes	Yes	2%	2.79%
9. Supported Housing	Yes	Yes	Yes	Yes	70% Served Within 45 Days of Referral	0%
10. Supported Employment	Yes	Yes	Yes	Yes	70% Served Within 120 Days of Referral	88.4%
11. Assertive Community Treatment (ACT)	Yes	Yes	Yes	Yes	85% Served Within 45 Days of Referral	81.6%
12. Newer - Generation Medications	Yes	Yes	Yes	Yes	70% of Adults with Schizophrenia Receive Atypical Medications	61.9%
13. Homeless (Adults)	Yes	Yes	Yes	Yes	150 Served + Comprehensive Strategy	292
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%.	88.8%

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
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%.	89.4%
16. Homeless C/Y	Yes	Yes	Yes	Yes	100 Served + Comprehensive Strategy	113 (July 1, 2010 – June 30, 2011)
17. Continuity of Care a. Adults b. C/Y	Yes	Yes	Yes	Yes	80% of Inpatient Discharges Seen Within 7 Days in Non-emergency Outpatient Setting.	Overall: 54.9% Adults: 58.4% Children: 46.6%
18. Community Resources	Yes	Yes	Yes	Yes	60% of DMH Expenses for Community Services	FY 06: 60.45% FY 07: 59 % FY 08: 57 % FY 09: 55% FY 10: 50%
19. Medicaid Utilization	Yes	Yes	Yes	Yes	49% of MHRS Billings Paid by Medicaid	50%

The Table 1 data are generally for the period from April 1, 2010 through March 31, 2011, although DMH has only received complete MCO data for the first two quarters of this reporting period. Since many of the data are claims-based, it should be noted that the performance levels will likely show some improvement once all claims for this period are processed and paid. The last run date for claims-based data was June 27, 2011. Data reported for Exit Criterion #16 (Homeless Children) is for the four quarter period beginning July 1, 2010 and ending June 30, 2011. Exit Criterion #18 (Community Resources) is for FY 2010 – which is the last full year for which DMH has an audited financial statement. This audit serves as the basis for the allocation methodology in EC #18.

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

1. Exit Criteria Met – Inactive Monitoring Status

There are now fourteen (14) Exit Criteria that have moved to inactive status – including five (5) since the time of the July 2010 Report to the Court.

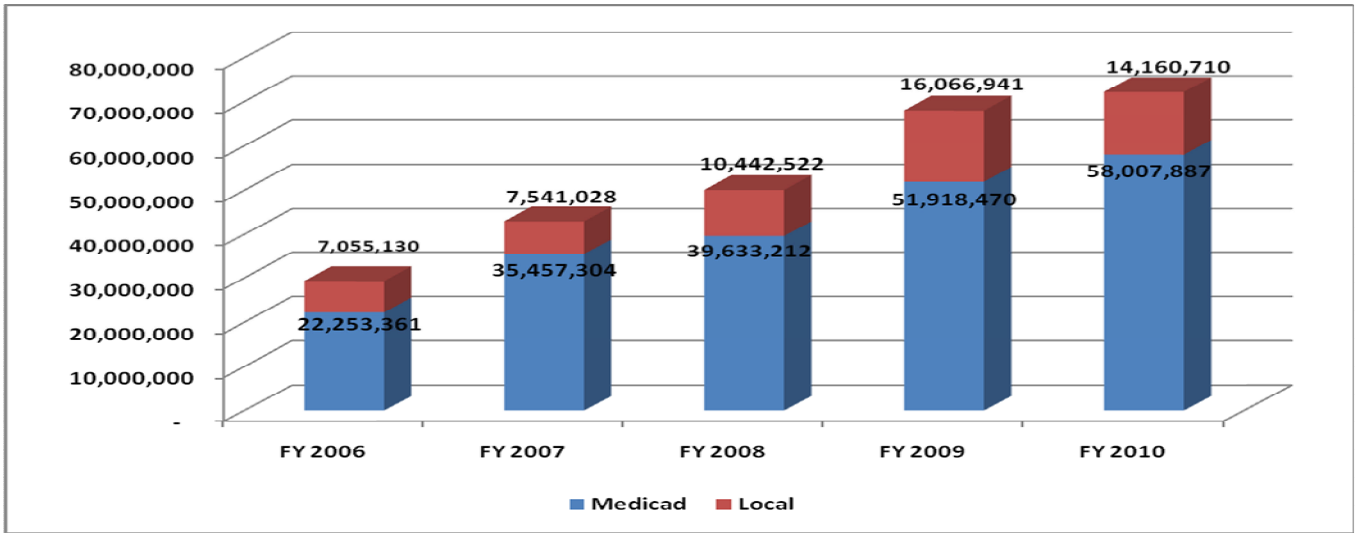
- Prescribing New Generation Medications for consumers with a diagnosis of schizophrenia (#12). This criterion was moved to inactive status as of the July 2007 Report to the Court. This performance level continues to be below the Dixon standard. DMH has not made any changes to policy with regard to prescribing practice and believes that the apparent drop in performance level may result from a combination of difficulties with data reporting and the fact that newer research suggests that atypical medications may not be more effective than the older medications. Anecdotally, providers report that some consumers refuse atypical medication. The atypical medications have increasingly been associated with weight gain, diabetes, metabolic syndrome and cardiovascular conditions. DMH now has a new Chief Clinical Officer, whose tasks will include monitoring practice patterns.

- Medicaid Utilization (#19). Moved to inactive status in January 2008.

- Community Resources (#18). Moved to inactive status in July 2008. This Exit Criterion has also dropped below the Dixon standard. In the Court Monitor's review of this criterion, the changing allocation of Federal Medicaid dollars is a major factor. In order to improve payment and Accounts Receivable collections processes, DMH and DHCF (formerly MAA) agreed in November 2008 to have DHCF assume responsibility for paying all Medicaid eligible claims. This represents a significant budgetary adjustment for DMH since these funds had previously been included in the DMH budget and counted toward the 60% of the agency expenditures for community based services. However the Exit Criteria measurement methodology was not revised to reflect this change.

  For FY 2009, the DMH retained only the match portion, or approximately 7.85 million of the Medicaid payment in the budget. This meant that the additional 44 million directed to payments for Medicaid eligible services were reflected in the DHCF budget, and not in the DMH budget. Had these funds been included in the FY 2009 calculation, DMH would have been at 62% of expenditures directed to community based services. For FY 2010, DMH retained 8.85M in the budget for Medicaid match. If the entire 58M were in the DMH budget, the percentage of expenditures for community based services would be 59.4%.

  The chart below indicates the growth in the MHRS program. It has more than doubled over the last five years while the **distribution** of payments for Medicaid eligible services increased slightly 80% versus 76% in FY 2007 over that time.



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

- Homeless Services for Adults (#13) and Children/Youth (#16). These two criteria were moved to inactive status in January 2009. The Child/Youth performance had dropped to 80 as of the July 2010 Report, but has improved due to some changes in the operation of the Homeless Outreach Program, which are discussed in section III.A.5 of the January 2011 report. Current performance for the period from July 1, 2010 through June 30, 2011 is 113 .

- Penetration – Child Youth with SED (#6) and Adults (#7). These two criteria were moved to inactive status in July 2010. Performance remains at the required level.

- Child/Youth in Natural Setting (#14). This criterion was moved to inactive status as of July 2010. Performance remains at the required level.

- Consumer Satisfaction Method(s) (#1). Following full review, this Exit Criterion moved to inactive status in January 2011. Performance remains at the required level.

- Children/Youth in Own (or Surrogate) Home (#15). Following extensive review, this Exit Criterion formally moved to inactive status in January 2011. Performance remains at the required level.

- Assertive Community Treatment (#11). Following extensive review, this Exit Criterion formally moved to inactive status in January 2011.

