FINAL COURT-ORDERED PLAN

TRANSITIONAL RECEIVER

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DIXON, ET AL. v. WILLIAMS

C.A. No. 74-285

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I. BACKGROUND AND OBSERVATIONS

A. History of the Dixon Lawsuit

In February 1974, a class of individuals civilly committed to St. Elizabeths Hospital, including lead plaintiff William Dixon, filed suit against the Federal government (which operated St. Elizabeths) and the District of Columbia (which was responsible for community mental health centers in the District). The plaintiff class, which ultimately included individuals at future risk of hospitalization due to the lack of community services, sought community-based mental health treatment for class members whose mental illnesses were not deemed by their treating professionals to be sufficiently severe to require hospitalization.

In December 1975, the District Court ruled that individuals subject to the Ervin Act have a statutory right to treatment in the least restrictive setting, including placement in alternative community facilities when treating professionals have determined such treatment is appropriate. In 1980, following two years of negotiations, the Federal and District defendants and counsel for the plaintiff class, agreed to the entry of a consent order and an implementation plan. The order established the Dixon Implementation Monitoring Committee as a mechanism for overseeing the execution of the Plan, including tracking the availability of necessary resources, advising the Court on systemic obstacles to reform, and reporting the concerns raised by the class members.

The Federal government transferred St. Elizabeths Hospital to the District of Columbia in 1987. This reorganization brought all of the District's mental health service components together under a single administration — the newly created Commission on Mental Health Services ("CMHS"). A new consent order and a 5-year Services Development Plan ("SDP") were approved by the Federal Court in 1992. When the District failed to meet its obligations thereunder, a Special Master was appointed in May 1993 to oversee the implementation of the SDP, the 1992 consent order, and prior Court orders.

In May 1995, as a result of a motion by plaintiffs to expand the powers of the Special Master into those of a Receiver, a new consent order was entered by the Court. The order provided for a $12 million increase in the community adult mental health services budget and for the engagement of outside consultants to review the management of CMHS and the Mobile Community Outreach Treatment Team ("MCOTT"). While these "Phase I" conditions were achieved, the "Phase II" recommendations — which called for the implementation of a management audit, the establishment of two MCOTTs, and the development of a Homeless Services Plan, among other things — were not successfully implemented.

In December 1996, based on the District's repeated non-compliance with the Dixon decrees, the plaintiffs again moved for the establishment of a Court-ordered Receivership. The Federal Court heard the motion in April 1997, and granted it in June 1997. The Court's order bestowed upon the Receiver broad powers over personnel, contracting, facilities and the budget. The overriding charge included the mandate for development of an integrated and comprehensive community-based system of care.

The first Receiver was appointed in October 1997. In October 1999, the Court heard a request from the plaintiffs for an independent audit of CMHS activities under the Receiver. The parties and the Receiver subsequently agreed to an audit of CMHS budgeting, procurement and patient account management, and to a stakeholder committee process to assess progress on issues of concern. Continued frustration with the pace and direction of progress ultimately led to the resignation of the first Receiver in March 2000.

Following negotiations among the parties, the Court issued a consent order establishing a Transitional Receivership starting April 1, 2000. The order stated that day-to-day operations of the mental health system would be returned to the District by January 1, 2001, at the earliest, or April 1, 2001, at the latest. The Transitional Receiver was charged with developing — in consultation with the parties — an integrated, comprehensive and cost-effective community-based plan for the provision of mental health care in the District (the "Plan"). This is that Plan.

Beginning with the assumption of day-to-day operations by the District, a probationary period not to exceed six months is to be used to determine whether the District has the capacity to implement, and is implementing, the Plan. The Transitional Receiver is to monitor the District's performance for the Court during this period. If the Transitional Receiver certifies that the District has the capacity to implement and is implementing the Plan, the Transitional Receivership will be terminated.

B. Observations on the Current State of the System

The central question that pervades the last 25 years of legal and organizational activity in the District mental health community is: What have we learned in that time that might be instructive in our planning for the future? Each person and organization involved in the long and frustrating process brings to this query a unique perspective forged from hard-fought, hard-earned experience. Because I am an outsider, however, I think I bring to the mix a different perspective, and perhaps one less affected by the trials and tribulations others have experienced in getting to this point. A few of my observations follow:

1. The Need for Direction

Although a plan for the future direction and development of the public mental health system in the District was drafted and approved in connection with the transition of St. Elizabeths to the District's control, neither it nor other plans developed over the years were ever fully implemented. This has often left many well-intended actors in the system moving in different directions and at different speeds. We must put in place a comprehensive Plan that will provide clear direction for the system.

