IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

WILLIAM DIXON, *et al*.	
Plaintiffs,	
v.	Civil Action No. 74-285 (TFH)
	Next Scheduled Event: Status Hearing
ADRIAN FENTY, *et al*.	May 28, 2009 at 10:00 a.m.
Defendants.	

DEFENDANT DISTRICT OF COLUMBIA'S APRIL 2009 STATUS REPORT

The Defendant, by and through counsel, herein files its April 2009 Status Report pursuant to the Court's Order dated November 3, 2008.

I. INTRODUCTION

This status report addresses the District of Columbia's progress with the *Dixon* exit criteria and provides an update on the status of the transition of consumers from the DCCSA, progress at Saint Elizabeths Hospital, and the budget for FY 10.

II. EXIT CRITERIA

The District of Columbia Department of Mental Health ("DMH") continues to make significant progress towards the performance targets established by the Consent Order of December 12, 2003 for the nineteen (19) exit criteria ("Consent Order"). A table showing the most recent performance data is attached. *See* Exhibit A, *Dixon* Exit Criteria Performance Levels for FY 2008.[1]

[1]DMH has been processing the remaining FY 2008 claims, so that all provider payments are made prior to March 31, 2009. Therefore, the data reported for the claims-based exit criteria is slightly higher than reported by the Court Monitor in his January 2009 report, because it reflects claims processing activity through March 24, 2009.

A. Exit Criteria on Inactive Monitoring Status

As discussed in the prior reports submitted by the Court Monitor and the District, six (6) of the nineteen (19) Exit Criteria have moved to inactive monitoring status.[2] DMH anticipates agreement with the Court Monitor that DMH will have satisfied performance targets for an additional three (3) to six (6) of the exit criteria within the next six months.

B. DMH Pending Requests for Inactive Monitoring Status

Exit Criterion #10: Supported Employment for Adults with Serious Mental Illness.

Required System Performance: 70% served within 120 days of referral.

DMH Performance: 92.9% served within 120 days of Referral.

The Dixon Exit Criterion for Supported Employment requires that 70% of persons referred receive supported employment services within 120 days of a referral. For FY 08, the average of persons receiving services within 120 days of referral was 93.75%[3]. The Department has clearly met this exit criterion.

Fiscal Year	First Quarter 10/1-12/31/07	Second Quarter 1/1-3/31/08	Third Quarter 4/1-6/30/08	Fourth Quarter 7/1-9/30/08	Total for FY08
Performance Indicator	88%	100%	87%	100%	93.75%
Numerator (Consumers served Within 120 days)	22	27	33	23	105
Denominator (Consumers Referred)	25	27	38	23	113

[2] Exit Criterion #12 moved to inactive monitoring status in July 2007. Exit Criterion #19 moved to inactive status in January 2008. Exit Criterion #18 moved to inactive status in July 2008. Exit Criterion # 8, #13 and #16 moved to inactive status in January 2009.

[3] *See* Exhibit B, Supported Employment, for a full description of the Department's program.

Additionally, the Department has a policy related to Supported Employment, *see* DMH Policy 508.1, and monitors compliance with its policy consistent with the requirement to verify the "degree to which relevant policy and practice is being followed by providers." December 12, 2003 Order. Monitoring includes the annual fidelity assessment of the supported employment providers (from 2004 through the present), collection and analysis of data regarding provider referral patterns for supported employment services (from October 2007 through present) and quarterly claims audits conducted by the Office of Accountability (starting in October 2008 for services rendered in FY 2008 and forward) and discussed further below. Therefore, Defendants' policy, monitoring, and actual performance should be sufficient to support movement of this criterion to inactive status. However, the Court Monitor disagrees and rather than focusing on verification of compliance with the policy as a whole, insists instead that the Department should analyze specifically whether individuals who should be referred to supported employment are, in fact, being referred. While this goal is incorporated in one sentence of the Department's overall policy, the Court Monitor has imposed additional methods to verify compliance with the policy that exceed the extensive evidence-based verification methods that the Department has already implemented. The Court Monitor's request exceeds the requirements of the Consent Order..

Notwithstanding our substantial disagreement on this issue, the Department continues to collaborate with the Court Monitor and has incorporated monitoring through its claims audit process for verifying adherence to the DMH policy regarding referrals. In August 2008, the Office of Accountability began conducting audits of FY 08 claims, using the RAT-STATS claims audit tool that queries whether educational or vocational goals are captured within the consumer's treatment plan. The results of the vocational queries are compiled and provided to the Supported Employment Coordinator. The Supported Employment Coordinator uses this

information to conduct targeted training and social marketing activities to mental health providers and consumers. This issue continues to be discussed with the Court Monitor on an on-going basis.

C. Additional Progress on Exit Criteria

DMH continues to make progress on the remaining Exit Criteria #1-7, #9, #11, #14 – 15, and #17. Specific details on the progress on these exit criteria have been submitted to the Court Monitor and he continues to receive updates during his bi-monthly visits.

Exit Criterion #1: Demonstrated Implementation and Use of Functional Consumer Satisfaction.

Required System Performance: Court Monitor must approve method of measuring consumer satisfaction and utilization of results.

DMH Performance: Two methods: (1) MHSIP and (2) convenience sampling and focus groups approved by Court Monitor; on-going progress in implementation of methods and use in quality improvement cycle.

The methods of conducting consumer satisfaction surveys have been completed and approved by the Court Monitor. These include (a) the Mental Health Statistics Improvement Program ("MHSIP") survey for adults and children; and (b) convenience sampling and focus groups conducted by the Consumer Action Network ("CAN").

DMH has been reviewing the results of the consumer satisfaction surveys through its established quality improvement processes. As a result of the analysis of the FY 2007 and FY 2008 MHSIP reports by the Internal Quality Council, recommendations were made for improvements to the MHSIP for the FY 09 survey, that are expected to both make the data more useful for quality improvement purposes and to increase the number of consumers that are surveyed. A consumer-led agency will be selected to implement the telephone-based survey, which will also include some surveys administered via mail, with an expected completion data of September 30, 2009.

Beginning in April 2008, representatives from the DMH Office of Accountability and Office of Consumer and Family Affairs have met periodically with CAN to restructure focus groups and convenience surveys, including the consumer satisfaction survey, such that the data and analysis will better enable the DMH Quality Council and Quality Committee to review and make recommendations and plans for quality improvement. The Office of Accountability has asked that the next focus groups determine the top 3 issues of consumer concern, and query consumers about their satisfaction with the coordination between the mental health provider and their physical medicine provider. This data will be used in conjunction with the current Quality Improvement initiative on Coordination of Care being administered by the Office of Accountability with all provider agencies.

Exit Criterion #2: Demonstrated Use of Consumer Functioning Review Method(s) as Part of the DMH Quality Improvement System for Community Services.

Required System Performance: Court Monitor must approve method of measuring consumer functioning and utilization of results.

DMH Performance: Review method (LOCUS/CALOCUS) approved; on-going progress in implementation and use in quality improvement system.

DMH uses the LOCUS/CALOCUS tool to measure consumer functioning.[4] The LOCUS/CALOCUS (CALOCUS is for children) is required to be completed by the provider every 90 days. In February 2009, DMH completed the migration of the LOCUS/CALOCUS application to a web-based application. The web-based application of LOCUS/CALOCUS is expected to enhance the providers' ability to both complete the LOCUS/CALOCUS, and for the providers and DMH to use the resulting data about consumer functioning for quality improvement activities. In November 2008, DMH staff were trained as "super users" of LOCUS/CALOCUS and the web-based application, and designated to serve as the trainer pool

[4] *See* Exhibit C, LOCUS sheet.

for a training-of-trainers ("TOT") initiative to train DMH providers. The clinical directors of the Core Service Agencies have identified staff within their agencies to serve as trainers, and these individuals along with other required LOCUS/CALOCUS users (e.g. CPEP) have been scheduled to attend the TOT training sessions. Trainings started on March 11, 2009, for LOCUS and CALOCUS trainers, and are scheduled to occur on a weekly basis through June 2009. All agencies will be required to train and authorize direct service providers to use the web-based LOCUS/CALOCUS application by August 31, 2009.

Concurrent with the implementation of the web-based LOCUS/CALOCUS application, the Office of Accountability is completing Quality Review Audits of clinical records. Among other things, the Quality Review Audit allows DMH to verify that a LOCUS/CALOCUS assessment was completed, as required by DMH policy. At the same time, DMH is reviewing and updating its LOCUS/CALOCUS policy to address concerns identified through the process of implementing the web-based application and the Quality Review Audits. .

Exit Criterion #3: Demonstrated Planning for and Delivery of Effective and Sufficient Consumer Services (Adult).

Required System Performance: 80%

DMH Performance: FY 08: 74%

Exit Criterion #4: Demonstrated Planning for and Delivery of Effective and Sufficient Consumer Services (Children/Youth).

Required System Performance: 80%

DMH Performance: FY 08: 36%

Exit Criterion 3 and 4 are addressed in tandem. In late FY 08, DMH established a unit to conduct Community Service Reviews (CSRs) throughout the year, to facilitate practice improvements for both the child and adult system of care. The unit consists of two full-time and

one half-time employees who have been integrally involved in the planning, development and implementation of both the FY09 Child and Adult CSRs. The staff of the CSR unit is currently serving as shadows and partners in coordinating the logistics for the *Dixon* reviews. The unit is scheduled to begin implementation of its own internal case reviews in September 2009, and will continue to increase its involvement in implementing *Dixon* reviews.

Adult CSRs (Exit Criterion #3) for FY 09 are scheduled for May 4 – 15, 2009. DMH is hopeful that the scores will continue to reflect improvement and will approach or meet the 80% system performance requirement for Exit Criterion #3.

The Child CSRs were conducted during the weeks of March 9 – 20, 2009. Preliminary results showed a 20% improvement in overall system performance from 2008. The final report is expected in June 2009. As a result of this review, the DMH Director has requested that the Director of Child Services convene a planning group to respond to the following issues:

1. What practice activities, standards and expectations need to be present for every individual served by DMH providers?
2. What is the role of the Community Support Worker in team formation and ensuring productive team functioning?
3. What is the role of the supervisor and what areas of practice do they need to continuously focus on?
4. What are barriers and solutions to implementing the proposed practice guidelines including activities that support better team formation and team functioning?

The report is due to the Director by May 15, 2009.

Exit Criterion #5: Demonstrated Provision of Services to Children and Adolescents (Ages 0 – 17).

Required System Performance: 5%

DMH Performance: 2.82%

Exit Criterion #6: Demonstrated Provision of Services to Children with Serious Emotional Disturbances.

Required System Performance: 3%

DMH Performance: 1.77%

Exit Criterion #7: Demonstrated Provision of Services to Adults. Required System Performance: 3%

DMH Performance: 2.46%

DMH has made substantial progress in addressing one of the pre-requisites for including children, youth and adults receiving mental health services through the Medicaid Managed Care Organizations ("MCOs") under contract with the Department of Health Care Finance ("DHCF" – the successor agency to the Department of Health Medical Assistance Administration) in reporting for Exit Criteria #5 and #7. DMH and DHCF finalized a Memorandum of Understanding on January 2, 2009, addressing the MCO contract obligations to DHCF and DMH for oversight of mental health services provided by the MCOs. (*See* Exhibit D, MOU). DHCF and DMH met with the MCOs on March 2, 2009 to review the MCOs' obligations under the MOU, including the specific reporting requirements related to *Dixon*.

The November 7, 2003 Court Order allows DMH to submit for inclusion in the penetration rate for Exit Criteria # 5 and #7, those persons who are provided mental health services in the District and for whom DMH has direct or shared responsibility. DMH expects to receive data from the MCO's that will allow DMH to more fully assess the number of individuals receiving mental health services in the District through district resources in early April. DMH will keep the Court Monitor informed of the results of the integration of the MCO data with DMH information.

Exit Criterion #9: Supported Housing.

Required System Performance: 70% Served within 45 days.

DMH Performance: 10.4%; the required system performance is being examined in terms of best practices.

DMH provides housing subsidies to 750 consumers in permanent supported housing. DMH has not included the consumers in other DMH supported housing programs and is reviewing those programs to include them. Additionally, DMH is examining national standards for supported housing programs and will be proposing an amendment to this criterion that better reflects best practices and the actual goal of not only placing consumers in housing but providing the supports that enable people to stay in permanent housing. DMH is working with the Court Monitor as it develops more appropriate standards for measuring its performance in permanent supported housing.

Exit Criterion #11: Demonstrated Provision of Assertive Community Treatment for Adults with Serious Mental Illness who have Been Assessed and Referred to this Service.

Required System Performance: 85% of people referred to ACT services will receive ACT services within 45 days of referral.

DMH Performance: 64.95% (as of 2/6/09).

DMH continues to work toward meeting the performance target for Exit Criterion #11, Assertive Community Treatment ("ACT"). The data collection metric used by the Department for Exit Criteria 11 was flawed and resulted in underreporting; it will be revised, before final submission to the *Dixon* Court Monitor and his data validation consultant for review and approval. DMH expects to complete the revisions to the data collection metric in mid-April.

In the past year, DMH has instituted several improvements in the ACT program including raising the rates for ACT services and increasing the capacity to provide ACT services. Current ACT providers include the DC CSA, Pathways to Housing, Family Preservation and Community Connections and Green Door. Community Connections have just recently been certified as ACT providers within the last six months, and Family Preservation will be adding a new ACT team.

(All DCCSA ACT consumers are scheduled to be transitioned to new ACT providers by the end of June 2009).

ACT referrals are also increasing. On September 30, 2008, there were 390 individuals enrolled in ACT; as of March 18, 2009, 473 consumers were enrolled. Referrals generally come from the Core Service Agencies, CPEP, the Homeless Outreach Team, community providers and St. Elizabeths Hospital. The Department is building the resources of the ACT providers into the strategy to provide community services for long-term patients of St. Elizabeths Hospital. The Department convenes a weekly Community Integration Team Meeting, run by the Division of Integrated Care (discussed under Exit Criterion #17) that focuses on those consumers who have been in the hospital and may have barriers or have challenges in returning to the community. Each of these consumers is considered for ACT in addition to any other services that may be needed in order to ease the transition from hospital to community.

The Department has also implemented two ongoing meetings to address ACT issues:

(a) The ACT Stakeholders meeting is held monthly. Its membership includes consumers, family members, advocates, clinicians, ACT Providers, and DMH staff. The advisory committee develops specific recommendations for improving the delivery of ACT services. The group has recently reviewed and subsequently modified referrals and access to ACT services, in order to make the process more efficient. Presently the group is looking at the role of the Peer Review Specialist on the ACT team, and at Supported Employment within Act.

(b) An ACT Providers meeting is also held monthly. Attendees include the Department ACT Program Managers and the ACT team leaders who meet to address ongoing operational issues.

Exit Criterion #14: Children/Youth in Natural Setting.

Required System Performance: 75% of SED with service in natural setting.

DMH Performance: 47.60% as of 2/2/09

Exit Criterion #15: Children/Youth in own (or Surrogate) Home.

Required System Performance: 85% of SED in Own or Surrogate Home

DMH Performance: 94% as of 2/2/09

The data for these two criteria will not be reviewed until DMH achieves 85% on the penetration rate targets established in Exit Criterion #6 for services to children and youth with serious emotional disturbances. As stated earlier in subsection (4), it is anticipated that with the inclusion of the MCO data, DMH will be closer to achieving this goal.

Exit Criterion #17: Demonstrated Continuity of Care Upon Discharge from Inpatient Facilities.

Required System Performance: 80% of Inpatient Discharges Seen Within 7 Days

DMH Performance: 54% as of 12/31/08

Exit Criterion #17 requires that 80% of known discharges from an inpatient psychiatric hospitalization will receive a non-emergency community-based service within seven (7) days. However, according to the national benchmarks, as reported by the National Committee for Quality Assurance for 2008, the Medicaid average for the nation is 42.5%. New England is the highest performing region with a rate of 61.3%[5]. As previously reported, in May, 2008, DMH requested that the Court Monitor modify the performance level required for Exit Criterion #17 to take into the consideration the national data that is now available. The Court Monitor has not agreed to recommend a modification of the Exit Criterion, which raises a concern about the Court's continued exercise of equitable powers to go beyond remedying violations of law to forcing the Department to exceed the highest performing region in the country by almost 20 percentage points, and almost 40 percentage points above the national average.

[5] The 2008 report did not break down the statistics by state, as it had in the 2007 report.

However DMH has made significant enhancements to its ability to provide continuous care to consumers exiting the hospital, primarily through the creation of a new unit at the MHA, the Integrated Care Division ("ICD"). The ICD has several functions including identifying consumers who have complex needs and are not well served or well connected to community providers. The ICD identifies and tracks individuals who have had multiple psychiatric inpatient admissions, multiple admissions to CPEP and episodes of homelessness and incarceration. In addition, the ICD also focuses on individuals discharged from Saint Elizabeths and from the DMH contracted acute inpatient care settings to ensure that they are linked to community providers. The ICD is an integral part of the Department's strategy to better serve individuals most in need and to reduce admissions and length of stay at Saint Elizabeths Hospital by identifying consumers who need a comprehensive array of services that include mental health, non-mental health, and informal supports to integrate to their fullest ability in their communities and families. The ICD is staffed with four (4) masters' level, clinically licensed staff who report to the Director of Integrated Care. By providing authority level care management the goal is to help consumers stay in their communities and with their families to their maximum ability and desire.

The ICD also manages the Integrated Care initiative, a pilot program designed to serve at a minimum thirty (30) long-term Saint Elizabeths patients who are ready to be discharged into the community. Washington Hospital Center was recently awarded the contract to provide 30 patients with intensive supports in every area to assist in their successful discharge.

III. ADDITIONAL DMH PROGRAMS

A. Closure of DCCSA and Transition of Consumers

The closure of the DCCSA and the transition of the current DCCSA consumers to other providers in the community have begun.[6] Based on the DC CSA treatment teams and a records review, DMH determined that as of December 19, 2008, the DC CSA actively serves 4,174 consumers—3,696 adults and 478 children/youth. To ensure that the proper capacity exists, the transition of DC CSA consumers will take place in two phases: 1) transition 2,500 consumers during Fiscal Year 2009, and 2) finalize the transition and close the DC CSA by March 31, 2010. About 650 individuals now served by the DC CSA with unique needs including language access and multicultural requirements; children enrolled in the psychoeducational school program; consumers who are deaf or hearing impaired; consumers with mental illness and mental retardation, and consumers in the outpatient restoration program will be transitioned to the Authority. The Director, DMH, held a number of meetings with consumers, family members and employees of the DCCSA to explain the transition, and letters and flyers have been distributed to consumers, both to their homes of record and at the places of service[7].

Assertive transition activities began this March 2009. DMH has created thirteen (13) Continuity of Care Transition Teams ("CCTT"), ten for transitioning adults and three for transitioning children. The CCTT consists of teams of two people, one credentialed employee and one peer support worker, who are charged with working with identified consumers during the transition to help them both select a new provider and to follow them through the transition to assure that the consumers continue receiving quality mental health services. Consumer Forums were held every Friday to provide an opportunity for consumers to get answers to their questions and talk to their peers. Provider Open Houses occurred in March with more scheduled

[6] Information about the DC CSA transition is available on the DMH website (www.dmh.dc.gov) and is updated frequently for consumers and stakeholders.
[7] *See* Exhibits E –J.

in April to offer consumers an opportunity to visit the various provider agencies to assist in their decision of choosing a new provider.

Consumer / Provider Choice Fairs were scheduled every Tuesday in March and will occur routinely through April and May to offer consumers an opportunity to learn about provider agencies and make their choice of new provider. Four fairs (March 3rd, 10th, 17th and 24th) have occurred to date, with a fifth scheduled for March 31st. As of March 31, 2009, 569 consumers have transitioned out of the DCCSA to new community providers.

To assist the providers who are enrolling DCCSA consumers and therefore need to increase their capacity prior to billing or payments, DMH created the Consumer Transition Voucher ("CTV") through emergency, and anticipated permanent, rule-making. (*See* 22A DCMR 33). DMH will pay a CTV of $787.50 to each DCCSA consumer's new clinical home. This money will assist the provider with the additional staffing, outreach, training or service requirements necessitated by the influx of new consumers.

B. Saint Elizabeths Hospital

(1) Staff Hiring

Saint Elizabeths Hospital ("Hospital") currently has one thousand and six (1006) positions. The Hospital has filled a total of two hundred thirteen (213) positions as of March 15, 2009. Over seventy eight percent (78%) of the filled positions were clinical. Fifty-four (54) positions are vacant, representing a five point three seven percent (5.37%) vacancy rate. Forty-seven (47) of the fifty-four (54) vacant positions are clinical. Nineteen percent (19%) of the fifty-four (54) vacancies are in some stage of the recruitment process, which means that a vacancy announcement has been issued or is in the process of being issued; applications have been received and reviewed; or a tentative selection has been made. Significantly, key

leadership positions have also been filled, including the hiring of a new Director of Medical Services and a Chief Administrative Officer.

(2) Quality of Care Issues

The Settlement Agreement with the Department of Justice ("DOJ") requires the District to submit reports to the DOJ on a regular basis regarding the current status and projected completion date of each provision of the Agreement. The most recent Saint Elizabeths Hospital Assessment as of March 2, 2009 is available at www.dmh.dc.gov and is incorporated by reference due to its large size.

The report documents many improvements at the hospital and identifies the challenges to staying apace the ambitious three (3) year plan. DOJ is currently conducting its bi-annual assessment this week, March 30 through April 3, with a report to follow within 60 days.

(3) Hospital Information System

DMH successfully implemented Phase I of the transition to the new electronic record management system at Saint Elizabeths Hospital (Avatar) on July 22, 2008. Phase I of implementation includes data on admission, discharge, pharmaceuticals, and laboratory services. Implementation activities included training three hundred sixty-nine (369) hospital employees and installing more than one hundred forty four (144) computers and twenty two (22) printers. Phase II of the implementation will integrate clinical assessments, treatment planning, and case notices into the Avatar system beginning in spring 2009.

(4) Construction of New Saint Elizabeths Hospital Building

The new hospital is now at 90% completion, and it is expected to be fully complete by September, 2009, with all inspections completed in the fall of 2009. Move-in will occur in February, 2010. The new hospital will satisfy the DOJ requirement to improve the

environmental conditions at the hospital, including safety, sanitary conditions, and accessibility. A copy of the February 2009 construction status report prepared by Gilbane, the construction manager, is attached and marked as Exhibit K. In addition, monthly construction full color pictorial updates are available at the Department's website, www.dmh.dc.gov.

(5) Implementation of Saint Elizabeths Hospital Discharge Plan

As previously reported, DMH initiated work on the Saint Elizabeths Discharge Plan on January 2, 2007. As of February 28, 2009, four hundred seventy five (475) consumers have been discharged from Saint Elizabeths Hospital through this initiative. Between November 2008 and February 2009, fifty-seven consumers were discharged with Hospital Discharge support provided by the new Integrated Care Division, discussed above. The Integrated Care Contract recently signed with Washington Hospital Center will target 30 long-term residents at Saint Elizabeths that have been difficult to place in the community and provide intensive wrap-around services to increase likelihood of community integration. *See* Exit Criterion 17, *supra*.

(6) Use of Acute Care Beds as Alternatives to Saint Elizabeths Hospital

Acute admissions to Saint Elizabeths have steadily declined over the past five years. (*See* Exhibit L, Admissions to St. Elizabeths by Fiscal Year). In FY 05, a total of 607 individuals were admitted to St. Elizabeth's Hospital; in FY 06, 569 were admitted, and in FY 07, only 289 people were admitted (out of a total of 632 admissions through DMH). The DMH has contracts with three community hospitals to provide acute care services: United Medical Center ("UMC") (formerly Greater Southeast Community Hospital); Providence Hospital; and the Psychiatric Institute of Washington. UMC can accommodate 30 acute consumers at one time, and Providence can accommodate 14. It is also expected that emergency admissions overall will decrease, as the newly-formed Integrated Care Division identifies those consumers who have

frequent admissions, and provides them with intensive care management to enable them to have greater success in the community. DMH continues to advocate for amendments to the Ervin Act to eliminate the statutory requirements that have deterred community hospitals from accepting acute involuntary patients. Those proposed amendments are currently being reviewed by the Office of Legal Counsel at OAG.

C. FY 10 Budget

Mayor Fenty submitted his proposed FY 2010 Budget to the Council of the District of Columbia on March 20, 2009. A copy of DMH's proposed budget is attached and marked as Exhibit M. Overall, the proposed FY 2010 Budget is 5.1% less than the approved FY 2009 Budget. Changes include the planned reduction in full-time equivalent employees resulting from the closure of the DC CSA, as well as a number of cost-saving initiatives outlined on pages E-43 and E-44 of the budget. Savings will be recognized in administrative and other efficiencies that are not expected to have an impact on services to consumers.

D. Comprehensive Crisis Emergency Services

DMH now has crisis emergency services for both adults and children. The Mobile Crisis Services, based at CPEP, serves adults and is a DMH-run operation. Mobile Crisis Services began operations on November 1, 2008; as of February 28, 2009, 616 individual consumers have been helped with over 3000 services. The staff consists of 18 members who make up a multidisciplinary team of mental health workers including peer counselors, mental health counselors and specialists, addiction treatment specialists, socials workers and psychiatrists. Team members provide numerous services and respond to individuals throughout the District who are experiencing a psychiatric crisis and are unable or unwilling to travel to receive mental health services. Team members also spend as much time as necessary with consumers to ensure

crisis stabilization and to make appropriate dispositions, and to provide necessary follow-up services. Finally, they also assist with linkages to other services that may be required by the consumer, such as ongoing mental health care, crisis beds, substance abuse detoxification and treatment, and medical care. A minimum of two MCS workers respond to each crisis situation. The teams are split into three shifts and provide coverage from 9 am – to 1 am every day of the year.

Crisis services for children and youth are conducted through contract by Anchor Mental Health Services. "ChAMPS" provides crisis intervention 24 hours a day 7 days a week to any child and family that is experiencing a crisis in the District of Columbia. ChAMPS began operations on October 28, 2008. Over the last two months, ChAMPS is averaging approximately 6-8 calls a day. In partnership with DMH a marketing campaign has been implemented to educate the court, the child serving agencies and the community on accessibility of this new service. ChAMPS has served approximately 239 children since opening on October 28, 2008.

E. Psychiatric Residential Treatment Facility Oversight

DMH continues its leadership of the Subcommittee on Residential Placement Coordination as part of the Mayor's Interagency Collaboration and Services Integration Commission. The subcommittee is charged with, among other things, developing standards for placement decisions for all District children being considered for residential placement. Currently DMH, the Child and Family Service Agency ("CFSA") and the Department of Youth Rehabilitation Services ("DYRS") have a common process that each agency uses for residential placements. By April 9, 2009, DMH will also be talking with DCPS and the MCOs about joining that same process or making modifications as necessary to reach a District-wide protocol

for a residential placement standard. DMH will be the "gate-keeper" for all residential placements from these District entities.