- Penetration – Children/Youth (#5). This Exit Criterion also formally moved to inactive status in January 2011. Performance remains at the required level.

- Consumer Functioning (#2) – DMH has submitted a letter requesting inactive status. The Court Monitor, upon thorough review, recommends that this Criterion move to inactive status.

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

   There are two (2) Exit Criteria that show notable progress but still require additional effort to meet the required performance level:

   - Consumer Service Reviews (CSR) for Adults (#3). 78% of the cases reviewed in February 2011 were found to have acceptable practice performance. The Dixon performance target is 80%. .

   - Supported Employment (#10). DMH has begun analyzing the agency-specific data from the quarterly event screens to determine the degree of compliance with the DMH policy. Targeted interventions are being made.

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

   There are three (3) Exit Criteria that will require concerted DMH/District effort to achieve the required performance level:

   - Consumer Service Reviews (CSR) for Children/Youth (#4). DMH has continued its targeted efforts to improved services by low-scoring CSA's. The overall FY'11 systems performance score of 59% is a significant improvement over the 49% in FY'10, but is still well below the Court requirement of 80%. Considerable and sustained worked will be required by DMH to improve practice performance by the large majority of DMH child/youth providers.

     Supported Housing (#9). DMH has made good progress in scrubbing the Housing Waiting List and has seen a reduction of persons on the waiting list of over 250 since May 2010. During this reporting period, fifty-nine

(59) housing opportunities (from capital-funded projects) became available for DMH consumers. After this reporting period, consumers from the Housing Waiting List (HWL) moved into fourteen (14) of these units. The waiting time for these consumers ranged from fourteen (14) months to seventy-three (73) months. Although performance under EC #9 was 0%, there has been active movement of the HWL, as people who have been waiting for an extended period of time have moved into new housing, The remaining forty-five (45) units will be filled in FY11 3Q and 4Q. DMH is also working on revisions to the DMH supported housing rules regarding the prioritization of housing supports.

- Continuity of Care (#17). The Integrated Care Division has continued its targeted efforts to improve continuity of care for adults and has begun a similar strategy for children/youth. The adult percentages have, for the most recent 6 months, have gone up to 72% on clinician self-report and 63% for paid claims. Considerable work remains on improving overall continuity of care performance.

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

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

1. Quality Improvement and Provider Oversight

The Office of Accountability (OA) has continued its vital role in monitoring providers and supporting quality improvement.

a. Claims Auditing of MHRS Providers

The OA Claims Auditing continues to do follow-up auditing for FY 2008. For FY 2008, 17 of the 31 providers (55%) had an initial claims failure rate below the established threshold of 85% positive compliance. Therefore, a second audit with a larger sample is done; currently OA has completed 15 of the 17 agencies that required a second sample – with no composite data yet available.

OA continues to perform the first round of audits for FY 2009. One of the major issues for OA in the past year was its first encounter with a substantiated fraud investigation involving one of the MHRS providers. Lacking any prior experience with this issue, there was no established protocol. Going forward, the decision was made to utilize the Compliance Committee as the administrative body to manage any future fraud allegations.

The planned process to extrapolate the MHRS failure rate for FY 2010 and beyond has been put on hold. DMH continues to recoup failed claims via the Department of Health Care Finance (DHCF) for only those sampled claims that are pulled for audits. However, the broader intent to recoup by extrapolating the failure rate to the totality of MHRS claims for the period has been temporarily suspended due to the need for DHCF to determine if its rules allow for this delegation of functions to DMH. If its rules do not permit, then new rules will need to be developed. This development will hopefully allow DMH providers to make greater internal progress in improving their compliance levels.

b. Compliance Committee

The DMH Compliance Committee continues to meet quarterly and reviews cross-cutting provider issues. Its broad representation within DMH – i.e. OA, HR, Fiscal, Legal, Programs and Provider Relations – makes this group uniquely qualified to tackle major issues, e.g. fraud investigations.

The fraud issue has prompted the Compliance Committee to develop methods to verify that consumers are in fact actively receiving services. Among options being pursued are consumer verification cards and sampled calls to consumers to verify the provision of services.

c. Quality Improvement

The Internal Quality Council (IQC) continues to be active. There are three major priorities for FY 2011: 1) the continued focus on measuring the degree to which MHRS consumers are actively linked to a primary care provider; 2) the documentation of clinical supervision by provider agencies and; 3) the degree to which LOCUS/CALOCUS scores are being utilized to inform the treatment planning process.

The external Quality Council (QC) continues to meet quarterly – with membership from most of the 30+ community providers. Among other topics, the provider scorecard continues to be discussed. Following the FY 2009 pilot phase, the original plan was to make the FY 2010 results publicly available via the DMH website. However, DMH leadership decided to make the final scores only available to the DMH provider community and only the star rating (one to five stars possible) instead of the raw scores. The intent is to make these scores public for FY 2011. Among the overall concerns regarding the scorecard is the lack of any

measurement of access – either at the overall DMH level or at the individual provider level. The IQC has agreed to take on this task – with the goal of defining access (perhaps across several dimensions) and determining how to measure it.

d. Integration of Data Bases

The OA staff have continued to build the capabilities of the current Microsoft Access Data Base – increasing the capacity for some data integration and trend analysis. DMH staff report that a portion of OA's information system needs have been incorporated into the iCAMS requirements Statement of Work. (see IIIA4c) However, the larger issue of maximizing the use of Share Point still remains as an overall IT challenge (see IIIA4). Until that occurs, OA will remain with an information system that is less than adequate in terms of being fully integrated and interactive.

Overall, OA continues to provide a vital function in monitoring compliance and helping to build in improved quality performance. It appears that key infrastructure pieces (IQC, QC, and Compliance Committee) are working well. The MHRS providers clearly still have a long way to go in improving billing compliance. The Provider Scorecard – as originally envisioned – should become a tool that is available not only to providers, but also to consumers, families, and the public at large.

2. Consumer and Family Affairs

The Office of Consumer and Family Affairs has continued to provide critical support for consumers in both advocating for priority services and engaging consumers in the direct provision of services. The following are highlights of activities that OCFA has carried out:

- Olmstead Conference – In December 2010, DMH/OCFA sponsored its 3rd Annual Olmstead Conference – once again collaborating with the D.C. Office of Disability Rights. The topic of "Community Inclusion – Building Resources and Safety Nets" was well-received by the approximately 250 consumers and staff who were in attendance.

- Consumer-run Organizations – The DMH funds 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 a number of years – with CAN providing a range of services including consumer satisfaction surveys, consumer self-advocacy, training and outreach.

The WRC has just completed its third year as a contracted consumer-run self-help center; it provides a variety of supports to consumers – including computer training, self-advocacy and "Double Trouble", a program for addressing issues of both mental illness and addiction. WRC averages in excess of 500 consumer visits per month. It continues to reach out to a range of community providers to provide mutual awareness and education.

DMH/OCFA also contracts with the local chapter of the National Alliance for Mental Illness (NAMI-DC) to provide a range of family and consumer education and training activities as well as family-to-family support and community outreach.

- Employment Opportunities – The DMH/OCFA has contracts with a total of twelve (12) consumers who work in different areas of DMH – three in administrative support roles, eight (8) working as Peer Transition Specialists with the Division of Integrated Care and one with OA who has conducted satisfaction surveys for the DC CSA transition process.

- Certified Peer Specialists – DMH began its Peer Specialist Certfication Training on June 6, 2011. A total of twelve (12) consumers were selected for the first class, which will require a total of 70 classroom hours and 80 hours of field practicum. The program was developed by a group of consumers and stakeholders with extensive technical assistance, coordination and support from the Division of Policy Support. At the successful completion of the classroom work and field practicum, individuals will be fully certified to work as peer specialists.