2. The Need to Establish a Separate "Authority" Responsibility

Historically, CMHS has both served as a provider of services and tried to oversee a fragmented, very dependent and largely underdeveloped system of care. The lack of any meaningful separation of these very diverse and inconsistent roles has led to endless confusion and often animosity within the system.

Even more problematic is the fact that when an organization, such as CMHS, attempts to function as both an authority and a provider, overall capacity questions are raised relating to the entity's ability to fulfill both roles. As a result, the critical (and non-delegable) "authority" tasks of creating and sustaining clear goals and values for the system tend not to receive the necessary attention. This historical barrier to CMHS success has been made essentially insurmountable by a confusing web of existing statutory requirements and limitations, as well as the lack of a legislative mandate requiring CMHS to promulgate and implement a set of system-wide goals and values.

We must establish a mental health agency with a meaningful separation between its authority and provider functions, and the unambiguous responsibility and authority, and the necessary resources, to promulgate and sustain clear goals and values for the system.

3. The Need to Redefine the Provider Role

Confusion and incapacity issues such as those faced by CMHS have led most governmental jurisdictions across the country to get entirely out of the business of directly providing outpatient/rehabilitation services. While it is not unusual for state governments to continue to operate public inpatient "safety net" facilities to supplement private inpatient capacity, it is now highly unusual for the governmental entity to be a major provider of community services. We must develop a publicly funded system with the incentives and capability for utilizing both public and private mental health services in the most appropriate and effective manner possible.

4. The Need for Clear and Sustained Leadership

For CMHS, a multiplicity of players and power bases across the executive, legislative and judicial arms of District government has led to a great deal of stalemating, inertia and stop-start activities. Symptomatic of this dynamic has been the continual change in leadership. The ability to attract and support high-quality, stable leadership must be viewed as a priority for the future.

5. The Need for the System to Embrace Change

The fact that the Federal Court has been involved with the District's mental health system for more than twenty-five years makes it clear that judicial intervention alone cannot bring about systems change. Fundamental and lasting systems change must come from within; it cannot be forced from the outside. We must create a mental health system that nurtures an environment that meets the needs and inspires the confidence of the stakeholder community.

6. The Need for Infrastructure

In order to provide comprehensive and functional mental health services to District residents, the mental health system must be supported by underlying systems for policy development, budgeting, purchasing, and information storage and retrieval. The historic ineffectiveness of such basic infrastructure systems throughout the District creates unique challenges for any policy initiative. It is easy to agree, for example, that a new financing mechanism for community services is long overdue. However, creating the necessary infrastructure to help make this happen is a daunting task. This Plan must put in place the resources necessary to create the infrastructure needed to operate an effective and responsive mental health system.

7. The Need for Productive Collaboration

The effectiveness and efficiency of the District's mental health system are dependent on the active support of other key City agencies. Other District agencies and the populations they serve are likewise dependent on coordination and cooperation with a well-functioning public mental health system. Without such collaboration, problems are typically addressed only in part, and creative opportunities to devise comprehensive solutions to "big picture" issues are lost. It is increasingly apparent that strong City leadership is necessary to create needed cross-agency collaboration. We must put in place a Plan that empowers the mental health system to play a leadership role in such collaboration.

8. The Need to Nurture Optimism

The amazing thing is not that the current system has bred numerous pockets of anger and frustration. The surprise is the number of people who continue to hope, and to find ways to make hope real — in spite of the system's shortcomings. The blueprint for the future must build on the system's strengths, and the undaunted commitment and devotion of many key people must be acknowledged and utilized.

II. APPROACH TO DEVELOPMENT OF THE PLAN

A. Purpose of the Plan

The purpose of this Plan is to provide an overall policy framework for meeting the Dixon mandate to develop and implement an effective and integrated community-based system of mental health care for consumers in the District of Columbia. It is crafted to achieve a delicate balance. The Plan must be sufficiently descriptive so as to provide strong guiding principles and a clear framework for the current and future direction of the District's mental health services. At the same time, it must retain the capacity to be dynamic as the new system unfolds and evolves.

For example, it is neither possible nor desirable to set out highly specific service targets, as these will change and be adjusted over time. The Plan attempts to create the greatest degree of "tightness" at the broadest level — e.g., clear statements of mission, values, goals, key functions and principles to drive the system — and to provide succinct descriptions of the role(s), governance structure and financing of the District's public mental health authority into the future.