An additional tool which DMH is developing to increase the quality of care that District children receive in these placements is a single quality assessment tool that all agencies can use to assess different residential placement options. This will allow DMH and other District agencies to be unified in their assessments of the residential placements, and create more incentive for those placement settings to improve their quality of care. This tool will be completed by the end of April, 2009.

IV. CONCLUSION

DMH continues to make significant progress in the exit criteria as it improves the system of mental health care to District residents.

Respectfully submitted,

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Exhibit A
DMH Exit Criteria Matrix

DMH Exit Criteria
Status Matrix
PERFORMANCE LEVELS
October 1, 2007 – September 30, 2008

No.	Exit Criteria	Policy In Place	Data Method In Place	DMH Validated Data System	Court Monitor Validated Data System	Status of Monitoring	Court Required Performance Level	Current Performance Level for FY 2008 (10/01/07 – 09/30/08)
1.	Consumer Satisfaction Method(s)	Yes **Policy 115.2**	N.A.	N.A.	N.A.	**Active**	Methods + Demonstrated Utilization of Results	Methods Completed. Evidence of QI cycle pending.
2.	Consumer Functioning Method(s)	Yes **Policy 300.1**	N.A.	N.A.	N.A.	**Active**	Methods + Demonstrated Utilization of Results	Methods Completed. Web-based application installed (02/09); super-user training completed (11/08); notice of training opportunities for provider staff distributed (02/09). Providers expected to begin using application after training. OA collects data during claims and quality audits for FY 08 (beginning 09/08); data will be used to create corrective action plans for providers who are not complying with policy. Data analysis of OA collected data pending.

DMH Exit Criteria
Status Matrix
PERFORMANCE LEVELS
October 1, 2007 – September 30, 2008

No.	Exit Criteria	Policy In Place	Data Method In Place	DMH Validated Data System	Court Monitor Validated Data System	Status of Monitoring	Court Required Performance Level	Current Performance Level for FY 2008 (10/01/07 – 09/30/08)
3.	Consumer Reviews (Adult)	Yes	Yes	Yes	Yes	**Active**	80% for Systems Performance	**FY 08: 74%**[1]
4.	Consumer Reviews (Child)	Yes	Yes	Yes	Yes	**Active**	80% for Systems Performance	**FY 08: 36%** [2]
5.	Penetration (C/Y 0-17 Years)[3]	Yes	Yes	Yes	Yes, as of January 25, 2007, revised April 23, 2008.	**Active**	5%	FY 08 Q1: 1.84 %[4] FY 08 Q2: 1.91 % FY 08 Q3: 1.99 % FY 08 Q4: 1.93 % **Total: 2.84 %**
6.	Penetration (C/Y with SED)	Yes	Yes	Yes	Yes, as of January 25, 2007 revised April 23, 2008.	**Active**	3%	FY 08 Q1: 1.15 %[5] FY 08 Q2: 1.19 % FY 08 Q3: 1.25 % FY 08 Q4: 1.22 % **Total: 1.79 %**

[1] Results from adult community service reviews conducted in June 2008 and reported by Human Systems Outcomes, Inc. in August 2008.
[2] Results from child/youth community service reviews conducted in March 2008 and reported by Human Systems Outcomes, Inc. in May 2008. Final data from the March 2009 review will be reported in the Court Monitor's July 2009 Report.
[3] The penetration rates reported for Exit Criteria 5, 6, 7 and 8 do not include unduplicated consumers who received Medicaid funded services from the four (4) Medicaid managed care organizations (MCOs) under contract with the District of Columbia.
[4] The run date for all claims based data reported for Exit Criteria 5, 6, 7 and 8 was March 24, 2009. All claims-based data is drawn from submitted claims deemed approved for payment by DMH on that date. Providers have up to ninety (90) days from the date of service to submit a claim. In addition, there are claims for services rendered in throughout FY 2008, which were rejected and returned to the provider for correction that may be resubmitted and approved for payment. The final claims submission cut-off for FY 2008 claims is December 31, 2008. Data reported for each quarter may include services provided to consumers in the previous and subsequent quarters. The data reported for the entire fiscal year represents an unduplicated count of consumers. Therefore, the data reported for the entire rolling four quarter period may show a higher percentage of consumers served, than shown in the data reported for each quarter during the period reported.

DMH Exit Criteria
Status Matrix
PERFORMANCE LEVELS
October 1, 2007 – September 30, 2008

No.	Exit Criteria	Policy In Place	Data Method In Place	DMH Validated Data System	Court Monitor Validated Data System	Status of Monitoring	Court Required Performance Level	Current Performance Level for FY 2008 (10/01/07 – 09/30/08)
7.	Penetration (Adults 18 + Years)	Yes	Yes	Yes	Yes, as of January 25, 2007 revised April 23, 2008.	**Active**	3%	FY 08 Q1: 1.71 %[6] FY 08 Q2: 1.75 % FY 08 Q3: 1.79 % FY 08 Q4: 1.76 % **Total: 2.49 %**
8.	Penetration (Adults with SMI)	Yes	Yes	Yes	Yes, as of January 25, 2007 revised April 23, 2008.	**Inactive**	2%	FY 08 Q1: 1.46 % FY 08 Q2: 1.51 % FY 08 Q3: 1.54 % FY 08 Q4: 1.53 % **Total: 2.12 %**[7]
9.	Supported Housing[8]	Yes **Policy 511.1**	Yes	Yes	Yes, as of January 17, 2008.	**Active**	70% Served Within 45 Days	FY 08 Q1: 5.8 % FY 08 Q2: 3.5 % FY 08 Q3: .6 % FY 08 Q4: .6 % **Total: 10.4 %**
10.	Supported Employment	Yes **Policy 508.2**	Yes	Yes	Yes, as of January 17, 2008.	**Active**	70% Served Within 120 Days	FY08 Q1: 88.0 % FY08 Q2: 100.0 % FY08 Q3: 87.0 % FY 08 Q4: 100.0 % **Total: 92.90%**[9]

[5] See footnotes 3 and 4.
[6] See footnotes 3 and 4.
[7] The Court Monitor found that DMH met the performance target for Exit Criterion 8 in his January 2009 report and recommended that this measure move to inactive monitoring status.
[8] DMH currently reports data regarding consumers who are receiving rental subsidies from DMH. DMH is reviewing its other supported housing programs and plans to propose an amendment to this performance measure to the Court Monitor.

DMH Exit Criteria
Status Matrix
PERFORMANCE LEVELS
October 1, 2007 – September 30, 2008

No.	Exit Criteria	Policy In Place	Data Method In Place	DMH Validated Data System	Court Monitor Validated Data System	Status of Monitoring	Court Required Performance Level	Current Performance Level for FY 2008 (10/01/07 – 09/30/08)
11.	Assertive Community Treatment	Yes. **Policy 340.6**	Yes	Yes	In process through the Monitor's consultant	**Active**	85% Served within 45 days of completed referral	FY 08 Q1: 50.0 % FY 08 Q2: 56.6 % FY 08 Q3: 66.6 % FY 08 Q4: 66.6 % **Total: 61.78%**[10]
12.	Newer – Generation Medications[11]	Yes **Policy 311.1**	Yes	Yes	Yes, as of January 25, 2007, revised April 23, 2008.	**Inactive**	70% of adults with schizophrenia receive atypical medications	FY 08 Q1: 90.90 % FY 08 Q2: 90.60 % FY 08 Q3: 90.30 % FY 08 Q4: 89.57 % **Total: 87.10 %**
13.	Homeless (Adults)	Yes **Policy 511.2**	Yes	Yes	Yes, as of December 21, 2007.	**Inactive**	150 Served + Comprehensive Strategy[12]	**Total: 157** [13]

[9] DMH submitted a letter to the Court Monitor on August 8, 2007, requesting that the Court Monitor find that DMH has met the performance target for Exit Criteria #10. Via letter dated October 25, 2008, the Court Monitor denied DMH's request, based on the need to validate the reliability of the data reported and the need to ensure that DMH was following its policy with regard to referrals for supported employment. DMH has instituted a social marketing program and has begun analysis to address the Court Monitor's concern about the system capacity. DMH provided the Court Monitor with a letter describing its social marketing program and explaining its analysis of the overall system capacity on April 15, 2008. The Court Monitor again denied DMH's request via letter dated August 4, 2008. DMH has continued to implement its social marketing program as outlined in the April 15th letter. Discussions with the Court Monitor regarding compliance continue.

[10] The data reported for Exit Criterion #11 was run on March 24, 2009.

[11] The data reported for Exit Criterion #12 was run on March 24, 2009. The Court Monitor found that DMH met the performance target for Exit Criterion 12 in his July 2007 report and recommended that the measure move to inactive monitoring status.

[12] The Court Monitor found that the comprehensive strategy developed by DMH, satisfied the requirements of Exit Criterion 13 and 16 in his January 2009 report.

[13] The data reported for Exit Criterion #13 was run on March 24, 2009. The data reported is only those persons with serious mental illness who received services from Pathways to Housing, which is a "Housing First" provider. The Court Monitor found that DMH met the performance target for Exit Criterion # 13 in his January 2009 report and recommended that the measure move to inactive monitoring status.

DMH Exit Criteria
Status Matrix
PERFORMANCE LEVELS
October 1, 2007 – September 30, 2008

No.	Exit Criteria	Policy In Place	Data Method In Place	DMH Validated Data System	Court Monitor Validated Data System	Status of Monitoring	Court Required Performance Level	Current Performance Level for FY 2008 (10/01/07 – 09/30/08)
14.	C/Y in Natural Setting[14]	Yes **Policy 340.4**	Yes	Yes	Yes, as of January 25, 2007, revised April 23, 2008.	**Active**	75% of SED With Service in Natural Setting	FY 08 Q1: 38.56 % FY 08 Q2: 42.20 % FY 08 Q3: 41.08 % FY 08 Q4: 35.67 %[15] **Total: 47.90%**
15.	C/Y in own (or surrogate)[16]	Yes **Policy 340.5**	Yes	Yes	Yes, as of January 25, 2007 revised April 23, 2008.	**Active**	85% of SED in Own Home or Surrogate Home	FY 08 Q1: 97.01 % FY 08 Q2: 97.10 % FY 08 Q3: 94.99 % FY 08 Q4: 95.59 % **Total: 94.15%**
16.	Homeless C/Y	Yes **Policy 511.2**	Yes	Yes	Yes, as of June 5, 2008.	**Inactive**	100 Served + Comprehensive Strategy[17]	**Total: 111**[18]

[14] The data reported by the Court Monitor for Exit Criteria 14 will not be reviewed until DMH achieves 85% of the penetration rate targets established in Exit Criterion 6 for services to children and youth with SED (Exit Criterion #6). Data reported was run on March 24, 2009.

[15] DMH began enforcing the requirement that providers roll-up all claims for same-day services to prepare for the transition to MAA during the fourth quarter of FY 08. Claims for services provided at more than one location are submitted with a location code of 99. The query used to extract data for this Exit Criterion does not include services with a location code of 99. As a result, data about the location of service provision may be under reported. DMH is examining methods for addressing the possible under-reporting.

[16] The data reported by the Court Monitor for Exit Criteria #15 will not be reviewed until DMH achieves 85% of the penetration rate targets established in Exit Criterion 6 for services to children and youth with SED. Data reported was run on March 24, 2009.

[17] See footnote 10.

[18] The data reported is for the period from late January through October 31, 2008. The member of the Homeless Outreach Team assigned to work with children/youth left DMH in May 2007. DMH recently hired a replacement for that staff person, who began employment on January 7, 2008. As a result of the staffing vacancy, data was not collected about services to homeless children and youth for the first quarter of FY 08. The Court Monitor found that DMH met the performance target for Exit Criterion 16 in his January 2009 report.

DMH Exit Criteria
Status Matrix
PERFORMANCE LEVELS
October 1, 2007 – September 30, 2008

No.	Exit Criteria	Policy In Place	Data Method In Place	DMH Validated Data System	Court Monitor Validated Data System	Status of Monitoring	Court Required Performance Level	Current Performance Level for FY 2008 (10/01/07 – 09/30/08)
17.	Continuity of Care[19] a. Adults b. C/Y	Yes **Policy 200.2 Policy 200.2A**	Yes	Yes	Yes, as of November 11, 2007.	**Active**	80% of Inpatient Discharges Seen Within 7 Days	Adults: 54.40 % Children: 50.49 % **Overall: 54.00%**
18.	Community Resources	Yes	Yes	Yes	Yes, as of October 16, 2008.	**Inactive**	60% of DMH Expenses for Community Services	**FY 06: 60.45%**
19.	Medicaid Utilization[20]	Yes	Yes	Yes	Yes, as of December 13, 2007.	**Inactive**	49% of MHRS Billings Paid by Medicaid	**FY 08: 46.7%[21]**

[19] The data reported for Exit Criteria #17 was extracted from eCura on February 2, 2009. Data is reported in the aggregate for the reporting period, since hospital admissions and discharges, as well as services rendered post discharge may cross fiscal year quarters. Refer to footnote 4 for information about the reporting of claims-based data.

[20] DMH submitted a letter to the Court Monitor on January 4, 2008, requesting that active monitoring of Exit Criteria #19 terminate, because DMH has satisfied the performance target. The Court Monitor recommended moving Exit Criteria #19 to inactive monitoring status in his January 2008 report. The plaintiffs counsel agreed with the Court Monitor's recommendation during the February 21, 2008 status hearing.

[21] Data is reported regarding revenue collection for FY 08 as of March 20, 2009. See footnote 4 regarding the reporting of claims-based data.

Exhibit B
Supported Employment

DC DEPARTMENT OF MENTAL HEALTH

Evidence-Based Supported Employment Program

The Department of Mental Health (DMH) provides an evidence-based supported employment program based on Department Policy 508.1, which states supported employment is designed for consumers with significant mental health diagnoses for whom competitive employment has not traditionally been available or for whom competitive employment has been interrupted or intermittent as a result of a significant mental health problem. The evidence-based model incorporates a standardization of supported employment principles, so that evidence-based supported employment can be clearly described, scientifically studied, and implemented. There are six (6) core principles of the evidence-based model of supported employment: 1) competitive employment is the goal; 2) supported employment is integrated with mental health treatment; 3) service eligibility is based on the consumer's choice; 4) consumer preferences are important; 5) job search starts soon after a consumer expresses interests in working; and 6) follow-along supports are continuous. Supported employment involves obtaining a part-time or full-time job in which a consumer receives supports in a competitive employment setting and in which the consumer earns at least minimum wage.

DMH has established a social marketing process to educate clinicians, case workers and consumers about the availability of supported employment services. The social marketing process consists of outreach to providers and consumers, promoting supported employment services through speaking engagements, and training for providers and consumers.

Referrals to supported employment come from a variety of sources such as:

- Consumer Self-Referral
- Consumer Referred by Access HelpLine
- Consumer Referred from DMH Programs
- Consumer Referred by Core Service Agency
- Consumer Referred by Community Organization

In FY 08 seven (7) programs provided evidence-based supported employment services funded by the DMH:

- Anchor Mental Health
- Community Connections, Inc.
- D.C. Community Services Agency
- Deaf Reach, Inc.
- Green Door, Inc.
- Pathways To Housing, Inc.
- Psychiatric Center Chartered, Inc.

Once a consumer has been referred to one of the supported employment programs, they participate in a Job Club which helps them to develop an understanding of the world of work and the things they will need to do to maintain a job.

While participating in a Job Club consumers are assigned to an Employment Specialist, who will work one-on-one with the consumer to identify job interests, create a resume and link with the DC Rehabilitation Services Administration (RSA). RSA will help the consumer obtain and maintain employment by purchasing work related clothing, tools/equipment, provide transportation vouchers, and pay for training or to further the consumer's education.

The Employment Specialist and consumer search for employment based on the consumer's interest and abilities through direct contact with employers, employment websites, and job fairs. A consumer may obtains a job within two weeks to three months, based on the type of job, hours, and pay desired. The Employment Specialist then helps the consumer to maintain the job by providing supports on and off the job.

Supports include ongoing work-based vocational assessments, job coaching, crisis intervention, and development of natural supports for each consumer.
Although follow-along supports are continuous, programs provide the service through a three-tiered level of service intensity. The first tier is a high level of intensity where program staff provides all phases of supported employment when the consumer enters the program and begins to search for a job. The second tier is a medium level of intensity where program staff supports the person on-the-job to help them maintain employment. Once the consumer has maintained employment for six months or longer, program staff place the consumer into the final tier, which is low intensity. At this stage of the program consumers who are successfully working receive follow-up contact on a biweekly to monthly basis through face-to-face meetings on and off the job site, phone calls and emails when possible.

The Supported Employment Dixon Exit Criteria states that 70% of persons referred receive supported employment services within 120 days of a referral. In FY 08 the average was 93.75%. The following table lists the performance indicators for FY08:

Fiscal Year	First Quarter 10/1-12/31/07	Second Quarter 1/1-3/31/08	Third Quarter 4/1-6/30/08	Fourth Quarter 7/1-9/30/08	Total for FYC
Performance Indicator	88%	100%	87%	100%	93.75%
Numerator (Consumers served Within 120 days)	22	27	33	23	105
Denominator (Consumers Referred)	25	27	38	23	113

The Supported Employment Consumer Outcome Table below provides performance outcome data for DMH approved supported employment programs for FY08 and the first quarter of FY09. A successful job placement is defined as a consumer employed for thirty (30) days.

Supported Employment Consumer Outcome Data:

Supported Employment Program	**Number of Consumers Enrolled in Service**		**Number of Consumers Placed in Competitive Employment**		**Average Number of Hours Worked Per Week**		**Average Hourly Wage**	
	FY08	FY09	FY08	FY09	FY08	FY09	FY08	FY09
D.C. Community Service Agency	110	63	32	22	24.0	20.0	$8.00	$8.00
Green Door, Inc.	118	92	70	67	25.5	26.9	$9.79	$9.50
Anchor Mental Health	64	80	35	34	24.0	24.2	$9.42	$10.00
Psychiatric Center Chartered	65	76	47	53	38.4	38.4	$9.55	$9.45
Community Connections	50	85	25	42	23.0	24.0	$9.00	$9.20
Pathways To Housing	41	56	4	9	17.0	19.0	$7.66	$8.10
Deaf Reach, Inc.[1]	29	49	11	9	28.0	28.0	$9.00	$9.00
Total:	**477**	**501**	**224**	**236**	**25.70**	**25.79**	**$8.92**	**$9.04**

Note:

1 Deaf Reach, Inc. provides services to individuals who are deaf and have a mental illness.

Companies That Employ Supported Employment Workers

Through supported employment a wide variety of employers within the private and public sectors have hired individuals with serious mental illness such as:

Home Depot
FedEx
Target
Shoppers Food Warehouse
Starbucks
Georgetown Hospital
Giant Food
Family Dollar
Metro One
Metro Access
Value City
Wal-Mart

Marshall's
Denny's
IHOP
Macy's
AMC Movies
McDonald's
Renta Center
William & Lee Law Firm
Safeway
Aramark
Tindley Sports & Health
Gallaudet University
American University
Hilton Hotel
Double Tree Hotel
California Tortia
Harris Teeter
Sears
K-Mart
Colonial Parking

District Agencies that employ supported employment workers:
Department of Employment Services
DC Public Library

Federal Agencies that employ supported employment workers:
Department of Defense
Department of the Interior
Federal Bureau of Prisons
Government Services Administration

Jobs Held By Supported Employment Workers

Supported employment workers perform many different job duties within the private and public sectors such as:
Administrative Assistant
Office Support Specialist
Customer Service Representative
Mailroom Clerk
Hostess
Security Guard
Grocery Bagger
Construction Helper
Cook
Event Specialist
Custodian
Retail Associate
Executive Assistant
Data Entry Specialist
Front Desk Operator
Movie Theater Clerk

Freight Associate
Sheet Metal Apprentice
Call Center Associate
Child Aide
Kitchen Aid
Laundry Attendant
Limousine Driver
Stock Clerk
Library Assistant
Home Health Aide
Certified Nurse Assistant
Apartment Building Concierge
Tour Bus Coordinator
Liquor Store Clerk
Utility Steward
Recreational Aide

Supported Employment Has Helped Individuals With Serious Mental Illness Work And Live In The Community

Many individuals with serious mental illness have improved their lives by participating in supported employment programs. Here are some examples:

- Consumer #1 is a 28 year old male who isolated himself in his bedroom at his parent's home and refused to interact with family members or people in the community. He enrolled in a supported employment program and with the help of an Employment Specialist obtained a part-time job at a Home Depot store as a Courtesy Clerk. He has been employed at the store for two years and currently works 40 hours per week. He has become very outgoing and through his hard work and dedication to his job, was selected as an employee of the month in 2008. Recently he bought a new car and moved into a new townhouse with his father.

- Consumer #2 is a 41 year old male with substance abuse issues who was homeless for several years. He enrolled in a supported employment program and with the help of an Employment Specialist obtained a job as a Bus Person at an Embassy Suites Hotel. He has been employed at the hotel for eight months working 30 hours per week. In the past, he had worked in the computer field, and now that he has successfully maintained a job, he has decided to go back into the computer field. Currently he's a candidate for a full-time Data Entry job with Pitney Bowles.

- Consumer #3 is a 46 year old male military veteran who was very ill, had been homeless, and had been discharged from several mental health programs due to difficulty in developing working relationships with case managers. A case manager whose friend operated a supported employment program referred the consumer to the supported employment program because the case manager believed the consumer could benefit from getting a job despite the severity of his illness. With the support of an Employment Specialist, the consumer obtained a job at the Pentagon as an Office Support Staff. He has been employed for a year and works 20 hours per week. In addition, now he has his own apartment and lives very independently.

Exhibit C
LOCUS Worksheets

Attachment B

LEVEL OF CARE UTILIZATION SYSTEM VERSION 2000

WORKSHEET

The LOCUS worksheet was originally designed to help the user complete the locus instrument and easily compute a LOCUS score. The worksheet contains each of the dimensions, the five rating levels and a check box for the corresponding rating criteria. Once the composite score is calculated, you can use AACP Level of Care Determination Grid, or the AACP Level of Care Determination Decision Tree, if the computer version is not available to obtain a level of care recommendation.

For information regarding the computer software, contact:
Deerfield Behavioral Health at (814) 456-2457, or on the Internet at http://www.dbhn.com

LOCUS WORKSHEET
VERSION 2000

Rater Name_____ Date_____

Please check the applicable ratings within each dimension and record the score in the lower right hand corner. Total your score and determine the recommended level of care using either the Placement Grid or the Decision Tree.

I. Risk of Harm
- ☐ 1. Minimal Risk of Harm
- ☐ 2. Low Risk of Harm
- ☐ 3. Moderate Risk of Harm
- ☐ 4. Serious Risk of Harm
- ☐ 5. Extreme Risk of Harm

Score _____

II. Functional Status
- ☐ 1. Minimal Impairment
- ☐ 2. Mild Impairment
- ☐ 3. Moderate Impairment
- ☐ 4. Serious Impairment
- ☐ 5. Severe Impairment

Score _____

III. Co-Morbidity
- ☐ 1. No Co-Morbidity
- ☐ 2. Minor Co-Morbidity
- ☐ 3. Significant Co-Morbidity
- ☐ 4. Major Co-Morbidity
- ☐ 5. Severe Co-Morbidity

Score _____

IV-A. Recovery Environment - Level of Stress
- ☐ 1. Low Stress Environment
- ☐ 2. Mildly Stressful Environment
- ☐ 3. Moderately Stressful Environment
- ☐ 4. Highly Stressful Environment
- ☐ 5. Extremely Stressful Environment

Score _____

IV-B. Recovery Environment - Level of Support
- ☐ 1. Highly Supportive Environment
- ☐ 2. Supportive Environment
- ☐ 3. Limited Support in Environment
- ☐ 4. Minimal Support in Environment
- ☐ 5. No Support in Environment

Score _____

V. Treatment and Recovery History
- ☐ 1. Full Response to Treatment and Recovery Management
- ☐ 2. Significant Response to Treatment and Recovery Management
- ☐ 3. Moderate or Equivocal Response to Treatment and Recovery Management
- ☐ 4. Poor Response to Treatment and Recovery Management
- ☐ 5. Negligible Response to Treatment

Score _____

VI. Engagement
- ☐ 1. Optimal Engagement
- ☐ 2. Positive Engagement
- ☐ 3. Limited Engagement
- ☐ 4. Minimal Engagement
- ☐ 5. Unengaged

Score _____

Composite Score ☐

Level of Care Recommendation ☐

Exhibit D
DHCF/DMH Memorandum of Understanding

Memorandum of Understanding
Between
The undersigned District of Columbia Agencies:

The Department Of Health Care Finance (DHCF)
And
The Department of Mental Health (DMH)
For Implementation of DHCF's Solicitation Number DCHC-2007-R-5050

I. INTRODUCTION

This Memorandum of Understanding ("MOU") is entered into between the Department of Health Care Finance ("DHCF") and the Department of Mental Health ("DMH"). This MOU establishes the duties, rights and responsibilities of each signatory agency with respect to enrollees in the District of Columbia ("District") Medicaid and D.C. HealthCare Alliance Managed Care Programs ("MCP") and the operational procedures to carry out those duties, rights and responsibilities. This MOU is the result of DHCF's procurement under Solicitation Number DCHC-2007-R-5050 and the resulting Contract, including all amendments and modifications, (herein after the "Contract") that DHCF has entered into with the selected Managed Care Organizations (MCOs) referred to herein as "Contractors" or "MCOs."

II. AUTHORITY

The legal authority for this MOU is set forth in section C.10.11.1.5 of the Contract.

III. OVERVIEW OF THE PARTIES

DHCF is the single state agency responsible for administering Title XIX of the Social Security Act (Medicaid, see 42 U.S.C. § 1396). DHCF also administers DC HealthCare Alliance program. DHCF develops eligibility, coverage, and payment policies for the Medicaid and Alliance programs, oversees the MCOs that provide health services to program Enrollees, facilitates, supports and/or coordinates the delivery of covered services by other District agencies, ensures that the MCP is compliant with all federal and District laws and regulations, works to ensure that the District fully utilizes federal funding for covered Medicaid services,[1] and analyzes new and existing federal and District health care delivery and financing policies to ensure that they promote efficient, effective, and appropriate health care.

DMH is a Cabinet-level Department that is authorized under D.C. Official Code § 7-1131.03(d). The primary purpose of DMH is to regulate the District's mental health system for adults, children and youth and their families, and provides mental health services directly through the Community Service Agency (CSA), (for community-based consumers of mental health services)

[1] The Health Care Finance Administration (previously the Department of Health, Medical Assistance Administration) shall work closely with all District agencies and the Budget Director of the Council of the District of Columbia, in establishing Medicaid rates and Medicaid waiver programs to maximize Federal dollars as a means of reimbursement for services provided by District of Columbia agencies. See, the Department of Health Care Finance Establishment Act of 2007, approved February 27, 2008 (D.C. Law 17-109) .

and St. Elizabeth's Hospital. DMH partners with the Department on Disability Services (DDS), to serve citizens who are in need of both mental health and developmental disability services in accordance with D.C. Official Code § 7-1305.15.