  DMH plans to access Medicaid funding for certified Peer Specialists by using a billing modifier on existing service codes – e.g. ACT Community Support, and CBI. The current state plan allows for credentialed, unlicensed staff to bill for specific components of MHRS under supervision of a qualified practitioner. The DMH certification program is designed to satisfy the credentialing requirement as well as the CMS requirements for billing for peer specialist services.

- Advisory Council – OCFA has determined that a standing Advisory Council has not proven to be an effective mechanism for gaining input. Rather, OCFA intends to conduct focused discussion groups on a periodic basis.

Overall, the OFCA has continued to support a growing number of ways in which consumers can both have voice within the system and also be directly involved in self-advocacy, training and employment.

3. Enforcement of Consumer Rights

OCFA continues to manage the consumer grievance process for DMH. The OCFA data indicate there were 127 total grievances filed for the 12-month period of April 1, 2010 to March 31, 2011. The rate of filed grievances is pretty consistent with prior periods – approximately 10 per month. Of the 127 grievances, 79 (62%) were from SEH, of which the majority are in areas of medication management, treatment rights or alleged physical abuse. However, of the 127 total grievances, fifteen (15) have gone to an external review process. Four (4) were held at Saint Elizabeths (two involving medication and two involving allegations of physical abuse).

The issue of an adequate data base for the grievance process is still unresolved. DMH staff report that the Grievance Process information system needs have been incorporated into the iCAMS requirements Statement of Work.
(See IIIA4c below)

4. Information Systems Development

There are three (3) major issues of note regarding the ongoing development of the DMH information system:

a. Ongoing support for AVATAR at SEH – SEH continues to work to complete the goal of implementing an electronic medical record (EMR). The final group of forms are in development and once those are completed, the system will largely be fully electronic. This constitutes a major accomplishment over the past 2 years. The next phase will be to make enhancements to the forms and resolve "bugs" and ongoing issues as to the system's speed, as well as development of management reports. As noted in III.D.2, there is still major work to be done in the improvement phase. Hopefully this phase will begin by fall 2011 – once all the forms are fully developed and loaded.

b. SharePoint Expansion – DMH has been utilizing Share Point for the past several years. It is, for example, the central portal for all policies, application links, announcements, etc. at SEH. SharePoint has had limited application within the Authority. The major issues have been the lack of a dedicated systems developer to manage the Share Point site and the lack of dollars to help do the

necessary software enhancements. One specific request currently at OCTO would provide the capability for Share Point to be used by MHRS providers for specific applications, e.g. reporting of grievances. SharePoint is currently available only for internal use. DMH is awaiting OCTO approval on this but remains hopeful this public-facing SharePoint effort can move forward.

c. Review of Existing Community IT Systems – DMH is currently evaluating the potential of creating a single IT care platform for authorizing, capturing, tracking and making claims requests by all of DMH's community providers. The intent would also be to utilize the District's MMIS system (OmniCaid) for all claims payments. The hope is that enhanced technology could be brought to bear via a web-based interface that would create easier system navigation, inquiry capabilities, and rate/billing flexibility. The DMH is at the early stages of defining a Statement of Work (SOW) to present to OCTO and others. The project is referred to as iCAMS. A new system of this magnitude would replace the current eCura system that DMH has had since the development of MHRS in 2002. By creating a single platform it would also presumably replace the current IT system used by many local providers. All of this will require considerable discussion with providers and other areas of D.C. government before any final decisions are made.

5. Organizational Development

The Division of Organizational Development (DOD) continues to manage three (3) major areas of critical support to the overall DMH mission.

a. DMH Training Institute – The DMH Training Institute has continued the strong progress that began in early 2010 with the hiring of a new Director. The Training Institute provides a broad array of basic/core training as well as advance/in-depth skill development. The Institute was approved for continuing education credit in the summer of 2010 by the D.C. Boards of Social Work and Counseling; this provides an additional inducement for staff. Among the highlights for the current year are: a training series for supervision competency; training certification in Co-occurring Disorders; and training in Functional Family Therapy. There is also, for the first time, a planned implementation for certification training for Community Support Workers; this is a critical first-step for front-line staff in need demonstrated by CSR reviews.

The Training Institute Director has also implemented a Provider Training Committee which meets every 2-3 months with

representatives of all the provider agencies. The two major tasks of this group are to develop a training needs assessment and identify and implement ways to share educational/training resources among providers.

The DOD continues to be the focal point in managing the ongoing Crisis Intervention Officer (CIO) training. Since its beginning in the spring of 2009, a total of 287 MPD officers have been through the 40-hour training and are now fully certified (of which 266 are still active). This has been a very effective effort and is strongly embraced by leadership and officers in MPD. The goal is still to train approximately 15%-20% of the MPD patrol officers; DMH indicates that it is currently at 8% of patrol officers who are certified. The training has also in the past year been expanded to include specific training for 911 call-takers and dispatchers at the Office of Unified Communications (OUC). A major part of this training is to help ensure that everyone receiving emergency calls understands why and how to dispatch mental health calls to a CIO-certified officer.

DMH and MPD continue to analyze the impact of CIO training on officer interventions and outcomes. The MPD-CIO Tracking Form, which is filled out by CIO officers after each incident, offers some basis to look at impact. It is noteworthy, for example, that CIO officers believe that in 35% of the cases they would have responded differently prior to the CIO training. DMH/MPD are analyzing other key data, e.g. the nature of incidents, behaviors observed, injury rates and outcomes of intervention. All of this analysis will hopefully continue to shape the training and operational details of the program.

b. CSR Unit – The internal CSR unit continues to have two (2) current staff. This unit has for the past two years taken on the major role in supporting the formal Dixon CSR reviews – providing some of the reviewer training and overseeing the majority of the logistical support. The CSR unit has been key to the development of the targeted CSR interventions of six (6) agencies over the past year (2 Adult and 4 Child/Youth). It is anticipated that a similar targeted strategy will grow out of the 2011 CSR reviews. One of the critical CSR learnings to date is that the CSR philosophy and practice implications have to be mainstreamed into the basic program and policy areas of DMH if these are truly going to take hold with CSA's. This will be a critical next step for DMH. So far, it is clear that agencies that have truly embraced the CSR model have made significant

improvements. The task ahead is to provide ongoing supports and expectations for all of the provider agencies.

c. Applied Research and Evaluation (ARE) – This five (5) member team has the ongoing task of analyzing and providing timely data to DMH decision-makers. They provide support on over 30 data-related projects, including training on LOCUS/ CALOCUS, the federal Data Infrastructure Grant (DIG), school-based mental health, Forensics, the CIO program, Integrated Care, etc. ARE is currently collaborating with the Office of Accountability (OA) and other internal stakeholders to develop a monthly report which reports critical system performance measures, and is intended for use by internal DMH executive staff, managers and supervisors. This report is in development and is scheduled to be finalized over the next month. They also disseminate a regular schedule of program and consumer-level reports, including but not limited to the LOCUS and CALOCUS service utilization reports for ACT and CBI, child services dashboard reports and the monthly Crisis Intervention officer (CIO) program report. In addition to these reports the unit will collaborate with St. Elizabeth's Hospital staff, OA, and other Office of Programs staff to produce a Public Data Report which will educate Washington DC residents and various stakeholders on the types of services funded by DMH. The report will identify areas such as access, service utilization, and additional criterion being identified by DMH's Executive Team. This report will be finalized by the end of the month as well. ARE staff provide on-going training and technical assistance related to program evaluation, data infrastructure development and utilization for agency, DMH program and systems leadership. The Court Monitor is very pleased to see this unit bring systematic analysis and data reporting tools to DMH leaders and managers.

Overall, the Division on Organizational Development has moved to create critical infrastructure support in the areas of training, quality of care (CSR), and applied data analysis. These are skill sets that will help drive the system to continued improvement in resource allocation and quality focus.