It is imperative that the new mental health system has the capacity to measure itself in key performance areas. The ongoing measurement of system performance from both organizational and services perspectives is critical to ongoing improvement in systems performance. Achievement of this objective requires agreement on the most critical areas to be measured, baseline measures in those areas, and an ongoing understanding that these areas will be measured over time.

The Plan, then, fulfills its purpose in three distinct ways:

- by articulating systems direction, philosophy, key functions and structure;
- by describing how the system's major roles and governance will take shape; and
- by ensuring that the system has the ongoing, built-in capacity to measure itself in key areas and to translate these findings into continual improvement.

B. Process for Plan Development

Information, impressions and advice concerning Plan development have been gathered in a variety of ways and from many sources. The Receiver's Advisory Council has regularly discussed the development of the Plan, raising and proposing Plan components, responses, and implementation activities. Various forums held with interested parties have provided opportunities for discussion and feedback. In addition, individual structured interviews have been conducted with key informants, including executive, legislative and judicial branch officials.

This process has been conducted to create an environment that promotes healthy and organized interaction, discussion and debate. The substance of the Plan is, of course, a matter uniquely reserved to the parties and ultimately the Court. The probability of achieving a successful transition to the new system of care will be vastly improved, however, because the Plan has been discussed and, hopefully, will be embraced by the wider governmental and mental health community.

III. KEY ELEMENTS OF THE NEW MENTAL HEALTH SYSTEM

A. Mission: Dynamic Systems of Care Built on Consumer Needs

The overall mission of the new District of Columbia mental health system is to develop, support, and monitor an effective and integrated community-based system of services for persons with identifiable mental health needs. To accomplish this mission, the system must be restructured to perform the different and more diverse functions necessary to significantly increase the total number of persons served.

As with any such system, the priority in service response and system design should be on those individuals with more severe forms of mental or emotional illness. This includes those who fall within the federally-accepted definitions of severely and persistently mentally ill adults or severely emotionally disturbed children and youth. Individuals with the highest degree of symptomatology and at greatest risk of pain and suffering have a higher probability of becoming a burden on their families, suffering academic failure, being incarcerated, abusing alcohol and other drugs, etc. Left untreated, these individuals disproportionately consume resources of numerous public systems, such as schools, child welfare agencies and law enforcement programs.

Contemporary mental health systems — when truly consumer driven — offer greater potential for serving individuals, including persons with severe illnesses, than ever before. In such systems, newer medications combine with a community system flexible enough to meet individual needs to provide consumers with a new sense of dignity and hope, as well as demonstrated participation and success in the larger community. Such a system will be "recovery based."

Such ends can only be achieved in a mental health system that is integrated, community-based, and provided primarily in the consumers' natural environments (e.g., schools, homes, neighborhood health clinics). These characteristics permit greater partnering with other helping professions, earlier identification of mental health issues, and reduced stigmatization. Further, the most significant strides can be made when progressively greater resources are targeted toward prevention and early intervention efforts focused on younger people and located in community settings.

At the heart of the new mission for the District's public mental health system is the need to create dynamic systems of care built on consumer needs. Meeting this obligation requires demonstrated commitment to a system-wide services philosophy that is:

- Person-centered: For children and youth, this means child-centered and family-focused. For both adults and children and youth, it means that the system must fundamentally align itself so as to respond to the unique types and mix of services each person (and family) requires.

- Community-based: The locus of services as well as accountability and defined decision-making responsibility should be at the community level.

- Culturally competent: Agencies and individual staff should be responsive to the unique cultural, racial and ethnic differences of all who are served.

B. Internalization of Consumer-Driven Core Values

In the reformed mental health system, all efforts, resources and behaviors must reflect the view that "the consumer is in charge." Core values must be defined, adopted, and translated into concrete behaviors and practices at each level of the organization. A consumer-driven process facilitated by the Transitional Receiver has identified the system's core values as respect, accountability, recovery-based, quality, education and caring. These values have been adopted, and are described more fully, in the Receiver's FY 2001 Strategic Plan.

Monitoring conformance with these values through standards and contracts is one powerful way to ensure that the system is consumer-driven. Broad and consistent commitment to these values should also underlie and thereby help stabilize relationships between the mental health system and external constituencies, such as courts and other agencies, and internal stakeholders, such as system employees. CMHS has already begun to successfully implement consumer-driven values with the CarePoint Project. This kind of effort must be continued and expanded.

