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*.,	October 14, 2010
Defendants.	

DEFENDANT DISTRICT OF COLUMBIA'S OCTOBER 2010 STATUS REPORT

The Defendant, by and through counsel, herein files its October 2010 Status Report pursuant to the Court's November 3, 2008 Order.

I. INTRODUCTION

The Defendant filed a "Motion to Vacate December 12, 2003 Consent Order and to Dismiss Action" in this case on September 4, 2009, and filed a Reply to the Plaintiff's response on September 7, 2010. As recognized by the Court during the March 19, 2010 Status Hearing, the District continues to comply in good faith with the Consent Order and demonstrates progress with the exit criteria. Without prejudice to its pending Motion, this Status Report will address the District of Columbia's continued improvement, as measured by the *Dixon* Exit Criteria, and provides an update on three (3) areas of interest to the Court: (a) the closure of the DCCSA (b) progress at Saint Elizabeths Hospital, (c) the budget for FY 11 and (d) the Crisis Intervention Officer program, a joint effort with the Metropolitan Police Department.

II. EXIT CRITERIA

A. Summary

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 ("Consent Order"). Since April 2010 when DMH filed its last status report, the Court Monitor has agreed that an additional four (4) criteria - namely, Exit Criteria # 1 (Consumer Satisfaction), 7 (Services to Adults), 14 (Children/Youth Receive Services in Natural Settings), and 15 (Children/Youth Receiving Services Live in Own/Surrogate Home)—be moved to inactive status, meaning the District has satisfied a total of 11 of the 19 exit criteria. The District renewed its request that Exit Criterion #11(Assertive Community Treatment) be moved to inactive status, a request which is still being considered by the Court Monitor. In the next few months DMH also expects to request inactive status for Exit Criterion #2 (Use of Consumer Functioning Data).

DMH continues to work cooperatively with the Court Monitor to address his concerns about Exit Criteria # 5 (Services to Children/Youth) and 10 (Supported Employment), to which he previously denied inactive status. For Exit Criteria #5, DMH is currently at 4.94%[1] of the required 5% and anticipates satisfying that numeric criterion shortly. In the next few months DMH also expects to re-submit its request for inactive status with updated information to address the Court Monitor's concerns on Exit Criterion #10.

DMH had requested that the required system performance for Exit Criterion # 9, Supported Housing, be modified to better reflect the goals of supported housing programs, which the Court Monitor has denied. However DMH continues to work with the Court Monitor on this issue. DMH has also previously requested that the Court Monitor modify the required system performance for Exit Criterion # 17, Continuity of Care, to better reflect the national data for performance in that area, but the Court Monitor has refused to agree with the proposed

[1] For the four quarter reporting period beginning January 1, 2009 and ending December 31, 2009.

modification. The remaining two criteria, Exit Criteria #3 and 4, are the Community Service Reviews, which are conducted annually. The next CSR for adults is scheduled to occur in February 2011, and the children's CSR will occur in May 2011. Due to a new program of intensive targeted training to selected providers, DMH believes its performance in the Adult CSR's will continue its acceptable trajectory, while the Children's CSR system performance results should substantially improve. For the Court's and Plaintiffs' convenience, the District has attached a chart that summarizes the current status and activities of the remaining exit criteria. (*See* Exhibit A, *Dixon* Exit Criteria Performance Levels for the four quarter period beginning April 1, 2009 and ending March 31, 2010.)[2]

B. Exit Criteria on Inactive Monitoring Status

To date, eleven (11) of the nineteen (19) Exit Criteria have moved to inactive monitoring status. 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 Criteria # 8, # 13, and # 16 moved to inactive status in January 2009. Exit Criterion # 6 moved to inactive status in March 2010; Exit Criterion # 7 in April 2010; # 14 in May, 2010; # 1 in August 2010; and # 15 moved to inactive status in September, 2010. (See Exhibits B – E, Letters from the Court Monitor for EC# 7,14,1, and 15).

B. DMH Pending Requests for Inactive Monitoring Status

Exit Criterion # 11: Assertive Community Treatment

Required System Performance: 85% Served within 45 days of Referral

[2] The data reported for the claims-based Exit Criteria set forth in Exhibit A are for the period from April 1, 2009 – March 31, 2010 , and were run on September 14, 2010, unless otherwise stated in footnotes to the Exhibit. Therefore, these data differ from the data reported by Court Monitor in his July 2010 report, which was run on June 24, 2010 and was incomplete because of the ninety (90) day delay in claims reporting (providers have up to 90 days to submit claims for a service).

DMH Performance: 86.93% for the four quarter period beginning April 1, 2009 and ending on March 31, 2010

Assertive Community Treatment, or "ACT," is an intensive, integrated service provided to adult consumers with serious mental illness who do not respond well to more traditional, less frequent mental health services. On December 9, 2009, DMH requested that the Court Monitor move Exit Criterion # 11 to inactive status. This request was denied by the Court Monitor via letter dated April 19, 2010. DMH submitted a supplement to its original request on September 2, 2010, which included the results of the 2010 completed fidelity audits and corrective plans for each ACT team. (*See* Exhibit F, EC # 11 Letter to the Court Monitor dated September 2, 2010). The Court Monitor has the request under consideration.

C. DMH Requests for Inactive Monitoring Status- inactive recommendation declined by Court Monitor

***Exit Criterion # 5*:** Penetration rate (Child/Youth 0-17 years)

Required System Performance: 5%

DMH Performance: 4.94% (for calendar year 2009)
4.82% (for the four quarter period beginning on April 1, 2009 and ending March 31, 2010)

Exit Criterion # 5 measures the number of children in the District with a mental health diagnosis who received a mental health service, compared against the number of children overall. The District requested the Court Monitor find that it had reached substantial compliance when the penetration rate was 4.34%, which the Court Monitor denied. However DMH has subsequently collected data concerning additional children who have a mental health diagnosis and receive mental health services through specific DMH programs, but were not previously considered, as well as children with mental health diagnoses who received mental health services through free-standing mental health clinics. DMH has worked with the Court Monitor and the

Court Monitor's data expert, Dr. Joan Durman, in regards to the necessary refinements to the data collection metric for this Exit Criterion, and has made significant progress in this area. Currently the District is has reached a 4.94% penetration rate for this Criterion, just short of the 5% required. The District remains confident that it will achieve full compliance with this Exit Criterion in the near future.

***Exit Criterion # 10*:** Supported Employment

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

DMH Performance: 91.52% 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 the four-quarter period between July 1, 2009 and June 30, 2010, the average of persons receiving services within 120 days of referral was 91.52%. DMH has clearly met this Exit Criterion and is sustaining its timely service performance.

Time Period	**Fourth Quarter 7/1/09 – 9/30/09**	**First Quarter 10/1/09 - 12/31/09**	**Second Quarter 1/1/10 – 3/31/10**	**Third Quarter 4/1/10 – 6/30/10**	**Four-quarter Performance**
Performance Indicator	75.00%	91.11%	100%	100%	91.52%
Numerator (Consumers Served Within 120 days)	56	45	30	20	151
Denominator (Consumers Referred)	42	41	30	20	133

The Court Monitor has, however, denied DMH's request to move this Exit Criterion to inactive status, insisting instead that DMH monitor compliance for each consumer - *i.e.*, whether

or not every individual who should be referred to supported employment is being referred. Notwithstanding the District's substantial disagreement with the Court Monitor on this issue, DMH developed an additional monitoring tool through adaptation within its *eCura* claims processing system, to which all providers have input and access. This monitoring tool requires input by the CSA regarding supported employment for every consumer at the 90-day quarterly event screen. DMH is now getting data from this tool and is working with each provider to ensure it understands both how to use the event screen for supported employment, and that it's staff fully understand the underlying purpose of the program.

DMH continues to collaborate with the Rehabilitative Services Administration ("RSA") to expand Supported Employment and increase service capacity. RSA entered into Human Care Agreements, or contracts, with DMH's six (6) Supported Employment service providers. However, delays involving RSA's authorization and payment processes have slowed the expansion of services and DMH and RSA have established a workgroup to resolve the issues with the goal of expanding Supported Employment by 150 consumers

DMH is finalizing its collaboration with the District's Department of Human Services ("DMH") to focus on individuals receiving Temporary Assistance to Needy Families ("TANF") who qualify for DMH services. DMH and DHS have entered into a Memorandum of Agreement and are currently in the process of negotiating a funding agreement which will fund additional positions in DMH's Supported Employment programs in order to provide these TANF recipients with Supported Employment services. This will also allow DMH to continue to expand its service capacity.

C. Additional Progress on Remaining Exit Criteria

DMH continues to make progress on the remaining Exit Criteria, # 2-4, 9, and 17. Specific details regarding DMH's progress on these Exit Criteria have been submitted to the Court Monitor, who continues to receive updates during his bi-monthly visits.

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; ongoing progress in implementation and use in quality improvement system.

The web-based LOCUS/CALOCUS tool, now fully implemented, will assist DMH to satisfy the requirements of Exit Criterion # 2. The technology and programming issues have been resolved, and the last hurdle is transitioning providers from a paper-based to a web-based system. All providers have been trained on the web-based LOCUS/CALOCUS, and DMH staff has been vigorously educating provider staff at the executive and the direct-services levels on the benefits of using the web-based system.

DMH has three specific areas in which the web-based LOCUS/CALOCUS system is being used to affect quality improvement: first is the actual compliance with the LOCUS/CALOCUS policy, which requires an updated LOCUS/CALOCUS to be completed every 180 days for every consumer, in addition to the requirement for a new LOCUS/CALOCUS whenever a higher level or care for ACT, Community-Based Intervention ("CBI"), hospitalization or a Psychiatric Residential Treatment Facility ("PRTF") is required. Secondly, DMH has begun an initiative to assess every individual currently placed in a contracted Community Residence Facility ("CRF") to determine if the person needs that particular level of care and the Department is using the LOCUS scores as an important instrument to assist in that assessment. This process will also be applied to monitoring of other high end services, including

ACT and CBI. Finally, DMH has developed a set of guidelines for appropriate application of level of care recommendations to the selection of specific MHRS and specialty services. Providers can use the guidelines as a resource to compare an individual's treatment plans and services with the LOCUS/CALOCUS recommendations for level of care, and to determine what (if anything) needs to be revised to enhance appropriateness of services for that individual. DMH anticipates that with this demonstrated use, Exit Criterion # 2 will be able to be moved to inactive status within the next few months as well.

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

Required System Performance: 80%

DMH Performance: FY 08: 74%
DMH Performance: FY 09: 70%
DMH Performance: FY 10: 76%

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%
DMH Performance: FY 09: 48%
DMH Performance: FY10: 49%

Exit Criteria 3 and 4 are addressed in tandem. DMH's internal CSR unit was instrumental in the FY 10 CSR training and reviews, and will be even more active for the FY 11 reviews. Under the supervision of Human Systems and Outcomes, Inc. (HSO), the company contracted by the Court monitor to conduct the CSRs, the CSR unit will lead both the adult and child/youth training for new reviewers and complete the training for returning reviewers. In addition to facilitating the training and review process, the CSR unit will assume a lead role in managing the overall quality of the reviews to include active participation in case judging and

case debriefing sessions. In order to further enhance the sustainability of the CSR process within DMH programs, a Request for Proposals ("RFP") is being posted to hire a consumer and/or family operated agency to handle the logistics of the CSR process (contacting consumers, obtaining permission and consents, scheduling interviews, and also participating in the reviews). Previously CAN was contracted by the Court Monitor to handle most of these functions; in order for DMH to assume this logistical process, an RFP had to be used to ensure compliance with the District's contracting requirements.

Additionally, DMH has identified six providers (two adult and four child/youth) to receive intensive technical assistance in an effort to receive targeted training with the goal of improving provider's system performance. DMH identified the six providers based on a matrix of criteria including: prior year CSR scores, number of consumers served, growth and/or projected growth of provider, and input from the Office of Programs and Policy. Each of the six providers received a focused review of their FY 10 CSR performance. Based on the individual agency results, providers identified areas of practice improvement. Each agency developed a six month to one year action plan to address those areas of focus and will begin implementation no later than October 1, 2010. All six agency plans have been received, with some returned for revisions. It is expected that these efforts will enhance the quality of practice at the six chosen providers which will be reflected in the system performance scores on the next annual CSR. Adult CSRs are scheduled to occur January 31 – February 18, 2011; child CSR's will occur May 9 – May 27, 2011.