B. Review of Independent Authority for Key Functions

1. Independent Personnel Authority

The Human Resources Division of DMH has successfully completed its realignment and integration of core H.R. functions between the Authority and SEH. This new model – completed in 2010 – retains policy development at the Authority but puts basic H.R. operations functions

(e.g. recruitment) at SEH. The goal of having a single H.R. division appears to have been achieved.

The DMH has also completed the large majority of the original KPMG recommendations. Key H.R. functions, e.g. recruitment and employee performance, are now fully implemented in an electronic format. This electronic processing of information has helped to offset the loss of 13 FTE's in the H.R. Division over the last year. The H.R. division has also done more in cross-training of staff so as to manage functions that were historically just specialty positions.

2. Independent Procurement Authority

The DMH Office of Contracts and Procurement (OCP) has continued its steady efforts to support the procurement system. Points of note include:

- The enhanced IT capability for OCP has not moved forward due to the loss of staff at the D.C. Office of Contracts and Procurement. The software is in place but the specific DMH contracts have not yet been uploaded. DMH officials believe this IT upgrade is still important to provide the current online status of contracts and prompts for managers regarding contract renewal. DMH is still hopeful this will get done in the not-too-distant future.

- OCP has continued to provide mandatory training on an annual basis for all COTR's. It also provides training for any new COTR's. In general, the emphasis on manager training in 2010 has created higher levels of procurement functioning and greatly reduced unhappiness with the procurement rules and process.

- OCP has continued to encourage its seven (7) contract specialists to achieve national certification as a Certified Professional Purchasing Buyer (CPPB). Four (4) of the seven (7) have addressed this and a fifth staff member recently took the test.

- DMH has continued its string of external success by not being noted in the "Yellow Book" – which is an annual independent procurement audit that identifies any procurement problems on an agency by agency basis. This is the fourth consecutive year DMH has not had any contract or procurement issues noted.

Overall, the OCP has continued its positive track record of enhanced contract and procurement support. The "noise" regarding this function has largely disappeared – thanks largely to consistent leadership, stable contract managers and enhanced training. The District Council enacted legislation that would allow for greater centralization of OCP functions;

this legislation would not impact DMH until 2013. Even at this point, it is unclear how this new legislation will impact the current DMH model – which by all accounts is working very well.

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 create cross-agency responses to special populations that are often the most at-risk. These initiatives include:

1. Forensics – The forensics program continues to be directed by the Adult Systems of Care (SOC) manager. The DMH continues to operate within the framework of the Sequential Intercept Model – which fundamentally means that mental health interventions should occur at all stages of penetration into the criminal justice system – from pre-booking to prison re-entry. All of the forensic programs (as described in the July 2010 Report to the Court) continue. These include: 1) Options Program – which provides (via contract with Community Corrections) immediate pre-trial mental health services to persons with a history of non-compliance; 2) Jail Liaison – with DMH providing a full time person to track and connect with all persons with SMI who are admitted to the DC Jail; 3) Linkage Plus – DMH contracts with Green Door to provide intensive services to persons leaving the jail with misdemeanor/ felony charges. (168 individuals served in FY 2011); 4) Court Liaison – DMH provides a full-time person co-located at the court to assist the Pre-Trial Services Agency (PSA) to screen and refer individuals who need mental health and/or other services; 5) Re-entry – DMH employs a re-entry coordinator to do screenings and referrals for persons coming from forensic hospitals, jails, and prisons; 6) Outpatient Competency Restoration – DMH (via the Mental Health Services Division) provides outpatient competency restoration to a limited number of individuals – with average referrals to this program of 10 per quarter and; 7) Streicher Requirements – The forensics team monitors all of those persons in DMH who are civilly committed – with particular attention to the timely completion of the required Periodic Psychiatric Exam (PPE). As of April 1, 2011, there were 200 persons who were civilly committed, of which approximately 144 were outpatients.

DMH continues to provide a pretty comprehensive array of forensics services. It continues to look for federal funding opportunities to further expand forensic services. The development of a viable data system is still a major challenge; the initial goal is to create access to the eCura data entry system for the re-entry coordinator and jail liaison.

2. Co-occurring Mental Illness and Substance Abuse – The Co-occurring Disorders (COD) federal grant ended on August 31, 2009. Since the grant ended there are no full-time dedicated staff working on co-occurring issues. However, one of the staff working in the Integrated Care Division has been assigned to conduct and manage the COD training program and to serve as the DMH representative on interagency workgroups addressing service delivery to people with co-occurring disorders. There is an overall commitment to the basic philosophy of integration of treatment for persons with COD and some continued efforts to expanding the COD model throughout the adult and child/youth system. Most notable efforts include:

   - Via the Training Institute, there are currently four (4) staff who are qualified to train on COD and two others being trained as trainers. There is a new class of persons (28 total) being trained on the 18 modules in the previously developed COD training manual. Successful trainees receive a certificate for COD competency.

   - The Court Urgent Care Clinic has effectively merged the previously separate mental health and drug/alcohol tracks. This sets the organizational stage for doing common assessments for MI/D&A.

   - The new Juvenile Mental Health Court began in February 2011. The new court intends to screen every child/youth arrested in the District, utilizing the comprehensive screening instrument known as the CONNORS. It will screen approximately 3,000 children/youth per year – including screening for drug/alcohol issues. This will create another opportunity for enhanced identification and treatment for children/youth with COD issues.

   - There is some renewed hope that, with new leadership at the Addictions Prevention and Recovery Administration (APRA), the DMH and APRA can develop co-located clinics and closer partnerships on things like the Federal

SAMHSA block grant. Activity at the federal level will force greater cooperation in planning and service delivery.

Overall, there are multiple opportunities for enhanced collaboration between the historically separate fields of mental health and drug/alcohol treatment. Given the high incidence of COD within the mental health system, it behooves DMH to create a clear leadership structure for this issue.

3. Co-occurring Mental Illness and Mental Retardation – DMH has continued its efforts to work collaboratively with the Department of Disability Services (DDS). Since 2007/2008, DDS has directly assisted in the movement of 18 patients with a co-occurring mental illness/mental retardation from St. Elizabeths Hospital to the community; most of these individuals have gone into a 1915(c) waiver program and a few into a small ICF/MR. DMH continues to provide follow-up for these individuals who are placed and with one exception this community transition has been very successful. While the DD system carries the primary service responsibility for those who are placed, CSA's are typically involved and provide some mental health services, e.g. medication management.

   DMH also provides a specialized team for this co-occurring population through the Mental Health Services Division (MHSD). This team works closely with DDS on joint service planning and currently has a total of 129 consumers being served, 105 of whom are also enrolled in DDS. Altogether, DMH is currently serving 232 individuals in its community system who meet the definition of co-occurring MI/MR, with 187 of those also enrolled in DDS.

   DMH indicates that there are periodic meetings with DDS leadership. Current topics of discussion have focused on joint training for the respective staff and the potential for DMH to develop a specialized crisis/emergency response capability for the DD service providers.

b. Supported Housing Capabilities

   DMH has made important strides in increasing the overall Permanent Supportive Housing (PSH) capacity and in "scrubbing" the waiting list to determine the level of continued interest and need.

Through its interagency work with the D.C. Housing Authority, DMH has been successful in adding 105 new Housing Choice vouchers. These were individuals that previously were paid for by DMH out of local dollars but were on the DCHA waiting list. This represents a major portion of the new DCHA housing vouchers available. With these new vouchers in place, DMH will be able to use its dollars for additional persons on the current Housing Waiting List (HWL). The current total capacity of directly-controlled DMH supported housing is 1,217 which includes: Home First (625); Supported Independent Living (433);**15** Shelter Plus Care (DMH grant) consumers; and **144** Shelter Plus Care consumers. . This total compares to 1,595 in May 2009 and 1,653 in May 2010. Prior data included the federal set-aside vouchers and local rent subsidies that were allocated to DMH consumers. For purposes of this analysis, DMH included only DMH funded or managed programs in the report of DMH directly-controlled housing. The federal set-aside vouchers and local rent subsidies currently allocated for DMH consumers are included in the overall DCHA data. As part of the work with DCHA on the recently awarded non-elderlydisabled vouchers, DMH has done a data match of all of its adult consumers with the DCHA list of persons served via housing vouchers – yielding a total of 2,562 DMH consumers (which includes the consumers with federal vouchers allocated to DMH (556), consumers in local rent subsidy programs referred by DMH (67) and consumers in Local Rent Supplement Programs referred directly by Core Services Agencies). Hence, the approximate grand total of DMH consumers receiving subsidized supported housing through the District is currently 3,779.