IV. STATEMENT OF PURPOSE

The purpose of this MOU is to establish the terms and conditions under which the parties will assure inter-agency coordination of the delivery of comprehensive and appropriate mental health services for Medicaid and Alliance Enrollees. This MOU is intended to:

1. Ensure that comprehensive and integrated mental health systems of care for Medicaid and Alliance Enrollees are planned, developed, coordinated, delivered and monitored in a timely and effective manner, in accordance with professionally accepted standards of care.

2. Maximize the utilization of mental health services and supports and to ensure that these services are provided by certified providers and are coordinated through each Enrollees' managed care plan;

3. Assure that Medicaid and Alliance managed care Enrollees, District agencies and administrative programs, managed care organizations, and policymakers have timely, complete, and transparent information about health system performance;[2]

4. Support the continued development and routine use of health information technology, including an accurate, complete and timely electronic data reporting system, for the purpose of internal and external planning, management and evaluation; and

5. Promote a strong working partnership between the MCOs and other District agencies and administrative programs serving Medicaid and Alliance managed care Enrollees.

V. SCOPE OF SERVICES

A. DHCF RESPONSIBILITIES

DHCF agrees to the following actions regarding Medicaid Managed Care Enrollees:

1. Work with the MCOs to ensure that the mental health services[3] set forth in Section C.8.2.8.4 of the Contract and Section C.8.2-3 of the Contract as amended by Modification M0001 (See Attachment 1 of this Agreement for specific services) are provided to Medicaid managed care enrollees.

2. Work with MCOs to ensure that care coordination for community-based intervention services, multi-systemic therapy (MST), assertive community treatment (ACT), and

[2] The Contract outlines several ways health system performance is monitored including care coordination utilization reporting requirements as set forth in Section C.10.
[3] Services shall be defined as they are in the Contract unless specifically noted otherwise herein.

community support services provided by DMH as set forth in section B.1 of this section are provided to Medicaid managed care enrollees (Section C.8.2.8.4 of the Contract).

3. Ensure that Contractors' mental health provider network:

   a. Has a sufficient number of appropriately skilled Providers in their network to provide the mental health services set forth in Attachment 1 of this Agreement to Medicaid managed care Enrollees (Section C.9 of the Contract);

   b. Includes DMH's Core Service Agencies (as this term is defined by DMH)[4] (Section C.9.2.8 of the Contract);

   c. Includes a sufficient number of:

      i. Social Workers, including those specializing in treatment of mental health conditions;
      ii. Inpatient psychiatric units for adults;
      iii. Inpatient pediatric psychiatric units;
      iv. Residential treatment facilities;
      v. Care Coordination staff (Section C.9.2.8 of the Contract);

   d. Has the capacity necessary to effectively diagnose, treat and manage individuals dually diagnosed with co-morbidities (Section C.9.2.8.9 of the Contract);

   e. Has the capability to provide assessment and stabilization of psychiatric crises, including those experienced with treating children or adolescents, are available on a twenty-four (24) hour basis, seven (7) days a week, including weekends and holidays (Sections C.8.2-3.1.2.5, C.10.2.4.1.3); and

   f. Has the capability to provide a phone-based assessment within fifteen (15) minutes of request. If, based on level of need or care criteria approved by DHCF an Enrollee requires immediate intervention or face-to-face assessment, this service shall be provided within ninety (90) minutes of completion of the phone assessment. (Section C.9.3.4.6 of the Contract) If the Enrollee does not require immediate intervention, services must be provided in accordance with the standards defined in Section C.9.3 of the Contract or as Medically Necessary.

   g. Mental health services shall be provided by practitioners with appropriate expertise in mental health with on-call access to an adult or child and adolescent psychiatrist (C.9.1.5 and C.9.2.8.1).

[4] See Contract Definitions. See also District of Columbia Official Code Title 7, Chapter 11A ("Department of Mental Health Establishment"), § 7-1131.02 ("Definitions).

4. DHCF shall ensure that Contractors complies with Section C.3.1.8 regarding NCQA accreditation of MCO and concomitant certification standards of network providers.

5. DHCF shall ensure that the travel time/distance to mental health Providers in Contractors' network shall not exceed thirty (30) minutes Travel Time (as defined in the Contract) by public transportation (C.9.3.3).

6. DHCF shall ensure that policies and procedures are developed collaboratively with DMH and Contractors to ensure appropriate referral, communication and coordination of care, sharing of relevant data for treatment, planning and operations, and case management.

7. DHCF shall ensure that Contractors develop and maintain a system to coordinate care for mental health services and supports that are not considered Medicaid managed care covered services. DHCF shall ensure Contractors assist in obtaining non-covered services and shall make necessary referrals for these services (C.10.9).[5]

8. DHCF shall ensure that Contractors prepare, distribute and maintain a directory of all mental health providers. This directory shall include Contractors' Network Providers as well as how Enrollees may access Providers available through other District programs, such as DMH. (Section C. 10.9.2.5 of Contract Modification M0001).

DHCF agrees to ensure that Contractors provide the following actions regarding Alliance Managed Care Enrollees:

1. Provide the following services to Alliance managed care Enrollees, as described in Sections C.8.3 and C.10 of the Contract:

    i. Identification of locations where Alliance Enrollees may receive mental health services (C.10.3.3.3.1.1.1);

    ii. Referrals through the Access Help Line, if needed, for Medically Necessary mental health services, as defined in the Contract;

    iii. Care Coordination, as defined in Section C.10.3.3.3. of the Contract; and

    iv. Coordination with DMH, as defined in Section C.10.3.3.3.1.1.1 of the Contract.

2. Ensure that Contractors develop and maintain a system to coordinate care for mental health services and supports. DHCF shall ensure Contractors assist in obtaining non-covered services and shall make necessary referrals for these services.[6]

[5] See Contract, C.10.3.3.3 Care Coordination for Non-Covered Services for Alliance Enrollees.
[6] See Contract, C.10.3.3.3 Care Coordination for Non-Covered Services for Alliance Enrollees.

DHCF agrees to the following actions regarding DMH:

1. Strengthen communication between Contractors and DMH by working with these parties to clarify the process, procedures and patient information regarding referrals of Enrollees to DMH for services.

2. Collaborate with DMH, to review Contractors' policies and procedures for referrals to DMH based on the District of Columbia Mental Health Rehabilitation Services (MHRS) Referral for Medicaid Managed Care Consumers, and work with Contractors to amend Contractors' policies and procedures as appropriate in collaboration with DMH and Contractors, for: 1) Children; 2) Children identified with Special Health Care Needs; 3) Adolescents; and 4) Adults.

3. Collaborate with DMH to document the referral process and procedures and require Contractors to distribute pertinent information to Enrollees through a Contract modification if necessary.

4. Establish expectations regarding a uniform quality of care by:

    i. Working collaboratively with DMH to develop performance measures to track quality of performance of Core Service Agency providers in caring for Medicaid and Alliance managed care enrollees;

    ii. Working collaboratively with DMH to develop reporting format, and periodicity of performance reports; and

    iii. Working collaboratively with DMH to develop and provide performance report to Enrollees on DMH providers.

5. Utilize the Medicaid definition of Medical Necessity included in the Contract for coverage determinations[7] and reimbursement for Enrollees unless DMH is solely responsible for coverage, in which case, DMH's medical necessity determination shall be used in determination of appropriateness of care (C.1.3.130 and C.8.2.5).

6. Ensure that Contractors expeditiously credential all DMH certified providers who qualify for MCO network inclusion (C.9.4.4).

7. Ensure that Contractors adhere to the following requirements:

    i. Designate a staff person as the contact/liaison person for coordination with DMH (C.10.6.5).

    ii. Reimburse DMH for services MCOs are responsible for under the Contract that are provided by DMH in accordance with the requirements set forth in Section C.11.7 of the Contract.

[7] A new medical necessity standard is currently under development by the Department of Health Care Finance.

iii. Include DMH Core Service Agencies or any other type of MHRS providers that DMH identifies to DHCF from time to time as needing to be included in the MCO network and DHCF directs inclusion in the MCOs provider network (V.A. 3(b) above) (C.9.2.8).

iv. Provide all relevant information related to medical care of Alliance Enrollees to DMH upon request.

v. Cooperate with DMH in developing and submitting additional reports as may be required by DMH including but not limited to reports that are needed to comply with any Court Orders or requests for information about mental health services in reference to DMH's compliance with the requirements of Dixon v Fenty .

8. Collaborate with DMH and Contractors to develop clinical criteria and guidelines for referral of Medicaid managed care Enrollees to a Psychiatric Residential Treatment Facility (PRTF) as follows:

i. In accordance with any relevant laws, policies, procedures, Court Orders, and Mayoral Orders, DMH shall determine with DHCF and Contractors, on a case-by-case basis, Enrollee referral to a PRTF and proposed plan of treatment and evaluation;

ii. DHCF and DMH shall develop a system to resolve disputes between Contractors and DMH; and

iii. Ensure that Contractors are responsible for paying for the first full calendar month (up to sixty days) of residence and treatment in a PRTF after which Enrollee is disenrolled from Contractors' managed care plan. (See Attachment 1, item #12). The cost of care for the Enrollee shall then be paid for under the Medicaid fee-for-service program.

9. Ensure that Contractors share medical records and treatment information of Medicaid and Alliance managed care Enrollees as authorized pursuant to the Health Insurance Portability and Accountability Act (HIPAA) and the District of Columbia Mental Health Information Act of 1978, as amended approved March 3, 1979 (D.C. Law 2-136; DC Official Code §7-1201.01 et *seq*).

10. Ensure that Contractors abide by the terms and conditions of the HIPAA Business Agreement provided by DHCF. (See Attachment 2).

11. Ensure that Contractors assign appropriate staff to participate in meetings sponsored by DMH and DHCF, pertaining to coordination of mental health services and discharge planning (C.16.3).

DHCF agrees to the following actions regarding Contractors:

1. Ensure that Contractors submit to DHCF for review and approval the following:

    i. Criteria and professional standards used for mental health coverage determinations (See Sections C.8.5.1.1, C.10.9.2, and C.10.1.1); and

    ii. All screening tools used by any Network provider for screening mental health issues in children, adolescents and adults.

2. Ensure Contractors receive written authorization from DHCF prior to denial of services that are included in an IEP or IFSP that has been developed in accordance with IDEA.[8]

3. Collaborate with DMH to develop a process that will address quality of care issues related to any providers (including Community Service Agencies) that may arise that MCOs will follow (C.10.9.2.9 of Contract Modification M0001).

4. Notify and educate MCOs regarding the quality of care process development and include in MCO training conducted by DHCF.

DHCF agrees to prepare the following Contract modifications to ensure that Contractors:

1. Submit the following mental health reports to DMH and provide the methodology used to collect the data in support of the reports:

    i. Monthly and Annual Report on Admissions to PRTF, categorized by age and gender for number of in-area admissions;

    ii. Monthly Report on Adolescents discharges and readmitted to PRTF within thirty (30) days of discharge, to residential care and to residential or psychiatric care;

    iii. Monthly Report on Children in other institutional care facilities also reported to DMH and categorized by: 1) Name, identification number, and facility; 2) Primary treatment need, Date of admission, total days to date; 3) Discharge potential; Target discharge date, Date of discharge; 4) Discharge disposition; and 5) Number of out-of-state admissions, by state of placement.

    iv. Twice a year report on number of denied inpatient psychiatric days per one-thousand (1,000) member months, by reason with denial letters sent directly to DMH; and

[8] See RFP in Contract, C.8.2.7.5 Contractors shall furnish EPSDT services to each Enrollee under age 21.

v. Quarterly report on number of Enrollees referred to DMH for mental health services, case management and care coordination services provided by Contractors for each referral.

2. Report to DMH any changes in a provider's credentialing information, including Contractors' refusal to credential or re-credential a provider.

3. Abide by all policies and procedures developed by DHCF and DMH regarding referral, reporting, communication, admission to a PRTF, quality of care and data sharing.

4. Submit the following mental health reports to DHCF:

i. Quarterly report of a GEO Access Map showing participating mental health providers by zip code of office locations and highlighting all providers with less than eighty percent (80%) panel availability.

ii. Report on mental health services utilization, follow-up, and referral for mental health services including:

1. Monthly and Quarterly report on psychiatric inpatient readmissions within thirty (30) days and one hundred eighty (180) days by diagnosis.

2. Monthly and Annual Report on Admissions to Psychiatric Residential Treatment Facilities categorized by age and gender for number of in-area admissions.

3. Monthly Report on Adolescents Discharged and readmitted to PRTF within 30 days of discharge, to residential care and to residential or psychiatric care.

4. Monthly Report on Children in other institutional care facilities categorized by:

a. Name, Identification number, Facility;
b. Primary treatment need, Date of admission, Total days to date;
c. Discharge potential, Target discharge date, Date of discharge;
d. Discharge disposition; and
e. Number of out-of-state admissions, by state of placement.

5. Twice a year report on number of denied inpatient psychiatric days per one-thousand (1,000) Member Months, by reason with denial letters.

6. Quarterly Report on number and identification of Enrollees referred to DMH for mental health services; case management and care coordination services provided by Contractors for each referral.

7. Quarterly Report on Number and percent of children screened for mental health problems (EPSDT report).

8. Annual report on mental health penetration/utilization by number and percent of Enrollees receiving inpatient, intermediate, and ambulatory services (MPT report).

9. Annual report on average length of stay for inpatient admissions.

10. Annual report on mental health expenditures by age, gender, and zip code.

5. Inform DMH when EPSDT, well child services for Alliance or Immigrant Children, or early and preventive periodic/interperiodic exams, reveal evidence of serious emotional disorder in Enrollees.

6. Collaborate with DMH regarding any proposed plans of treatment, evaluations and, to determine on a case-by-case basis, regarding referrals of any Enrollee to a PRTF before a placement is made. DMH shall make the final determination regarding referral and treatment based on a family team meeting convened through DMH's system of care for children.

B. DMH RESPONSIBILITIES

DMH agrees to the following actions:

1. Provide community-based intervention services, multi-systemic therapy (MST), assertive community treatment (ACT), and community support services to eligible Medicaid managed care enrollees.

2. Provide mental health services to Alliance managed care enrollees (as defined in Attachment 1) and work with the Alliance contractor to ensure that each enrollee has a treatment plan.

3. Ensure that medications that are covered under DMH's formulary are not required to be covered by the MCOs.

4. Report to Contractors upon Contractors request, on a monthly basis, utilization data regarding all Medicaid and Alliance managed care Enrollees who have received DMH services, by type and provider of services, date of service, and duration of service.

5. Share all medical records and treatment information related to treatment, planning and operations for Medicaid and Alliance managed care Enrollees with Contractors.

6. Report any changes in provider certification to Contractors.

7. Collaborate with DHCF and Contractors to amend, as necessary, and approve polices and procedures for referral to DMH.

8. Collaborate with DHCF and Contractors to amend, as necessary, and approve polices and procedures regarding the sharing of Enrollees' medical information for treatment, planning and operations.

9. Collaborate with DHCF and Contractors to develop clinical criteria and guidelines for referring all Enrollees to a PRTF.

10. Evaluate and report to DHCF regarding the quality of care and treatment provided at each Medicaid-enrolled PRTF.

11. Ensure that Contractors provide any and all information to DMH regarding quality of care concerns in a PRTF where Contractor has the information related to the care of an Enrollee.

12. Ensure that all medical records, including a discharge plan, are provided to Contractors upon an Enrollee's discharge from a PRTF.

13. Upon DHCF's request, submit to DHCF a report that updates DHCF on the implementation of this MOU and identifies any problems DMH has identified in carrying out this MOU.

14. Participate in interagency meetings convened by DHCF (to include MCOs and CSAs) to be held periodically on a date to be decided by both parties, to discuss issues that arise between DMH, DHCF and the MCOs, including issues that arise as a result of changes in law or regulation.

VI. DATA SHARING

A. Confidentiality

1. The parties to this MOU will use, disclose, restrict, safeguard, and dispose of all information related to services provided under this MOU, in accordance with all relevant Federal and District statutes, regulations and policies.

2. The parties agree that, unless otherwise expressly permitted by this MOU, information about Enrollees shall be considered confidential and shall be protected by DHCF, DMH and the Contractors (See Section C.1.2.1.17, C.1.2.1.39, C.1.2.1.43, and C.16.9).

B. Sharing of Data Between Parties to this MOU.

1. The parties agree that protected health information ("PHI") with respect to Enrollees receiving treatment or services from DMH and the Contractors may be exchanged between the parties for Treatment, Payment and Health Care Operations ("TPO") without an Enrollee's authorization.

2. In the event that information exchanged between the parties is not for TPO, the parties shall execute the attached HIPAA Business Agreement (See Attachment 2) in order to ensure that Enrollees PHI is protected. Parties also agree that PHI received under this MOU will not be used or disclosed in a manner that would violate HIPAA. Information received by either Party in the performance of responsibilities associated with the performance of this MOU shall remain the property of the DHCF.

3. This MOU incorporates by reference the provisions of the Memorandum of Understanding Concerning the Sharing of Student Healthcare Information between several District of Columbia agencies, including the Parties to this MOU. Nothing in this MOU is intended to alter the agreements memorialized in that MOU.

VII. DURATION OF MOU AND TERMINATION

A. The term of this MOU shall be from the date of execution of this MOU and extend through the term of the contract between DHCF and Contractors unless otherwise terminated in accordance with subsection B. below.

B. This MOU shall terminate at any time upon mutual, written agreement of the parties.

C. Agreements reflected in this MOU will be automatically binding on the successor of each signatory to this MOU unless the parties mutually agree to changes in the terms of this MOU.

D. This MOU does not confer any enforceable rights or remedies upon any person other than the parties.

VIII. MODIFICATION

Either Party may initiate discussions regarding modifications to this MOU by giving notice to the other Party at least thirty (30) business days in advance of the proposed date of modification. However, modifications to this MOU shall be incorporated in the form of an amendment dated and signed by the authorized representatives of each of the parties participating in the MOU at the time of the amendment.

IX. RESOLUTION OF DISPUTES [9]

In the event of a dispute, difference of interpretation, or appeal of a decision regarding the terms and/or conditions of this MOU, the aggrieved party shall notify the other party in accordance with the Notice provision contained in Section XI of this MOU. Settlement shall first be sought through a meeting of the Chief Operating Officers (COOs) of each Department, who shall meet not later than ten (10) business days from the Notice of the dispute. If the COOs cannot resolve the dispute, the Directors of each Department that are signatories to this MOU (or representatives designated by the Directors) shall meet within ten (10) business days of the COO's meeting. If the Directors cannot reach a settlement, the aggrieved party shall refer the matter to the City Administrator in writing, whose final determination shall be binding upon the parties.

X. LEGAL COMPLIANCE

The Parties shall comply with all applicable laws, rules, and regulations whether now in force or hereafter enacted or promulgated.

XI. NOTICE

Any notice sent or required to be sent under the terms of this MOU shall be sent or delivered to the Parties to this MOU by delivery to the individuals designated by each Party as contact points under this MOU. The following individuals are the contact points for each Party under this MOU:

Director of Policy
Department of Health Care Finance
825 N. Capitol Street, N.E.
Fifth Floor
Washington, DC 20002

Chief of Staff
Department of Mental Health
64 New York Avenue, NE, 4th Floor
Washington, DC 20002

[9] It will be important to determine if there are areas where the MCOs and/or may have disputes with each agency concerning service delivery to enrollees. Once these potential issues are identified a separate and specific dispute resolution process may be necessary to resolve these disputes.

(202) 673-3538 (office)
(202) 673-3433 (fax)

XII. DEFINITIONS

A. Assertive Community Treatment: Shall have the same definition as set forth in section 3499, Chapter 34 of Title 22A of the District of Columbia Municipal Regulations (DCMR).

B. Community-Based Intervention Services: Shall have the same definition as set forth in section 3499, Chapter 34 of Title 22A DCMR.

C. Community Support Services: Shall have the same definition as set forth in section 3499, Chapter 34 of Title 22A DCMR.

D. Enrollee: Shall have the same definition as set forth in Section C.1.3.80 of the Contract. Any individual enrolled in the District of Columbia's Medicaid or Alliance managed care program.

E. Multi-Systemic Therapy: Shall have the same definition as set forth in section 3499, Chapter 34 of Title 22A DCMR.

F. Payment: Shall have the same definition as set forth in 45 CFR § 164.501.

G. Protected Health Information: Shall have the same definition as set forth in 45 CFR § 160.103.

XII. EFFECTIVE DATE

The MOU shall be effective immediately upon execution of the last signatory.

IN WITNESS WHEREOF, the Parties hereto have executed this MOU as follows:

Department of Health Care Finance

_____ Date: 1/2/09
Name of Agency Director
Director

Department of Mental Health

_____ Date: 12/31/08
Name of Agency Director

ATTACHMENT 1[10]

A. Medicaid Managed Care Enrollees

The Department of Health Care Finance will work with the MCOs to ensure that the mental health services set forth below are provided to Medicaid managed care Enrollees:

1. Care Coordination and Case management for Enrollees receiving the following services from DMH (Section C.8.2.8.4 of the Contract) :

    a. Community-Based Interventions
    b. Multi-systemic therapy (MST)
    c. Assertive Community Treatment (ACT)
    d. Community Support

2. Services furnished by a network of mental health care Providers, including
    a. Diagnostic and Assessment Services
    b. Physician and mid-level visits, including:
        i. Individual counseling
        ii. Group counseling
        iii. Family counseling
        iv. FQHC services

3. Medication/Somatic Treatment.

4. Crisis services, including mobile crisis/emergency services provided by DMH, or Core Services Agencies certified by DMH to provide this service.

5. Inpatient Hospitalization and Emergency Department services.

6. Day Services.

7. Intensive Day Treatment.

8. Case Management services, as described in Section 1915(g)(2) of the Social Security Act and 42 U.S.C. § 1396n(g)(2), for individuals identified by the Department of Mental Health (DMH) as being chronically mentally ill or seriously emotionally disturbed.

9. Inpatient psychiatric facility services for individuals under age twenty-one (21) as described in 42 C.F.R. § 440.160.

[10] Please note, items 2 through 14 are included in Section C.8.2-3 of Contract modification MOOO1.

10. Pregnancy-related services described in 42 C.F.R. §§ 440.210(a)(2), and (3), including treatment for any mental condition that could complicate the pregnancy.

11. Patient Psychiatric Residential Treatment Facility services (PRTF) for individuals less than age 22 years[11].

12. Education regarding how to access mental health services.

13. All mental health services for children that are included in an IEP or IFSP during holidays, school vacations, or sick days from school.

14. Services provided to MCO – enrolled students in school settings to the extent that the following requirements are met:

a. The provider has a Sliding Fee Schedule for billing for children and youth without an IEP;
b. The Provider is credentialed as a network provider by the Contractor;
c. The Provider has an office in the school and provides services in that office; and
d. The Provider bills the MCO for the services using the codes provided by DHCF.

B. Alliance Managed Care Enrollees

DMH shall ensure that the following services are provided to Alliance managed care Enrollees:

1. Rehabilitation Services (as this term is defined the Definition Section and the State Plan) shall be provided to the Alliance managed care Enrollees, including:

a. Diagnostic/Assessment
b. Medication/Somatic Treatment (Individual and Group)
c. Counseling (Individual On-Site, Individual Off-Site, and Group)
d. Community Support (Individual and Group)
e. Crisis/Emergency
f. Day Services
g. Intensive Day Treatment
h. Community-Based Intervention
i. Assertive Community Treatment

[11] The initial placement decision is made by DMH and Contractors shall pay for one full calendar month (up to 60 days). This is subject to any related Mayoral order. See also District of Columbia Official Code Title 7, Chapter 11A ("Department of Mental Health Establishment").

Exhibit E
Consumer Flyer – Stay Informed

Stay Informed

Attend a Consumer Forum to stay informed, get answers to your questions, and talk to your peers.

Consumer Forums are held EVERY FRIDAY

From 10:00 am—12:00 noon

At the DC CSA

1250 U Street, NW, 4th Floor

If you have questions or need help, call the Office of Consumer and Family Affairs. ***(202) 673-4733***

Exhibit F
Easy as ABC flyer

1- 2 - 3 It's as easy as ABC

3 Easy Steps to a New Mental Health Provider

1 Get to know the other mental health providers. Attend a Consumer/Provider Choice Fair for face-to-face meetings.

2 Decide on a new provider who fits your needs. Fill out the Consumer Choice Form or call the Access Helpline at 1-888-793-4357.

3 Make Your Appointment and GO.

If you have questions or need help, call the Office of Consumer and Family Affairs. ***(202) 673-4733***

Exhibit G
Easy as ABC brochure

Stay Informed

Attend a Consumer Forum

When Every Friday, 10 am - 12 noon

Where DC CSA
1250 U Street, NW 4th Floor

Remember

When selecting a new mental health provider:

- It's *Your* Choice.
- Choose the one that fits you.
- You can choose from more than 20 providers.

If you have questions or need help, call the Office of Consumer and Family Affairs.
(202) 673-4733

DC DEPARTMENT OF MENTAL HEALTH

1-2-3
IT'S AS EASY AS
ABC

Three Easy Steps to A New Mental Health Provider

IT'S AS EASY AS ABC

- Step 1. Get to know the other mental health providers.
- Step 2. Decide on a new provider who fits your needs. Fill out a Consumer Choice Form or call the Access Helpline at 1-888-793-4357.
- Step 3. Make Your Appointment and GO.

To help you choose a new mental health provider:

- Attend a Consumer/Provider Choice Fair.
- Attend a Provider Open House to visit their offices and meet their staffs.
- Talk about your options with your doctor, case manager, or treatment team.
- Talk to your peers about where they are getting their services.

Exhibit H
Choice Fair Schedule March 2009

Attend a Consumer/Provider Choice Fair

Learn about your mental health provider options

March 3, 10am—12 noon -- Spring Rd / 3700 10th Street, NW (Paul Robeson)

March 10, 10am—12 noon -- 35 K Street NE

March 10, 6 pm—8 pm -- 821 Howard Road, SE (child/youth providers)

March 17, 10am—12 noon -- St. Elizabeths Hospital Chapel

March 24, 10am—12 noon - - 3849 Alabama Ave, SE

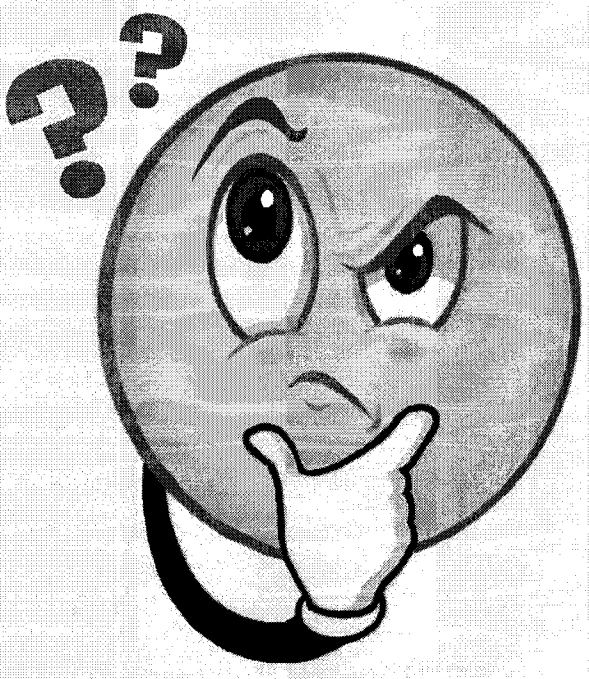
March 31, 6 pm—8 pm - - 1250 U Street, NW (child/youth providers)

Talk to your case manager if you need assistance with transportation to a Consumer / Provider Fair.