C. Mandated Separate and Independent Authority Role

The new District mental health agency, hereinafter the "Department of Mental Health" (the "Department" or "DMH"), will be created as a cabinet-level agency, with its Director reporting directly to the Mayor's Office. The key task of the new Department must be to provide the governmental leadership and oversight functions necessary to manage a complex and pluralistic community mental health system. The new Department's structure and authority must give it a clear mandate to play this key role actively and aggressively. This authority must be separate and distinct within DMH's structure, with clear demarcation between the authority role and any role DMH plays as a provider. This is important not only because the work of an authority and a provider are vastly different, but also because the "authority side" of the Department will have certification and licensure responsibility for all mental health services and programs — including any that the Department may deliver directly.

1. DMH's Powers and Duties

Legislation establishing the new Department must grant DMH the powers and duties necessary to carry out its "authority" responsibilities. Key authority functions include those discussed below.

a) Quality Improvement and Provider Oversight

In order to carry out the new comprehensive regulation and licensing mandate described below, DMH will hire adequate numbers of trained staff to certify and/or license and monitor all non-hospital mental health facilities and programs for which licensure is required under District law, including specifically Community Residence Facilities, Medicaid Day Treatment Programs, Free-Standing Mental Health Clinics, Residential Treatment Centers for Children and Youth, and Mobile Community Outreach Treatment Team Services. It should be noted that individual professionals will continue to be licensed according to current practice, and therefore will not be licensed by DMH. The Department will also develop standards for certification of Core Service Agencies (described in detail below) and specialty service agencies. Through its quality improvement and provider oversight function, the Department will implement means to stimulate, oversee and reinforce the values of a consumer-driven model.

b) Planning and Policy Development

DMH will be responsible for mental health planning and policymaking. It will develop the District's mental health plan and take a leadership role in ensuring that the planning and policies of other District agencies are consistent with the District's mental health plan. DMH will also promulgate policies and rules to govern the mental health system. DMH will develop and adopt an annual strategic plan which will be used to measure system performance throughout the year.

The annual strategic plan will build upon the Receiver's Plan and will incorporate specific tasks and timelines, and provide for clear management accountability for their accomplishment. The Department will involve consumers, community stakeholders, providers and staff in its planning processes.

c) Medicaid Responsibilities

The Department will utilize Medicaid as a major funding source for community-based services and will seek to maximize Medicaid reimbursement at both the services and administrative levels. DMH will administer — via written agreement with the Medical Assistance Administration ("MAA") — those portions of the state Medicaid program relating to mental health. DMH must therefore have the delegated authority to fulfill all of the responsibilities of a health plan, in active collaboration with the MAA.

The Department will implement the Medicaid Rehabilitation Option ("MRO") to support an array of community services for Medicaid eligible individuals. Over the past fifteen years, more than 40 states have used the MRO model. It is now the single most significant method of federal reimbursement of community mental health services, particularly for adults with long term disabilities and children and youth with significant emotional problems.

The Department must have the ability to develop specific MRO services, fee for service rates, eligibility criteria, information systems, payment mechanisms, etc. While substantial progress has been made during the development of this Plan, full implementation of the MRO will take a minimum of 18 to 24 months, and will require a continuing commitment of resources. A specific MRO plan with key tasks and timelines will be shared with providers and advocates.

d) Systems of Care Management

DMH will play the key leadership role in the design and development of an overall "systems of care" model. These systems of care will address the challenges faced by adults, children and youth with more severe forms of mental illness and/or emotional problems, who often must deal with multiple and often unconnected service systems. Implementing this model will require DMH to take the lead in developing alternative approaches to the planning, funding and delivery of services. These approaches stress strong cross-agency partnerships, a shared responsibility for ultimate outcomes, mobile/onsite responses by mental health professionals, a shared philosophy of consumer-driven services and family-driven supports, and the mixing and matching of funding streams to support an overall services plan.

In developing systems of care, the Department must exhibit leadership in serving the special populations and services for which it will be responsible, including children and youth and adults, with particular attention to individuals who are homeless, have a forensic status, or need housing and other special supports. Leaders responsible for each of these special service areas must develop a clear vision, create cross-agency partnerships, and involve consumers and family members as full participants in service planning and evaluation. Under the systems of care model, DMH should also develop utilization management strategies to assure that consumers receive the right services, in the right amount, at the right time.