DMH has also done considerable work on the Housing Waiting List. This number had grown to 1,113 as of May 31, 2010. As of May 24, 2011, the number had dropped to 859. The decline is attributable to two major reasons: 1) the creation of new housing vouchers as discussed above and; 2) The person-by-person consumer contacts to clarify current status of housing needs. This process has identified a number of people from the list who had, for example, moved out of the District, no longer needed housing supports, etc. DMH is now confident that there is no one on the waiting list with a duration of more than five (5) years who has not been offered supported housing. Some consumers who have been on the waiting list more than five (5) years have not been able to access supported housing because of the level of medical care or other supports needed. The next phase is to work through the 447 persons who have been waiting from 2-5 years; this will take 2-3 months to complete.

DMH also continues to work with the Corporation for Supportive Housing (CSH) to develop a new Housing Plan for DMH. It is not clear when this process will be complete.

Overall, there is continued effort and progress on the whole area of supported housing. The additional vouchers from DCHA are a real plus – given the scarcity of housing resources. Staff efforts to clean up the housing waiting list are proving to be very informative. One of the next steps is for DMH to clarify its policy and practice for the prioritization of housing supports.

c. Supported Employment Capability

DMH continues to fund six (6) CSA's to provide specialized supported employment services. With the additional funding from DDS/RSA, each SE provider was able to add one new staff per program and increase its capacity by 20 consumers. This increased the overall capacity of the SE program to 595. Although the capacity is 595, the number of consumers who received a SE to date in FY11 is 650. Given this number, DMH staff expect to serve 700 consumers by the end of this fiscal year.. The RSA monies fund the initial costs of intake, assessment, job development and placement, job coaching and the first 90 days of employment; this has allowed DMH resources to go towards the longer-term costs of helping people maintain jobs – either full or part time.

The major ongoing task for supported employment continues to be that of DMH monitoring the enforcement of the DMH policy on supported employment. Starting on May 1, 2010, DMH began to require CSA's to complete specific employment-related questions on periodic event screen data requirements. This process is beginning to yield critical data as to which CSA's are in fact discussing and offering employment services to consumers. A targeted protocol is being implemented to ensure two (2) things: 1) that CSA's are completing the event screen accurately; and 2) provision of training/technical assistance on the value of supported employment services. DMH has recently intensified its analysis of the Event Screen data. Analysis of data is now done on a weekly basis – with the intent of sharing individual CSA data in monthly meetings with Clinical Directors. Low performing CSA's are being provided with technical assistance and there is some indication that the percentages of persons being offered supported employment is on the upswing.

For the period of April 1, 2010 to March 31, 2011, there were 273 new referrals to supported employment. This compares to 242 for

the period of April 1, 2009 to March 31, 2010. This increase can be attributed to DMH implementing its SE event screen protocol consisting of technical assistance and training to CSA's on how to correctly offer the service to consumers and complete the event screen questions, in addition to weekly monitoring of event screen responses.

d. Assertive Community Treatment (ACT) Capability

DMH continues to demonstrate its strong commitment to a comprehensive ACT program. As of March 31, 2011, there was a total capacity in thirteen (13) ACT teams of 1,180, and current census of 1,068. This reflects a growth of over 100% in census over the past two (2) years. As the program has grown and reached more high-risk consumers, the number of referrals has dropped from last year (418 vs. 213) but has likely achieved a sustainable level. It is noteworthy that during the past year (April 1, 2010 – March 31, 2011) 92 of the accepted referrals came from programs with high levels of acuity and/or risk, e.g. inpatient acute care, forensic, SEH, Homeless and CPEP.

DMH has also continued its policy and practice of conducting annual fidelity assessments for each of the ACT teams – utilizing the Dartmouth Fidelity Scale for ACT. The fidelity assessment review for this year will be completed by September 2011 – with required improvement plans to be submitted to DMH by December 2011. DMH has been aggregating the Dartmouth scores and conducting training for ACT teams in areas that show patterns of low performance. DMH has also continued its multi-faceted Annual Performance Improvement Workplan for FY 2012. This includes a variety of “down and in” tasks including things such as: providing specialized training in substance services, motivational interviewing and the use of peer specialists; reconvening an internal stakeholder group to discuss common concerns; and developing specialized knowledge and training regarding forensic services.

Overall, the ACT program has maintained its positive momentum from FY 2011. It appears that ACT has not only achieved its targeted goals of reaching those consumers most at risk but also stayed focused on building ACT teams with high fidelity and ongoing commitment to quality improvement.

2. Review of Child/Youth Systems of Care

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

DMH has continued its efforts to develop and finalize a 3-5 year plan for children's mental health services in the District. The broad goal of the planning has been to look not only at traditional mental health service interventions but also at the public health aspects of early detection, health promotion, and prevention. Some of the specific objectives include: 1) reduce the number of youth in out-of-home residential settings and re-invest saved dollars to expand intensive outpatient services; 2) increase services to the 0-5 age group; 3) improve the level of family involvement at all levels of the system and; 4) implement a wider array of Evidence-Based Practices (EBP's). The final draft of this 3-5 year plan has been circulated for comment to stakeholders within the D.C. child/youth system. It is anticipated that, following this review and comment period, DMH will finalize the plan by September 30, 2011. The Court Monitor, in review of the final draft, is pleased with the scope of the review as well as the specific areas of recommendation. The key will be to create ongoing commitment and monitoring to ensure the major elements of the plan "take life."

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

The School Based Mental Health Program (SMHP) continues as a vital element of the DMH child and youth program. SMHP continues to operate a 2-tiered staffing model for the 59 schools in which they have provided services; SMHP has provided Tier 1 services in 45 schools and Tier 2 services in 14 schools. Of the 59 total schools, 50 are in DCPS and 9 are Public Charter Schools. Tier 1 involves a full time clinician while for Tier 2 clinicians are part time (typically 20 hours per week). Out of the 200+ schools in the DCPS and the Public Charter System, it is obvious that DMH cannot reach all schools within the constraints of its current $4.5 million budget. Decisions about which schools participate in the SMHP program have been made jointly by DMH and for the DC Public Schools, staff within the Chancellor's office. These decisions are based largely on school readiness and the availability of other resources, e.g. school counselors and social workers.

The SMHP continues its model of providing not only direct treatment, but also intervening via consultations with teachers, parents and others. SMHP staff also provide general information/presentations to staff that are more focused on primary prevention. For school year 2010/2011, the total number of referrals seen fell somewhat (6%) but there was a significant jump

in some key service areas, e.g. family therapy (up 24%) and home visits (up 79%). There was also a sharp 50% drop in the number of students referred for outside services. This is likely reflective of the degree of professional skill that SMHP staff are providing in a wide array of interventions. Being able to bill directly also provides an incentive.

The SMHP began using the Ohio Scales in 2007/2008 to measure changes in problem severity as viewed by the student, the parents and by staff. The data over the past 3 years are consistent in showing the significant reduction of behavioral and emotional symptoms after treatment as perceived by students, staff and parents respectively.