If you have questions or need help, call the Office of Consumer and Family Affairs. ***(202) 673-4733***

Exhibit I
How do I choose?

How do I choose a new mental health provider?



- Ask your case manager, doctor or treatment team for help
- Attend a Consumer / Provider Choice Fair to learn about your options
- Attend a Provider Open House
- Talk to your family, friends, and network members for guidance
- Call the Access HelpLine 1-888-793-4357

Exhibit J
Letter to DCCSA consumer 2/1/09

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF MENTAL HEALTH

OFFICE OF THE DIRECTOR

February 10, 2009

Dear DC CSA Consumers, Family Members, Guardians:

The Department of Mental Health has issued its plan to transition consumers served by the DC Community Services Agency (DC CSA) to other mental health providers. Please be assured that no one will lose services because of this transition. And, you will select your new provider. We are planning the transition to take place over the next several months to allow you time to have multiple opportunities to meet with providers face to face and decide which one best fits your needs.

How will you choose a new provider?

- You will have a number of chances to meet with other providers. Provider Fairs will be held every Tuesday in March starting on March 3. The dates are March 3, 10, 17, 24, and 31. They will be held at DC CSA sites and at Saint Elizabeths Hospital. You can get the schedule at any DC CSA office or on the DMH website, www.dmh.dc.gov.
- Providers will hold Open Houses to allow you a chance to see their location and meet their staff. You can also get this schedule at any DC CSA office or on the website.
- Peer support will be available to help you select a new provider. A Peer Support Partner will work with you to ensure a smooth transition.

We will provide transportation to Provider Fairs and Open Houses, if necessary. Please contact your community support worker if you need this service.

Where can you get more information about the transition?

- Talk to your doctor, community support worker or treatment team
- Attend a consumer forum which is held every Friday,10 a.m. to 12 noon, at 1250 U Street NW, fourth floor
- Read flyers, pamphlets and posters about the transition available at all DC CSA sites.
- Call Vivi Smith, Office of Consumer and Family Affairs, (202) 673-4733
- Visit the DMH website www.dmh.dc.gov

We expect that most people will select a new provider by August 1, 2009. I am committed to making this transition as smooth as possible so I encourage you to call Ms. Smith with any concerns you may have.

Sincerely,

Stephen T. Baron
Director

Exhibit K
Feb. 09 St. E New Hospital Report

St. Elizabeth's Hospital Project
Monthly Summary Report

Gilbane

Month/Year: February 2009 Date: 4 March 2009

Construction Manager Summary

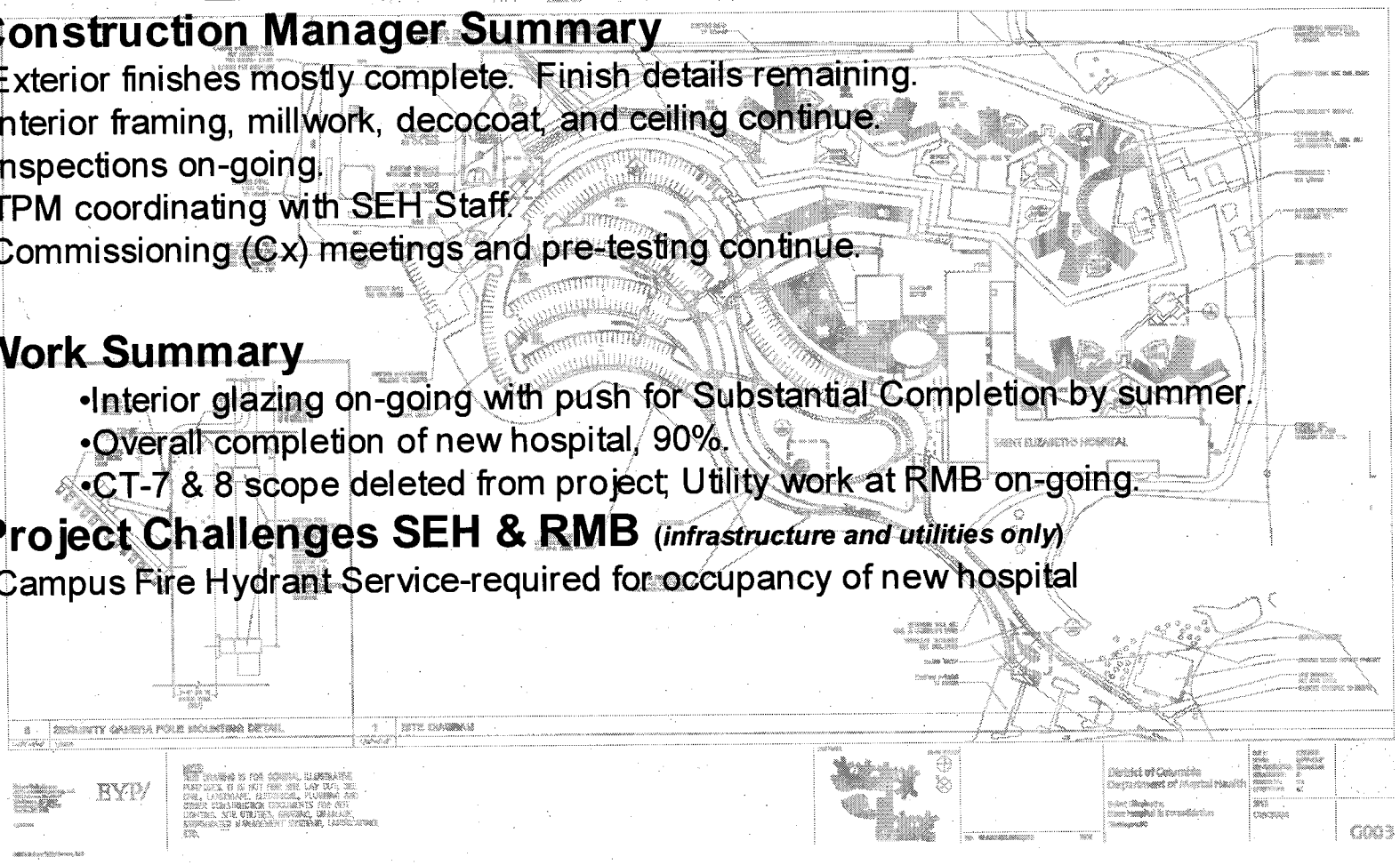
- Exterior finishes mostly complete. Finish details remaining.
- Interior framing, millwork, decocoat, and ceiling continue.
- Inspections on-going.
- TPM coordinating with SEH Staff.
- Commissioning (Cx) meetings and pre-testing continue.

Work Summary

- Interior glazing on-going with push for Substantial Completion by summer.
- Overall completion of new hospital, 90%.
- CT-7 & 8 scope deleted from project; Utility work at RMB on-going.

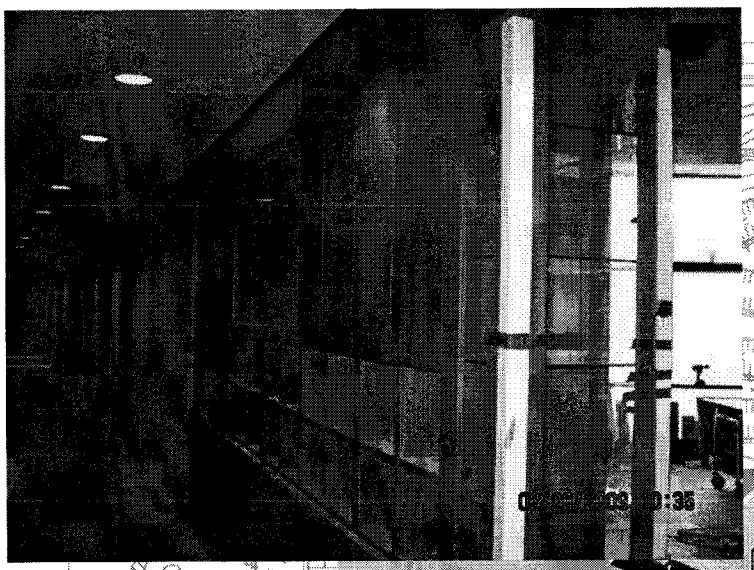
Project Challenges SEH & RMB (*infrastructure and utilities only*)

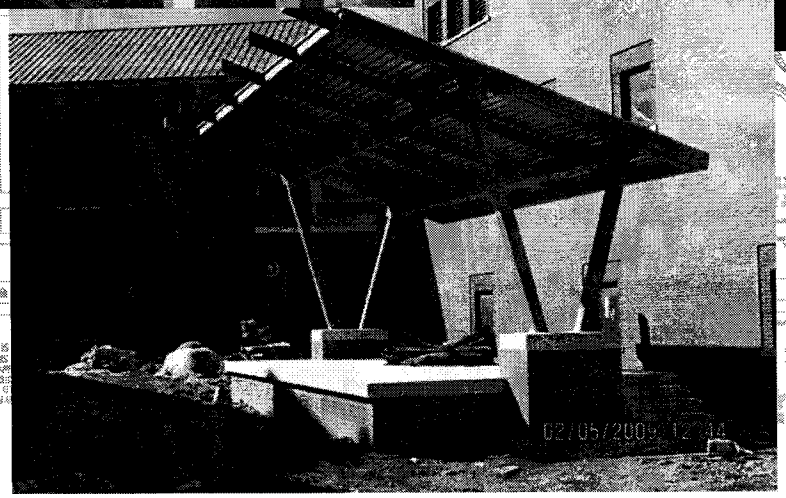
- Campus Fire Hydrant Service-required for occupancy of new hospital



Project Progress Photos

Gilbane





Top Left: Typical Pod Millwork
Above: Museum Stonework
Left: Outdoor Event Stage

Project Controls and Budget Summary

Gilbane

St. Elizabeth's New Hospital

Original Contract Value:	$139,915,510
Approved Changes:	142
Current Contract Amount:	$156,918,913
Pending Changes (OME):	$ 4,184,135
Pending contract Value:	$161,103,048

RMB, CT-7, CT-8

Original Contract Value:	$13,247,000
Approved Changes:	0
Current Contract Value:	$13,247,000
Pending Changes (OME):	$ 0
Pending Contract Value:	$13,247,000

Submittal Update (TBI Submittals)

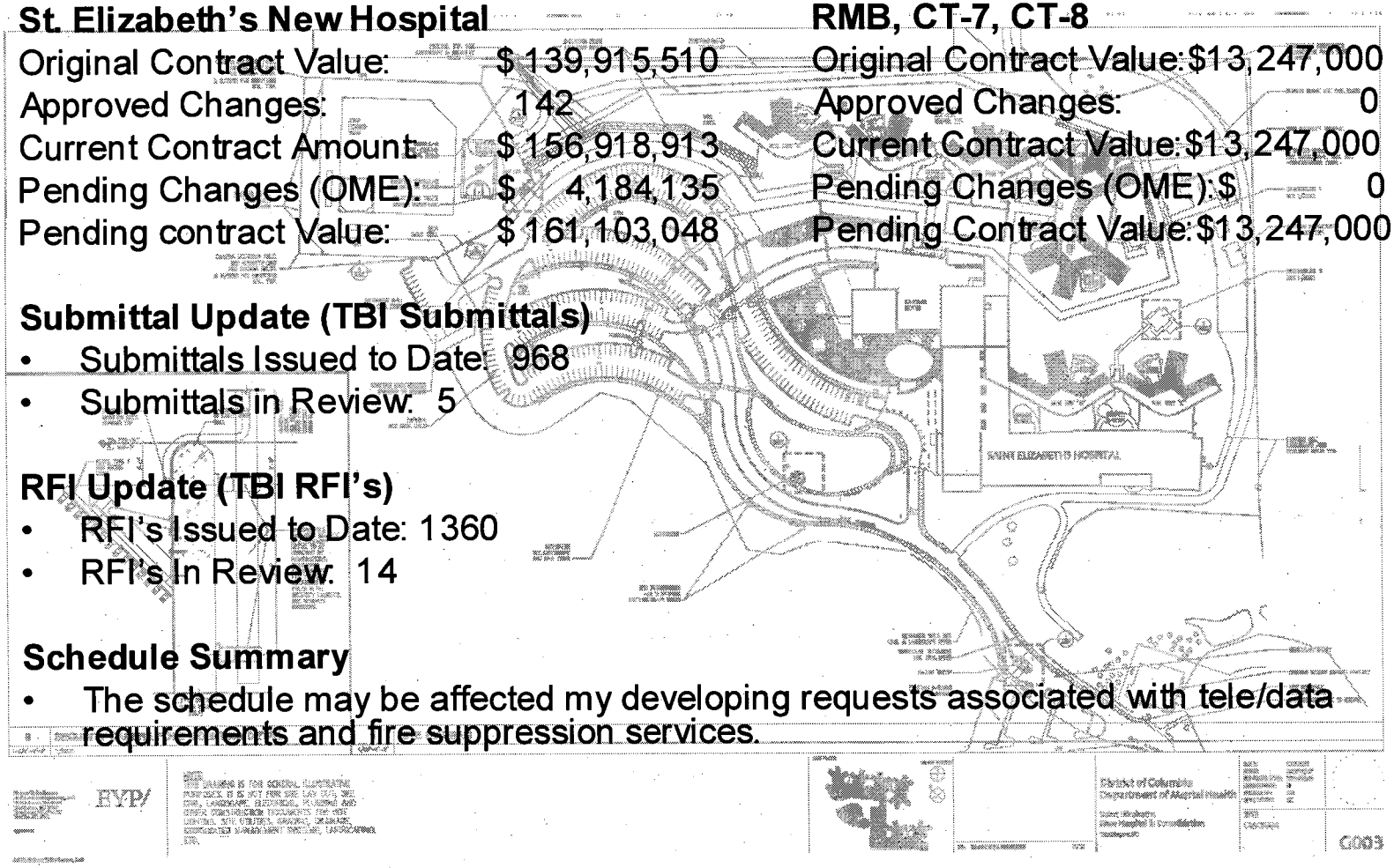
- Submittals Issued to Date: 968
- Submittals in Review: 5

RFI Update (TBI RFI's)

- RFI's Issued to Date: 1360
- RFI's In Review: 14

Schedule Summary

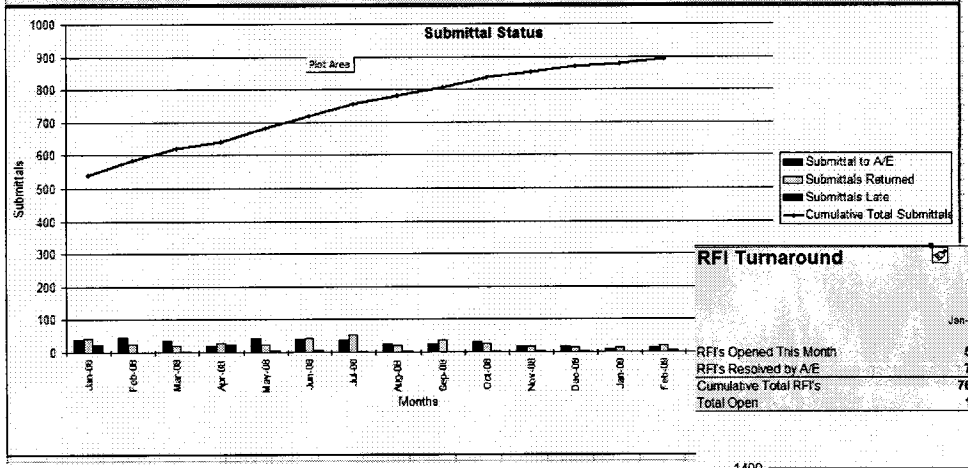
- The schedule may be affected my developing requests associated with tele/data requirements and fire suppression services.



Project Controls Review

Submittals Status — **ST. ELIZABETH'S NEW HOSPITAL** — Project 3207

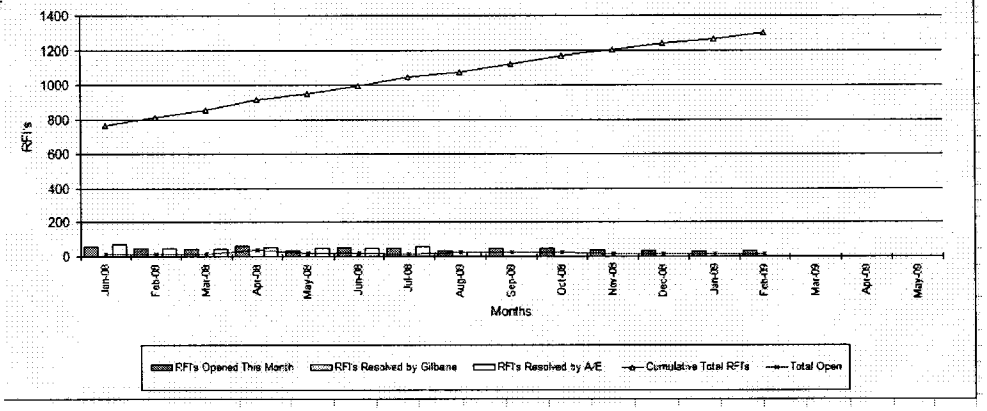
Submittal Turnaround	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09
Submittal to A/E	38	46	36	21	41	38	37	24	24	32	16	18	8	15		
Submittals Returned	43	26	21	29	23	43	54	21	36	24	16	15	15	21		
Submittals Late	22	0	3	22	6	7	3	4	1	2	3	2	1	5		
Cumulative Total Submittals	538	584	620	641	682	720	757	781	805	837	853	871	879	894		



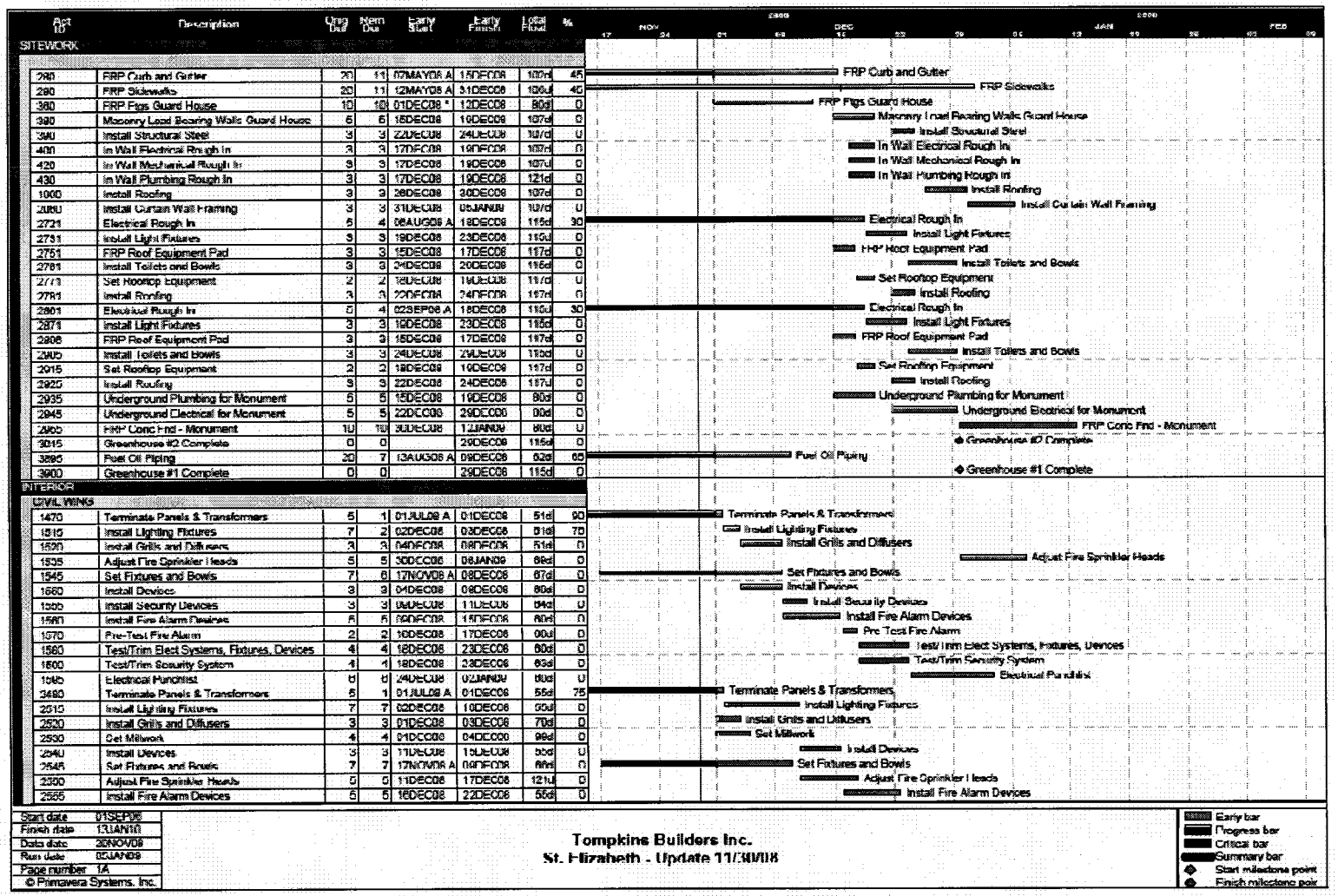
RFI Turnaround — **ST. ELIZABETH'S HOSPITAL** — Project 3207

	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09
RFI's Opened This Month	56	49	40	61	33	50	48	32	45	46	36	34	28	35			
RFI's Resolved by A/E	70	46	41	51	46	49	55	24	42	43	52	29	31	45			
Cumulative Total RFI's	765	814	854	915	948	998	1046	1078	1123	1166	1204	1238	1266	1301			
Total Open	12	16	14	37	21	20	13	24	23	26	13	16	12	14			

Chart 1. RFI Turnaround



Schedule



Act ID	Description	Orig Dur	Rem Dur	Early Start	Early Finish	Total Float	%
SITEWORK							
280	FRP Curb and Gutter	20	11	07MAY08 A	15DEC08	103d	45
290	FRP Sidewalks	20	11	12MAY08 A	31DEC08	126d	40
380	FRP Pigs Guard House	10	10	01DEC08 *	12DEC08	80d	0
390	Masonry Load Bearing Walls Guard House	5	5	15DEC08	19DEC08	107d	0
390	Install Structural Steel	3	3	22DEC08	24DEC08	107d	0
400	In Wall Electrical Rough In	3	3	17DEC08	19DEC08	103d	0
420	In Wall Mechanical Rough In	3	3	17DEC08	19DEC08	107d	0
430	In Wall Plumbing Rough In	3	3	17DEC08	19DEC08	121d	0
1000	Install Roofing	3	3	29DEC08	30DEC08	107d	0
2080	Install Curtain Wall Framing	3	3	31DEC08	05JAN09	107d	0
2721	Electrical Rough In	5	4	08AUG08 A	18DEC08	115d	30
2731	Install Light Fixtures	3	3	19DEC08	23DEC08	115d	0
2751	FRP Roof Equipment Pad	3	3	15DEC08	17DEC08	117d	0
2781	Install Toilets and Bowls	3	3	24DEC08	26DEC08	116d	0
2771	Set Rooftop Equipment	2	2	18DEC08	19DEC08	117d	0
2791	Install Roofing	3	3	22DEC08	24DEC08	107d	0
2801	Electrical Rough In	5	4	02SEP08 A	18DEC08	115d	30
2871	Install Light Fixtures	3	3	19DEC08	23DEC08	115d	0
2886	FRP Roof Equipment Pad	3	3	15DEC08	17DEC08	117d	0
2905	Install Toilets and Bowls	3	3	24DEC08	29DEC08	110d	0
2915	Set Rooftop Equipment	2	2	18DEC08	19DEC08	117d	0
2925	Install Roofing	3	3	22DEC08	24DEC08	107d	0
2935	Underground Plumbing for Monument	5	5	15DEC08	19DEC08	80d	0
2945	Underground Electrical for Monument	5	5	22DEC08	29DEC08	80d	0
2955	FRP Conc Fnd - Monument	10	10	30DEC08	12JAN09	80d	0
3015	Greenhouse #2 Complete	0	0		29DEC08	115d	0
3895	Fuel Oil Piping	20	7	13AUG08 A	09DEC08	62d	65
3900	Greenhouse #1 Complete	0	0		29DEC08	115d	0
INTERIOR							
CIVIL WORKS							
1470	Terminate Panels & Transformers	5	1	01JUL08 A	01DEC08	51d	90
1515	Install Lighting Fixtures	7	2	02DEC08	03DEC08	51d	70
1520	Install Grills and Diffusers	3	3	04DEC08	08DEC08	51d	0
1535	Adjust Fire Sprinkler Heads	5	5	30DEC08	08JAN09	66d	0
1545	Set Fixtures and Bowls	7	6	17NOV08 A	08DEC08	67d	0
1560	Install Devices	3	3	04DEC08	08DEC08	80d	0
1565	Install Security Devices	3	3	04DEC08	11DEC08	94d	0
1580	Install Fire Alarm Devices	5	5	09DEC08	15DEC08	80d	0
1670	Pre-Test Fire Alarm	2	2	16DEC08	17DEC08	90d	0
1580	Test/Trim Elect Systems, Fixtures, Devices	4	4	18DEC08	23DEC08	80d	0
1600	Test/Trim Security System	4	4	18DEC08	23DEC08	89d	0
1660	Electrical Punchlist	5	5	24DEC08	02JAN09	80d	0
2480	Terminate Panels & Transformers	5	1	01JUL08 A	01DEC08	55d	75
2510	Install Lighting Fixtures	7	7	02DEC08	10DEC08	55d	0
2520	Install Grills and Diffusers	3	3	01DEC08	03DEC08	70d	0
2530	Set Millwork	4	4	01DEC08	04DEC08	99d	0
2540	Install Devices	3	3	11DEC08	15DEC08	55d	0
2545	Set Fixtures and Bowls	7	7	17NOV08 A	09DEC08	68d	0
2550	Adjust Fire Sprinkler Heads	5	5	11DEC08	17DEC08	121d	0
2555	Install Fire Alarm Devices	5	5	16DEC08	22DEC08	55d	0