e) Child, Youth and Family Services

Effective services for children, youth and their family must be developed and organized by the new Department. DMH must establish, through an interagency workgroup, a cross-systems approach to funding, policymaking and establishment of a single system of care for children and youth with mental health needs. New MRO services, especially community based intervention, must provide alternatives to out-of-District placement of children and youth. Care management strategies, including streamlined, integrated service planning that meet the needs of children and youths and their families in a variety of settings, must be implemented across all systems of care. Service strategies including school based service strategies, must also be put in place. Strategies aimed at supporting and treating children who are the responsibility of the Children and Family Services Agency ("CFSA"), or the Youth Services Administration ("YSA"), or who are homeless or separated from their families, must be a priority. All services must be consumer and family based, with families playing an integral part in service planning and decision-making.

f) Consumer and Family Affairs

Departmental planning and evaluation must involve consumers and family members at all stages to instill across the agency a deeply-held belief that the people best equipped to evaluate priorities and practices are consumers themselves. Like most state departments of mental health, CMHS has created a separate Office of Consumer and Family Affairs ("OCFA"). While this is an important first step, it does not — in and of itself — accomplish the end goal of creating a consumer-driven system of care. To do this, leaders and managers at all levels must embrace consumer involvement in the design, implementation and evaluation of services. For example, this Office could direct the monitoring and measurement of the system's conformance to the consumer driven core values. The new OCFA will have its own discrete budget, and will continue to be a full partner in the team that leads the Department's delivery systems efforts.

g) Organizational Development and Training

As services are reformed, the size and responsibilities of the Department's workforce are likely to change, and the need for training and staff development will intensify. All staff providing services will be required to demonstrate knowledge and performance competencies in a range of areas, including the recovery model and cultural competence. The Department will establish a Training Institute, develop strong working relationships with local universities and other professional resources, and provide a continuous learning environment for consumers, community stakeholders, staff and providers. It is also critical that the Department work with organized labor to find effective ways to manage the ongoing retraining and redeployment of staff throughout this dynamic period of change.

h) Enforcement of Consumer Rights

Consumers and their advocates need effective administrative mechanisms to enforce statutory protections for consumers of public mental health care. The Department must, through the thoughtful and innovative involvement of neutral third parties, develop and implement non-judicial processes to protect consumers and address their grievances. Fundamental fairness, such as the meaningful opportunity to be heard, whether individually or through one's representatives, and real enforcement consequences, must be hallmarks of such a system, and must be proposed by the Department in rules adopted with the support of community stakeholders. Fortunately, there are many successful models that can be explored. Implementing the fair hearing processes required under federal Medicaid law will be a good beginning, but the Department must extend these kinds of protections to all consumers of public mental health care. It is important that the development and initial implementation of a consumer protection process and full and fair grievance procedures be accomplished before the end of the Receivership.

2. DMH Leadership Roles

Many DMH leadership positions will report directly to the Director of the Department, have responsibilities that cut across agency lines, and exercise authority that traditionally has been held by other District officials (such as full procurement and personnel authority). In exercising such authority, the Department's leadership will follow the substantive laws and policies of the District and work collaboratively with District leaders to ensure cross-agency teamwork and participation. If existing laws and regulations impede implementation of the Plan, the Director will consult with the Mayor to develop an appropriate resolution. This cooperation will balance the legitimate and important District-wide control function with DMH's mental health system responsibilities and strong consumer service and support philosophy.

a) Chief Financial Officer

The financing and delivery of health care is a complex endeavor. The Department's Chief Financial Officer ("CFO"), will be appointed by the District's CFO in collaboration with the Director. The CFO will directly report to, be ultimately responsible to, and be under the supervisory direction of the District's CFO, through the Director. The CFO will be responsible for working as part of the DMH leadership team to develop fiscal strategies consistent with the overall direction for the system and in compliance with applicable District and Medicaid laws and policies. The CFO will advocate for and advance the policy objectives of the Director, to the extent consistent with his or her ultimate responsibility to and supervisory control by the District's CFO. The CFO must put into place sound budgeting systems, establish and maintain clear accountability for management responsibility, produce financial and performance reports on a timely basis, develop financial policies that ensure adequate internal controls, monitor the fiscal development and performance of both DMH and private providers, and develop and implement the billing systems that will be necessary to support MRO and other contracts.

b) Chief Information Officer

The new Chief Information Officer ("CIO") must establish the information systems policies and technology to support an increasingly community- and third party provider- based mental health system. The CIO must work in partnership with internal and external provider entities in offering information systems training, support and consultation. These responsibilities will require capital investment in both hardware and software. The CIO will actively coordinate with the Office of the Chief Technology Officer ("OCTO") in establishing needed information systems' plans and policies.