The SMHP has continued its effort to bill for treatment services. It appears that the initial billing issues of last year have been worked through and SMHP staff have now accepted billing as a reality. Billing revenues come predominantly from students who are enrolled through the District's MCO's and includes approximately one-third (1/3) of the total services of a given clinician – with the remainder spent in doing non-billable activities of prevention or early intervention. The projected collection of $175,000 in billing revenue for the 2010 - 2011 school year appears to be on target.

In addition to the core element of SMHP, the CYSD has continued and expanded its efforts to provide a variety of needed prevention/early prevention services in the District. A brief summary of these efforts would include:

- Healthy Futures – This project began in May 2010 and currently serves 25 child development centers throughout the District. This program places one early childhood mental health specialist in each child development center one day per week to help identify early children who need mental health interventions. This program is funded via a mix of Federal grants and local agencies, including funds from the Deputy Mayor for Education. Georgetown University is doing a detailed evaluation of this program. Initial outcomes are positive, but there is uncertainty as to whether full funding will be available.

- Primary Project – CYSD continues to manage this early intervention program which began in the 2008/2009 school year. This program is targeted to students with mild school adjustment problems. Utilizing a standardized screening assessment, identified students are then connected with trained

Child Associates, who work in child-led play interventions for 30 minutes per week over 12-15 weeks. This program has shown positive results, but the program had to be reduced in scope in 2010/2011 due to the lack of funding. DMH has continued to fund the overall supervision of the program out of local funds. However, the funding for the Child Associates for the 2011/2012 school year is at risk and would require an additional $236,000 to provide service to 13 schools.

- Parent Infant Early Childhood Enhancement (PIECE) – This early childhood program is targeted to children ages 8 and under. While it has been part of the DMH children services for many years, it has been retooled in the past year and has moved into specially designed and rehabbed space at 821 Howard Road. The target group are children with significant emotional/behavioral concerns who are often disruptive in pre-school, early school or home settings. The program provides comprehensive assessments and relies heavily on parental involvement in understanding and learning to manage disruptive child behaviors. The program is locally funded and normally lasts 12-16 weeks for a given child/family. The PIECE program began in October 2010, but reached its full capacity in February 2011. To date there have been 83 referrals – with a full program capacity of 120. The staff have been trained on two Evidence Based Practices: Incredible Years and Parent Child Interaction Therapy (PCIT) which are additional treatment modalities offered by the PIECE program. Social marketing for the program has begun for pre-schools, child care centers, physicians, etc.

Overall the DMH/CYSD have done an excellent job of supporting the SMHP – even in tough economic times. Hopefully, billing efforts will continue to grow. It is also heartening to see a number of innovative prevention/early prevention efforts. The obvious risk is the degree to which these programs are built on local dollars which are currently in short supply. DMH advocacy and support is evident and commendable for these critical early interventions.

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

The DMH through its Child/Youth Services Division (CYSD) has continued its diligent efforts to create a consistent cross-agency effort to provide intensive supports for children/youth in their home community to preclude residential care or to shorten length of stay when residential care is needed. The Court Monitor notes

continual progress on this on-going effort. The following developments are noted as examples of the progress underway:

- DMH is now the keeper of the data base for all children/youth from the District who are placed into PRTF's. All child-serving agencies are expected to submit regular reports to DMH for any child admitted or discharged with key identifying information. This is the first time this data responsibility has been clearly vested in one agency.

- The development of a single assessment process for all PRTF admissions is now in place. The PRTF Review Panel has been meeting on a weekly basis since April 14, 2011 – with representatives from all of the child-serving agencies. After full review and discussion, the DMH child psychiatrist assigned to this panel must approve any given admission as having met the medical necessity criterion. As of June 1, 2011, the Department of Health Care Finance (DHCF) will stop Medicaid payments for any child/youth who does not meet medical necessity. The only exclusions (in terms of participating agencies) are HSCSN and the MCO's – who have indicated willingness to participate but need staff to help manage.

- DYRS has become a full partner in this process. One of their concerns about a centralized process has been the issue of timeliness of reviews. To this end, DYRS has provided DMH with a full time staff person to help complete all DYRS applications.

- DMH has assumed responsibility for monitoring all children/youth who are placed in a PRTF through this centralized process. As of April 1, 2011, this number stood at 83 – which appeared to be relatively stable over the past 12 months (April 1, 2010 – March 31, 2011). However, for the entire 12-month period, there were 106 discharges versus 85 admissions. This DMH-monitored number of 83 represents roughly half of all of the approximately 160 children/youth who are currently in PRTF's. The cross-agency review panel has not worked out a process to ensure more standardized monitoring protocols for all agencies.

- DMH continues to contract with Choices, Inc. to provide wraparound services for children/youth who can be diverted from PRTF's or returned home more quickly with the provision of intensive services. The D.C. Wraparound

program served a total of 228 children/youth for the period of April 1, 2010 – March 31, 2011. Of this total, 177 were a part of the DCPS School Wraparound project and the remaining 51 were from the community Wrap program which is directly tied to children/youth who can be diverted from PRTF's.

The major outstanding area still to be addressed is how to memorialize all of the cross-agency efforts. Because of the multi-agency nature of this process, there is concern about the enforceability of any single agency's rule-making authority. Hence, the latest plan is to seek a mayoral order to accomplish the same end. An order has been drafted but not yet signed at the time of this Report.

d. RTC Reinvestment Program and Assessment Center

The RTC Reinvestment Program is responsible for monitoring all PRTF placements that come from DMH, CFSA or any other fee-for-service Medicaid placement. For the past year, DMH has also been monitoring all MCO children/youth after 30 days of placement. For the April 1, 2010 to March 31, 2011 period, the average number of monitored children/youth was 83. However, as of March 31, 2011, this number had dropped to 66. It should also be noted that the RTC Reinvestment staff monitor children/youth once discharged from PRTF's; this number currently runs about 105 at any point in time. CYSD also continues to manage the average length of stay (ALOS) for all discharges from PRTF's. For the 106 children/youth discharged from April 2010 to March 2011, the ALOS was 416 days. This represents a 20 percent (20%) decrease as compared to the period from April 2009 – March 2010, when the average length of stay was 519 days.

The CYSD continues to run the Assessment Center, which conducts mental health evaluations for the juvenile justice system, CFSA and any Medicaid fee-for-service youth being evaluated for PRTF placement. For FY 2010, the Assessment Center completed a total of 863 assessments (272 domestic relations, 147 juvenile and 444 neglect). This compares to 969 completed assessments for FY 2009 – 872 for FY 2008. CYSD staff note the continued decline of neglect referrals and the relative increase in domestic relations referrals. For children/youth the average timeframe for a completed assessment is now down to 13.1 days (from referral date to completion date). DMH continues to look at the issue of whether a billing system can be put in place. For assessments,

it appears that a State Plan Amendment would be necessary for Medicaid billing and a sliding fee schedule for self-pay individuals. No specific timelines to accomplish this have been presented.

e. Choice Providers

DMH continues to support the concept of a limited number of Choice providers. The basic concept of a Choice provider remains the same – namely to have more comprehensive and accessible services. The six (6) Choice providers get some additional contracted dollars (ranging from $15,000 - $125,000) that can be used primarily for non-traditional services that are not otherwise covered by Medicaid (e.g. flex funds). CFSA has continued to provide in funding to support the Choice provider program in FY 2011. The DMH Choice providers are not the exclusive providers of mental health services for CFSA children/youth because there is still a need for very specialized service in some cases (e.g. grief counseling, sexual abuse, trauma, etc.) However, the percentage of CFSA dollars spent on non-Choice providers has dropped from 40% (as reported in the July 2010 Report to the Court) to 21%. This drop suggests that Choice providers are meeting an expanding array of overall CFSA needs.