Start date	01SEP08
Finish date	12JAN10
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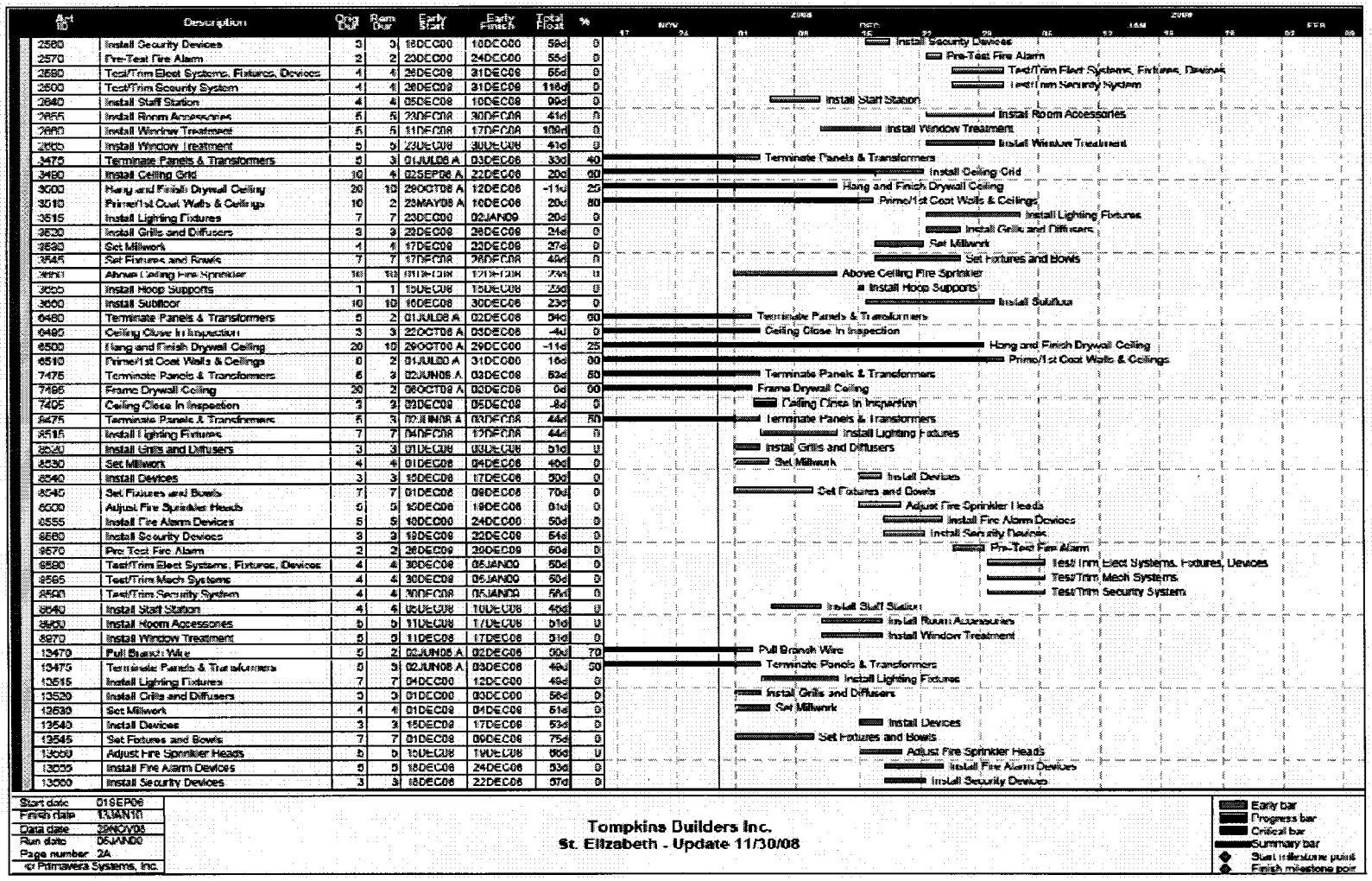
Tompkins Builders Inc.
St. Elizabeth - Update 11/30/08

Early bar
Progress bar
Critical bar
Summary bar
Start milestone point
Finish milestone point

Schedule



Act ID	Description	Orig Dur	Rem Dur	Early Start	Early Finish	Total Float	%
2580	Install Security Devices	3	3	18DEC08	10DEC08	56d	0
2570	Pre-Test Fire Alarm	2	2	23DEC08	24DEC08	55d	0
2590	Test/Trim Elect Systems, Fixtures, Devices	4	4	26DEC08	31DEC08	55d	0
2600	Test/Trim Security System	4	4	26DEC08	31DEC08	118d	0
2640	Install Staff Station	4	4	05DEC08	10DEC08	99d	0
2655	Install Room Accessories	5	5	23DEC08	30DEC08	41d	0
2660	Install Window Treatment	5	5	11DEC08	17DEC08	109d	0
2665	Install Window Treatment	5	5	23DEC08	30DEC08	41d	0
3475	Terminate Panels & Transformers	5	3	01JUL08 A	03DEC08	33d	40
3480	Install Ceiling Grid	10	4	02SEP08 A	22DEC08	20d	60
3000	Hang and Finish Drywall Ceiling	20	10	29OCT08 A	12DEC08	-11d	25
3510	Prime/1st Coat Walls & Ceilings	10	2	23MAY08 A	10DEC08	20d	80
3515	Install Lighting Fixtures	7	7	23DEC08	02JAN09	20d	0
3520	Install Grills and Diffusers	3	3	23DEC08	26DEC08	24d	0
3530	Set Millwork	4	4	17DEC08	22DEC08	27d	0
3545	Set Fixtures and Bowls	7	7	17DEC08	26DEC08	49d	0
3551	Above Ceiling Fire Sprinkler	10	10	01DEC08	12DEC08	25d	0
3555	Install Hoop Supports	1	1	15DEC08	15DEC08	23d	0
3600	Install Subfloor	10	10	16DEC08	30DEC08	23d	0
6480	Terminate Panels & Transformers	5	2	01JUL08 A	02DEC08	94d	60
6485	Ceiling Close In Inspection	3	3	22OCT08 A	03DEC08	-4d	0
6500	Hang and Finish Drywall Ceiling	20	10	29OCT08 A	29DEC08	-11d	25
6510	Prime/1st Coat Walls & Ceilings	8	2	01JUL08 A	31DEC08	16d	80
7475	Terminate Panels & Transformers	5	3	02JUN08 A	03DEC08	83d	50
7485	Frame Drywall Ceiling	20	2	06OCT08 A	03DEC08	0d	90
7495	Ceiling Close In Inspection	3	3	02DEC08	05DEC08	-8d	0
8475	Terminate Panels & Transformers	5	3	02JUN08 A	03DEC08	44d	50
8515	Install Lighting Fixtures	7	7	04DEC08	12DEC08	44d	0
8520	Install Grills and Diffusers	3	3	01DEC08	03DEC08	51d	0
8530	Set Millwork	4	4	01DEC08	04DEC08	46d	0
8540	Install Devices	3	3	15DEC08	17DEC08	30d	0
8545	Set Fixtures and Bowls	7	7	01DEC08	09DEC08	70d	0
8600	Adjust Fire Sprinkler Heads	5	5	15DEC08	19DEC08	31d	0
8555	Install Fire Alarm Devices	5	5	18DEC08	24DEC08	50d	0
8560	Install Security Devices	3	3	18DEC08	22DEC08	54d	0
9570	Pre-Test Fire Alarm	2	2	29DEC08	30DEC08	50d	0
9590	Test/Trim Elect Systems, Fixtures, Devices	4	4	30DEC08	05JAN09	50d	0
9595	Test/Trim Mech Systems	4	4	30DEC08	05JAN09	50d	0
9600	Test/Trim Security System	4	4	30DEC08	05JAN09	50d	0
9640	Install Staff Station	4	4	05DEC08	10DEC08	48d	0
9650	Install Room Accessories	5	5	11DEC08	17DEC08	31d	0
9670	Install Window Treatment	5	5	11DEC08	17DEC08	31d	0
13479	Pull Branch Wire	5	2	02JUN08 A	02DEC08	90d	70
13475	Terminate Panels & Transformers	5	3	02JUN08 A	03DEC08	46d	50
13515	Install Lighting Fixtures	7	7	04DEC08	12DEC08	46d	0
13520	Install Grills and Diffusers	3	3	01DEC08	03DEC08	56d	0
13530	Set Millwork	4	4	01DEC08	04DEC08	51d	0
13540	Install Devices	3	3	15DEC08	17DEC08	53d	0
13545	Set Fixtures and Bowls	7	7	01DEC08	09DEC08	75d	0
13600	Adjust Fire Sprinkler Heads	5	5	15DEC08	19DEC08	86d	0
13555	Install Fire Alarm Devices	5	5	18DEC08	24DEC08	53d	0
13560	Install Security Devices	3	3	18DEC08	22DEC08	57d	0

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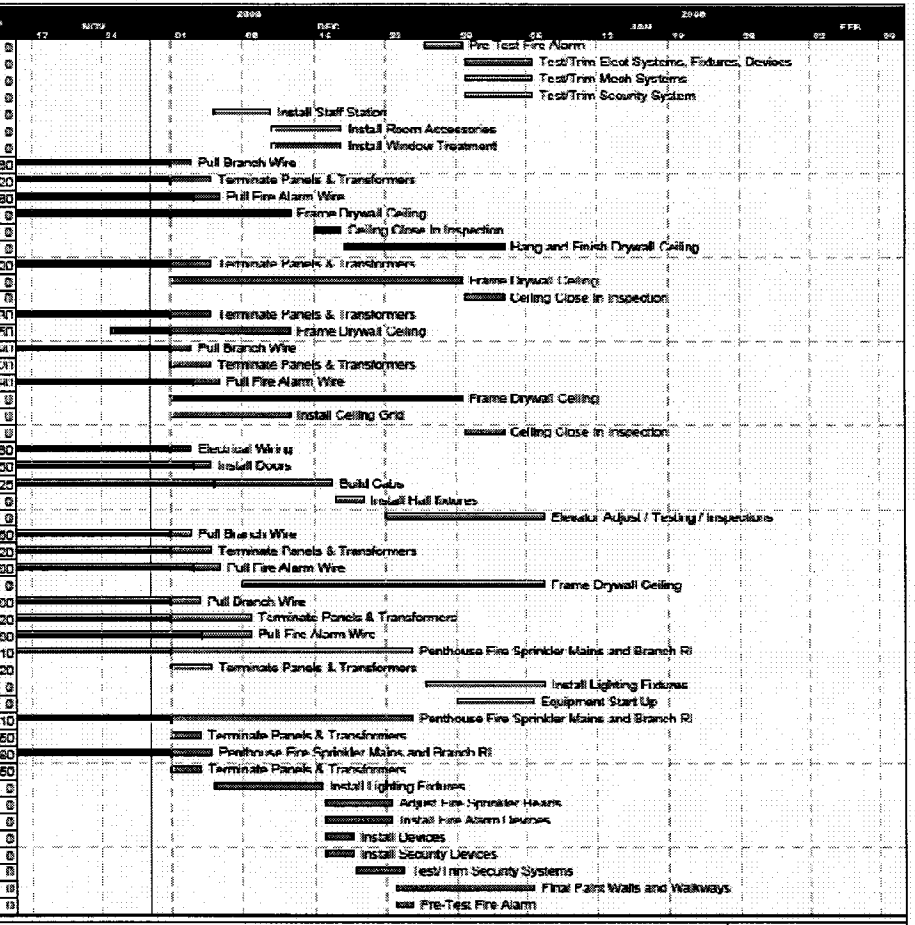
Tompkins Builders Inc.
St. Elizabeth - Update 11/30/08

Early bar
Progress bar
Critical bar
Summary bar
Start milestone point
Finish milestone point

Schedule

Gilbane

Act ID	Description	Orig Dur	Rem Dur	Early Start	Early Finish	Total Float	%
13070	Pre-Test Fire Alarm	2	2	29DEC08	29DEC08	53d	0
13080	Test/Trim Elect Systems, Fixtures, Devices	4	4	30DEC08	05JAN09	53d	0
13085	Test/Trim Mech Systems	4	4	30DEC08	05JAN09	53d	0
13090	Test/Trim Security System	4	4	30DEC08	05JAN09	01d	0
13640	Install Staff Station	4	4	05DEC08	10DEC08	51d	0
13650	Install Room Accessories	5	5	11DEC08	17DEC08	56d	0
13660	Install Window Treatment	5	5	11DEC08	17DEC08	56d	0
14485	Pull Branch Wire	5	2	02JUN08 A	02DEC08	54d	60
14500	Terminate Panels & Transformers	5	4	12JUN08 A	04DEC08	52d	20
14506	Pull Fire Alarm Wire	7	3	02JUN08 A	08DEC08	61d	60
14616	Frame Drywall Ceiling	20	10	20OCT08 A	12DEC08	2d	0
14626	Ceiling Close In Inspection	3	3	15DEC08	17DEC08	2d	0
14630	Hang and Finish Drywall Ceiling	10	10	18DEC08	02JAN09	2d	0
16600	Terminate Panels & Transformers	5	4	02JUN08 A	04DEC08	56d	20
16616	Frame Drywall Ceiling	20	20	01DEC08	26DEC08	2d	0
16626	Ceiling Close In Inspection	3	3	30DEC08	02JAN09	3d	0
17485	Terminate Panels & Transformers	5	4	02JUN08 A	04DEC08	56d	20
17515	Frame Drywall Ceiling	20	10	29NOV08 A	15DEC08	10d	50
21470	Pull Branch Wire	5	2	02JUN08 A	02DEC08	56d	60
21490	Terminate Panels & Transformers	5	4	01DEC08	04DEC08	56d	20
21496	Pull Fire Alarm Wire	7	3	02JUN08 A	05DEC08	63d	60
21499	Frame Drywall Ceiling	20	20	01DEC08	29DEC08	-4d	0
21505	Install Ceiling Grid	10	10	01DEC08	12DEC08	52d	0
21509	Ceiling Close In Inspection	3	3	30DEC08	02JAN09	15d	0
21600	Electrical Wiring	5	2	28JUL08 A	02DEC08	70d	60
21670	Install Doors	3	2	04AUG08 A	04DEC08	70d	50
21675	Build Cabs	10	8	04AUG08 A	16DEC08	70d	25
21680	Install Hall fixtures	3	3	17DEC08	19DEC08	70d	0
21685	Elevator Adjust / Testing / Inspections	10	10	22DEC08	06JAN09	70d	0
23475	Pull Branch Wire	5	2	03MAR08 A	02DEC08	54d	60
23480	Terminate Panels & Transformers	5	4	02JUN08 A	04DEC08	02d	20
23485	Pull Fire Alarm Wire	7	3	02JUN08 A	05DEC08	01d	60
23490	Frame Drywall Ceiling	20	20	08DEC08	06JAN09	-9d	0
20480	Pull Branch Wire	8	3	02JUN08 A	03DEC08	86d	60
20485	Terminate Panels & Transformers	5	0	07JUL08 A	08DEC08	80d	20
20500	Pull Fire Alarm Wire	8	3	02JUN08 A	08DEC08	121d	60
32520	Penthouse Fire Sprinkler Mains and Branch	20	10	22OCT08 A	24DEC08	46d	10
32550	Terminate Panels & Transformers	5	4	01DEC08	04DEC08	35d	20
32560	Install Lighting Fixtures	7	7	26DEC08	06JAN09	46d	0
32590	Equipment Start Up	5	5	29DEC08	05JAN09	20d	0
33520	Penthouse Fire Sprinkler Mains and Branch	20	10	22OCT08 A	24DEC08	46d	10
33550	Terminate Panels & Transformers	5	3	01DEC08	03DEC08	41d	50
34520	Penthouse Fire Sprinkler Mains and Branch	20	1	22SEP08 A	04DEC08	67d	80
34550	Terminate Panels & Transformers	5	3	01DEC08	03DEC08	56d	50
34560	Install Lighting Fixtures	7	7	05DEC08	16DEC08	67d	0
34600	Adjust Fire Sprinkler Heads	5	5	16DEC08	22DEC08	116d	0
34610	Install Fire Alarm Devices	5	5	16DEC08	22DEC08	67d	0
34620	Install Devices	3	3	16DEC08	18DEC08	81d	0
34630	Install Security Devices	3	3	16DEC08	18DEC08	123d	0
34640	Test/Trim Security Systems	3	3	19DEC08	23DEC08	123d	0
34650	Final Paint Walls and Walkways	8	8	29DEC08	06JAN09	116d	0
34660	Pre-Test Fire Alarm	2	2	29DEC08	29DEC08	53d	0



Start date	01SEP08
Finish date	13JAN10
Data date	20NOV08
Run date	05JAN09
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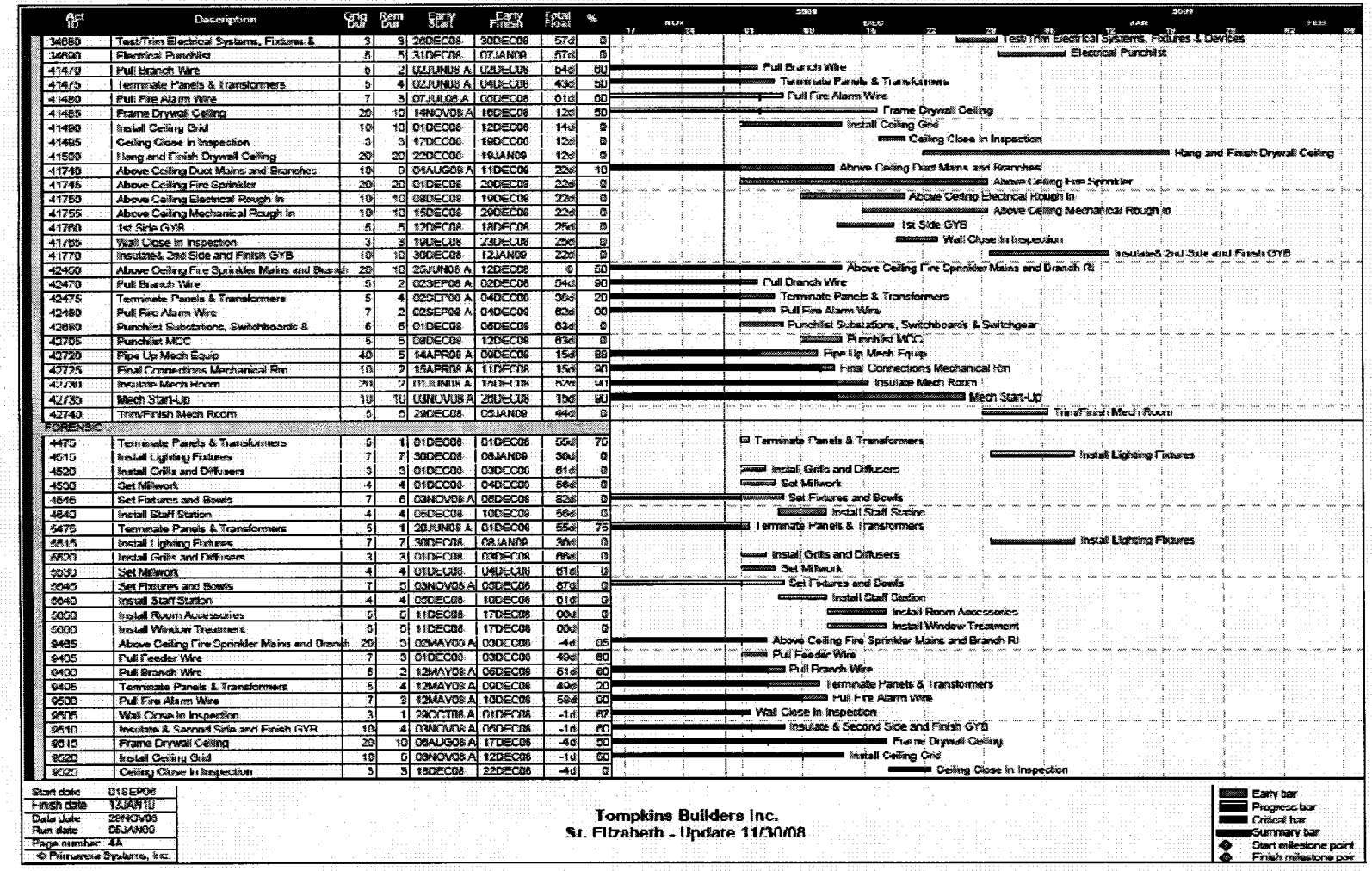
Tompkins Builders Inc.
St. Elizabeth - Update 11/30/08

Early bar
Progress bar
Critical bar
Summary bar
Start milestone point
Finish milestone point

Schedule

Gilbane



Act ID	Description	Orig Dur	Rem Dur	Early Start	Early Finish	Total Float	%
34880	Test/Trim Electrical Systems, Fixtures &	3	3	28DEC08	30DEC08	57d	0
34890	Electrical Punchlist	5	5	31DEC08	07JAN09	57d	0
41410	Pull Branch Wire	5	2	02JUN08 A	04DEC08	94d	60
41415	Terminate Panels & Transformers	5	4	02JUN08 A	04DEC08	43d	20
41420	Pull Fire Alarm Wire	7	3	07JUL08 A	03DEC08	61d	60
41455	Frame Drywall Ceiling	20	10	14NOV08 A	10DEC08	12d	50
41460	Install Ceiling Grid	10	10	01DEC08	12DEC08	14d	0
41465	Ceiling Close In Inspection	3	3	17DEC08	19DEC08	12d	0
41500	Hang and Finish Drywall Ceiling	20	20	22DEC08	16JAN09	12d	0
41740	Above Ceiling Duct Mains and Branches	10	0	06AUG08 A	11DEC08	22d	10
41745	Above Ceiling Fire Sprinkler	20	20	01DEC08	29DEC08	22d	0
41750	Above Ceiling Electrical Rough In	10	10	03DEC08	19DEC08	22d	0
41755	Above Ceiling Mechanical Rough In	10	10	15DEC08	29DEC08	22d	0
41760	1st Side GYB	5	5	17DEC08	19DEC08	25d	0
41765	Wall Close In Inspection	3	3	18JUL08	23JUL08	25d	0
41770	Insulate& 2nd Side and Finish GYB	10	10	30DEC08	12JAN09	22d	0
42400	Above Ceiling Fire Sprinkler Mains and Branch	20	10	25JUN08 A	12DEC08	0	50
42470	Pull Branch Wire	5	2	02SEP08 A	02DEC08	54d	90
42475	Terminate Panels & Transformers	5	4	02OCT08 A	04DEC08	36d	20
42480	Pull Fire Alarm Wire	7	2	03SEP08 A	04DEC08	62d	90
42680	Punchlist Substations, Switchboards &	5	5	01DEC08	05DEC08	83d	0
42705	Punchlist MCC	5	5	08DEC08	12DEC08	83d	0
42720	Pipe Up Mech Equip	40	5	14APR08 A	09DEC08	15d	88
42725	Final Connections Mechanical Rm	10	2	15APR08 A	11DEC08	15d	90
42730	Insulate Mech Room	20	2	01JUN08 A	10DEC08	5d	90
42735	Mech Start-Up	10	10	03NOV08 A	28DEC08	10d	50
42740	Trim/Finish Mech Room	5	5	29DEC08	05JAN09	44d	0
FORENSIC							
4475	Terminate Panels & Transformers	0	1	01DEC08	01DEC08	55d	70
4510	Install Lighting Fixtures	7	7	30DEC08	08JAN09	30d	0
4520	Install Grills and Diffusers	3	3	01DEC08	03DEC08	61d	0
4530	Set Millwork	4	4	01DEC08	04DEC08	58d	0
4545	Set Fixtures and Bowls	7	6	03NOV08 A	08DEC08	82d	0
4640	Install Staff Station	4	4	05DEC08	10DEC08	56d	0
5475	Terminate Panels & Transformers	5	1	20JUN08 A	01DEC08	55d	75
5515	Install Lighting Fixtures	7	7	30DEC08	08JAN09	30d	0
5520	Install Grills and Diffusers	3	3	01DEC08	03DEC08	61d	0
5530	Set Millwork	4	4	01DEC08	04DEC08	61d	0
5545	Set Fixtures and Bowls	7	5	03NOV08 A	05DEC08	87d	0
5640	Install Staff Station	4	4	05DEC08	10DEC08	61d	0
5660	Install Room Accessories	5	5	11DEC08	17DEC08	00d	0
5680	Install Window Treatment	5	5	11DEC08	17DEC08	00d	0
9485	Above Ceiling Fire Sprinkler Mains and Branch	20	3	02MAY08 A	03DEC08	-4d	85
9405	Pull Feeder Wire	7	3	01DEC08	03DEC08	49d	60
9410	Pull Branch Wire	5	3	12MAY08 A	08DEC08	51d	60
9415	Terminate Panels & Transformers	5	4	12MAY08 A	09DEC08	49d	20
9500	Pull Fire Alarm Wire	7	3	12MAY08 A	10DEC08	58d	90
9505	Wall Close In Inspection	3	1	29OCT08 A	01DEC08	-1d	67
9510	Insulate & Second Side and Finish GYB	10	4	03NOV08 A	05DEC08	-1d	60
9515	Frame Drywall Ceiling	20	10	06AUG08 A	17DEC08	-4d	50
9520	Install Ceiling Grid	10	0	03NOV08 A	12DEC08	-1d	50
9525	Ceiling Close In Inspection	3	3	18DEC08	22DEC08	-4d	0

Start date	01SEP08
Finish date	12JAN10
Data date	29NOV08
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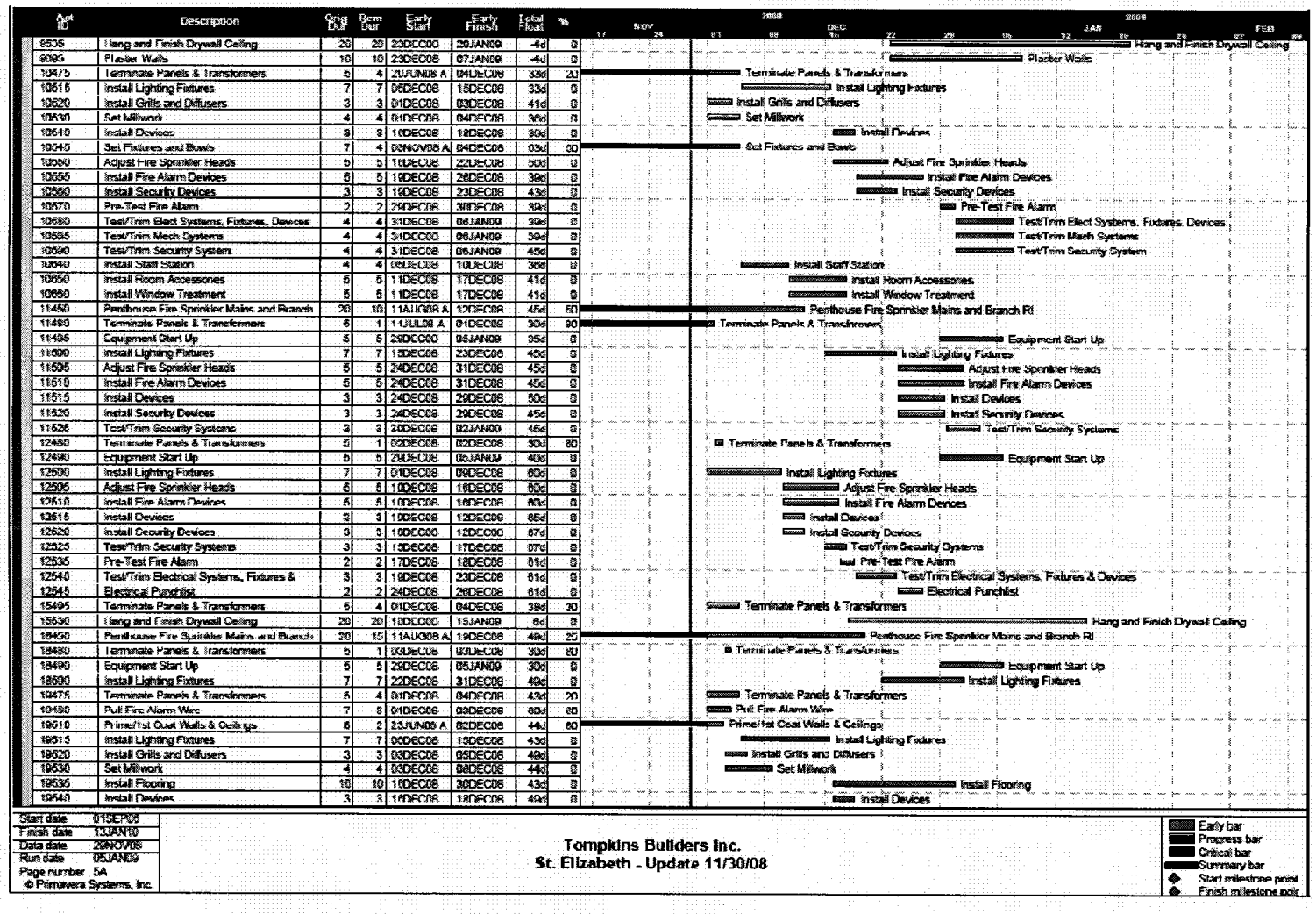
Tompkins Builders Inc.
St. Elizabeth - Update 11/30/08