Exit Criterion # 9: Supported Housing.

Required System Performance: 70% Served within 45 days

DMH Performance: 10%; the required system performance is being examined in terms of best practices

DMH currently has the capacity to provide Supported Housing to 1,646 consumers, which exceeds the supported housing available in Maryland and Virginia combined. The Supported Housing programs include housing subsidies for 750 consumers, supported housing for more than 461 additional consumers living in Supported Independent Living programs, and 90 federal vouchers specifically reserved for DMH consumers. The partnership with the Department of Community and Housing Development ("DHCD") continues; currently $13.7 million of the $14 million in capital funds has been committed to develop new, or greatly improve existing, housing for DMH consumers. The grant requirements dictate that restrictive covenants must be recorded with the Register of Deeds, restricting these units to use by DMH consumers for a minimum of 25 years. As of March 30, 2010, 63 of the 248 current pipeline units have been completed, and 61 are occupied by individuals with a psychiatric illness. Referrals are now being processed for the remaining two (2) vacancies. Using the existing capital funds, $1 million has been granted to Cornerstone, Inc., a non profit housing development organization, for a Housing Improvement Program initiative ("HIPi") grant. As a term of the HIPi grant, Cornerstone was required to find in matching funds that it could use to assist homeowners in smaller projects to improve housing for DMH consumers; for the "independent" Community Residence Facility operators who have projects of less than $15,000, no matching funds will be required. Cornerstone already has committed $323,442 of these grant funds for the improvement of sixty-eight (68) units. DMH has been authorized an additional $1 million in capital funds for the FY 11 Budget to continue this tremendously successful partnership.

Although the Court Monitor denied DMH's October 29, 2009 request to modify Exit Criterion # 9, to better reflect "achievable, useful and reasonable measures" for supported housing including: sustainability (consumers in housing for more than one year); supportive

services; and percentage of the District's population with Serious Mental Illness that receive supported housing, DMH continues to work with the Court Monitor on this criterion. The DMH Housing Plan should be completed, with the assistance of The Corporation for Supported Housing ("CSH"), by the end of December, 2010. As stated above, the partnership with DHCD continues with an additional $1 million from the FY 11 budget dedicated to increasing and improving the housing available to consumers.

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: 53.63% for the four quarter period beginning April 1, 2009 and ending March 31, 2010. (55.49% adults and 49.2% child/youth)

Exit Criterion # 17 requires that 80% of people known to be discharged from an inpatient psychiatric hospital receive a non-emergency community-based service within seven (7) days of discharge. While the District has not yet met that standard, its performance remains above the national averages of all Medicare and Medicaid plans. Based on data reported by the National Committee for Quality Assurance ("NCQA")[3] for 2009, the national average was 42.6% of Medicaid patients seen within 7 days of discharge from hospitalization; the District's average for April 1, 2009 – March 31, 2010 was 53.25% (up from 47.8% for FY 09). Similarly, for the 30-

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[3] NCQA is a private, 501(c)(3) not-for-profit organization dedicated to improving heath-care quality, and has developed quality standards and performance measures for a broad range of health-care entities. NCQA accredits health plans in every state, the District of Columbia, and Puerto Rico that cover 109 million Americans, or 70.5% of all Americans enrolled in health plans. NCQA accreditation requires annual reporting on performance measures from the accredited healthcare plans. These performance measures are referred to as the Healthcare Effectiveness Data and Information Set ("HEDIS") and are used by health plans, employers and other health-insurance purchasers to measure performance on various dimensions of care and service. (*See* http://www.ncqa.org, accessed February 18, 2010.)

day post-discharge service information, the national average for Medicaid patients was 61.7%, while the District's was 69.5% (same time period).

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 are now available, which the Court Monitor refused. DMH continues to work to refine its performance in this area.

The DMH Integrated Care Division ("ICD") monitors and assists provider performance on this Exit Criterion. A Care Manager in the ICD is responsible for monitoring the CSA follow-up and compliance with discharge plans for all individuals discharged from Saint Elizabeths Hospital. Additionally, Care Managers provide continuity of care monitoring to consumers discharged from Providence Hospital, United Medical Center, and the Psychiatric Institute of Washington ("PIW") who were originally admitted with authorization from DMH. A staff person from the DMH Children and Youth Services Division was retrospectively reviewing discharges for children from CNMC and PIW; this position is now being moved into the ICD as a full-time position effective October 2010 and will provide both hospital discharge support and continuity of care monitoring post discharge using the same methodology that have been implemented for adult consumers, adjusted to the unique needs of children and youth. DMH anticipates that the addition of the child focused care manager will significantly improve performance by the child-serving CSAs.

III. ADDITIONAL DMH PROGRAMS

A. Closure of DCCSA and Transition of Consumers

The closure of the DCCSA and the transition of DCCSA consumers to private providers or to the newly created Mental Health Services Division ("MHSD") were completed on schedule

before March 31, 2010. DMH continues to monitor former DCCSA consumer visits to CPEP, and the DMH ICD has individually followed each DCCSA consumer who visited CPEP for FY 10. Preliminary data shows that since December 2009, the number of former DCCSA consumers who had an involuntary admission to a psychiatric hospital has steadily declined from 24 (December 2009) to 9 (August 2010), or from 30% of all admissions in December 2009 (the highest during FY 10) to 11% in August 2010.

B. Saint Elizabeths Hospital

(1) Construction of New Saint Elizabeths Hospital Building

Following the Grand Opening of the new hospital on April 22, 2010, patients were moved into the building on May 3, 2010. Phase III work began shortly after that, once John Howard Pavilion ("JHP") was cleared. Phase III includes abatement and demolition of JHP, along with the construction of the new recreation park and parking areas for the hospital. Phase III is anticipated to continue into the first half of 2011. DMH and the District are very excited at this addition to the public mental health system.

(2) Implementation of Saint Elizabeths Hospital Census Reduction Plan

The hospital census continues to decline. On September 21, 2009, there were 342 patinets at Saint Elizabeths (179 individuals with a civil status, 163 for forensic issues); a year later, on September 20, 2010, there were 312 patients (146 civil patients, 166 forensic patients). Thirty-six (36) patients are hospitalized in the older RMB building.

Acute admissions to community hospitals continue, thus relieving Saint Elizabeths from serving as the District's primary acute care hospital. For the first 11 months of FY 10 (October 2009 through August 2010), acute care admissions to Saint Elizabeths totaled 57 out of 775 total acute care admissions – or 7.3% of all acute care admissions. (*See* Exhibit G, FY 10 Involuntary

Hospital Admissions Monthly Report). This is a significant drop even from FY 09, when acute care admission to Saint Elizabeths was 14% of all acute care admissions. DMH is finalizing a contract with Washington Hospital Center to accept acute involuntary admissions, in addition to the three community hospitals (UMC, Providence, and PIW) that currently accept involuntary adult admissions authorized by DMH. The ICD staff participates in continuity of care reviews at these community hospitals. During the continuity of care review, the ICD care manager and the hospital staff review the plan of care in the hospital and the coordination with the individual's CSA. Upon discharge, the care manager works with the CSA to ensure continuity of care visits are completed and that discharge recommendations are followed. The ICD staff monitors all discharges from Saint Elizabeths Hospital and the community hospitals to track follow-up care.

C. Crisis Intervention Officers

The Crisis Intervention Officer (CIO) Initiative represents a groundbreaking effort between law enforcement, mental health and community stakeholders to improve outcomes of police interactions with people with mental illnesses. Launched in April of 2009, the CIO Initiative is a collaboration spearheaded by DMH, the Metropolitan Police Department (MPDC), and the DC Chapter of the National Alliance on Mental Illness (NAMI).

Since the first class was offered in April 2009, eight CIO classes with 171 total officers, or about 7% of MPD's workforce, have been trained. The goal is to train 15-20% of the total workforce. One more CIO class is scheduled for November 2010, and an additional five classes have been scheduled for 2011. Call takers and dispatchers from the Office of Unified Communications have also been trained on the roles and responsibilities of CIOs, and the dispatchers' roles in assessing and dispatching CIOs on-scene. The MPD Special Order for Crisis Intervention Officers was released to MPD officers in September of 2010, and will

increase visibility, awareness and utilization of CIO's in their intended roles. At the same time, a special training was held for MPD watch commanders and other supervisors to ensure that the CIO's role and capabilities were understood and properly utilized.

DMH meets monthly with MPD CIO Coordinators to collect data, address barriers to implementation, and to provide resources and information to assist CIOs in their work. Collection of data from the CIOs in the field is still very much in a pilot phase, but as the program matures the data will be analyzed to quantify the actual value that CIOs add to the treatment of the mentally ill in the District.

D. FY 11 Budget

The FY 2011 Budget for the District of Columbia was approved by the D.C. Council on June 28, 2010, and is awaiting passage by the U.S. Congress. Overall, the FY 2011 DMH Budget is 9.2% less than the approved FY 2010 DMH Budget. Savings will be recognized in fixed costs and non-personnel services, as well as shifting some previously locally-funded services to Medicaid billings, and are expected to have minimal impact on services to consumers. Other changes include a planned reduction in full-time-equivalent employees resulting from the closure of the DCCSA and the reorganization of Saint Elizabeths Hospital.

IV. CONCLUSION

The District has an effective, vibrant community-based public mental health system and continues its significant progress in meeting the *Dixon* Exit Criteria.

FILED: October 1, 2010

Respectfully submitted,

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EXHIBIT A

Exhibit A

DMH Exit Criteria
Status Matrix
PERFORMANCE LEVELS
APRIL 1, 2009 – MARCH 31, 2010

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
1.	Consumer Satisfaction Method(s)	Yes	N.A.	N.A.	N.A.	**Inactive**	Methods + Demonstrated Utilization of Results	Letter requesting inactive status submitted to Court Monitor on June 4, 2010. Approved on August 16, 2010.
2.	Consumer Functioning Method(s)	Yes	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. Target for full automation is October 2009. Current focus is on customized reporting and demonstrated use of the application.
3.	Consumer Reviews (Adult)	Yes	Yes	Yes	Yes	**Active**	80% for Systems Performance	**FY 10: 76%**[1]
4.	Consumer Reviews (Child)	Yes	Yes	Yes	Yes	**Active**	80% for Systems Performance	**FY 10: 49%** [2]

[1] Results from adult community service reviews conducted in May 2010, reported by Human Systems Outcomes, Inc. to the Dixon Court Monitor.
[2] Results from child/youth community service reviews conducted in March 2010, reported by Human Systems Outcomes, Inc. (HSO) to the Dixon Court Monitor.

Exhibit A

DMH Exit Criteria
Status Matrix
PERFORMANCE LEVELS
APRIL 1, 2009 – MARCH 31, 2010

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
5.	Penetration (C/Y 0-17 Years)[3][4]	Yes	Yes	Yes	Yes, as of January 25, 2007, revised April 23, 2008 and February 23, 2010.	**Active**	5%	**Total: 4.96 %**[5]
6.	Penetration (C/Y with SED)[6]	Yes	Yes	Yes	Yes, as of January 25, 2007 revised April 23, 2008 and February 23, 2010.	**Inactive**	3%	**Total: 3.16 %**[7]
7.	Penetration (Adults 18 + Years)[8]	Yes	Yes	Yes	Yes, as of January 25, 2007 revised April 23, 2008 and February 23, 2010.	**Inactive**	3%	**Total: 3.33 %**[9]

[3] The run date for all MHRS claims based data reported for Exit Criteria 5 and 7 was September 14, 2010 for the four quarter period beginning on April 1, 2009 and ending on March 31, 2010. 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. 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.

[4] The data reported for Exit Criteria 5, 6, 7 and 8 includes data about services provided to unique consumers who received a mental health service that was covered by one of the Medicaid Managed Care Organizations (MCOs), Free Standing Mental Health Clinics, School-Based Mental Health Programs, PRTFs, Wrap Around and the Assessment Center. On February 24, 2010, the District submitted a letter to the Court Monitor requesting inactive monitoring status based upon substantial compliance with the performance target for Exit Criterion #5. The request was denied by the Court Monitor via letter dated March 24, 2010.

[5] Data reported is for the four quarter period from April 1, 2009 through March 31, 2010.

[6] On February 24, 2010, the District submitted a letter to the Court Monitor requesting inactive monitoring status based upon compliance with the performance target. The request for inactive status was approved by the Court Monitor via letter dated March 24, 2010.