DMH tracks the number of CFSA referrals to Choice providers, the number of new Diagnostic Assessments completed and the timeliness in which children are seen. In FY2010 CFSA referred a total of 360 CFSA child consumers to the choice provider network through the Office of Clinical Practice referral process, compared to 372 referrals in FY2009. The total combined number of diagnostic assessments completed by Choice providers was 349 for FY 2010 (as compared to 413 for FY 2009). The average number of days between consumers' enrollment and diagnostic interview was 15 days, which represents a decrease from 22 days in FY09. In FY2010, Choice Providers averaged 13 days between consumers' diagnostic interview and first date of service following the diagnostic interview; this data set was not tracked in 2009. To that end, it takes an average of 28 days from enrollment to first service for CFSA involved children/youth referred to Choice Providers. According to CYSD staff, the amount of time (total of 28 days on average from referral to treatment) reflects the fact that most Choice providers contract with part time counselors to provide the direct service and are thus dependent upon their accessibility.

f. Child Welfare/Foster Care

DMH continues to co-locate staff at CFSA as part of the overall compliance with the Amended Implementation Plan (AIP) of LaShawn. For the time period of April 1, 2010 to March 31, 2011, the Child and Youth Clinical Practice Unit (CYCPU) clinicians co-located at CFSA conducted 199 mental health screens out of 647 total children/youth who were removed from their home or became foster care re-entries. Of the 199, 156 (79%) were determined to need mental health services. The AIP continues to be the overall framework for the CFSA and DMH relationship. The key elements, in addition to the on-site work of CYCPU, are the child and youth mobile crisis team (ChAMPS), the D.C. Wraparound program and Choice providers. The DMH working relationship with CFSA continues to be good. The only major issue is a budgetary one – with an open question as to whether the $2.5 million CFSA dollars that are currently transferred to DMH for mental health services will continue in FY 2012. This is an ongoing point of discussion in preparation for the FY 2012 budget.

Overall, the Court Monitor continues to believe that CYSD is making solid progress on multiple fronts. It is particularly good to see concrete progress on the long-standing PRTF issues. The 3-5 year plan should provide clear structure for the remaining tasks in the overall goal of creating a comprehensive child/youth mental health system in the District.

D. DMH's Role as Provider

1. Planning for New/Consolidated Hospital

DMH continues to work toward completion of Phase 3 – which includes all projects to complete the new campus following the occupancy of the new Hospital in May 2010.

The $3.2 million dollar fire suppression project for the entire campus will be complete and in service by July 22, 2011. The project required the replacement of all fire hydrants and valves and the unplugging of many corroded/clogged water lines. DMH has also installed a temporary pump station for the campus, which will be in place until the District installs a major new water tower (2 million gallons capacity) to serve SEH and the entire community. The water tower project is expected to be complete in 2013.

The old John Howard building was demolished in February/March 2011 and the $11.0 million project to build a new secure outdoor exercise/activity yard is underway. This project will also include the creation of new surface parking to accommodate up to 300 spaces. The new yard will be directly accessible to the intensive section of the new Hospital and will be even larger than the old outdoor yard. The target date for completion is December 2011.

The RMB project to renovate 50 overflow beds for SEH and provide renovated space for the DMH Authority is on hold. As the census of the Hospital has continued to decline, there appears to be growing belief that the new building is adequate to handle current and future needs. The DMH Authority is scheduled to move into new leased space at 609 H Street, N.E. in September 2011 due to the expiration of the current lease. The longer term location of the Authority is unclear at the time of this Report. DMH continues to work with the Department of Real Estate Services on this planning effort.

2. Quality of Care Issues at SEH

The Department of Justice (DOJ) completed its seventh visit to SEH on May 16-18, 2011. The final DOJ Report from that visit has not yet been submitted, but staff notes from the May 18, 2011 Exit Conference and personal interviews with SEH leadership indicate that this was another very positive visit. The five (5) person DOJ review team was consistent in their overall view that the quality of care at SEH continues to show marked improvement. They pointed particularly to progress in: the timeliness and quantity of discipline assessments; discharge planning process; recovery planning and; the upgraded programming in both TLC's.

Given the large number of improvements, the DOJ reviewers have recommended that the concentrated focus of remaining improvements should be in four (4) areas:

a. Violence Reduction

There is concern about the number of reported patient assaults. For the last six months of calendar year 2010 there was an average of 64 patient assaults per month for the entire Hospital; for the first five (5) months of 2011 this number has been reduced to 47 per month – a decrease of 17 per month. Even with these improvements, DOJ is recommending a number of additional strategies to include:

- Ensure risk assessments are included in recovery plans and treatment team review.
- Analyze trends in violence at the unit level to understand frequencies of needed intervention, e.g. time of day.
- Develop more comprehensive training of all staff in prevention-based non-violence interventions. Note: SEH is looking at potential outside vendors to do this training.

b. Medical Care – DOJ is recommending some additional steps to improve the physical/medical care of patients. These include:

- Improve the early identification of illnesses – with focus on improved nurse/physician communication.
- For patients returning from outside medical facilities, improve the documentation of medical care.
- Improve the morbidity/mortality review process – with increased emphasis on issues of morbidity.
- Conduct mock "code blue" drills on all units and shifts.

c. Nursing Care

There is a continued degree of concern about both the availability and role of registered nurses (RN's) at SEH. Specific recommendations include:

- Increase the total number of RN's to achieve a significantly improved ratio of RN's to total nursing staff (a 50-55% RN mix). Note: SEH has received budgetary approval to add 60 RN's – with the goal of adding 30 additional by July 31, 2011 and another 30 by September 2011. This increase in nursing staff is intended to help overall nursing care move from custodial care to a real focus on engagement and recovery.
- Improve nursing interventions in both psychiatric and physical areas.
- Improve the ability of nursing staff to detect and intervene earlier for persons with physical and/or behavioral issues.

d. AVATAR

The Hospital IT system was identified as having multiple shortcomings and should be a high-priority area for improvement:

- Identify the resources necessary to implement an overall AVATAR strategic improvement plan. Note: SEH and DMH IT staff have developed and submitted a 120-day plan to address the multiple IT concerns.

- Prioritize the development of the remaining assessments and forms.
- Seek formal input from user staff about the positives and negatives of the AVATAR system.

Overall, it appears that DOJ is increasingly pleased with the positive gains at SEH. The sense is that not only are improvements happening but that the pace of improvements has stepped up. It is clear that SEH leadership has stabilized in all of the major leadership positions and has coalesced into an effective planning and implementation group. The DOJ will be back in the fall of 2011 for its next review of progress.

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

DMH has continued its positive track of making maximum utilization of local acute care hospitals. For the 6-month period of October 2010 through March 2011, there were only 13 direct acute care admissions to SEH. This compares to 21 for the prior 6 months and to 40 for the two 6-month periods prior to that. There were no instances in which an individual was not admitted to a local hospital due to the lack of a bed; this is the first time this mark has been achieved. The major providers continue to be UMC with an average of 35 admissions per month and Providence with an average of 30 admissions per month. The Psychiatric Institute of Washington (PIW) continues to accept admissions who are insured (Medicare or some other form of private insurance). The Washington Hospital Center (WHC) contract, which was signed in early 2011, added four (4) additional beds. For February and March 2011, WHC averaged eight admissions per month. The total number of admissions to SEH (acute and subacute) averaged 13 for the recent 6-month period; this is also a reduction from 18 for the prior 6-month period and has contributed to the ability of SEH to continue referring its census.

The overall progress on the use of acute care is very encouraging. It is significant to have WHC available to accept involuntary admissions, even though the number of beds is small. The situation at UMC continues to evolve. While it is still unclear what the long-term solution will be, the District appears to be committed to maintaining a viable hospital at that location.

4. Development and Implementation of the Integrated Care Initiative

The Integrated Care Division (ICD) continues to provide intensive care management for specific high-risk populations in the system. ICD continues to manage and oversee the New Directions program via

contract with the Washington Hospital Center (WHC). This program targets long-term (and often very difficult to place) patients at SEH. Of the total contract of thirty (30), twenty-seven (27) have actually been placed in the community through a combination of intensive community readiness and intensive patient readiness.