Early bar
Progress bar
Critical bar
Summary bar
Start milestone point
Finish milestone point

Schedule



Act ID	Description	Orig Dur	Rem Dur	Early Start	Early Finish	Total Float	%
8805	Hang and Finish Drywall Ceiling	20	20	23DEC08	20JAN09	-4d	0
9965	Plaster Walls	10	10	23DEC08	07JAN09	-4d	0
10475	Terminate Panels & Transformers	5	4	20JUN08 A	04DEC08	33d	20
10515	Install Lighting Fixtures	7	7	05DEC08	15DEC08	33d	0
10620	Install Grills and Diffusers	3	3	01DEC08	03DEC08	41d	0
10630	Set Millwork	4	4	01DEC08	04DEC08	34d	0
10640	Install Devices	3	3	16DEC08	18DEC08	30d	0
10645	Set Fixtures and Bowls	7	4	09NOV08 A	04DEC08	03d	80
10650	Adjust Fire Sprinkler Heads	5	5	16DEC08	22DEC08	30d	0
10655	Install Fire Alarm Devices	5	5	16DEC08	26DEC08	36d	0
10660	Install Security Devices	3	3	19DEC08	23DEC08	43d	0
10670	Pre-Test Fire Alarm	2	2	29DEC08	30DEC08	30d	0
10680	Test/Trim Elect Systems, Fixtures, Devices	4	4	31DEC08	06JAN09	30d	0
10685	Test/Trim Mech Systems	4	4	31DEC08	06JAN09	30d	0
10690	Test/Trim Security System	4	4	31DEC08	05JAN09	45d	0
10940	Install Staff Station	4	4	05DEC08	10DEC08	30d	0
10650	Install Room Accessories	5	5	11DEC08	17DEC08	41d	0
10660	Install Window Treatment	5	5	11DEC08	17DEC08	41d	0
11450	Penthouse Fire Sprinkler Mains and Branch	20	10	11AUG08 A	12DEC08	45d	60
11480	Terminate Panels & Transformers	5	1	11JUL08 A	01DEC08	30d	80
11485	Equipment Start Up	5	5	29DEC08	05JAN09	35d	0
11500	Install Lighting Fixtures	7	7	15DEC08	23DEC08	45d	0
11505	Adjust Fire Sprinkler Heads	5	5	24DEC08	31DEC08	45d	0
11510	Install Fire Alarm Devices	5	5	24DEC08	31DEC08	45d	0
11515	Install Devices	3	3	24DEC08	29DEC08	50d	0
11520	Install Security Devices	3	3	24DEC08	29DEC08	45d	0
11525	Test/Trim Security Systems	3	3	29DEC08	02JAN09	45d	0
12480	Terminate Panels & Transformers	5	1	02DEC08	02DEC08	30d	80
12490	Equipment Start Up	5	5	29DEC08	05JAN09	40d	0
12500	Install Lighting Fixtures	7	7	01DEC08	09DEC08	60d	0
12505	Adjust Fire Sprinkler Heads	5	5	10DEC08	16DEC08	60d	0
12510	Install Fire Alarm Devices	5	5	10DEC08	16DEC08	60d	0
12515	Install Devices	3	3	10DEC08	12DEC08	65d	0
12520	Install Security Devices	3	3	10DEC08	12DEC08	67d	0
12525	Test/Trim Security Systems	3	3	15DEC08	17DEC08	67d	0
12535	Pre-Test Fire Alarm	2	2	17DEC08	18DEC08	61d	0
12540	Test/Trim Electrical Systems, Fixtures &	3	3	19DEC08	23DEC08	61d	0
12545	Electrical Punchlist	2	2	24DEC08	26DEC08	61d	0
15495	Terminate Panels & Transformers	5	4	01DEC08	04DEC08	38d	20
15530	Hang and Finish Drywall Ceiling	20	20	18DEC08	15JAN09	6d	0
18450	Penthouse Fire Sprinkler Mains and Branch	20	15	11AUG08 A	19DEC08	48d	25
18480	Terminate Panels & Transformers	5	1	03JUL08 A	03JUL08	33d	80
18490	Equipment Start Up	5	5	29DEC08	05JAN09	30d	0
18500	Install Lighting Fixtures	7	7	22DEC08	31DEC08	40d	0
19475	Terminate Panels & Transformers	5	4	01DEC08	04DEC08	43d	20
19480	Pull Fire Alarm Wire	7	3	01DEC08	03DEC08	60d	60
19510	Prime/1st Coat Walls & Ceilings	5	2	23JUN08 A	02DEC08	44d	60
19515	Install Lighting Fixtures	7	7	09DEC08	15DEC08	43d	0
19620	Install Grills and Diffusers	3	3	03DEC08	05DEC08	40d	0
19630	Set Millwork	4	4	03DEC08	08DEC08	44d	0
19635	Install Flooring	10	10	16DEC08	30DEC08	43d	0
19640	Install Devices	3	3	18DEC08	18DEC08	40d	0

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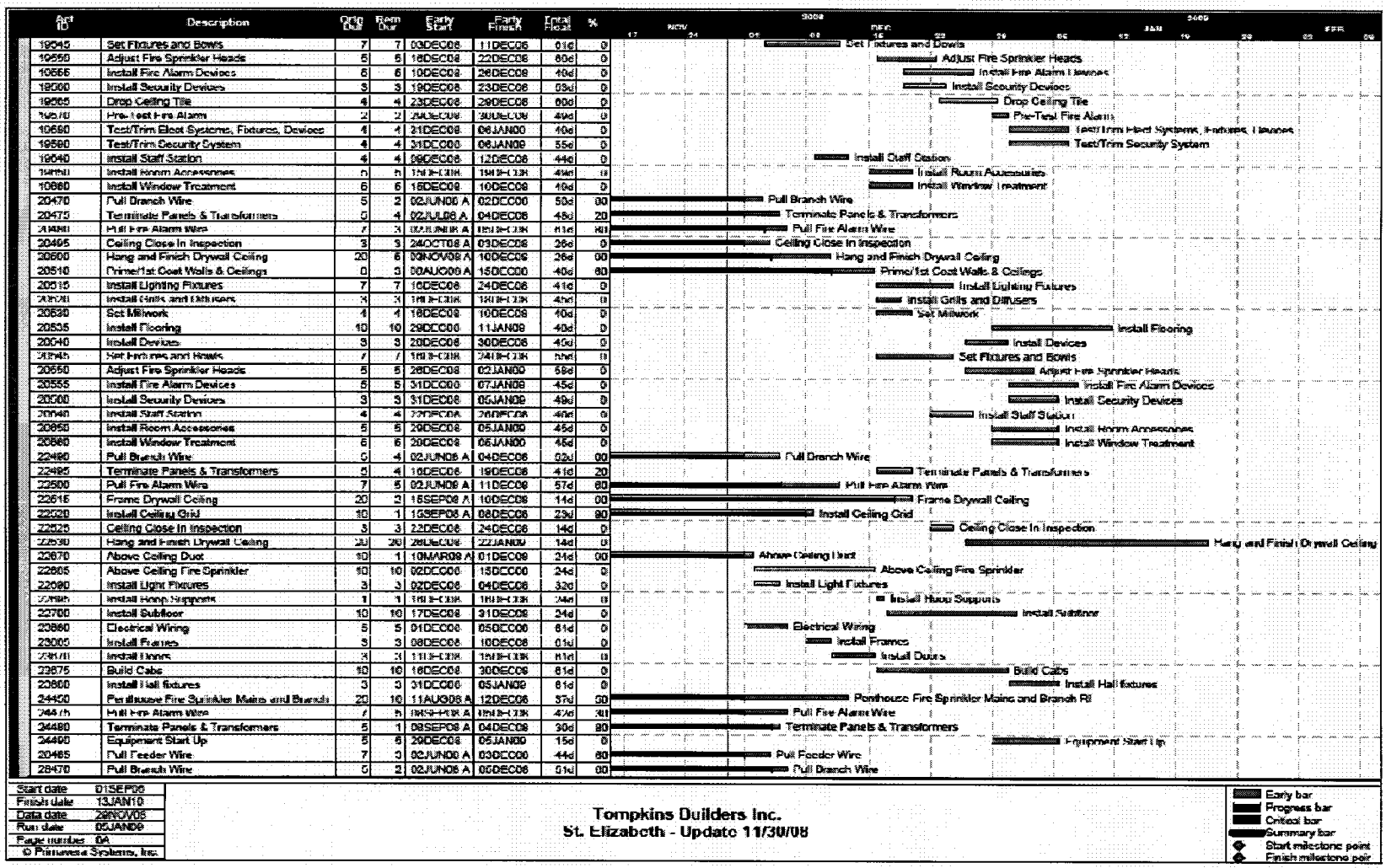

Act ID	Description	Orig Dur	Rem Dur	Early Start	Early Finish	Total Float	%
19045	Set Fixtures and Bowls	7	7	03DEC08	11DEC08	01d	0
19550	Adjust Fire Sprinkler Heads	5	5	18DEC08	22DEC08	80d	0
19555	Install Fire Alarm Devices	5	5	19DEC08	23DEC08	79d	0
19500	Install Security Devices	3	3	19DEC08	23DEC08	03d	0
19565	Drop Ceiling Tile	4	4	23DEC08	29DEC08	60d	0
19570	Pre-Test Fire Alarm	2	2	29DEC08	30DEC08	49d	0
19580	Test/Trim Elect Systems, Fixtures, Devices	4	4	31DEC08	06JAN09	40d	0
19590	Test/Trim Security System	4	4	31DEC08	06JAN09	55d	0
19040	Install Staff Station	4	4	09DEC08	12DEC08	44d	0
19880	Install Room Accessories	5	5	15DEC08	19DEC08	49d	0
19880	Install Window Treatment	5	5	15DEC08	19DEC08	49d	0
20470	Pull Branch Wire	5	2	02JUN08 A	02DEC08	50d	80
20475	Terminate Panels & Transformers	5	4	02JUL08 A	04DEC08	48d	20
20480	Pull Fire Alarm Wire	7	3	02JUN08 A	11DEC08	01d	60
20495	Ceiling Close In Inspection	3	3	24OCT08 A	03DEC08	36d	0
20500	Hang and Finish Drywall Ceiling	20	5	03NOV08 A	10DEC08	36d	00
20510	Prime/1st Coat Walls & Ceilings	0	3	03AUG09 A	15DEC08	40d	80
20515	Install Lighting Fixtures	7	7	10DEC08	24DEC08	41d	0
20520	Install Grills and Diffusers	4	4	16DEC08	19DEC08	40d	0
20530	Set Millwork	4	4	16DEC08	19DEC08	40d	0
20535	Install Flooring	10	10	29DEC08	11JAN09	40d	0
20040	Install Devices	3	3	29DEC08	30DEC08	45d	0
20545	Set Hardware and Hooks	7	7	16DEC08	24DEC08	52d	0
20550	Adjust Fire Sprinkler Heads	5	5	26DEC08	02JAN09	58d	0
20555	Install Fire Alarm Devices	5	5	31DEC08	07JAN09	45d	0
20500	Install Security Devices	3	3	31DEC08	05JAN09	49d	0
20040	Install Staff Station	4	4	22DEC08	29DEC08	46d	0
20850	Install Room Accessories	5	5	29DEC08	05JAN09	45d	0
20860	Install Window Treatment	5	5	29DEC08	05JAN09	45d	0
22490	Pull Branch Wire	5	4	02JUN08 A	04DEC08	02d	00
22485	Terminate Panels & Transformers	5	4	10DEC08	19DEC08	41d	20
22500	Pull Fire Alarm Wire	7	5	02JUN08 A	11DEC08	57d	60
22515	Frame Drywall Ceiling	20	2	15SEP08 A	10DEC08	14d	00
22520	Install Ceiling Grid	10	1	15SEP08 A	08DEC08	23d	90
22525	Ceiling Close In Inspection	3	3	22DEC08	24DEC08	14d	0
22530	Hang and Finish Drywall Ceiling	20	20	26DEC08	22JAN09	14d	0
22670	Above Ceiling Duct	10	1	10MAR08 A	01DEC08	24d	00
22665	Above Ceiling Fire Sprinkler	10	10	02DEC08	15DEC08	24d	0
22090	Install Light Fixtures	3	3	02DEC08	04DEC08	32d	0
22680	Install Hanger Supports	1	1	19JUN08 A	19JUN08	24d	0
22700	Install Subfloor	10	10	17DEC08	31DEC08	24d	0
22860	Electrical Wiring	5	5	01DEC08	05DEC08	61d	0
23005	Install Frames	5	3	08DEC08	10DEC08	01d	0
23010	Install Doors	3	3	11DEC08	15DEC08	61d	0
23675	Build Cabs	10	10	16DEC08	30DEC08	61d	0
22800	Install Hall fixtures	3	3	31DEC08	05JAN09	61d	0
24400	Penthouse Fire Sprinkler Mains and Branch	20	10	11AUG08 A	12DEC08	57d	00
24415	Pull Fire Alarm Wire	7	5	02JUN08 A	11DEC08	43d	60
24480	Terminate Panels & Transformers	5	1	08SEP08 A	04DEC08	30d	80
24490	Equipment Start Up	5	5	29DEC08	05JAN09	15d	0
20465	Pull Feeder Wire	7	3	02JUN08 A	03DEC08	44d	80
28470	Pull Branch Wire	5	2	02JUN08 A	05DEC08	01d	00

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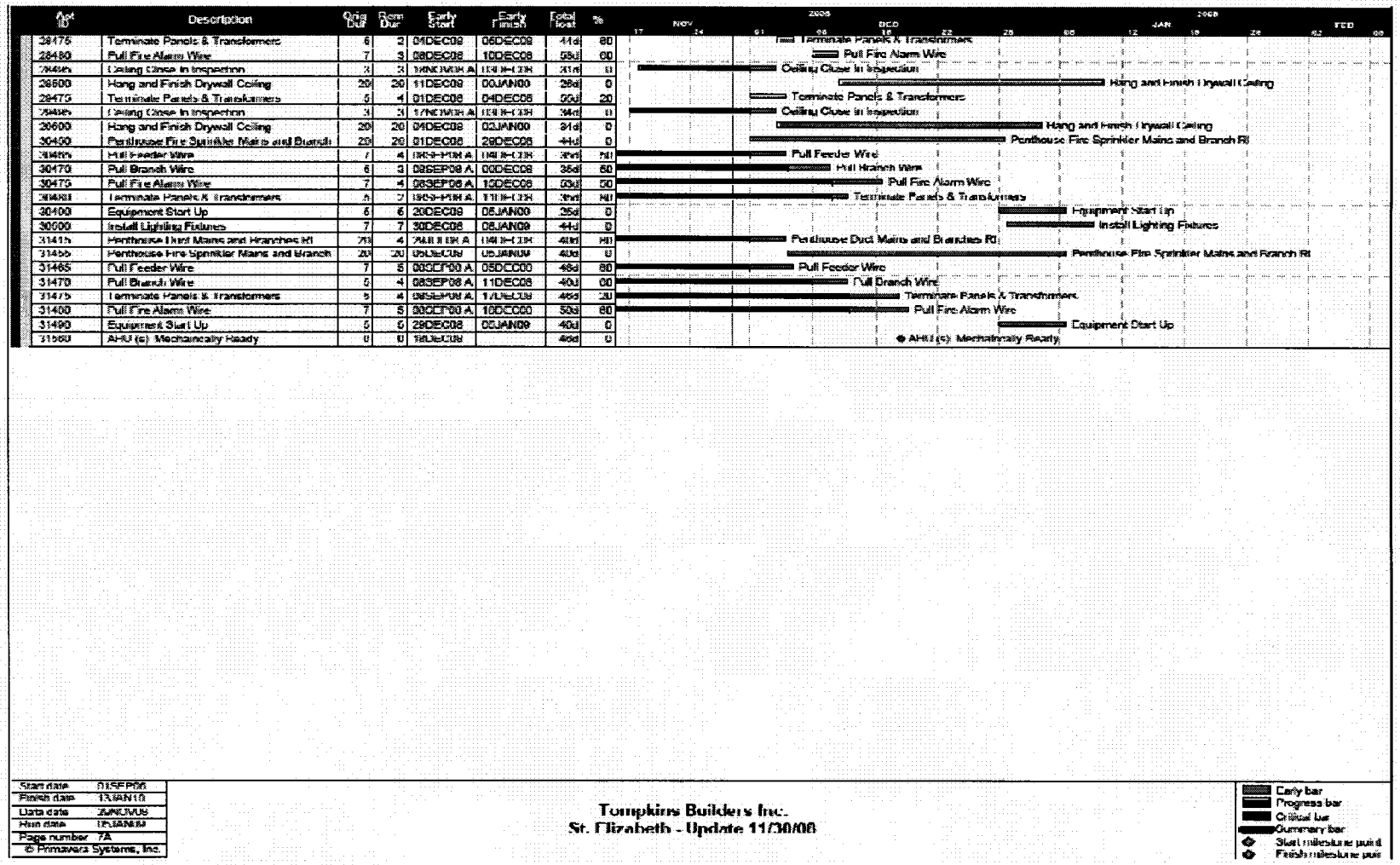

Act ID	Description	Orig Dur	Rem Dur	Early Start	Early Finish	Total Float	%
28475	Terminate Panels & Transformers	6	2	04DEC08	05DEC08	44d	80
28480	Pull Fire Alarm Wire	7	3	08DEC08	10DEC08	58d	60
28485	Ceiling Close In Inspection	3	3	10NOV08 A	12NOV08	31d	0
28500	Hang and Finish Drywall Ceiling	20	20	11DEC08	08JAN09	28d	0
28475	Terminate Panels & Transformers	5	4	01DEC08	04DEC08	50d	20
28485	Ceiling Close In Inspection	3	3	17NOV08 A	19NOV08	24d	0
28500	Hang and Finish Drywall Ceiling	20	20	04DEC08	02JAN09	31d	0
30450	Penthouse Fire Sprinkler Mains and Branch	20	20	01DEC08	29DEC08	44d	0
30465	Pull Feeder Wire	7	4	03SEP08 A	10DEC08	35d	80
30470	Pull Branch Wire	6	3	08SEP08 A	09DEC08	35d	60
30475	Pull Fire Alarm Wire	7	4	08SEP08 A	10DEC08	50d	50
30480	Terminate Panels & Transformers	5	2	10SEP08 A	11DEC08	35d	60
30490	Equipment Start Up	5	5	29DEC08	05JAN09	35d	0
30500	Install Lighting Fixtures	7	7	30DEC08	08JAN09	44d	0
31441h	Penthouse Duct Mains and Branches RI	20	4	25NOV08 A	19DEC08	40d	80
31446b	Penthouse Fire Sprinkler Mains and Branch	20	20	05DEC08	05JAN09	40d	0
31465	Pull Feeder Wire	7	5	03SEP08 A	05DEC08	46d	80
31470	Pull Branch Wire	5	4	08SEP08 A	11DEC08	40d	60
31475	Terminate Panels & Transformers	5	4	08SEP08 A	11DEC08	46d	20
31480	Pull Fire Alarm Wire	7	5	03SEP08 A	10DEC08	50d	60
31490	Equipment Start Up	5	5	29DEC08	05JAN09	40d	0
31560	AHU (s) Mechanically Ready	0	0	18DEC08		46d	0

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Exhibit L
SEH admission by Fiscal Year

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF MENTAL HEALTH

Division of Integrated Care
Office of Programs and Planning

Admissions to St Elizabeth Hospital by Fiscal Year

The Division of Care Coordination began prior authorizing admissions to St Elizabeths Hospital in Fiscal Year 2003 as the first step in many to reduce the number of admissions to St Elizabeths Hospital. The following Charts describe the decrease in the total number of admissions to St Elizabeths over time. As community hospitals began to contract with DMH to provide involuntary inpatient treatment, even greater relief to SEH admissions was achieved and is also reflected in these charts.

Chart 1: Total Number of Admissions to St Elizabeth Hospital by Fiscal Year

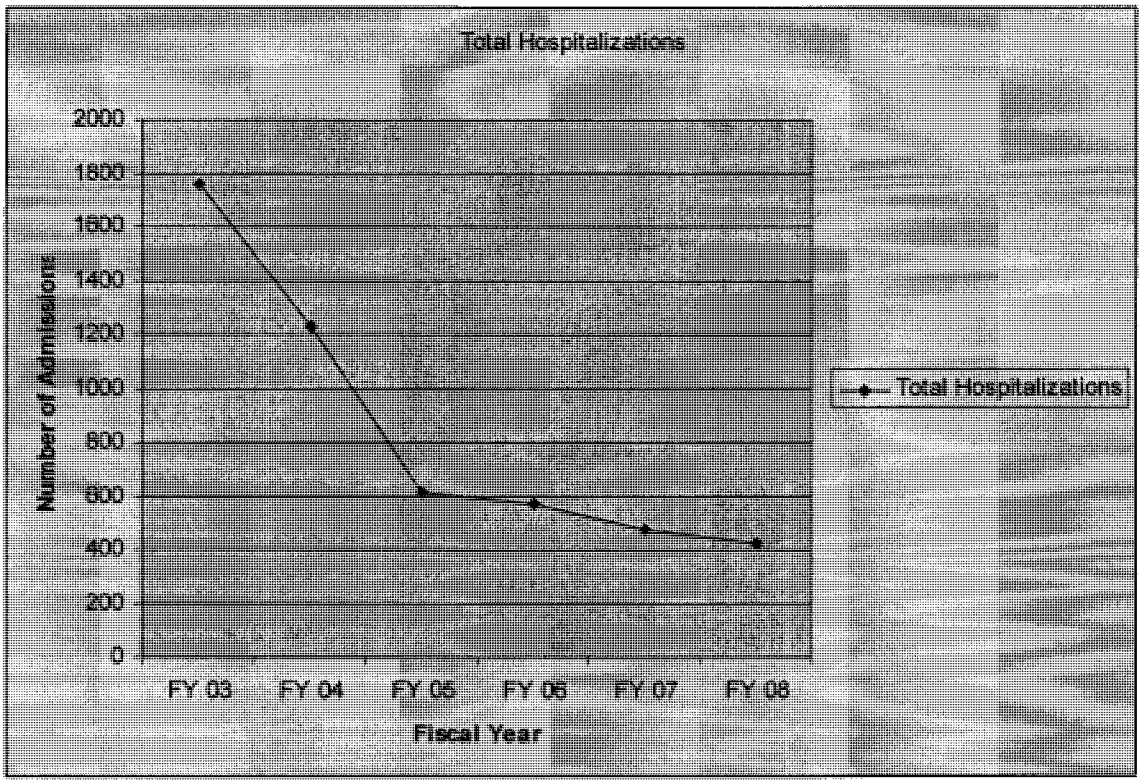


Chart 2: Average Monthly Number of Admissions to St Elizabeths Hospital by Fiscal Year