[7] See footnotes 3 and 4 regarding data reporting and claims lag. Data reported for Exit Criteria 6 and 8 was run on June 24, 2010.

[8] On February 24, 2010, the District submitted a letter to the Court Monitor requesting inactive monitoring status based upon substantial compliance with the performance target. The request was denied by the Court Monitor via letter dated March 24, 2010. DMH submitted a second request for inactive monitoring status DMH requested inactive monitoring status based upon compliance with the performance target via letter dated April 2, 2010. Inactive status was approved by the Court Monitor via letter dated April 19, 2010.

[9] See footnotes 3 and 4 regarding data reporting and claims lag.

Exhibit A

DMH Exit Criteria
Status Matrix
PERFORMANCE LEVELS
APRIL 1, 2009 – MARCH 31, 2010

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
8.	Penetration (Adults with SMI)	Yes	Yes	Yes	Yes, as of January 25, 2007 revised April 23, 2008 and February 23, 2010.	**Inactive**	2%	**Total: 2.97 %**[10]
9.	Supported Housing[11]	Yes	Yes	Yes	Yes, as of January 17, 2008.	**Active**	70% Served Within 45 Days	**Total: 10.0 %**
10.	Supported Employment[12]	Yes	Yes	Yes	Yes, as of January 17, 2008.	**Active**	70% Served Within 120 Days	**Total: 84.71 %**[13]
11.	Assertive Community Treatment	Yes.	Yes	Yes	Yes, as of November 19, 2009.	**Active**	85% Served within 45 days of completed referral	**Total: 86.93%**[14]

[10] 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. See footnotes 3 and 4 regarding data reporting and claims lag. See footnote 7 regarding data report run date.

[11] DMH currently reports data regarding consumers who are receiving rental subsidies from DMH. On October 26, 2009, DMH submitted a letter to the Dixon Court Monitor requesting a modification of the performance indicators for Exit Criterion 9. A response to the letter is pending. The data reported is based upon the approved reporting metric.

[12] 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.

[13] Data is reported for the four quarter period beginning on April 1, 2009 and ending on March 31, 2010. Please note that the lag time for reporting provision of supported employment services is 120 days after the end of the reporting period, so the data reported is not complete for the 4th quarter.

[14] The data reported for Exit Criterion #11 was run on September 14, 2010 for the four-quarter period beginning on April 1, 2009 and ending on March 31, 2010. On December 9, 2009, DMH submitted a letter to the Court Monitor, requesting that the Court Monitor find that DMH met the performance target for Exit Criterion #11 and move the measure to inactive monitoring status. This request was denied on April 19, 2010. DMH submitted a supplemental letter requesting that the Court Monitor find that DMH met the performance target for Exit Criterion #11 and move the measure to inactive monitoring status on September 2, 2010. This letter remains pending.

Exhibit A

DMH Exit Criteria
Status Matrix
PERFORMANCE LEVELS
APRIL 1, 2009 – MARCH 31, 2010

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
12.	Newer – Generation Medications[15]	Yes	Yes	Yes	Yes, as of January 25, 2007, revised April 23, 2008.	**Inactive**	70% of adults with schizophrenia receive atypical medications	**Total: 64.1 %**
13.	Homeless (Adults)	Yes	Yes	Yes	Yes, as of December 21, 2007.	**Inactive**	150 Served + Comprehensive Strategy[16]	**Total: 276** [17]
14.	C/Y in Natural Setting[18]	Yes	Yes	Yes	Yes, as of January 25, 2007, revised April 23, 2008.	**Inactive**	75% of SED With Service in Natural Setting	**Total: 81.2%**[19]
15.	C/Y in own (or surrogate)[20]	Yes	Yes	Yes	Yes, as of January 25, 2007 revised April 23, 2008.	**Inactive**	85% of SED in Own Home or Surrogate Home	**Total: 89.6 %**[21]
16.	Homeless C/Y	Yes	Yes	Yes	Yes, as of June 5, 2008.	**Inactive**	100 Served + Comprehensive Strategy[22]	**Total: 80**[23]

[15] The data reported for Exit Criterion #12 was run on September 14, 2010 for the four-quarter period beginning on April 1, 2009 and ending on March 31, 2010. 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.

[16] 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.

[17] The data reported for Exit Criterion #13 was run on September 14, 2010 for the four-quarter period beginning on April 1, 2009 and ending on March 31, 2010. 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.

[18] DMH has achieved 85% of the penetration rate targets established in Exit Criterion #6 for services to children and youth with SED (Exit Criterion #6), which is a pre-requisite for requesting inactive monitoring status for Exit Criterion #14. On March 9, 2010, DMH submitted a letter to the Court Monitor requesting inactive monitoring status for Exit Criterion #14 based upon performance during FY 2009. This request was granted via letter dated May 7, 2010.

[19] The data reported for Exit Criterion #14 was run on September 14, 2010 for the four-quarter period beginning on April 1, 2009 and ending on March 31, 2010.

[20] DMH has achieved 85% of the penetration rate targets established in Exit Criterion #6 for services to children and youth with SED (Exit Criterion #6), which is a pre-requisite for requesting inactive monitoring status for Exit Criterion #15. On March 9, 2010, DMH submitted a letter to the Court Monitor requesting inactive monitoring status for Exit Criterion #15 based upon performance during FY 2009. This letter remains pending.

[21] The data reported for Exit Criterion #15 was run on September 14, 2010 for the four-quarter period beginning on April 1, 2009 and ending on March 31, 2010.

Exhibit A

DMH Exit Criteria
Status Matrix
PERFORMANCE LEVELS
APRIL 1, 2009 – MARCH 31, 2010

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
17.	Continuity of Care[24] a. Adults b. C/Y	Yes	Yes	Yes	Yes, as of November 11, 2007.	**Active**	80% of Inpatient Discharges Seen Within 7 Days	**Overall: 53.63%** **Adults: 55.49%** **Children: 49.2%**
18.	Community Resources	Yes	Yes	Yes	Yes, as of October 16, 2008.	**Inactive**	60% of DMH Expenses for Community Services	**FY 06: 60.45%** **FY 07: 59 %** **FY 08: 57 %**
19.	Medicaid Utilization[25]	Yes	Yes	Yes	Yes, as of December 13, 2007.	**Inactive**	49% of MHRS Billings Paid by Medicaid	**FY 10: 50.9%**[26]

[22] See footnotes 16 and 17 regarding inactive status of monitoring and comprehensive strategy.
[23] Data is reported for the four quarter period from October 1, 2008 through September 30, 2009.
[24] The data reported for Exit Criteria #17 was run on September 14, 2010 for the four quarter period beginning on April 1, 2009 and ending on March 31, 2010. 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.
[25] 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.
[26] Data is reported regarding revenue collection for FY 10 as of September 1, 2010.

EXHIBIT B

Exhibit B

Dennis R. Jones
Office of Dixon Court Monitor

1111 W. 10th Street
Psychiatry Building, Room 201
Indianapolis, IN. 46202-4800
(317) 278-9130

April 19, 2010

Mr. Stephen Baron, Director
Department of Mental Health
64 New York Avenue NE
Fourth Floor
Washington, DC 20002

Re: Evidence of Compliance with Exit Criteria #7 – Provision of Services to Adults

Dear Mr. Baron,

I have reviewed your letter of April 2, 2010, regarding compliance levels on Exit Criterion #7 – Provision of Services to Adults. Your April 2, 2010 letter documents that DMH has achieved a penetration rate of 3.01% based on a total of 14,640 adults served out of a total District census for adults of 485,621 for the four (4) quarters beginning January 1, 2009 and ending December 31, 2009.

I appreciate the continued improvement that DMH has made on this Exit Criterion. The Court Monitor finds that DMH has now reached the required compliance level of 3%. Therefore, I recommend that this Exit Criterion move to inactive status.

Sincerely,

Dennis R. Jones, MSW, MBA
Dixon Court Monitor

cc: Robert Duncan
Anthony Herman
Iris Gonzalez
Anne Sturtz ✓

EXHIBIT C

Exhibit C

Dennis R. Jones
Office of Dixon Court Monitor

1111 W. 10th Street
Psychiatry Building
PB, Room A208
Indianapolis, IN. 46202
(317) 278-9130

May 7, 2010

Mr. Stephen T. Baron, Director
Division of Mental Health
64 New York Avenue NE
4th Floor
Washington, DC 20002

Re: Evidence of Compliance with Exit Criterion #14 – Provision of Services to Children & Youth with Serious Emotion Disturbance (SED) in Natural Settings

Dear Mr. Baron,

I have reviewed your letter of March 9, 2010, which requests that the Court Monitor find that DMH has achieved the required performance levels for Exit Criterion #14 and that the Court Monitor should therefore cease active monitoring on #14.

In review of the March 9, 2010, letter the Court Monitor finds that: 1) the DMH has met the requirements for policy and practice; 2) the DMH has met the data validation requirements for this measure; and 3) DMH has achieved the required performance levels for this Criterion. The performance requirements for #14 are two-fold. First, the DMH must achieve a penetration rate for SED children/youth of at least 2.5%. The DMH has documented that for the four quarters of FY '09 it has achieved a penetration rate of 2.56%; this rate is based upon MHR'S claims submitted as of March 4, 2010. The second performance requirement is that DMH must document that a minimum of 75% of children/youth who are served by DMH had a service in a natural setting. For the same FY '09 period, DMH has documented that 2226 (out of the total of 2925 SED children/youth served) were provided a service in a natural setting. This 76.1% performance level exceeds the required 75% performance threshold.

Based on these findings, the Court Monitor finds that the District has met all of the required performance elements for Exit Criterion #14 and should therefore move to inactive status on this measure.

Sincerely,

Dennis R. Jones, MSW, MBA
Dixon Court Monitor

cc: Anthony Herman, Counsel to the Plaintiffs
Iris Gonzales, Counsel to the Plaintiffs
Grace Graham, Counsel for the Defendants
Robert Duncan, Counsel for the Court Monitor

EXHIBIT D

Exhibit D

Dennis R. Jones
Office of Dixon Court Monitor

1111 W. 10th Street
Psychiatry Building
PB, Room A208
Indianapolis, IN. 46202
(317) 278-9130

August 16, 2010

Stephen T. Baron, Director
Department of Mental Health
64 New York Avenue NE
Fourth Floor
Washington, DC 20002

Re: Evidence of Compliance with Exit Criteria #1 – Methods of Measuring Consumer Satisfaction

Dear Mr. Baron,

I have reviewed your letter of June 4, 2010 requesting inactive monitoring status on Exit Criterion #1. This Exit Criterion requires that DMH select specific consumer satisfaction method(s), which must be approved by the Court Monitor and that DMH shall then implement these method(s) so as "to provide timely, accurate and service-specific information". The key factor is that "consumer satisfaction data is being considered and utilized as appropriate to improve the availability and quality of care".

DMH selected three (3) different consumer satisfaction methods and has included these in DMH policy 115.2, (Consumer Satisfaction Methods). I approved these three (3) as of my July 2006 Report to the Court. These methods include: 1) the use of the nationally standardized Mental Health Statistics Improvement Program (MHSIP) Survey regarding consumer satisfaction; 2) random convenience sampling of consumers and; 3) the use of focus groups to obtain feedback from consumers on specific issues or services. The implementation of these consumer satisfaction methods has been via contracts; several different consumer groups have performed the annual MHSIP Survey and the Consumer Action Network (CAN) has conducted the convenience sampling and focus groups methods.

I have reviewed the three (3) specific quality improvement initiatives that have grown out of information received from consumers via the above-referenced methods. These include:

1. The Analysis and Utilization of MHSIP Survey Data – The DMH in the 2009 MHSIP Survey made improvements to the long-standing deficiencies in the MHSIP survey design and protocol, in response to recommendations made by the Internal Quality Committee (IQC). As a result, participation improved by 33% for adults and 27% for children & youth from the 2008 survey. DMH has performed a careful analysis of the 2009 MHSIP results which were presented to the

IQC in April 2010. The IQC has identified four (4) specific satisfaction areas that will require additional analysis before actions steps are taken.

2. Consumer Participation in Treatment – The DMH learned from the 2008 CAN Focus Group Report that many consumers had concerns about lack of participation in treatment planning. As a result, DMH has developed a Quality Review tool that measures markers of consumer involvement in treatment planning. This review tool was implemented as part of the overall pilot phase of the new Provider Scorecard in FY 2009. For FY 2010, the results of the quality reviews, as reported in the Scorecard, will be publicly available to providers and consumers. Consumers can then make informed choices about which provider can best meet their needs – with consumer participation as one of the measures.