The ICD is also the point of managing the continuity of care requirements for DMH as consumers move from inpatient to outpatient settings – consistent with the requirements of Exit Criterion #17 which requires a non-emergency outpatient visit within seven (7) days of discharge from an inpatient unit. The ICD now has over a year's experience in its efforts on the adult side. The results have been encouraging – with 7-day self report scores of 72% for the period of October 1, 2010 to March 31, 2011, and 63% for paid claims for the same period. DMH continues to analyze the data to determine the reasons for the gap between clinician self-report data and paid claims data.

The ICD has employed a staff person to work in parallel fashion on the child/youth; this effort started in April 2011, so there is only 1 full month of data from which to measure results. DMH indicates that the same model used on the adult side will be used for children/youth – namely with the DMH staff person on-site at acute care facilities to track linkage and help reduce any barriers. Hopefully, the same positive results will soon be forthcoming for children/youth as for adults.

5. Development and Implementation of the Mental Health Services Division (MHSD)

The DMH continues to run its own CSA-providing a range of specialized outpatient services that are not easily provided via the private contracted CSA's. All of the adult services are provided at 35 K Street. The child/youth are housed at 821 Howard Road S.E. and have a primary focus of prevention/early prevention; the child/youth is managed by CYSD and is discussed in III.C.2.b of this Report. The MHSD, however, does provide direct psychiatric support to the child/youth program.

As reported in the January 2011 Report to the Court, the MHSD served a total of 4,874 consumers (unduplicated) in FY 2010. One of the largest programs of the MHSD continues to be the same-day services walk-in clinic at 35 K Street. This service currently averages 291 consumers/month or a daily average of 15 (October 2010 – March 2011). This is up from the 13/day average of FY 2010. This clinic sees a combination of persons new to the system or currently enrolled

in a CSA. It appears, per recent tracking, that about 42% of same-day service visits are for medication refills from consumers in other CSA's. The same-day service is staffed by a psychiatrist, psychiatric resident, triage nurse and approved qualified practitioner, who is a social worker. Other MHSD psychiatrists, nurses, social workers, and the Residents Clinic provide support to the same-day service as a portion of their overall duties.

The MHSD continues to run the Physicians Practice Group (PPG), which provides part time psychiatric support to other CSA's as requested (on-site) and also sees consumers directly at 35 K Street for medication management; most of these consumers are also enrolled in a CSA, for other services although some are seen only at MHSD for medication management. This has proven to be a critical support service for the system – both for adults and child/youth. Eight (8) of the MHSD psychiatrists provide support to a total of seven (7) different CSA's. The PPG also supports the child/youth program at Howard Road in its early childhood (PIECE) program and for child/youth same-day services at Howard Road.

The MHSD also continues to provide other District-wide specialized services – most notably the Multi-Cultural Program, Deaf/Hard of Hearing Services, I/DD Services and the Outpatient Competency Restoration Program. Each of these programs has a unique history and mission. MHSD also runs its own pharmacy for persons without insurance support. As the number of people eligible for Medicaid has increased in the District, the demand for the pharmacy has gone down and the budget has been reduced from its FY 2010 base of $3.0 million to a projected budget of $1.8 million for FY 2012.

The MHSD has continued to tackle the issues of staff productivity and billings. For FY 2011, the minimum requirement of billable hours is 65% for psychiatrists and 60% for all other staff; these percentages are figured on the basis of work hours available – with the exclusion of holiday, vacation and other time off. There is clear data that productivity levels have significantly improved for all the MHSD teams. A dramatic example is for child psychiatrists who went from 30% productivity level in FY 2010 to 66% for the second quarter of FY 2011. MHSD has worked with human resources and managers and staff to ensure that progressive disciplinary steps are taken for staff who are persistently below the standard. In like kind, MHSD continues to work with DMH billing staff to maximize timely billings. FY 2010 collections were above projections. While it is still too early to forecast FY 2011, it appears that the same positive trends continue, it is also notable that MHSD is seeing a significant increase in

Medicaid enrollees, which obviously reduces the demand on local dollars.

Overall the MHSD has done an effective job in managing a number of unique programs. It has also done an effective job of paying attention to the business needs for adequate productivity and collections. DMH had indicated it would conduct a review of the going-forward role of the PPG in particular and the MHSD overall. This has apparently not yet been done.

E. Review of Status of DMH 2011 Budget and Status of 2012 Budget

For FY 2011, DMH absorbed additional budget reductions of $ 25 million or 14 % in local funds. These cuts resulted in service rate cuts and reduced funding for multiple programs. DMH had done a careful job of targeting reductions so as to minimize the impact on core service areas. It has also continued to look at any and all areas for improved revenue – some of which have been discussed in this Report. However it should be noted that DMH has been included in a bill for supplemental local funding that was introduced by the City Council on July 1, 2011 that would provide $3.5m in supplemental funding for the agency that would carry through the FY 2012 budget until expended. This action was approved by the District Council on July 12, 2011.

For FY 2012, the agency local budget will be reduced by $5.2m when compared to the approved FY 2011 budget. These reductions would primarily be in three areas; community contract services, MHRS funding reductions, and personnel reductions. The agency is currently developing a plan to apply the supplemental funds to the community contracts and MHRS budgets to partially offset the impact of the planned reductions.

IV. Follow-up on Other Previously Identified Recommendations

A. Status of Community System Redesign

The January 2011 Report to the Court summarized many of the final recommendations of the Redesign Workgroup. While there are important redesign efforts happening, it appears that the formal efforts of the redesign work are now completed. The redesign energy now appears to be happening in the various arenas that were identified in this Report, e.g. new IT planning, the Children's Plan, etc. There is no concerted effort to implement the recommendation of regulating and funding (via DMH) free-standing mental health clinics; this is primarily due to limited manpower resources at DMH, as well as budget restraints. However, DMH has convened workgroups to review and restructure the community support benefit and to further examine the administrative burdens of the current system on the providers. Both workgroups resulted from the work of the system redesign workgroup.

In addition, there have been some discussions between DMH and the Department of Health Care Finance (DHCF) about addressing the fragmentation in the child/youth service delivery system. In early June 2011, DMH submitted a system of care planning grant to SAMHSA, requesting funding to convene a planning process to address the fragmented delivery system, including the issue of mental health services delivered by the MCOs. If DMH is awarded this funding, a planning initiative will commence in the fall.

As part of the District's overall health care reform efforts, DHCF has convened a Service Delivery Subcommittee of the Health Care Reform Implementation Committee. The goal of the Service Delivery Subcommittee is to develop specific demonstration proposals for the Centers for Medicare and Medicaid Services (CMS) which offer new service delivery models in the District for serving both fee-for-service and managed care beneficiaries. These proposals will be designed to take advantage of the funding benefits offered through the federal health reform legislation, and will focus on the concepts of medical homes and accountable care organizations for a yet-to-be determined range of beneficiaries. DMH has been invited to participate on the Service Delivery Health Committee.

In May 2011, DMH began working collaboratively with DHCF and DOH to develop a request to CMS for a health home planning grant. A health home would include mental health and substance abuse treatment services, along with medical care for a target population of consumers. The request is expected to be submitted by DHCF later this month.

As noted earlier in this Report (See III.C.1.a), the whole area of co-occurring disorders for mental health/substance abuse needs concerted attention and leadership. There are multiple systemic issues, including the need for improved identification, care coordination, funding, training, and organizational structures. The Mayor's Office and District Council need to tackle the going forward relationship between DMH and APRA – with an eye toward creating a unified behavioral health system inclusive of mental health and substance abuse.

V. Recommendations

Based on the findings in this Report and prior Reports to the Court, the Court Monitor does not make any additional recommendations.