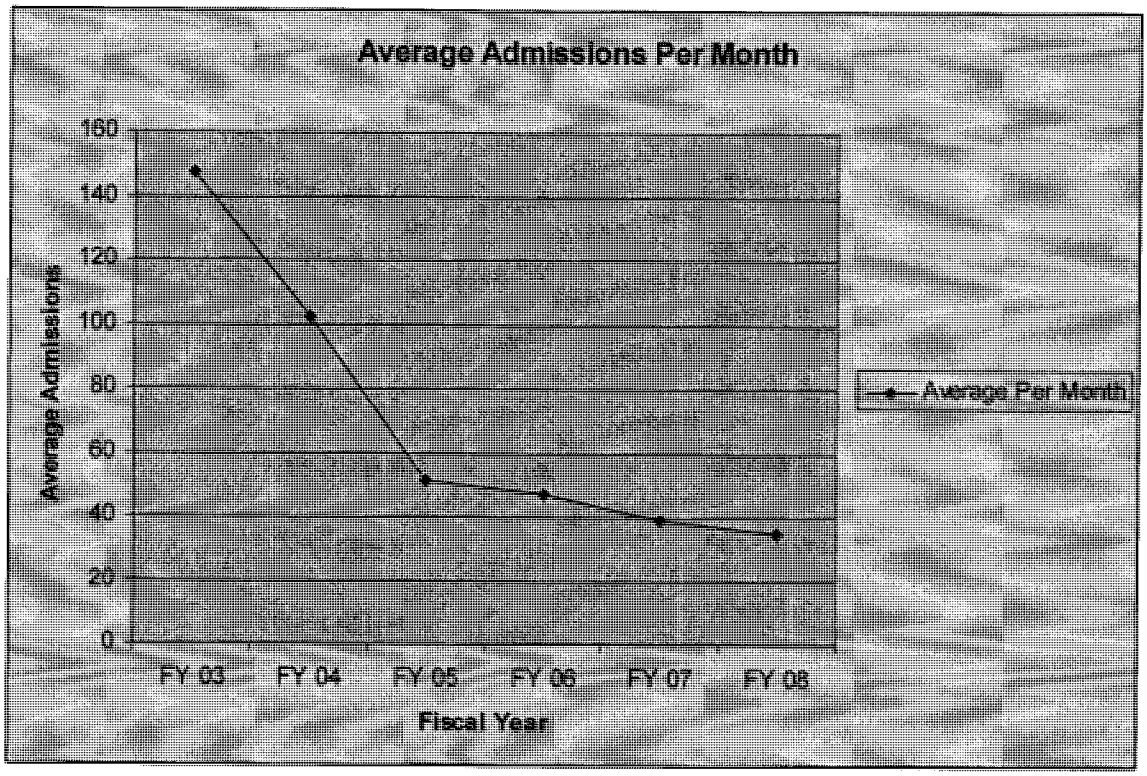


Chart 3: Total Number of Admissions by Facility Type by Fiscal Year

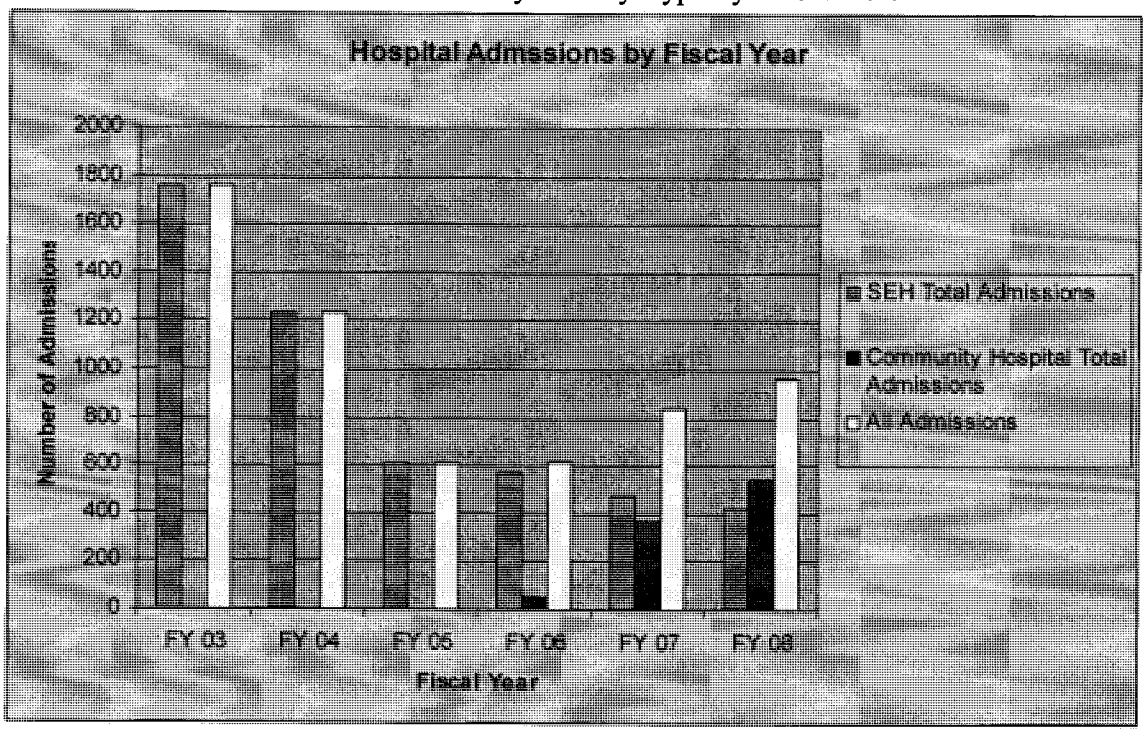
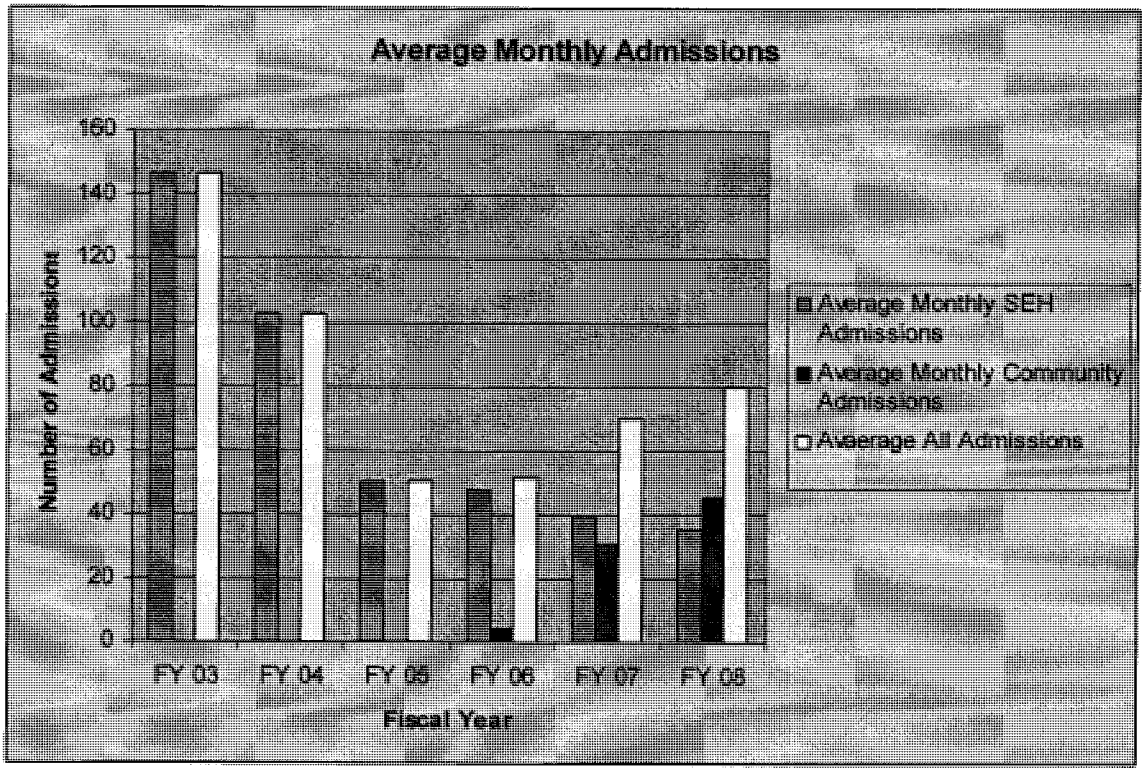


Chart 4: Average Monthly Number of Admissions by Facility Type by Fiscal Year



Conclusion:
The high number of admissions in FY 03 may be reflective of the base-line year for admissions to St Elizabeths Hospital before any real controls were implemented. As greater clinical control and more resources were secured over time, the total numbers admitted to St Elizabeths has steadily declined.

Some of the clinical controls implemented and the resources developed were:

1) Prior Authorization of All Admissions
2) Encouragement of Community Hospitals to Treat Any Voluntary Admission
3) Creation of Community Partnerships to Admit Involuntary Consumers in the Community
4) Implementation of Crisis Beds

Total admissions to any facility have been increasing as community capacity to accept involuntary admissions improves.

Exhibit M
DMH FY10 Proposed Budget

(RM0)

Department of Mental Health

www.dmh.dc.gov
Telephone: 202.673.7440

Description	FY 2008 Actual	FY 2009 Approved	FY 2010 Proposed	% Change from FY 2009
Operating Budget	$224,916,861	$228,485,704	$216,752,307	-5.1
FTEs	1,421.3	1,627.3	1,387.1	-14.8

The mission of the Department of Mental Health (DMH) is to support prevention, resiliency and recovery for District residents in need of public mental health services.

Summary of Services

DMH is responsible for developing, supporting and overseeing a comprehensive, community-based, consumer driven, culturally competent, quality mental health system that is responsive and accessible to children, youth, adults, and their families. DMH contracts with a network of community-based, private providers and also provides direct services through Saint Elizabeths Hospital, the District of Columbia Community Services Agency (DCCSA), the Comprehensive Psychiatric Emergency Program, the Homeless Outreach Program and the School-Based Mental Health Program.

The agency's FY 2010 proposed budget is presented in the following tables:

FY 2010 Proposed Gross Funds Operating Budget, by Revenue Type

Table RM0-1 contains the proposed FY 2010 agency budget compared to the FY 2009 approved budget. It also provides the FY 2007 and FY 2008 actual expenditures.

Table RM0-1
(dollars in thousands)

Appropriated Fund	Actual FY 2007	Actual FY 2008	Approved FY 2009	Proposed FY 2010	Change from FY 2009	Percent Change*
General Fund						
Local Funds	192,871	207,627	209,832	200,712	-9,119	-4.3
Special Purpose Revenue Funds	3,522	2,589	3,808	4,424	616	16.2
Total for General Fund	**196,393**	**210,216**	**213,640**	**205,136**	**-8,503**	**-4.0**
Federal Resources						
Federal Payments	5	13	0	0	0	N/A
Federal Grant Funds	138	281	1,642	1,222	-420	-25.6
Federal Medicaid Payments	4,074	4,018	3,924	6,068	2,144	54.6
Total for Federal Resources	**4,216**	**4,312**	**5,566**	**7,290**	**1,724**	**31.0**
Private Funds						
Private Grant Funds	8	-4,543	0	117	117	0.0
Total for Private Funds	**8**	**-4,543**	**0**	**117**	**117**	**0.0**
Intra-District Funds						
Intra-District Funds	45,274	14,932	9,280	4,209	-5,071	-54.6
Total for Intra-District Funds	**45,274**	**14,932**	**9,280**	**4,209**	**-5,071**	**-54.6**
Gross Funds	**245,891**	**224,917**	**228,486**	**216,752**	**-11,733**	**-5.1**

*Percent Change is based on whole dollars.

Note: If applicable, for a breakdown of each Grant (Federal and Private), Special Purpose Revenue type and Intra-District agreement, please refer to **Schedule 80 Agency Summary by Revenue Source** in the **Operating Appendices** located on the Office of the Chief Financial Officer's website.

FY 2010 Proposed Full-Time Equivalents, by Revenue Type

Table RM0-2 contains the proposed FY 2010 FTE level compared to the FY 2009 approved FTE level by revenue type. It also provides FY 2007 and FY 2008 actual data.

Table RM0-2

Appropriated Fund	Actual FY 2007	Actual FY 2008	Approved FY 2009	Proposed FY 2010	Change from FY 2009	Percent Change
General Fund						
Local Funds	1,302.8	1,300.4	1,493.0	1,311.1	-181.9	-12.2
Special Purpose Revenue Funds	36.0	34.4	37.0	37.0	0.0	0.0
Total for General Fund	**1,338.8**	**1,334.8**	**1,530.0**	**1,348.1**	**-181.9**	**-11.9**
Federal Resources						
Federal Grant Funds	18.7	12.9	6.5	4.0	-2.5	-38.0
Federal Medicaid Payments	0.0	18.7	0.0	2.0	2.0	0.0
Total for Federal Resources	**18.7**	**31.6**	**6.5**	**6.0**	**-0.5**	**-7.0**
Intra-District Funds						
Intra-District Funds	78.0	54.9	90.9	33.0	-57.9	-63.7
Total for Intra-District Funds	**78.0**	**54.9**	**90.9**	**33.0**	**-57.9**	**-63.7**
Total Proposed FTEs	**1,435.5**	**1,421.3**	**1,627.3**	**1,387.1**	**-240.2**	**-14.8**

FY 2010 Proposed Operating Budget, by Comptroller Source Group

Table RM0-3 contains the proposed FY 2010 budget at the Comptroller Source group (object class) level compared to the FY 2009 approved budget. It also provides FY 2007 and FY 2008 actual expenditures.

Table RM0-3
(dollars in thousands)

Comptroller Source Group	Actual FY 2007	Actual FY 2008	Approved FY 2009	Proposed FY 2010	Change from FY 2009	Percent Change*
11 Regular Pay - Cont Full Time	77,334	83,124	94,584	81,820	-12,764	-13.5
12 Regular Pay - Other	7,598	8,318	7,234	8,405	1,171	16.2
13 Additional Gross Pay	4,889	7,423	3,420	4,550	1,130	33.0
14 Fringe Benefits - Curr Personnel	16,927	18,145	19,032	16,631	-2,402	-12.6
15 Overtime Pay	7,747	7,638	2,527	3,700	1,173	46.4
99 Unknown Payroll Postings	0	1	0	0	0	N/A
Subtotal Personal Services (PS)	**114,496**	**124,650**	**126,798**	**115,106**	**-11,692**	**-9.2**
20 Supplies and Materials	11,024	12,465	10,318	9,597	-721	-7.0
30 Energy, Comm. and Bldg Rentals	9,697	9,344	9,106	11,991	2,885	31.7
31 Telephone, Telegraph, Telegram, Etc	1,621	1,732	1,630	1,621	-9	-0.5
32 Rentals - Land and Structures	5,457	4,413	4,422	4,661	240	5.4
33 Janitorial Services	2	3	4	26	23	624.6
34 Security Services	3,553	3,805	3,643	6,042	2,398	65.8
35 Occupancy Fixed Costs	6	0	20	77	57	279.8
40 Other Servicesa nd Charges	7,093	8,783	9,813	8,737	-1,075	-11.0
41 Contractual Services - Other	39,037	33,589	39,227	39,719	492	1.3
50 Subsidies and Transfers	45,001	23,720	22,068	17,949	-4,118	-18.7
70 Equipment & Equipment Rental	2,166	1,825	1,438	1,225	-212	-14.8
91 Expense Not Budgeted Others	6,739	588	0	0	0	N/A
Subtotal Nonpersonal Services (NPS)	**131,396**	**100,267**	**101,688**	**101,646**	**-42**	**0.0**
Gross Funds	**245,891**	**224,917**	**228,486**	**216,752**	**-11,733**	**-5.1**

*Percent Change is based on whole dollars.

Program Description

The Department of Mental Health operates through the following 5 programs:

Mental Health Authority - provides mental health services to ensure there is access to services, monitor the service system, support for service providers operates the Mental Health Rehabilitation Services (MHRS) fee for service system and provides grant funding for services covered through (MHRS) system. The program regulates the District's public mental health system, identifies the appropriate mix of programs, services and supports necessary to meet the mental health needs of District of Columbia residents.

This program contains the following 17 activities:

- **The Office of the Director** – provides the leadership for the design, development, communication and delivery of mental health services and supports and identifies approaches to enhance access to services that support recovery and resilience;
- **Office of the Chief Clinical Officer** – provides advises the Director and set standards for provision of clinical care throughout the public mental health system for children, youth and adults. The Comprehensive Psychiatric Emergency Program (CPEP), a 24/7 site based program to provide emergency care, extended observation, and mobile crisis services is also within this office. Infrastructure building, practice enhancement and training to serve persons with co-occurring mental illnesses and substance use disorders in a function of the Office;
- **Clinical Management** - provides a medical management treatment team for MHRS providers; and functions as a safety net for psychiatric medications and pharmacy education services for consumers enrolled in the DMH network who have no pharmacy benefits;
- **Consumer and Family Affairs** - provides expertise on the consumer/family perspective and promotes and protects the legal, civil and human rights of consumers;
- **Office of Programs and Policy** – provides the design, delivery, and evaluation of mental health services and support for children, youth, families, adults and special populations to maximize their ability to lead productive lives;
- **Adult Services** – provides information on the array of services and supports needed by adults to achieve their highest level of recovery from mental illness. Adult Services within the authority provides services directly to people who are homeless and/or in crisis. In addition, Adult services is responsible for residential services and for developing affordable housing opportunities for individuals with serious mental illness and supporting the development and implementation of evidenced-based practices such as Assertive Community Treatment (ACT), Supported Employment, Supported Housing and services to individuals with co-occurring disorders of mental illness and substance abuse disorders;
- **Housing Division** - provides bridge housing subsidies and capital funding to finance the development of new affordable permanent housing units for people with serious mental illness. An array of scattered site housing is provided through local bridge subsidies and federal vouchers;
- **Care Coordination** – provides information, support, crisis services, access and linkages access to a full range of mental health services for District residents;
- **Comprehensive Psychiatric Emergency Program (CPEP)** - provides mental health services to adults in psychiatric crisis with a need for stabilization to prevent harm to self or others. Services enhanced to convert hospitalizations, prevent decompensation and provide mobile crisis intervention for this same population;
- **Children and Youth Services** – provides services responsible for developing an all-inclusive system of care for children, adolescents and their families that promotes prevention/early intervention, continuity of care, community alternatives to out-of-home and residential placements and diversion from the juvenile justice system. Child and Youth Services within the authority provides direct school-based services, youth forensic services and oversight of youth placed in Residential Treatment Centers (RTCs);
- **School Mental Health Program** - provides tools that promote social and emotional development and address psycho-social and mental health problems that become barriers to learning. The program is responsible for the direct provision of prevention, early intervention and brief treatment services to 48 DC public and public charter schools;

- **Forensic Services** - provides mental health services and continuity of care to individuals involved in the criminal justice system who have serious mental illnesses; oversees a network of providers to ensure that individuals under court supervision and/or leaving the criminal justice system have access to a full range of services;
- **The Office of Strategic Planning, Policy, and Evaluation** - provides guidance regarding mental health strategic planning, policy development, grants management and development, and evaluation of services. This includes serving as the liaison to the Dixon Court Monitor;
- **Grants Management** - provides information on federal, foundation and other sources of funding for new and continuing program initiatives that address the mandates and directives of the Dixon Court order for a comprehensive community-based mental health system, by increasing the number of new program activities and continuing funding for existing program activities to minimize the use of local dollars for these purposes;
- **Integrated Care** – seeks to reduce the inpatient census/reducing admissions at St Elizabeths Hospital by identifying consumers who need a comprehensive array of services that include mental health, non-mental health, and informal supports to integrate to their fullest ability in their communities and families; and coordinates, manages, and evaluates the care for these consumers to improve their quality of life and tenure in a community setting;
- **Office of Accountability and Compliance** - provides oversight of providers for DMH to ensure that they meet or exceed the service delivery and documentation standards for Mental Health Rehabilitation Services (MHRS) or Mental Health Community Residence Facilities (MHCRF) and comply with all applicable District and federal laws and regulations; monitors the provider network, investigates complaints and unusual incidents and makes policy recommendations; and
- **Provider Relations** - provides technical assistance, training and coaching support to the DMH provider network.

Community Services Agency (DCCSA) - provides service functions in FY 2010 have been transferred within DMH to the Agency's Mental Health Authority and direct client services have been outsourced in FY 2010. The remaining activity contains funding for the residual payouts of employees.

This program contains the following activity:

- **Office of the Chief Executive Officer** - provides management of services to the D.C. Community Services Agency.

The **St. Elizabeths Hospital** program's principal purpose is to provide psychiatric, medical, and psychosocial inpatient psychiatric treatment to adults to support their recovery and return to the community. The goal is to maintain an active treatment program which fosters recovery and independence as much as possible. In addition, this program manages housekeeping, building maintenance and nutritional services, to provide a clean, safe and healthy hospital environment for patients, families, and employees so the patients can receive quality care. The St. Elizabeths Hospital program also ensures staff credentialing, licensing privileges and provision of medication and medical support services to eligible consumers in order to effectively treat mental illness and enhance their recovery. This program is part of the system that ensures the hospital's compliance with Centers for Medicare and Medicaid Services/Joint Commission on Accreditation of Healthcare Organizations (CMS/JCAHO) standards.

This program contains the following 13 activities:

- **The Office of the Chief Executive Officer** - provides planning, policy development and mental health system design for the District to create a comprehensive and responsive system of mental health care;
- **Clinical and Medical Affairs (CMA)** - provides active treatment to the inpatient population at St. Elizabeths Hospital to improve the quality of life through a recovery-based therapeutic program. CMA monitors services to eligible consumers in order to effectively treat mental illness and enhance clients' recovery;
- **Engineering and Maintenance** - provides maintenance and repairs to the hospital to ensure a functional, safe and secure facility for customers, visitors and staff in order to maximize the benefits of therapeutic treatment;

- **Support Services** - provides services for formulation and management of the hospitals budget, approves and finances all procurements. Assures the overall financial integrity of the hospital establishes the training curriculum for all levels of hospital staff and assures compliance with agreed upon training programs especially clinical staff to maintain health and safety of patients and employees;
- **Forensic Services** - provides court-ordered forensic diagnostic, treatment, and consultation services to defendants, offenders and insanity acquitees committed by the criminal divisions of the local and federal court;
- **Housekeeping** - provides a clean and sanitized environment throughout St. Elizabeths Hospital facilities to enhance the therapeutic environment and level of clinical performance in all clinical and non-clinical areas;
- **Materials Management** - provides and delivers materials, supplies, postal and laundry services to patients, DMH staff employees and customers so that they can provide or receive quality patient care, respectively. Provides inventory of goods received and stock replenishment, and performs electronic receiving for all goods and services received in the Hospital;
- **Medical Services** - provides prescriptions, medical screening, and education, medical assessment, medication (pharmacy), podiatry services, respiratory care and diet consultation to inpatient population, and employee Health Services to staff at SEH so that they can improve the quality of life through a recovery based therapeutic program. To provide quality medical care for inpatients at St. Elizabeths Hospital in concert with psychiatric care to optimize physical and mental health and facilitate discharge into the community in a recovery-based model;
- **Nursing Services** - provides active treatment and comprehensive, quality nursing care to the inpatient population at St. Elizabeths hospital, 24 hours a day, and 7 days a week to improve the quality of life through a recovery based therapeutic program.
- **Nutritional Services** - provides optimum nutrition and food services in a safe and sanitary environment, medical nutrition therapy and nutrition education services;
- **Psychiatric Services** - provides comprehensive assessment, treatment and aftercare planning, utilizing the most advanced scientific and evidence-based methods in accordance with the recovery-based model for all adult residents of the District of Columbia, who may from time to time require hospitalization; and
- **Security and Safety** - provides a safe and secure facility for consumers, visitors and staff in order to maximize the therapeutic environment; and
- **Transportation and Grounds** - provides and manages the resources, administrative functions, contracts, funding and staff, to provide a safe, secure and therapeutic physical environment for patients, staff and visitors hospital-wide, and provides management and oversight of the full realm of grounds maintenance services including snow and ice removal, solid medical waste disposal, grounds maintenance services for patients and employees so that they can receive and provide quality patient care, respectively, and live in a safe and therapeutic environment. The purpose of the Transportation and Grounds activity is to provide vehicles and drivers for transportation services to include, but not be limited to, patient food deliveries department-wide, patient/staff transport District-wide, among other services.

Community Contract Providers - provides prevention, comprehensive assessments, linkage, treatment and emergency services to promote resilience and recovery for children, youth, families, and adults.

This program contains the following activity:

- **Mental Health Rehabilitation Services** - provides medically-necessary diagnosis/assessment and treatment services to children, youth, families and adults who are residents of the District of Columbia so that they can be resilient, experience recovery and achieve a healthy productive life, in the "least restrictive environment".

Agency Management Program - provides for administrative support and the required tools to achieve an agency's operational and programmatic results. This program is standard for all agencies using performance-based budgeting.

Agency Financial Operations - provides comprehensive and efficient financial management services to and on behalf of District agencies so that the financial integrity of the District of Columbia is maintained. This program is standard for all agencies using performance-based budgeting.

Program Structure Change

The Department of Mental Health program changes in the FY 2010 Proposed Budget include the addition of two new cost centers. The Clinical Management unit, which serves as a medical management treatment team for MHRS providers; and function as a safety net for psychiatric medications and pharmacy education services for consumers enrolled in the DMH network who have no pharmacy benefits; and Integrated Care unit, which seeks to reduce the inpatient census/reducing admissions at St Elizabeths Hospital by identifying consumers who need a comprehensive array of services.

FY 2010 Proposed Operating Budget and FTEs, by Program and Activity

Table RM0-4 contains the proposed FY 2010 budget by program and activity compared to the FY 2009 approved budget. It also provides the FY 2008 actual data.