3. Medical Co-Morbidity – DMH has targeted the whole issue of the high rate of medical morbidity for individuals with serious mental illness. This problem of premature death due to medical conditions has been widely discussed in national studies and is also evident in DMH's Mortality Review process. Starting in 2008, the IQC began a Quality Improvement Initiative intended to increase the number of consumers linked to primary care providers and to also reduce the number of medically-related adverse incidents. DMH has shown that, as a result of this Initiative, the percentage of consumers linked to primary care increased over the first year from 70.2% to 82% - an increase of 12%. This is an excellent example of DMH utilizing its Quality Wheel (Plan, Do Study, Act).

Based on the above analysis, it is clear that DMH now has an infrastructure in place to perform quality improvement. It is also clear that DMH is utilizing the consumer satisfaction methods to improve the availability and quality of care. Therefore, I recommend that Exit Criterion #1 (Consumer Satisfaction Methods) move to an inactive status.

Dennis R. Jones, MSW, MBA
Dixon Court Monitor

Cc : Anthony Herman, Plaintiffs Counsel
Iris Gonzales, Plaintiffs Counsel
Robert Duncan, Counsel for Court Monitor
Grace Graham, Counsel for District of Columbia

EXHIBIT E

Exhibit E

Dennis R. Jones
Office of Dixon Court Monitor

1111 W. 10th Street
Psychiatry Building
PB, Room A208
Indianapolis, IN. 46202
(317) 278-9130

September 13, 2010

Stephen T. Baron, Director
Department of Mental Health
64 New York Avenue NE
Fourth Floor
Washington, DC 20002

Re: Evidence of Compliance with Exit Criterion #15– Provision of Services to Children and Youth with SED Living in Their Own or Surrogate Homes

Dear Mr. Baron,

I write in response to your letter of March 9, 2010, with supplemental letters on March 25, 2010 and July 22, 2010. These letters request that the Court Monitor cease active monitoring on Exit Criteria #15– Provision of Services to Children and Youth with SED Living in Their Own or Surrogate Homes. I have reviewed all of the relevant information and data re: EC #15 and have had multiple conversations with the parties regarding same.

Per the Consent Order of December 12, 2003, this Exit Criterion requires that 85% of all children/youth served by DMH with SED will be living in their own home or a surrogate home. The measurement of this criterion is conditioned upon DMH first achieving a penetration rate for SED children/youth of at least 2.5%. The Court Monitor finds that for the four consecutive quarters beginning on April 1, 2009 and ending on March 31, 2010, DMH achieved a penetration rate for children/youth with SED of 2.61%--thus exceeding the penetration rate pre-condition of 2.5%. For this same time period, DMH served 2663 children/youth in their own or surrogate home out of the total of 2977 SED children/youth who were served. This translates to a performance level of 89.45% which exceeds the Court-approved requirement.

The Court Monitor also finds that DMH has developed policies and practices that are essential to the goal of maintaining children/youth in their own (or surrogate) home or returning them to home as soon as possible if they are placed in a Psychiatric Residential Treatment Facility (PRTF). The Court Monitor particularly notes the positive ongoing role of the RTC Reinvestment Unit (RTCR) in assessing (for appropriateness) all out-of-home placements for Medicaid fee-for-service children/youth. The RTCR also monitors all fee-for-service Medicaid PRTF placements to assure adequate treatment, ongoing medical necessity, and connectivity to needed community services upon discharge. As the Court Monitor has

noted in multiple reports to the Court, the remaining gap is for non-Medicaid children/youth who bypass the DMH system and are placed without DMH review or services intervention. DMH has made significant efforts to determine the number of children/youth who were in PRTF's but did not receive an MHRS service. The best available estimate is 235 for FY '09 (October 1, 2008 – September 30, 2009). It should be noted that 87 of this total were from DCPS but DMH was not provided with unique identifiers; hence DMH could not match to its MHRS data base to determine if these children received an MHRS service. If all of the 235 children/youth were included in the denominator for the FY '09 period, (i.e. all SED children/youth who were served inclusive of all PRTF admissions), the percentage of compliance would be 85.9% (2716 served in own/surrogate home out of 3160 total children served).

In review of all this, the Court Monitor finds that the DMH has met the Court-approved criterion on Exit Criteria #15 and is recommended to move to inactive status. At the same time, it is recognized that additional work remains for the District as part of the larger systems of care requirement for children and youth.

Dennis R. Jones, MSW, MBA
Dixon Court Monitor

Cc : Anthony Herman, Plaintiffs Counsel
Iris Gonzales, Plaintiffs Counsel
Robert Duncan, Counsel for Court Monitor
Grace Graham, Counsel for District of Columbia

EXHIBIT F

Exhibit F

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF MENTAL HEALTH

Office of the Director

September 2, 2010

Dennis R. Jones, Monitor
1111 10th Street, Suite 201
Indianapolis, Indiana 46202

Re: Dixon et al. v. Fenty, et al.
CA No. 74-285 (TFH)
Evidence of Compliance with Exit Criterion #11 – Demonstrated Provision of Assertive Community Treatment to Adults With Serious Mental Illness

Dear Mr. Jones:

I am pleased to report that DMH has met and exceeded the performance target for Exit Criterion #11 – Demonstrated Provision of Assertive Community Treatment (ACT) to Adults with Serious Mental Illness ("Exit Criterion #11") for the four quarter period beginning April 1, 2009 and ending March 31, 2010. Accordingly, DMH hereby requests that the Dixon Court Monitor: (1) find that DMH has achieved the performance levels required for Exit Criterion #11; (2) report on the performance levels to the U.S. District Court; and (3) cease active monitoring of Exit Criterion #11.

This letter responds to your letter of April 19, 2010 denying our request to find that the Department of Mental Health ("DMH") had met the performance target for Exit Criterion #11 and supplements my letters of December 9, 2009, February 4, 2010, February 12, 2010 and February 23, 2010 regarding Exit Criterion #11 and the provision of ACT services in the District of Columbia. In your April 19, 2010 letter, you found that DMH satisfied the performance target requirement to provide ACT services within seven (7) days of referral to over 85% of the adults with SMI referred for the service. However, you also found that DMH had not met the requirement for demonstrating policy compliance. This letter addresses the policy compliance concerns outlined in your April 19, 2010 letter, as well as additional questions you raised during recent meetings with the DMH ACT staff, and to provide current performance data for the period from April 1, 2009 through March 31, 2010 demonstrating continued compliance with the performance target.

ACT Capacity and Referrals of Eligible Individuals

As discussed in my letter of December 9, 2009, DMH has set a goal to continue to increase the capacity of the public mental health system to provide ACT services.[1] To meet this goal, the ACT programs expanded from five (5) ACT teams operated by three (3) providers to eleven (11) ACT teams operated by six (6) providers[2]. DMH memorialized its expansion goal in the annual Performance Management Plan for FY 2009, continued the goal in its Performance Management Plan for FY 2010 and proposes to continue this goal in FY2011. The target for FY 2009 was enrollment of 500 consumers. The target for FY 2010 was enrollment of 650 consumers. The target for FY 2011 is enrollment of 850 consumers. The target for FY 2012 is enrollment of 1,000 consumers.[3] As of August 12, 2010, there are 939 consumers enrolled in ACT services, exceeding our goal for FY 2010 and FY 2011.

As you know, ACT is a service that is to be provided to individuals most in need. The expansion of services is intended to ensure that individuals with high needs have access to ACT services. Therefore, we have put in place a number of systemic processes to ensure that those individuals with high needs are routinely assessed for potential referral to ACT. As previously discussed, DMH encourages ACT referrals from a variety of sources whose services are targeted to individuals most in need of high intensity mental health services. These include the DMH's High-Utilizer projects (frequent users of CPEP and inpatient services), the Saint Elizabeths discharge project, the Homeless Outreach Program and community organizations or advocacy organizations, such as Miriam's Kitchen, N Street Village, the New Hope Ministry and University Legal Services.

Analysis of the ACT referral source data for the period from April 1, 2009 – March 31, 2010 shows that 47% of the total referrals for ACT services came from a combination of the DMH processes for identifying consumers eligible for and needing ACT services and various sources outside the public mental health system. Thirty-two percent (32%) came from a combination of the DMH High-Utilizer projects, Saint Elizabeths discharge project or the Homeless Outreach program. An additional fifteen percent (15%) of the referrals came from sources designated as "other." For this reporting period, "other" sources include non-CSAs, such as Miriam's Kitchen, University Legal Services and New Hope Ministry. A chart with detailed information about referral sources is attached for your reference and marked as ***Exhibit A***.

To ensure that individuals most in need receive ACT services, LOCUS scores are used by DMH as a qualifier for ACT services. Individuals referred to ACT services must have a LOCUS score

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[1] National prevalence data indicated that the District needed to increase its capacity to provide ACT services. DMH also received requests for expanded ACT services from stakeholders, including judges, homeless providers and Saint Elizabeths Hospital staff.

[2] Current ACT providers are Anchor, Community Connections, Green Door, Family Preservation, Hillcrest, Pathways to Housing. A twelfth team, operated by Capital Community Services is in start-up.

[3] A copy of DMH's FY 2010 Performance Management Plan is available on the District's website (www.dc.gov). Click on the CapStat link. The Key Performance Indicators, including the indicator for ACT capacity are included in the annual Performance Management Plan and include performance targets for FY 2011 and FY 2012.

of 20 – 22 or higher to initially receive ACT services. *See* DMH Policy 340.6A, para. 5d. However, a LOCUS score alone does not qualify an individual for ACT services, nor are CSA's required to refer all individuals with a LOCUS score between 20 -22 to ACT. As you know, DMH has implemented a web-based LOCUS/CALOCUS application, which will facilitate analysis of LOCUS data for a variety of quality improvement purposes, including an overall evaluation of the level of services provided to all individuals in comparison to LOCUS scores. DMH is working with providers to fully adopt the use of the web-based application, so that data about LOCUS scores and level of services provided, including ACT, can be examined in the aggregate by program staff.

ACT Fidelity

On November 7, 2007, DMH adopted Policy 340.6, Provision of Assertive Community Treatment (ACT) to Adult Consumers. *See* January 2008 Report to the Court, page 10. In 2009, DMH amended the 2007 policy by incorporating the practice guidelines and standards already implemented and in use by DMH and MHRS providers in the provision of ACT services. The Dartmouth ACT Scale ("DACTS"), used to conduct fidelity assessments of ACT teams, was formally adopted in the 2009 policy but had already been in use since the 2008 ACT fidelity assessments. *See* DMH Policy 340.6A.

DMH has developed and implemented a program of annual fidelity assessments for each ACT team, using the DACTS fidelity tool (described below). This process began in 2008, when the New York State ACT Institute was contracted to conduct baseline fidelity assessments of the then existing five (5) ACT teams.[4] The DACTS was used to conduct the assessment and the FY 2008 fidelity assessment and subsequent activities contributed to the development of the FY 2010 ACT work plan which addressed quality improvement strategies, reporting structures and the development of an internal DMH Fidelity Assessment team.

As DMH moved the ACT fidelity assessments internally to DMH staff, we contracted with the ACT Center of Indiana to provide training to all ACT Team Leaders and the DMH Fidelity Assessment Team[5] in March 2010. In March 2010, the DMH Fidelity Assessment team began conducting fidelity assessments using the DACTS.

The DACTS is a twenty-eight (28) item scale that assesses the degree of fidelity to the ACT model along three (3) categories: Human Resources (caseload ratios, staffing patterns, team member specialties etc.), Organizational Boundaries (admission criteria, responsibility for admission and discharge from inpatient facilities, team admissions and discharges etc.) and Nature of Services (e.g. services provided in the community, intensity of services, frequency of contact etc.). A copy of the DACTS scoring protocol is attached for your reference and marked

[4] In FY 2008, ACT teams were operated by three (3) providers: the District of Columbia Community Services Agency ("DCCSA"), Family Preservation and Pathways to Housing.
[5] The DMH Fidelity Assessment team includes the ACT Coordinator and Adult Systems of Care Manager, as well as representatives from the Integrated Care Division, the Office of Accountability and Provider Relations.

as ***Exhibit B***. A copy of a chart containing detailed DACTS scoring by provider and domain is attached for your reference and marked as ***Exhibit C***.

Each ACT team received a report about the results of the fidelity assessment. A sample report is attached for your reference and marked as ***Exhibit D***. The results were discussed with each ACT team either during a meeting or via conference call. Each ACT team submitted a performance improvement plan for those domains scored three (3) or less as required by DMH.

The ACT coordinator and Adult Systems of Care Manager reviewed each performance improvement plan and gave feedback to each provider. Each ACT provider is required to prepare and submit monthly updates on the status of implementation of its performance improvement plan to the ACT Coordinator and Adult Systems of Care Manager.

In addition, the FY 2011 ACT workplan includes a number of activities which will support improving fidelity scores across teams. The FY 2011 work plan for ACT focuses on five (5) areas identified as needing system-wide improvement based upon the results of the fidelity assessment. Those five (5) areas are: (1) supported employment (H10); (2) co-occurring disorders (H9, S7 and S9); (3) participation of peer specialists on ACT teams (S10); (4) staff retention (H5) and (5) dual diagnosis groups (S8). The provision of dual disorder treatment groups requires the establishment of an ACT group billing rate and this process is underway and anticipated to be in place in early FY 2011.

In order to assist the ACT teams to improve services in preparation for the next fidelity assessment, the ACT Coordinator and Adult Systems of Care Manager will developing training and consultative opportunities for those ACT staff providing specialized services in the area of supported employment and co-occurring disorders. This training will occur throughout FY 2011. In addition, there will be two ACT Core Trainings in the Fall FY 2011 (September 15 and a date in late October/Early November) and two in the Spring/Summer of FY 2011. A copy of the FY 2011 ACT work plan is attached for your reference and marked as ***Exhibit E***.

ACT Oversight

The Adult Systems of Care Manager and ACT Coordinator have been working with multiple stakeholders ensure that the ACT teams provide quality services to ACT consumers. DMH has three active groups that have distinct responsibilities in ensuring that District residents have access to high functioning ACT programs. These are:

(1) **The ACT Workgroup**. This is an internal DMH workgroup that focuses primarily on quality issues. Members include representatives from Provider Relations, the Integrated Care Division, Office of Accountability, Access Helpline and the Comprehensive Psychiatric Emergency Program. Each program interacts with the ACT Providers. The ACT Workgroup provides a forum for sharing information between the different divisions to support comprehensive monitoring and oversight of the ACT providers and meets quarterly. The ACT

Workgroup has reviewed the results of the recent fidelity assessment. A copy of the minutes from the July 13, 2010 meeting is attached for your reference and marked as ***Exhibit F***.

(2) **ACT Advisory Committee**. The ACT Advisory Committee continues to meet quarterly. The committee includes representatives from each of the ACT providers, advocates and consumers. The primary purpose of the group is to provide feedback to the ACT providers from primary consumers and organizations who serve individuals with complex needs. For example, members of the ACT Advisory Committee have raised concerns about ACT services for forensic consumers. The ACT Advisory Committee has advocated for DMH to develop a Forensic ACT team (FACT) team in the District and in the short term designating members of each ACT team to concentrate on consumers with forensic issues. Another issue of concern is the present cultural and language capability of the ACT teams.

Recently, the ACT Advisory Committee voiced concerns about consumers who have or will be transitioning (from one ACT team to another ACT Team, from the ACT team to the traditional Community Support Team, or relocating from the District to another jurisdiction). The committee wanted to know how this is being done and monitored to ensure a successful transition.[6]

(3) **The ACT Provider Workgroup**. This group is comprised of the certified ACT providers and meets monthly to discuss ACT operational issues. Topics discussed include: the quality of ACT Services; and improving relationships with the inpatient providers, CPEP and local social service organizations. Difficult and challenging cases are reviewed and discussed with the group, to promote problem-solving while enhancing and promoting the delivery of quality services. Training continues be a concern for the ACT providers, so the Adult Systems of Care Manager and the ACT Coordinator are working with the Training Institute to develop and offer training on Motivational Interviewing and Integrated Dual Disorders Treatment.

During your August 12, 2010 meeting with the ACT staff, you asked about the process for resolving complaints about ACT. Complaints about ACT are referred to Eugene Wooden and Michele May, who identify a plan of action. When these issues appear to be system related problems, they are addressed at the appropriate level. For example, a complaint was received that a consumer no longer wanted to receive ACT services, although his treatment team felt that

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[6] DMH requires the ACT team to schedule a formal meeting to discuss the transition and ensure that transitional planning is completed. Generally a shared caseload is implemented for thirty (30) days, so the teams involved in transition (both the transferring team and the receiving team) can work with each other to ensure a smooth transition. If a consumer is relocating out of the District, DMH works to with the new jurisdiction to arrange connection with a local mental health provider.

the level of care was necessary. Mr. Wooden convened a meeting with the consumer, the consumer's advocate, the CSA and the ACT team to discuss and resolve the issue.

In addition, DMH has the authority to intervene if there are performance concerns. DMH's Deputy Directors of Programs and Accountability are responsible for making those determinations. In the past, we have exercised this level of authority in suspending new admissions for several months with one provider. DMH worked closely with the provider on its ACT services until the quality of services was acceptable, at which time new referrals were allowed.

ACT Action Plans and Organizational Plans

As discussed in my letter of December 9, 2009 and above, DMH adopted the DACTS as part of the revision of its ACT Policy. *See* DMH Policy 340.6A. Generally, DMH requires providers to submit a plan of action that describes how they plan to implement new or revised policies. Since the fidelity assessment process was scheduled to begin in March 2010 (approximately 90 days after the issuance of the revised ACT Policy), DMH did not require providers to submit a plan of action because the fidelity assessment was expected to identify specific areas requiring improvement. As discussed above, each provider is required to submit a plan of improvement to address the results of the fidelity assessment. Those plans will be used to ensure compliance with applicable policy, as well as the DACTS scale.

The MHRS certification regulations require each ACT provider to adopt an ACT Organizational Plan. *See* 22-A DCMR Section 3423.8. The ACT Organizational Plans are required to include three (3) specific elements: (1) a description of the particular treatment models utilized, types of intervention practice, and typical daily curriculum and schedule; (2) a description of the staffing pattern and how staff are deployed to ensure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences and illnesses are accommodated; and (3) a description of how the ISSP is modified or adjusted to meet the needs specified in each consumer's IRP/IPC.

The Adult Systems of Care Manager and ACT Coordinator have reviewed the ACT Organizational Plans for all the certified ACT providers that are on file with the Office of Accountability. The ACT Organizational Plans vary in the description of service delivery and implementation. To improve consistency of service delivery, the Adult Systems of Care Manager, ACT Coordinator and staff from the Office of Accountability are developing a new format for the ACT Organizational Plans, which will be implemented as each provider is newly certified or recertified. The timeframe for ACT provider recertification is attached for your reference and marked as ***Exhibit G***.

Performance Data.

DMH has achieved and exceeded the 85% performance target required by Exit Criterion #11 since January 2009 (six consecutive quarters). Most recently, DMH achieved an 86.6%

Exhibit F

performance level for the four (4) quarter period beginning on April 1, 2009 and ending on March 31, 2010. A chart showing the performance level by quarter is set forth below:

EXIT CRITERIA #11 – ASSERTIVE COMMUNITY TREATMENT[7] PERFORMANCE TARGET: 85.00%					
	FY 09 Q3	**FY09 Q4**	**FY10 Q1**	**FY 10 Q2**	**TOTAL**
ACT SERVICE PROVIDED[8]	92	60	75	78	305
ACT AUTHORIZED[9]	102	69	84	97	352[10]
PERFORMANCE LEVEL	90.1%	86.9%	89.2%	80.4%	**86.6%**

Conclusion

DMH has demonstrated its commitment to the provision of ACT services throughout the District, in accordance with the DACTS model. As discussed above, DMH has fully implemented a system for addressing the policy compliance concerns raised in your April 19, 2009 letter. DMH has met and exceeded the performance target for Exit Criterion #11 for the four quarter period beginning April 1, 2009 and ending March 31, 2010. Accordingly, DMH hereby requests that the Dixon Court Monitor: (1) find that DMH has achieved the performance levels required for Exit Criterion #11; (2) report on the performance levels to the U.S. District Court; and (3) cease active monitoring of Exit Criterion #11.

If you have any questions or wish to discuss this matter further, please feel free to call me.

Sincerely,

Stephen T. Baron
Director

Cc: Anthony Herman, Counsel to the Dixon Plaintiffs
Grace Graham, Counsel for the District of Columbia

[7] The Exit Criteria Order defines the performance target for this exit criterion as "the number of adults (aged 18 and over) with serious mental illness served within the reporting period who received assertive community treatment within 45 days of referral as a percentage of all adults with serious mental illness referred for assertive community treatment during the reporting period." For purposes of the calculation, DMH uses the definition of serious mental illness included in the operational definition of Exit Criterion #7 (a primary mental health diagnosis of 295-297.1, 298.9, 300.4, 309.81, or 311).

[8] Based upon submitted claims approved for payment as of June 24, 2010.

[9] The number of persons who satisfied the requirements for authorization to receive ACT services.

[10] See footnote #6 above.

EXHIBIT A
ACT REFERRAL SOURCE DATA

April 1, 2009 - March 31, 2010

REFERRING PROVIDER	FY 09 Q3	FY 09 Q4	FY 10 Q1	FY 10 Q2	TOTAL REFERRALS
Anchor	0	10	21	7	38
Community Connections	64	41	33	40	178
Family and Child	0	3	0	0	3
Family Preservation	1	1	2	3	7
Fihankra	0	0	0	1	1
Green Door	20	7	9	10	46
Hillcrest	0	0	0	3	3
Latin American Youth	0	0	0	1	1
Life Stride	0	1	3	0	4
DC CSA/Mental Health Services Division	7	1	2	1	11
McClendon Center	2	0	12	8	22
Other[1]	14	15	13	21	63
Pathways to Housing	0	0	0	0	0
Psychiatric Center Chartered	0	1	0	0	1
Scruples	1	0	0	0	1
Universal	0	1	0	1	2
Washington Hospital Center[2]	10	7	9	11	37
TOTAL	**119**	**88**	**104**	**107**	**418**[3]
OTHER REFERRALS AS A PERCENTAGE OF TOTAL	**12%**	**17%**	**12%**	**20%**	**15%**

[1] Other referral sources during this reporting period include the inpatient psychiatric units at the George Washington University Medical Center, the Georgetown Hospital, Sibley and Washington Hospital Center; the Georgetown Ministry for the Homeless, Rachel's Women's Center, Father McKenna Center, University Legal Services, Christ House, N Street Village, Miriam's Kitchen and the New Hope Ministry.

[2] Washington Hospital Center also operates the New Directions Program, which is an initiative focusing on transitioning long term patients from Saint Elizabeths Hospital to the community.

[3] ACT admission criteria do not mandate that a consumer have a serious mental illness as a pre-requisite to receipt of ACT services. Consumers referred for ACT are required to meet certain functional criteria and may have a deferred diagnosis (799.9) or a non-SMI diagnosis at the time of referral. Therefore, the total number of referrals to the ACT program may differ from the number of referrals included in the calculation of the performance measure for Dixon Exit Criterion 11, which requires the inclusion of only consumers with a specified SMI diagnosis at the time of referral.

REFERRING DMH INITIATIVE	FY 09 Q3	FY 09 Q4	FY 10 Q1	FY 10 Q2	TOTAL REFERRALS
High Utilizers	14	8	2	14	38
CPEP High Utilizers	8	7	6	10	31
Saint Elizabeths Discharge Project	5	8	6	12	31
Homeless Outreach Program	10	12	7	8	37
TOTAL REFERRALS FROM SPECIFIC DMH INITIATIVES	**37**	**35**	**21**	**44**	**137**
TOTAL REFERRALS	**119**	**88**	**104**	**107**	**418**
REFERRALS AS A PERCENTAGE OF TOTAL	**31%**	**40%**	**20%**	**41%**	**32%**

Protocol for Assertive Community Treatment Fidelity Scale
(Dartmouth Assertive Community Treatment Scale – DACTS)

This document is intended to help guide your administration of the Assertive Community Treatment (ACT) Fidelity Scale. With a few minor modifications, this scale is the Dartmouth Assertive Community Treatment Scale (DACTS) developed by Teague, Bond, and Drake (1998). In this document you will find the following:

1) Introduction: This gives an overview of ACT and a who/what/how of the scale. Plus there is a checklist of suggestions for before, during, and after the fidelity assessment that should lead to the collection of higher quality data, more positive interactions with respondents, and a more efficient data collection process.