Table RM0-4

(dollars in thousands)

	Dollars in Thousands				Full-Time Equivalents			
Program/Activity	Actual FY 2008	Approved FY 2009	Proposed FY 2010	Change from FY 2009	Actual FY 2008	Approved FY 2009	Proposed FY 2010	Change from FY 2009
(0001) Default								
(0002) Default Program For Budget	-729	0	0	0	0.0	0.0	0.0	0.0
Subtotal (0001) Default	**-729**	**0**	**0**	**0**	**0.0**	**0.0**	**0.0**	**0.0**
(1000) Agency Management								
(1010) Personnel	1,887	2,450	1,593	-857	18.6	20.5	9.6	-10.9
(1015) Training & Employee Development	1,175	548	397	-151	12.6	4.5	2.5	-2.0
(1017) Labor Relations	320	460	259	-200	3.0	5.0	2.0	-3.0
(1020) Contracting & Procurement	567	898	1,053	156	5.0	7.0	10.0	3.0
(1030) Property Management	3,390	3,387	8,223	4,836	2.0	2.0	2.0	0.0
(1040) Information Technology	5,525	5,229	5,783	554	23.0	25.0	29.0	4.0
(1050) Financial Management-agency	4,579	3,317	3,235	-82	56.7	11.0	19.5	8.5
(1055) Risk Management	256	117	1	-116	2.0	1.0	0.0	-1.0
(1060) Legal Services	-1	300	288	-12	0.0	0.0	0.0	0.0
(1070) Fleet Management	135	0	0	0	0.0	0.0	0.0	0.0
(1080) Communications	215	227	339	112	1.0	1.0	2.0	1.0
(1085) Customer Services	65	65	63	-2	0.0	0.0	0.0	0.0
(1087) Language Access	90	75	104	28	0.0	0.0	0.0	0.0
(1099) Court Supervision	0	0	828	828	0.0	0.0	0.0	0.0
Subtotal (1000) Agency Management	**18,202**	**17,074**	**22,166**	**5,093**	**123.9**	**77.0**	**76.6**	**-0.4**
(100F) DMH Financial Operations								
(110F) DMH Budget Operations	563	555	536	-19	4.0	4.0	4.0	0.0
(120F) DMH Accounting Operations	769	841	848	7	7.0	12.0	12.0	0.0
(130F) DMH Fiscal Officer	238	232	242	10	6.0	2.0	2.0	0.0
Subtotal (100F) DMH Financial Operations	**1,570**	**1,628**	**1,627**	**-1**	**17.0**	**18.0**	**18.0**	**0.0**
(1800) Mental Health Authority								
(1810) Ofc of the Director/ Chief Exec Officer	2,669	1,775	1,756	-19	14.0	6.0	11.0	5.0
(1815) Off of the Chief Clinical Officer	0	3,780	4,789	1,008	0.0	3.2	5.0	1.8
(1816) Clinical Management	0	0	7,508	7,508	0.0	0.0	27.3	27.3
(1820) Consumer & Family Affairs	863	919	1,232	313	2.0	2.0	3.0	1.0

(Continued)

Table RM0-4 (Continued)
(dollars in thousands)

Program/Activity	Dollars in Thousands				Full-Time Equivalents			
	Actual FY 2008	Approved FY 2009	Proposed FY 2010	Change from FY 2009	Actual FY 2008	Approved FY 2009	Proposed FY 2010	Change from FY 2009
(1800) Mental Health Authority (cont.)								
(1825) Off of Programs & Policy	0	1,112	2,552	1,440	0.0	7.0	25.0	18.0
(1830) Adult Services	3,023	1,912	17,766	15,854	23.3	12.0	13.0	1.0
(1835) Housing	0	6,470	6,455	-15	0.0	7.0	4.0	-3.0
(1840) Care Coordination	7,923	2,021	3,732	1,711	60.0	24.0	26.0	2.0
(1845) Comprehensive Psych Emer Prog - CPEP	0	7,090	6,815	-274	0.0	72.5	63.5	-9.0
(1850) Children & Youth Services	9,625	4,994	7,805	2,811	67.4	24.3	31.8	7.6
(1855) School Mental Health Prog	0	4,076	4,915	839	0.0	52.0	44.6	-7.4
(1860) Forensic Services (Jail Diversion)	606	1,529	1,323	-206	4.0	5.0	5.0	0.0
(1865) Off-strategic Planning,Policy Eval&supp	0	591	694	104	0.0	5.0	6.0	1.0
(1870) Grants Management	227	117	1	-116	2.0	1.0	0.0	-1.0
(1875) Integrated Care	0	0	340	340	0.0	0.0	4.0	4.0
(1880) Office of Accountability (GI)	1,609	1,408	2,131	722	14.7	13.5	21.5	8.0
(1890) Provider Relations	450	452	472	20	4.0	4.0	4.0	0.0
Subtotal (1800) Mental Health Authority	**26,997**	**38,246**	**70,285**	**32,039**	**191.4**	**238.5**	**294.7**	**56.2**
(2800) Community Services Agency								
(2810) Ofc of the Chief Executive Officer - CSA	4,898	4,135	5,291	1,156	13.0	13.0	40.5	27.5
(2815) Adult & Family Services - CSA	16,122	16,922	0	-16,922	152.5	170.9	0.0	-170.9
(2820) Children Youth & Family Services - CSA	4,983	5,792	0	-5,792	46.3	56.9	0.0	-56.9
(2825) Clinical Support - CSA	520	525	0	-525	3.0	3.0	0.0	-3.0
(2830) Consumer Advocacy - CSA	60	56	0	-56	1.0	1.0	0.0	-1.0
(2845) Intake & Continuity Of Care -CSA	495	474	0	-474	6.0	6.0	0.0	-6.0
(2850) Pharmacy - CSA	3,981	4,211	0	-4,211	10.0	10.0	0.0	-10.0
(2855) Quality Improvement - CSA	769	828	0	-828	10.0	10.0	0.0	-10.0
(2860) Security & Safety - CSA	1,164	1,300	0	-1,300	0.0	0.0	0.0	0.0
(2865) Off of the Chief Operating Officer	0	2,053	0	-2,053	0.0	30.0	0.0	-30.0
Subtotal (2800) Community Services Agency	**32,992**	**36,296**	**5,291**	**-31,005**	**241.7**	**300.8**	**40.5**	**-260.3**
(3800) Saint Elizabeths Hospital								
(3805) Office of the Chief Executive	1,918	1,818	1,948	130	11.8	9.0	15.0	6.0
(3810) Clinical & Medical Affairs - SEH	17,351	13,801	15,092	1,291	101.8	132.0	144.5	12.5
(3815) Engineering & Maintenance - SEH	12,958	12,643	15,127	2,484	22.0	24.0	22.0	-2.0
(3820) Support Services	0	1,791	1,789	-2	0.0	31.0	23.0	-8.0
(3825) Forensic Services - SEH	2,652	4,071	2,913	-1,157	26.5	29.8	28.0	-1.8
(3830) Housekeeping - SEH	2,669	2,719	2,491	-228	88.8	58.0	52.0	-6.0
(3835) Materials Management - SEH	1,122	896	1,371	475	12.0	12.0	9.0	-3.0
(3840) Medical Services - SEH	9,078	8,069	5,760	-2,310	48.7	56.0	45.8	-10.3
(3845) Nursing -SEH	35,167	31,327	32,943	1,616	382.3	475.3	462.5	-12.8

(Continued)

Table RM0-4 (Continued)
(dollars in thousands)

	Dollars in Thousands				Full-Time Equivalents			
Program/Activity	Actual FY 2008	Approved FY 2009	Proposed FY 2010	Change from FY 2009	Actual FY 2008	Approved FY 2009	Proposed FY 2010	Change from FY 2009
(3850) Nutritional Svcs (In/Out Patients)-SEH	4,952	4,936	4,908	-28	50.6	50.0	47.0	-3.0
(3855) Psychiatric Services - SEH	7,578	8,411	10,033	1,622	58.9	71.9	72.5	0.6
(3860) Security & Safety - SEH	3,188	2,980	3,512	533	19.0	21.0	21.0	0.0
(3865) Transportation & Grounds - SEH	1,833	1,886	1,559	-327	25.0	23.0	15.0	-8.0
Subtotal (3800) Saint Elizabeths Hospital	**100,466**	**95,347**	**99,447**	**4,100**	**847.2**	**993.0**	**957.3**	**-35.8**
(5000) Direct Community Services								
(5010) Community Mental Health Services	3	0	0	0	0.0	0.0	0.0	0.0
Subtotal (5000) Direct Community Services	**3**	**0**	**0**	**0**	**0.0**	**0.0**	**0.0**	**0.0**
(7000) Direct Patient Care								
(7010) Active Treatment	-639	0	0	0	0.0	0.0	0.0	0.0
Subtotal(7000) Direct Patient Care	**-639**	**0**	**0**	**0**	**0.0**	**0.0**	**0.0**	**0.0**
(7800) Community Contract Providers								
(7820) Mental Health Rehabilitation Services	15,516	17,185	8,759	-8,426	0.0	0.0	0.0	0.0
(7825) Mental Health Rehab Svcs - Local Match	11,541	7,858	9,177	1,319	0.0	0.0	0.0	0.0
(7830) Mental Health Rehab Svcs - Medicaid Ffp	-492	0	0	0	0.0	0.0	0.0	0.0
(7840) Residential Treatment Centers	25,238	14,852	0	-14,852	0.0	0.0	0.0	0.0
Subtotal (7800) Community Contract Providers	**51,803**	**39,895**	**17,936**	**-21,959**	**0.0**	**0.0**	**0.0**	**0.0**
(9960) Yr End Close								
No Activity Assigned	-4,162	0	0	0	0.0	0.0	0.0	0.0
Subtotal (9960) Yr End Close	**-4,162**	**0**	**0**	**0**	**0.0**	**0.0**	**0.0**	**0.0**
(9980) Payroll Default Program								
No Activity Assigned	0	0	0	0	0.0	0.0	0.0	0.0
Subtotal (9980) Payroll Default Program	**0**	**0**	**0**	**0**	**0.0**	**0.0**	**0.0**	**0.0**
(SE00) St. Elizabeths Hospital								
(GENL) General Cost Centers	-1,587	0	0	0	0.0	0.0	0.0	0.0
Subtotal (SE00) St. Elizabeths Hospital	**-1,587**	**0**	**0**	**0**	**0.0**	**0.0**	**0.0**	**0.0**
Total Proposed Operating Budget	**224,917**	**228,486**	**216,752**	**-11,733**	**1,421.3**	**1,627.3**	**1,387.1**	**-240.2**

(Change is calculated by whole numbers and numbers may not add up due to rounding)

Note: For more detailed information regarding the proposed funding for the activities within this agency's programs, please see **Schedule 30-PBB Program Summary By Activity** in the **FY 2010 Operating Appendices** located on the Office of the Chief Financial Officer's website.

Major Baseline Adjustments, Cost Savings and Policy Initiatives

Initial Adjustments: The following adjustments were made in Local funds; a net increase of $3,136,456 for fixed costs in multiple programs, a net decrease of $6,499,736 in personal services due to net effect of personal services changes including impact of the change and governance of operations related to the DC Community Services Agency (DCCSA), and a net increase of $4,429,280 in multiple programs due to the impact of FY 2009 one-time rescissions, the reallocation of funding associated with the restructuring of mental health services previously provided by the DCCSA and the reallocation of funds to properly reflect the operational functions within the Mental Health Authority. In Federal Grants Funds a decrease of $169,917 that reflects projected grant award reductions. In Federal Medicaid Payments an increase of $189,188 and 2 FTEs in the Mental Health Authority is due to projected Federal reimbursement for administrative costs related to provision of Medicaid services. In Intra-District Funds a decrease of $5,071,127 is related to Medicaid funding for services formerly reimbursed in the DCCSA program.

Cost Savings: Saint Elizabeths will reduce its contingent of drivers, maintenance mechanics, materials handlers, and housekeeping staff, eliminating 18 positions and saving $821,461. A billing department and laboratory at the hospital will be reorganized, with many functions shifted outside the agency to save $886,829, while eliminating 13 positions. The Mental Health Authority (MHA), DMH's oversight and administrative unit, will also undergo significant changes. This budget accommodates a realignment of the DMH's human resources and IT departments, reducing staffing by 16 positions and saving $1,219,803. The budget also calls for a reduction in staffing within MHA, DMH's Office of Programs, and the Office of the Director, including the elimination of 29 positions and savings of $2,274,949. DMH will also change the way it pays clinicians within its school based mental health program. In FY 2010, each position in the school mental health program will be reduced to 0.8 FTEs, accounting for the 10-month school year worked by clinicians, saving the District $682,816. Altogether, these changes eliminate 83 FTEs, reducing costs by $5,885,858.

DMH's proposed budget also calls for $2,154,157 in reductions to various administrative, consulting, and training contracts as well as reductions in supplies and materials costs. In addition, DMH will seek relatively modest efficiencies within two programs – supported independent living and residential group homes – to align spending with underutilization of both programs. The proposed $145,705 reduction in supported independent living represents a six percent savings, which will be realized from vacancy rates and not a service reduction. Likewise, the $324,697 savings from residential group homes amounts to less than 5 percent of total budgeted spending. DMH believes neither of these reductions, nor a $200,000 proposed reduction to its forensic program, will result in a reduction in services. To achieve further savings of $170,313, DMH plans to shift a portion of assessment services for youth referred by the Child and Family Services Agency from a contract to qualified choice providers able to provide comparable services at a lower cost. Saint Elizabeths will significantly reduce its Work Adjustment Training Program, saving $600,000 by reducing the size of a somewhat outdated program that pays patients a minimum wage to work at the hospital. Instead, the hospital will limit the program to a small number of patients that cannot leave the hospital grounds. Others will be shifted into community-based work training programs. DMH will also direct $1,077,377 of savings from the closure of DC CSA to provide further savings and help close the city's budget gap. This amount of savings represents less than 3 percent of CSA's FY 2009 budget, and is the only direct savings related to the CSA closure. Efficiencies in the operations of the court monitor overseeing the Dixon lawsuit will generate another $50,000 in savings.

A number of other initiatives will save funding through policy changes and increased revenues that will offset Local Funds and help fill the budget gap. The agency projects that it will boost Medicaid reimbursements by $1,954,850 through enhanced administrative claiming and by implementing new Medicaid billing codes. DMH will increase reimbursements by $400,000 by billing MCOs for services provided through the school based mental health program. Saint Elizabeths will collect an additional $216,000 in reimbursements by claiming Social Security Disability payments made to patients at the hospital. In addition, DMH projects that it will save $200,000 in Local Funds by enforcing a

requirement that all providers submit claims within 90 days. On a smaller scale, the proposed budget adds $34,280 to account for a revised estimate of procurement costs. Likewise, this budget reduces electricity costs by $90,764, fleet maintenance costs by $45,194, and occupancy costs by $7,373. The budget reduces holiday premium payments to employees by $85,301, in accordance with a subtitle of the Budget Support Act.

Protected Programs: For DMH, FY 2010 will be a transformational year. This proposed budget achieves necessary and significant cost savings, while also protecting the resources necessary to accomplish two major undertakings: the opening of a new Saint Elizabeths Hospital; and the closure DMH's Community Service Agency (CSA) through the successful transition of approximately 4,000 consumers into quality care offered by community based providers.

Throughout this budget, DMH seeks to protect resources for the District's most vulnerable residents. At Saint Elizabeths, this proposed budget makes no reductions to direct care staff such as nurses, technicians, counselors and other clinicians. Continuity of staffing will foster continued improvement in treatment as the hospital moves to a new facility, and as DMH works to satisfy requirements of a settlement agreement with the Department of Justice. The FY 2010 budget also protects resources necessary for the successful closure of CSA, which currently provides direct mental health services to about 4,000 District residents. DMH will continue operating the CSA until March 31, 2010 – six months longer than originally planned – to ensure that every CSA consumer makes a successful transition into a quality community mental health care provider. To accommodate this prolonged timeline, DMH's budget shifts roughly $3,409,618 million and 40.5 FTEs into CSA to continue providing direct services through the first six months of FY 2010. In addition, DMH's budget preserves nearly all other savings from the CSA closure to run an orderly transition and build capacity among community mental health care providers. A team of DMH staff will ensure that every consumer currently served by CSA is matched with a quality provider. And providers throughout the District will receive support from DMH, including cash vouchers tied to every CSA consumer that transitions successfully. By redirecting these funds into the community, and by giving consumers choice, DMH will help build a stronger public mental health system capable of serving more people.

Policy Initiatives: This budget increases DMH's budget for overtime pay by $1,225,305 to more accurately align the budget to actual overtime costs at Saint Elizabeths. The proposed DMH overtime budget - $3.7 million for FY 2010 – represents a substantial increase in the FY 2009 Approved level, but sets an aggressive goal of significantly reducing overtime expenditures from actual spending in recent years. The budget adds $2,420,000 in one-time funding to offset the utilities costs of operating two hospitals during the transition into a new Saint Elizabeths, as well as moving expenses and waste removal costs related to the move.

FY 2009 Approved Budget to FY 2010 Proposed Budget, by Revenue Type

Table RM0-5 itemizes the changes by revenue type between the FY 2009 approved budget and the FY 2010 proposed budget. The three categories of changes reflected in this table are: (1) changes to the baseline budget (includes agency request), (2) changes representing cost savings or efficiencies, and (3) changes related to policy initiatives.

Table RM0-5
(dollars in thousands)

	Program	BUDGET	FTE
LOCAL FUND: FY 2009 Approved Budget and FTE		**209,832**	**1,493.0**
Initial and Baseline Adjustments			
Net effect of fixed cost adjustments - Funding adjustments for OPM est.	Multiple Programs	3,136	0.0
Net effect of salary and benefits changes - Salary step and other personal services funding adjustments in cluding the impact of DCCSA closure	Multiple Programs	-6,500	-139.5
Intra-agency Changes - Reallocation of funding due to DCCSA closure including impact of FY 2009 one-time rescissions.	Multiple Programs	4,429	0.0
Policy Initiatives and Cost Savings			
Shift - Allocation of funds to support collective bargaining agreement with metal trades council; Funds transferred from workforce investment.		243	0.0
Reduce - Realign IT department throughout DMH to reflect changes to size and structure of the department.	Agency Management	-400	-5.0
Cost Decrease - Achieve 5 percent cost savings within residential group home program due to excess capacity; savings calculated using conservative vacancy estimates based on recent usage.	Mental Health Authority	-325	0.0
Cost Decrease - Achieve cost savings by shifting assessment services for CFSA youth clients from outside contractor to well-qualified choice provid.	Mental Health Authority	-170	0.0
Cost Decrease - Adjust school-based mental health staffing to reflect 10-month schedule worked by staff.	Mental Health Authority	-683	-7.0
Cost Decrease - Enforce timely filing requirements for providers that fail to submit claims within 90 days.	Mental Health Authority	-200	0.0
Cost Decrease - Realize efficiencies within forensic services program through improved procurement and streamlined delivery of services.	Mental Health Authority	-200	0.0
Cost Decrease - Reduce expenditures on court monitor costs through various ongoing efficiencies, including co-location of offices within facil.	Mental Health Authority	-50	0.0

(Continued)

Table RM0-5 (Continued)
(dollars in thousands)

	Program	BUDGET	FTE
Policy Initiatives and Cost Savings (cont.)			
Cost Decrease - Structure funding levels for supported independent living services to align with nine percent vacancy rates within the program, reducing costs by six percent.	Mental Health Authority	-146	0.0
Reduce - Realign staffing within Office of Programs.	Mental Health Authority	-380	-3.5
Cost Decrease - Reorganize and outsource billing department at Saint Elizabeths Hospital to increase revenues and achieve cost efficiencies.	Saint Elizabeth's Hospital	-478	-7.0
Cost Decrease - Shift of $500,000 to DDS and DHCF to offset the cost of transitioning patients into the Medicaid Home and Community Based Waiver in FY 2010.	Saint Elizabeth's Hospital	-500	0.0
Cost Increase - Provide $2.1 million in one-time funding to offset increased utility costs associated with operating two hospitals during transition to new Saint Elizabeths facility.	Saint Elizabeth's Hospital	2,100	0.0
Cost Increase - Provide one-time funding to offset moving and waste disposal costs during the move to a new Saint Elizabeths Hospital.	Saint Elizabeth's Hospital	320	0.0
Cost Savings - Reorganize and outsource laboratory functions at Saint Elizabeths Hospital to more efficiently provide services through an outside provider.	Saint Elizabeth's Hospital	-409	-6.0
Reduce - Adjust number of materials handlers to meet the needs of a new Saint Elizabeths Hospital.	Saint Elizabeth's Hospital	-188	-4.0
Reduce - Align housekeeping staffing to meet the needs of a new Saint Elizabeths Hospital.	Saint Elizabeth's Hospital	-156	-4.0
Reduce - Reduce number of vacant and filled maintenance mechanics positions to align with the needs of new Saint Elizabeths Hospital.	Saint Elizabeth's Hospital	-106	-2.0
Reduce - Reorganize and refocus Work Adjustment Training Program to focus on core inpatient users of the program at Saint Elizabeths. Transition other users to existing community based work programs.	Saint Elizabeth's Hospital	-600	0.0
Reduce - Reorganize motor pool to a more appropriate size to meet the needs of a new, more efficient Saint Elizabeths Hospital.	Saint Elizabeth's Hospital	-373	-8.0
Cost Decrease - Identify efficiencies to achieve a blanket reduction in supplies and materials costs throughout DMH.	Agencywide	-595	0.0
Cost Decrease - Identify efficiencies to make a blanket reduction in consulting and training contracts.	Agencywide	-400	0.0
Cost Decrease - Reduction to expenditures within various contracted services and outside consulting (CSG40) throughout DMH.	Agencywide	-1,159	0.0
Cost Decrease - Align electricity budget with revised OPM estimate.	Multiple	-91	0.0
Cost Decrease - Align fleet budget with revised DPW estimates.	Multiple	-45	0.0
Cost Decrease - Align occupancy budget with revised OPM estimates.	Multiple	-7	0.0
Cost Decrease - Recapture a portion of cost savings related to closure of DC Community Services Agency of an amount less than 3 percent of FY09 budget levels.	Multiple	-1,077	0.0
Cost Decrease - Reduce projected holiday premium payouts.	Multiple	-85	0.0
Cost Increase - Align procurement assessment budget with revised OCP estimates.	Multiple	34	0.0
Cost Increase - Provide additional funds to align overtime budget with a more accurate estimate of actual expenditures.	Multiple	1,225	0.0
Reduce - Realign and reduce human resources staffing throughout DMH.	Multiple	-820	-11.0
Reduce - Realign staffing within Mental Health Authority to reduce various vacant and filled staff positions.	Multiple	-719	-8.0
Reduce - Reduce clerical and office support staffing.	Multiple	-518	-10.0

(Continued)

Table RM0-5 (Continued)
(dollars in thousands)

	Program	BUDGET	FTE
Policy Initiatives and Cost Savings (cont.)			
Reduce - Reorganize staffing within the Office of the Director; eliminate various vacant and filled positions.	Multiple	-658	-7.5
Shift - Shift funding from CSP to CSA to reflect costs of operating portions of CSA during the first six months of FY10.	Community Contract Providers	-3,410	0.0
Shift - Increase reimbursements through billing MCOs for services provided through school based mental health program.	Mental Health Authority	-400	0.0
Shift - Shift funding from CSP to CSA to reflect the costs of operating portions of CSA during the first six months of FY10.	Community Services Agency	3,410	40.5
Shift - Maximize Medicaid reimbursements through enhanced administrative claiming.	Mental Health Authority	-1,100	0.0
Shift - Increase federal medicaid reimbursements through implementation of new billing code for multi-systemic therapy, a form of community based intervention for adolescents.	Mental Health Authority	-855	0.0
Shift - Realize cost efficiencies through collection of SSDI payments from patients at Saint Elizabeths.	Saint Elizabeth's Hospital	-216	0.0
LOCAL FUND: FY 2010 Proposed Budget and FTE		**200,712**	**1,311.0**
SPECIAL PURPOSE REVENUE FUNDS: FY 2009 Approved Budget and FTE		**3,808**	**37.0**
Policy Initiatives and Cost Savings			
Shift - Increase reimbursements through billing MCOs for services provided through school based mental health program.	Mental Health Authority	400	0.0
Shift - Realize cost efficiencies through collection of SSDI payments of patients at Saint Elizabeths	Saint Elizabeth's Hospital	216	0.0
SPECIAL PURPOSE REVENUE FUNDS: FY 2010 Proposed Budget and FTE		**4,424**	**37.0**
FEDERAL GRANT FUND: FY 2009 Approved Budget and FTE		**1,642**	**6.5**
Initial and Baseline Adjustments			
Net effect of salary and benefits changes - Salary funding adjustments to reflect projected reduction in grants awards.	Multiple Programs	-170	-2.5
Intra-agency Changes - Adjustment for projected reduction in grants	Multiple Programs	-250	0.0
FEDERAL GRANT FUND: FY 2010 Proposed Budget and FTE		**1,222**	**4.0**
FEDERAL MEDICAID PAYMENTS: FY 2009 Approved Budget and FTE		**3,924**	**0.0**
Initial and Baseline Adjustments			
Net effect of salary and benefits changes - Salary step and other personal services funding adjustments.	Mental Health Authority	189	2.0
Policy Initiatives and Cost Savings			
Shift - Maximize Medicaid reimbursements through enhanced administrative claiming.	Mental Health Authority	1,100	0.0
Shift - Increase federal medicaid reimbursements through implementation of new billing code for multi-systemic therapy, a form of community based intervention for adolescents.	Revenue	855	0.0
FEDERAL MEDICAID PAYMENTS: FY 2010 Proposed Budget and FTE		**6,068**	**2.0**
PRIVATE GRANT: FY 2009 Approved Budget and FTE		**0**	**0.0**
Initial and Baseline Adjustments			
Intra-Agency Changes - Adjustment for projected private grants award.	Saint Elizabeth's Hospital	117	0.0
PRIVATE GRANT: FY 2010 Proposed Budget and FTE		**117**	**0.0**
INTRA-DISTRICT FUNDS: FY 2009 Approved Budget and FTE		**9,280**	**90.9**
Initial and Baseline Adjustments			
Net effect of salary and benefits changes - Projected reductions in Federal Medicaid payments due to closure of the DCCSA and the shifting of federal payments to the Department of Health Care Finance.	Community Services Agency	-4,220	-57.9
Intra-Agency Changes - Shift of Medicaid funding to DHCF	Saint Elizabeth's Hospital	-851	0.0
INTRA-DISTRICT FUNDS: FY 2010 Proposed Budget and FTE		**4,209**	**33.0**
Gross for RM0 - Department of Mental Health		**216,752**	**1,387.0**

Agency Performance Plan

The agency's Performance Plan has the following objectives for FY 2010:

Objective 1: Expand the range of mental health services.

Objective 2: Increase access to mental health services.

Objective 3: Continually improve the consistency and quality of mental health services.

Objective 4: Ensure system accountability.

Agency Performance Measures

Table RM0-6

Measure	FY 2007 Year-End Actual	FY 2008 Original Target	FY 2008 Year-End Actual	FY 2009 Projection	FY 2010 Projection	FY 2011 Projection
Objective 1:						
Number/percent of schools with a school-based mental health program[1]	42	48	58	58/23.7%	68/27.6%	78/31.3%
Number of new affordable housing units developed	0	150	0	150	100	150
Objective 2:						
Total number of consumers served (adults/children)[2]	9,843/3,101	13,365/5,375	11,431/2,777	13,500/5,525	13,800/5,775	14,000/6,000
Number of CPEP/Adult Mobile Crisis Team Visits	3,333/N/A	3,780/500	3,605/N/A	3,780/700	3,850/1,400	4,000/1,800
Crisis stabilization bed utilization[3]	N/A	75%	N/A	80%	85%	90%
Total number of adult consumers receiving an ACT service	N/A	440 (baseline)	500	500	650	850
Objective 3:						
Percent of patients readmitted to Saint Elizabeths Hospital within 30 days of discharge	8.3%	10%	8.5%	9%	8%	6%
Percent of patients readmitted to Saint Elizabeths Hospital within 180 days discharge	19.0%	25%	20.80%	23%	22%	20%
Percent of MHRS eligible children discharged from inpatient psychiatric hospitals who receive a community-based, non-emergency service within 7 days of discharge[4]	45%	80%	46%	60%	70%	80%
Percent of MHRS eligible adults discharged from inpatient psychiatric hospitals who receive a community-based, non-emergency service within 7 days of discharge[5]	35%	80%	51%	60%	70%	80%
Objective 4:						
Percent of Total Federal Revenue Collected[6]	52.8%	55%	50.70%			
Percent of Medicaid claims submitted to DHCF that are paid	76%	76%	79%	82%	85%	88%

(Continued)

Agency Performance Measures (Continued)

Table RM0-6

Measure	FY 2007 Year-End Actual*	FY 2008 Original Target	FY 2008 Year-End Actual	FY 2009 Projection	FY 2010 Projection	FY 2011 Projection
Objective 4: (cont.)						
Percentage of clean claims adjudicated by DHCF or MCO within 5 business days of submission	77%	N/A (revised KPI)	—	95%	95%	98%
Number of Dixon exit criteria targets met and approved for inactive monitoring by the Court Monitor	1	10	3	13	15	19

[1] The denominator for this calculation (249) is the total of DCPS and Charter Schools based upon information available on www.dc.gov. It includes 57 schools identified as kindergarten and preschool, elementary, middle, junior and high schools.

[2] Reporting for this indicator is calculated based upon the requirements of Dixon Exit Criterion #5 (penetration rate for services to children & youth) and criterion #7 (penetration rate for services to adults).

[3] This indicator was revised during FY 2008, since DMH does not collect data about the number of consumers referred to a crisis stabilization bed diverted from an inpatient psychiatric bed. DMH has been reporting utilization of crisis beds throughout FY 2008 and will continue to report on this measure throughout FY 2009.

[4] This indicator is also tracked as Dixon Exit Criterion #17. The target for exiting the Dixon case is 80%. Targets for FY 2009 and FY 2010 have been adjusted to reflect expected performance based upon performance throughout FY 2008.

[5] This indicator is also tracked as Dixon Exit Criterion #17. The target for exiting the Dixon case is 80%. Targets for FY 2009 and FY 2010 have been adjusted to reflect expected performance based upon performance throughout FY 2008.

[6] The information reported for this indicator is calculated in accordance with the formula required for reporting on Dixon Exit Criterion #19 (collection of federal revenue). The Dixon Court Monitor has found that DMH has satisfied the performance requirement for Dixon and has deemed Exit Criterion #19 inactive. Although DMH is required to continue to report on its performance to the Court Monitor, it will no longer report on this indicator for purposes of this performance management plan.