2) Item-Level Protocol: The protocol explains how to rate each item. In particular, it provides:

a) A *definition* and *rationale* for each fidelity item. These items have been derived from a comprehensive review of evidence-based literature.

b) A list of *data sources* most appropriate for each fidelity item (e.g., chart review, clinician interview, team meeting observation).

c) Where appropriate, a set of *probe questions* to help elicit the critical information needed to score the fidelity item. These probe questions were specifically generated to help you collect information from respondents that is free from bias such as social desirability.

d) Decision rules that will help you correctly score each item. As you collect information from various sources, these rules will help you determine the specific rating to give for each item.

3) Cover sheet: This form obtains background information about the study site. The data are not used in determining fidelity, but provide important information for classifying programs, such as size and duration of program, type of parent organization, and community characteristics.

4) Worksheets and Summary Table: These sheets can be used or adapted for tallying the chart review.

5) Score Sheet: The sheet provides instructions for scoring, including how to handle missing data; plus cut-off scores for full, moderate, and inadequate implementation.

Reference: Teague, G. B., Bond, G. R., & Drake, R. E. (1998). Program fidelity in assertive community treatment: Development and use of a measure. American Journal of Orthopsychiatry, 68, 216-232.

Assertive Community Treatment (ACT) Fidelity Scale: Introduction

ACT Overview

As an evidence-based psychiatric rehabilitation practice, ACT provides a comprehensive approach to service delivery to consumers with severe mental illness (SMI). ACT uses a multidisciplinary team, which typically includes a psychiatrist, a nurse, and at least two case managers. ACT is characterized by (1) low client to staff ratios; (2) providing services in the community rather than in the office; (3) shared caseloads among team members; (4) 24-hour staff availability, (5) direct provision of all services by the team (rather than referring consumers to other agencies); and (6) time-unlimited services.

Overview of the Scale

The ACT Fidelity Scale contains 28 program-specific items. The scale has been developed to measure the adequacy of implementation of ACT programs. Each item on the scale is rated on a 5-point scale ranging from 1 ("Not implemented") to 5 ("Fully implemented"). The standards used for establishing the anchors for the "fully-implemented" ratings were determined through a variety of expert sources as well as empirical research. The scale items fall into three categories: human resources (structure and composition); organizational boundaries; and nature of services.

What Is Rated

The scale ratings are based on current behavior and activities, not planned or intended behavior. For example, in order to get full credit for Item O4 ("responsibility for crisis services"), it is not enough that the program is currently developing an on-call plan.

Unit of Analysis

The scale is appropriate for organizations that are serving clients with SMI and for assessing adherence to evidence-based practices, specifically for an ACT team. If the scale is to be used at an agency that does not have an ACT team, a comparable service unit should be measured (e.g., a team of intensive case managers in a community support program). The DACTS measures fidelity *at the team level* rather than at the individual or agency level.

How the Rating Is Done

To be valid, a fidelity assessment should be done in person, i.e., through a site visit. The fidelity assessment requires a minimum of 6 hours to complete, although a longer period of assessment will offer more opportunity to collect information; hence, it should result in a more valid assessment. The data collection procedures include chart review, team meeting observation, home visits, and semi-structured interview with the team leader. Clinicians who work on the ACT teams are also valuable sources of data; most frequently the assessors obtain this information when accompanying them on home visits. Data may be obtained through other sources (e.g., supervisors, consumers) as appropriate.

Some items require calculation of either the mean or the median value of service data (e.g., median number of community-based contact contacts); specific administration instructions are given as needed for individual items (see below).

For some items that require chart review for rating, the intent is to use charts selected at random. Some processes for randomly selection are suggested below; assessors should feel free to use whatever method is most convenient or practical for the particular visit.

- Prior to site visit, request the team leader select 20 charts for review; from these 20 charts, assessors select 10 at random.
- Center provides a de-identified list of clients (i.e., ID numbers) and the assessors use random selection to choose 10.

- It is important to select the most representative sample of charts; if a team assigns clients to different levels of service intensity, the sample should reflect this (e.g., a team with 30% of its clients on Level 1, 60% of clients on Level 2, and 10% on Level 3, 30% of reviewed charts should come from Level 1 clients, 60% of reviewed charts from Level 2, and so on).

How to Rate a Newly-Established Team

For ACT teams in the start-up phase, the time frame specified in individual items may not be met. For example, item H5 asks for the turnover rate during the last two years; Item O2 asks for the number of new clients during the last six months. Assessors should prorate time frames for teams that have been in operation for a shorter amount of time than specified in the individual items. (Specific instructions given for pertinent items.)

How to Rate Programs Using Other Program Models

The DACTS is designed to assess programs following the ACT model. If a case management or other program is rated on the DACTS, some items do not apply. This protocol does not cover every possible case of program model. In most instances, if an item cannot be rated, the assessor should assign a value of "1" for that item.

Who Does the Ratings

The scale can be administered internally by an agency/program or by an external review group. If it is administered internally, it is obviously important for the ratings to be made objectively, based on hard evidence, rather than made to "look good." Circumstances will dictate decisions in this area, but we encourage agencies to choose a review process that fosters objectivity in ratings, e.g., by involving a staff person who is not centrally involved in providing the service. With regard to external reviews, there is a distinct advantage in using assessors who are familiar with the program, but at the same time are independent. The goal in this process is the selection of objective and competent assessors.

Fidelity assessments should be administered by individuals who have experience and training in interviewing and data collection procedures (including chart reviews). In addition, raters need to have an understanding of the nature and critical ingredients of ACT. We recommend that all fidelity assessments be conducted by at least two raters in order to increase reliability of the findings.

Missing Data

The scale is designed to be filled out completely, with no missing data on any items. It is essential that raters obtain the required information for every item. It is critical that raters record detailed notes of responses given by the interviewees. If information cannot be obtained at time of the site visit, it will be important for the raters to collect it at a later date.

Fidelity Assessor Checklist

Before the Fidelity Site Visit:

- *Review the sample cover sheet.* This sheet is useful for organizing your fidelity assessment, identifying where the specific assessment was completed, along with general descriptive information about the site. You may need to tailor this sheet for your specific needs (e.g., unique data sources, purposes for the fidelity assessment).

- *Create a timeline for the fidelity assessment.* Fidelity assessments require careful coordination of efforts and good communication, particularly if there are multiple assessors. Therefore, it may be useful to list all the necessary activities leading up to and during the visit. For instance, the timeline might include a note to make reminder calls to the program site to confirm interview dates and times.

- *Establish a contact person at the program.* You should have one key person who arranges your visit and communicates beforehand the purpose and scope of your assessment to program staff. Typically this will be the ACT team leader. Exercise common courtesy in scheduling well in advance, respecting the competing time demands on clinicians, etc.

- *Establish a shared understanding with the site being assessed.* It is *essential* that the fidelity assessment team communicates to each program site the goals of the fidelity assessment; assessors should also inform the program site about who will see the report, whether the program site will receive this information, and exactly what information will be provided. The most successful fidelity assessments are those in which there is a shared goal among the assessors and the program site to understand how the program is progressing according to evidence-based principles. If administrators or line staff at the study site fear that they will lose funding or look bad if they don't score well, then the accuracy of the data may be compromised. The best agreement is one in which all parties are interested in getting at the truth.

- *Indicate what you will need from respondents during your fidelity visit.* In addition to the purpose of the assessment, you will need to briefly describe what information you will need, who you will need to speak with, and how long each interview or visit will take to complete. The fidelity visit will be most efficient if the team leader gathers in advance as much as possible of the following information:

    - Roster of ACT staff – (roles, full-time equivalents (FTEs))
    - Staff vacancies each month for last 12 months (or as long as program has existed, if less than 12 months)
    - Number of staff who have left the team over the last two years (or since program started if less than two years old)
    - A written description of the team's admission criteria
    - Roster of ACT clients
    - Number of clients with dual disorders
    - Number of clients admitted to ACT program, per month, for last six months
    - How many clients have terminated from the program in the last year, broken down in these categories:
        - Graduated (left because of significant improvement)
        - Left town
        - Closed because they refused services or team cannot find them
        - Deceased
        - Other (explain)
    - List of the last 10 clients admitted to psychiatric hospital
    - List of the last 10 clients discharged from psychiatric hospital
    - Number of clients living in supervised group homes
    - Number of clients for whom the ACT team contacts their informal support network (e.g., family member, landlord, etc.) at least once. (Helpful for team leader to have a list of names at the time of interview.)

Note: Reassure the team leader that you will be able to conduct the fidelity assessment even if not all of the above information is available. You should indicate that some information is more critical (e.g., staffing and number of active clients).

- θ *Inform the contact person that you will need to observe at least one team meeting during your visit.* This is an important factor in determining when you should schedule your assessment visit to the program.

- θ *Alert your contact person that you will need to sample 20 charts.* It is preferable from a time efficiency standpoint that the charts be drawn beforehand, using a random selection procedure. Obviously, a program can falsify the system by hand picking charts and/or updating them right before the visit. If there is a shared understanding that the goal is to better understand how a program is implementing services, this is less likely to occur.

During Your Fidelity Site Visit:

- θ *Tailor terminology used in the interview to the site.* For example, if the site uses the term "member" for consumer, use that term. If "practitioners" are referred to as clinicians, use that terminology. Every agency has specific job titles for particular staff roles. By adopting the local terminology, the assessor will improve communication.

- θ During the interview, *record the names of all relevant programs, the total number of consumers, and the total number of clinicians.*

- θ *Obtain a random sample of charts:*
  - For the chart review, select 10 charts at random. One appropriate method is to examine the roster of client names. Divide the number of clients by 10 and round down. Suppose there are 65 clients, then the number would be 6. Starting at an arbitrary name, select every 6th name on the roster.
  - If the caseload is known to be stratified, for example if the team uses a level of care system in which every client is classified, and if this level of care is related to intensity of services, then a preferred sampling method is to stratify the sample according the level of care. Example: Suppose the team has 50 Level 1, 30 Level 2, and 20 Level 3 clients. Then select 5 Level 1, 3 level 2, and 2 level 3 clients, using a random sampling strategy.
  - In some cases, there may be a lag between when a service is rendered and when it is documented in the client's chart. When sampling chart data, try to gather data from the most recent time period where documentation is completed in full to get the most accurate representation of services rendered. The most up-to-date time period might be ascertained by asking the team leader, clinicians, or administrative staff. The point is to avoid getting an inaccurate sampling of data where office-based services (e.g., nurses visits or weekly groups) might be charted more quickly than services rendered in the field (e.g., Case manager progress notes).

- θ *If discrepancies between sources occur, query the team leader to get a better sense of the program's performance in a particular area.* The most common discrepancy is likely to occur when the Team leader interview gives a more idealistic picture of the team's functioning than do the chart and observational data. For example, on item S1, the chart review may show that client contact takes place largely in the office; however, the team leader may state that the clinicians spend the majority of their time working in the community. To understand and resolve this discrepancy, the assessor may say something like, "Our chart review shows xx% of client contact is office-based, but you estimate the contact at yy%. What is your interpretation of this difference?"

- θ *Before you leave, check for missing data.* It is a good idea to check in with the program leader at the end of the visit to review and resolve any discrepancies if possible.

After Your Fidelity Site Visit:

- If necessary, *follow up on any missing data* (e.g., by phone calls or email to the program site). This would include a discussion with the team leader about any discrepancies between data sources that arise after the visit has been completed.

- Assuming there are two assessors, *both should independently rate the fidelity scale.* The assessors should then compare their ratings and resolve any disagreements. Come up with a consensus rating.

- *Tally the item scores and determine which level of implementation was achieved* (See Score Sheet).

- *Send a follow-up letter to the site.* In most cases, this letter will include a *fidelity report,* explaining to the program their scores on the fidelity scale and providing some interpretation of the assessment, highlighting both strengths and weaknesses. The report should be informative, factual, and constructive. The recipients of this report will vary according to the purposes, but would typically include the key administrators involved in the assessment.

- If the fidelity assessment is given repeatedly, it is often useful to *provide a visual representation of a program's progress over time* by graphing the total fidelity scale using an EXCEL spreadsheet, for example. This graph may be included in the fidelity report.

ITEM DEFINITIONS, RATIONALES, AND SCORING

Human Resources: Structure and Composition

H1. Small Caseload

Definition: Client/clinician ratio of 10:1

Rationale: ACT teams should maintain a low consumer to staff ratio in the range of 10:1 in order to ensure adequate intensity and individualization of services.

Sources of Information:

a) Team leader interview

- Begin interview by asking team leader to identify all team members, their roles, and whether they are full time. From this roster, calculate the number of full-time equivalent (FTE) staff and confirm with team leader. Possible questions include:
- *"How many staff work on the ACT team?"*
- *"How many consumers are currently served by the team?*

In counting the current caseload, include all "active" clients. The caseload totals should include any client who has been formally admitted, even if it is as recent as the last week. The definition of active status is determined by the team, but note that the count will affect other fidelity items, such as frequency of visits.

b) Agency documents

- Some ACT teams have a Cardex or similar organization system, or the roster of active clients will be listed elsewhere. If there is doubt about the precise count of the caseload, then these documents can be consulted as a crosscheck on the count.

Item Response Coding: Count all team members who conduct home visits and other case management duties. Unless there are countervailing reasons, count all staff providing direct services (including substance abuse specialist, employment specialist, and team leader) EXCEPT the psychiatrist. Do not include administrative support staff when determining the caseload ratio.

FORMULA: (# CLIENTS PRESENTLY SERVED) / (# FTE STAFF)

If this ratio is 10 or less, the item is coded as a "5."

Special case: Do not count staff who are technically employed by the team but who have been on extended leave for 3 months or more.

H2. Team Approach

Definition: Provider group functions as a team; clinicians know and work with all clients.

Rationale: The entire team shares responsibility for each client; each clinician contributes expertise as appropriate. The team approach ensures continuity of care for clients, and creates a supportive organizational environment for practitioners.

Sources of Information:

a) Chart review

- Review charts for 10 randomly selected clients. Remember to use the most complete and up-to-date time period from the chart. Ask the team leader, clinicians, or an administrative person for the most recent, but complete period of documentation. Data should be taken from the last two full calendar weeks prior to the fidelity visit (or the most recent two-week period available in the charts if the records are not current). Count the number of different ACT team members who have had a face-to-face contact with the client during this time. Determine the percentage of clients who have seen more than one team member in the two-week period.

b) Team leader interview

- *"In a typical two-week period, what percentage of clients see more than one member of the team?"*

c) Clinician interview

- During a home visit, ask the case manager which ACT team members have seen this client this week.
- *"How about the previous week?"*
- *"Is this pattern similar for other clients?"*

d) Client interview

- *"Who have you seen from the ACT team this week? How about last week?"*
- *"Do you see the same person over and over, or different people?"*

e) **Other data sources (e.g., computerized summaries)**

- Use this data source if available, but ask the team leader for information about how it is compiled and how confident one can be in its accuracy.

Item Response Coding: Use chart review as the primary data source. Determine the number of different staff who have seen each client. The score on the DACTS is determined by the percentage of clients who have contact with more than one ACT worker in the two-week period. For example, if $\geq$ 90% of clients see more than one case manager in a two-week periodm, the item would receive a "5."

If the information from different sources is not in agreement, (for example, if the team leader indicates a higher rate of shared caseloads than do the records), then ask the team leader to help you understand the discrepancy. The results from a chart review are overruled if other data (e.g., Team leader interview, internal statistics) conflict with or refute it.

H3. Program Meeting

Definition: Program meets frequently to plan and review services for each client.

Rationale: Daily team meetings allow ACT practitioners to discuss clients, solve problems, and plan treatment and rehabilitation efforts, ensuring all clients receive optimal service.

Sources of Information:

a) Team leader interview

- *"How often does the ACT team meet as a full group to review services provided to each client?"*
- *"How many clients are reviewed at each meeting?"*

b) Internal documentation

- Confirm with attendance roster of team meetings, if available. The client service log (e.g., a Cardex that holds summary data for each client) may be helpful in determining whether each client is discussed (even briefly) at each meeting.

Item Response Coding: This count includes clinical review meetings only; **exclude administrative and treatment planning meetings** from the count for this item. The expectation is that all full-time team members should attend all meetings; the team psychiatrist may attend fewer meetings (to receive full credit, psychiatrist should attend at least once a week). Part-time team members are expected to attend at least twice weekly in order to receive full credit on this item. Team members from all shifts should be routinely in attendance.

If the team meets at least 4 days a week and reviews each client each time, a "5" is scored. If the team meets 4 or more days a week but does not discuss each client each time, they would earn a "4" for this item.

Poor attendance at the team meeting does not count against the score on this item if the program holds the *expectation* that all team members attend; however, poor attendance is something to note in the fidelity assessment report.

H4. Practicing Team Leader

Definition: Supervisor of front line clinicians provides direct services.

Rationale: Research has shown this factor was among the five most strongly relatedto better client outcomes. Team leaders who also have direct clinical contact are better able to model appropriate clinical interventions and remain in touch with the clients served by the team.

Sources of Information:

a) Team leader interview

- *"Do you provide direct services to clients?"*
- [if "yes"] *"What percentage of your time is devoted to direct services?"*

b) Productivity records

- Some agencies require staff to keep track of direct service time. Ask if this applies at this agency and ask to see the information for the last calendar month (or some similar unit of time). Make sure that the chosen period of time is typical; e.g., exclude a week in which the center was undergoing JCAHO accreditation.

Item Response Coding: Give more weight to the actual records than the verbal report. If there is a discrepancy, ask team leader to help you understand it.

If the team leader provides services at least 50% of the time, the item is coded as a "5."

H5. Continuity of Staffing

Definition: Program maintains the same staffing over time.

Rationale: Maintaining a consistent staff enhances team cohesion; additionally, consistent staffing enhances the therapeutic relationships between clients and providers.

Sources of Information:

a) Team leader interview

- In advance of the fidelity visit, request that the team leader have available a list of all employees over past two years (or for the duration of the existence of the program)
- *"What is the total number of staff positions on the ACT team?*
- *"Name the team members who have left in the past two years."* [if the team has been in existence for a shorter period, use the formula below to adjust for the shortened time frame].

Item Response Coding:

FORMULA: (# STAFF TO LEAVE/TOTAL # POSITIONS) X (12/#MONTHS)

EXAMPLES: There were 20 staff workers who occupied the 9 line positions at West over 24 months, compared with 7 staff workers for 5 line positions at South over 23 months. The "annual turnover rate was 61.1% for West versus 20.9% for South.

WEST: [11/9 x 12/24] =61.1%
SOUTH: [2/5 x 12/23] =20.9%

If the annual turnover rate is 10% or less, then the item is coded as a "5." A staff member who has been on an extended leave for 3 months or more is considered among the number of staff who have left, even if they technically remain in their position.

H6. Staff Capacity

Definition: Program operates at full staffing.

Rationale: Maintaining consistent, multidisciplinary services requires minimal position vacancies.

Sources of Information:

a) **Team leader interview**

- In advance of the fidelity visit, request that the team leader have available a list of unfilled positions for each month over past year (or for the duration of the existence of the program)

- Ask the team leader to go through the past 12 months, month by month.
- *"Did you have any position vacancies in January?* [if "yes", ask *"How many?"*]. Continue through all 12 of the previous months (or for the length of time the program has been operating, if less than 12 months).
- *"Have you had anyone who has been on leave for more than one month during the last 12 months?"* [Count any extended absences, e.g., sick leave or leave after the birth of a child, in the same fashion as months of vacancies]

Item Response Coding: For each month, calculate the vacancy rate:

for new teams look for vacancy

FORMULA:

100* (SUM OF # VACANCIES EACH MONTH) / (TOTAL # STAFF POSITIONS x 12) — ?

Include the psychiatrist, but exclude any administrative support staff when determining total staff positions. Calculate the mean monthly vacancy rate (given by the above formula) for the 12-month period. Subtract from 100%.

If the program has operated at 95% or more of full staffing capacity for the last 12 months, the item is coded as a "5." If a member of the team is on extended leave for 1 month or more, this counts as a position vacancy.

H7. Psychiatrist on staff

Definition: Per 100 clients, at least one full-time psychiatrist is assigned to work with the program.

Rationale: The psychiatrist serves as medical director for the team; in addition to medication monitoring, the psychiatrist functions as a fully integrated team member, participating in treatment planning and rehabilitation efforts.

Sources of Information:

a) Team leader interview

- Information regarding FTE psychiatrist is obtained during the initial review of the staffing.
- Calculate the FTE psychiatrist time per 100 clients (see formula, below)

b) Clinician interview

- *"What is the psychiatrist's role on the team?"*
- *"Does he/she come to meetings?"*
- *"Is s/he readily accessible?"*
- *"Does the psychiatrist ever see clients who are not on the ACT team?"*

c) Client interview

- *"How often do you see the team psychiatrist?"*
- *"Do you use the ACT team psychiatrist for medications?"*

Item Response Coding:

FORMULA: [(FTE value x 100) / # clients served] = FTE per 100 clients

EXAMPLES:

West has .75 FTE psychiatrist for a 50-client program. South has .75 FTE for a 120-client program.

WEST: [(.75 * 100) / 50] = 1.5 FTE psychiatrist → item coded as a "5"
SOUTH: [(.75 * 100) /120] = .63 FTE psychiatrist → item coded as a "3"

If information across sources is not consistent, the assessor should ask for clarification during the team leader interview or make follow-up contact with the program. As with all scale items, the rating should be based on the most credible evidence available to the assessor (e.g., even if the psychiatrist is reported as 1.0 FTE to a 100-person ACT team, if the clients and clinicians consistently report that she is unavailable for consultation, a lower score on this item is likely appropriate).

If at least one full-time psychiatrist is assigned directly to a 100-client program, the item is coded as a "5."

NOTE FOR ITEMS H8-H11: PROGRAMS DO NOT RECEIVE CREDIT FOR HAVING SPECIALISTS ON STAFF (e.g., RN, substance abuse or vocational specialists) IF THE PERSON ASSIGNED TO THAT POSITION IS ON LEAVE AT THE TIME OF THE FIDELITY VISIT AND HAS BEEN ON LEAVE FOR 3 MONTHS OR MORE.

H8. Nurse on staff

Definition: At least two full-time nurses are assigned to work with a 100-client program.

Rationale: The full-time RN has been found to be a critical ingredient in successful ACT programs. The nurses function as full members of the team, which includes conducting home visits, treatment planning, and daily team meetings. Nurses can help administer needed medications and serve to educate the team about important medication issues.

Sources of Information:

a) Team leader interview

- Information regarding FTE RNs is obtained during the initial review of the staffing.
- Calculate the FTE nurse time per 100 clients (see formula, below)

b) Clinician interview

- *"What is the nurse(s)' role on the team?"*
- *"Does he/she come to meetings?"*
- *"Is she/he readily accessible?"*
- *"Does the nurse ever have responsibilities (or clients) outside the ACT team?"*

c) Client interview

- *"How often do you see the team nurses?"*

Item Response Coding:

FORMULA: [(FTE value X 100) / # clients served] = FTE per 100 clients

If inconsistent, the assessor should reconcile information across sources and score accordingly.

If two full-time nurses or more are members of a 100-client program, the item is coded as a "5."

H9. Substance abuse specialist on staff

Definition: At least two staff members on the ACT team with at least one year of training or clinical experience in substance abuse treatment, per 100-client program

Rationale: Concurrent substance use disorders are common in persons with severe mental illness. Appropriate assessment and intervention strategies are critical.

Sources of Information:

a) Team leader interview

- Information regarding FTE substance abuse specialists is obtained during the initial review of the staffing.
- Regarding each substance abuse specialist, determine if each has at least one year of training and/or experience in substance abuse treatment.
- Calculate the FTE substance abuse specialist time per 100 clients (see formula, below)

Item Response Coding:
FORMULA: [(FTE value X 100) / # clients served] = FTE per 100 clients

A person who has state certification or licensure in substance abuse counseling meets the training/experience requirements; such credentialing is sufficient, but not necessary to obtain full credit on this item. If a substance abuse counselor is "loaned" from another program or otherwise works part time on the team (e.g., he or she has another role at the center), give partial credit in accordance with the percentage of time dedicated to the ACT team.

If two FTEs or more with one year of substance abuse training or supervised substance abuse treatment experience are assigned to a 100-client program, the item is coded as a "5."

H10. Vocational specialist on staff

Definition: Program includes at least one staff member with at least one year of training/experience in vocational rehabilitation and support.

Rationale: ACT teams emphasize skill development and support in natural settings. Fully integrated ACT teams include vocational services that enable clients to find and keep jobs in integrated work settings.

Sources of Information:

a) Team leader interview

- Information regarding FTE vocational specialist is obtained during the initial review of the staffing.
- Calculate the FTE vocational specialist time per 100 clients (see formula, below)

Item Response Coding:
FORMULA: [(FTE value X 100) / # clients served] = FTE per 100 clients

Full credit may be given even if the team's vocational specialist belongs to a separate supported employment team IF she or he sees only ACT clients; otherwise, give partial credit according to the percentage of time the vocational specialist works with ACT clients.

If, for a 100-client program, two FTEs or more with one year vocational rehabilitation training/supervised experience were assigned, the item is coded as a "5."

H11. Program size

Definition: Program is of sufficient size to consistently provide necessary staffing diversity and coverage.

Rationale: The ACT team provides an integrated approach to mental health services, through which the range of treatment issues are addressed from a variety of perspectives; it is critical to maintain adequate staff size and disciplinary background in order to provide comprehensive, individualized service to each client.

Sources of Information:

a) Team leader interview

Information regarding FTE vocational specialist is obtained during the initial review of the staffing.
Item Response Coding: If the program has at least 10 FTE staff, the item is coded as a "5." Count all staff, including psychiatrist (exclude administrative support staff).

Organizational Boundaries

O1. Explicit admission criteria

Definition: The program has a clearly identified mission to serve a particular population; it uses measurable and operationally defined criteria to screen out inappropriate referrals. Admission criteria should be pointedly targeted toward the individuals who typically do not benefit from usual services. ACT teams are intended for adults with severe mental illness. In addition to these very general criteria, an ACT team should have some further admission guidelines tailored to their treatment setting. Examples of more specific admission criteria that might be suitable include:

- Pattern of frequent hospital admissions
- Frequent use of emergency services
- Individuals discharged from long-term hospitalizations
- Co-occurring substance use disorders

- Homeless
- Involvement with the criminal justice system
- Not adhering to medications as prescribed
- Not benefiting from usual mental health services (e.g., day treatment)

Rationale: ACT is best suited to clients who do not effectively use less intensive mental health services.

Sources of Information:

a) Team leader interview

- *"Does your ACT team have a clearly defined target population with whom you work?"*
- *"What formal admission criteria do you use to screen potential clients?"*
- *"How do you apply these criteria?"*
- *"Who makes referrals to the ACT team?"*
- *"Who has the final say as to whether or not a person is served by the ACT team?"*
- *"Are there circumstances where you **have to** take clients onto your team?"*
- *"What recruitment procedures do you use to find clients for the ACT team?"*
- *"Do you have some ACT clients who you feel do not really need the intensity of ACT services?"*

b) Clinician interview

- *"How does an individual become a client of the ACT team?"*

c) Internal records

- Note documentation of application of explicit admission criteria

Item Response Coding: If the program serves a well-defined population and all clients meet explicit admission criteria, the item is coded as a "5."

O2. Intake rate

Definition: Program takes clients in at a low rate to maintain a stable service environment.

Rationale: In order to provide consistent, individualized, and comprehensive services to clients, a low growth rate of the client population is necessary.

Sources of Information:

a) Team leader interview

- In advance of the fidelity visit, request that the team leader have a list of the new admissions for the last six months.
- *"How many new clients have you taken on, per month, during the last six months?"*

Item Response Coding: If the highest monthly intake rate during the last six months was no greater than six clients, the item is coded as a "5." For new teams, this score may be low if the team is under pressure to serve a full caseload; their rating on this item will likely improve once they have been in operation for a period of time.

O3. Full responsibility for treatment services

Definition: ACT team directly provides psychiatric services and medication management, counseling/psychotherapy, housing support, substance abuse treatment, and employment/rehabilitative services, in addition to case management services.

Rationale: Clients benefit when services are integrated into a single team, rather than when they are referred to many different service providers, furthermore, an integrated approach allows services to be tailored to each client.

Sources of Information:

a) Team leader interview

- Through discussion with the team leader, determine which services are provided by the team, and for which services clients are referred elsewhere. Determine the nature of services offered by the team.
- *"Do your clients see other psychiatrists outside of the ACT team?"*
- *"Do some clients receive case management services from their residences?"*
- *"Do any clients live in supervised group homes? If yes, how many? What is the nature of the case management/rehabilitation services?"* [If more than 10% are living in a group residence and receiving services that generally duplicate what the ACT team would otherwise be doing – e.g., if they are heavily staffed, then this should be counted as brokered residential services.]
- *"What percentage of clients receives additional (non-ACT) case management services?"*
- *"I am going to read you a list. Which of the following services do your clients receive from another department within your agency (or to another agency , and which do your team provide directly?"* (Query for details on particular services as necessary)
    1. *case management*
    2. *medication prescription, administration, monitoring, and documentation*
    3. *counseling/individual supportive therapy*
    4. *housing support*
    5. *substance abuse treatment*
    6. *employment or other rehabilitative services (e.g., ADLs, vocational counseling/support)*

b) Clinician interview:

- Ask similar questions as for team leader

c) Client interview.

- *"Who helps you get your services for housing? For employment?"*
- *"Who helps you besides the ACT team?"*

Item Response Coding: Team leader is the primary source. If there are discrepancies, follow up. In general, the team should offer these services in proactive, systematic, and inclusive fashion to all clients. If the team is responsible for 90% or more of each of these types of services for its clients, the item is coded as a "5."

O4. Responsibility for crisis services

Definition: Program has 24-hour responsibility for covering psychiatric crises.

Rationale: An immediate response can help minimize distress when persons with severe mental illness are faced with crisis. When the ACT team provides crisis intervention, continuity of care is maintained.

Sources of Information:

a) Team leader interview

- *"What 24-hour emergency services are available for ACT clients?"*
- *"What is the ACT team's role in providing 24-hour emergency services?"*

Item Response Coding: If the program provides 24-hour coverage directly (i.e., an ACT team member is on-call at all times, typically by carrying a beeper), the item is coded as a "5." If the team is not the first line of crisis intervention (e.g., they are notified of crises through the general crisis line for the mental health center), a lower score is appropriate. Code as "4" if crisis line reliably calls ACT team for any situation beyond routine.

O5. Responsibility for hospital admissions

Definition: ACT team is closely involved in hospital admissions.

Rationale: More appropriate use of psychiatric hospitalization occurs, and continuity of care is maintained, when the ACT team is involved with psychiatric hospitalizations.

Sources of Information:

a) Team leader interview

- In advance of the fidelity visit, request that the team leader compile a list of the last 10 hospital admissions. Review each admission with the team leader.
- *"What happened on this admission (i.e., describe the process as it involves the ACT team)?"*
- *"Was the team aware of the admission in advance?"*
- *"In general, what role does the ACT team play in the decision to hospitalize an ACT client?"*
- *"Are any ACT team clinicians in regular contact with the hospital?"*
- *"Does the ACT team policy differ from the rest of the agency with regard to hospital admissions?"*

b) Clinician interview

- *"How often is the team involved in the decision to admit a client for psychiatric hospitalization?"*
- *"Describe the process the team goes through when a client needs to be admitted to a hospital."*

Item Response Coding: Determine the percentage of admissions in which the ACT team was involved admissions. If 95% or more of all admissions involved the ACT team, the item is coded as a "5."

O6. Responsibility for hospital discharge planning

Definition: Program is involved in planning for hospital discharges.

Rationale: Ongoing participation of the ACT team during a client's hospitalization and discharge planning allows the team to help maintain community supports (e.g., housing), and continuity of service.

Sources of Information:

a) Team leader interview

- In advance of the fidelity visit, request that the team leader compile a list of the last 8-10 hospital discharges. Review each discharge with the team leader.
- *"What happened on this discharge?"* (i.e., describe the process as it involves the ACT team)
- *"Was the team aware of the discharge in advance?"*
- *"For clients hospitalized in the last year, what percentage was the ACT team involved in the decision/planning for discharge?"*
- *"What role does the ACT team play in psychiatric or substance abuse discharges?"*
- *"Does the ACT team role in hospital discharges differ from the general agency policy?"*

b) Clinician interview.

- *"How often is the team involved with discharge planning when a client is hospitalized for psychiatric or substance abuse reasons?"*

Item Response Coding: Determine the number of discharges where the ACT team was involved. If 95% or more of all discharges were planned jointly between the ACT team and the hospital, the item is coded as a "5."

O7. Time-unlimited services/Graduation rate

Definition: Program does not have arbitrary time limits for clients admitted to the program cases but remains the point of contact for all clients indefinitely as needed.

Rationale: Clients often regress when they are terminated from short-term programs. Time-unlimited services encourage the development of stable, ongoing therapeutic relationships.

Sources of Information:

a) Team leader interview .

- In advance of the fidelity visit, request that the team leader compile a list of clients who have been discharged from the program within the last 12 months. Review these discharges with the team leader.

- *"How many of these individuals have you graduated because they no longer needed services?"*
- *"What percentage of ACT clients are expected to be discharged from their team within the next 12 months?"*
- *"Does your team use a level or step-down system for clients who no longer required intensive services?"* [if "yes"] Probe for specifics: what criteria are used, how contact is maintained, etc.

Item Response Coding: Calculate percentage of clients discharged; include only clients who "graduated" (i.e., whose need for services became reduced—omit from the count any clients who left due to relocation or dropping out of treatment – these are counted in Item S2). The intent of this item is to gauge the program philosophy about graduation. If all clients are served on a time-unlimited basis, with fewer than 5% expected to graduate from the program annually, the item is coded as a "5".

Nature of Services

Overall instructions: For estimates of several of the service items (e.g., S1, S4, S5, and S6) subjective estimates from team leader or case managers are usually not very helpful. Often these staff will say, "It depends." Consequently, written documentation is the primary source for these items. The fidelity assessors should ask the team leader for their opinion about the best data source to obtain this information, but the default is chart review, unless they can make a case for a better source.

S1. Community-based services

Definition: Program works to monitor status, develop skills in the community, rather than in office.

Rationale: Contacts in natural settings (i.e., where clients live, work, and interact with other people) are thought to be more effective than when they occur in hospital or office settings, as skills may not transfer well to natural settings. Furthermore, more accurate assessment of the client can occur in his or her community setting because the clinician can make direct observations rather than relying on self-report. Medication delivery, crisis intervention, and networking are more easily accomplished through home visits.

Sources of Information:

a) Chart review (See "During Your Visit" on Page 7 for instructions how to choose charts)

- Calculate the ratio of community-based visits to the total number of face-to-face contacts for each of the 10 charts reviewed. Determine the median value (the average of the 5th and 6th numbers when all values are rank-ordered – see chart review worksheet). Remember to use the most complete and up-to-date time period from the chart. Ask the team leader, clinicians, or an administrative person for the most recent, but complete period of documentation.

b) Review of internal reports/documentation, if available.

c) Clinician interview

- *"What percentage of your contacts with clients are in the community and what percentage are in the office?"*

d) Client interview

- *"Where do you see people from the ACT team the most?"*
- *"How often do you go to the ACT office?"*

Item Response Coding: *See general instructions at beginning of Services Section.* **In scoring this item, count face-to-face contacts with clients. Do not count phone calls and do not count contacts with collaterals or family members.** Use chart data as a primary data source. If the information from different sources disagrees (for example, if the team leader indicates a higher rate of community-based services than do the records), then ask the team leader to help you understand the discrepancy.

If at least 80% of total service time occurs in the community, the item is coded as a "5."

S2. No dropout policy

Definition: Program engages and retains clients at a mutually satisfactory level

Rationale: Outreach efforts, both initially and after a client is enrolled on an ACT team, help build relationships and ensure clients receive ongoing services.

Sources of Information:

a) Team leader interview

- The data from O7 should be referenced when completing this item. [In advance, ask team leader to provide a list of all client discharged in the last 12 months. Review with team leader the rationale for each person's discharge.] For this count, exclude individuals who graduated the program (See Item O7). Count people who have dropped out, i.e., refused services, cannot be located, or have been closed because the team determined that they could not serve them. Also include those who have left the geographic area IF the ACT team did not provide referrals for services for continuing care in the new location.
- *"How many clients dropped out during the last 12 months?"*
- *"For the clients who have moved, what efforts did the ACT team make to connect them to services in their new location?"* [Check for documentation of referrals, if available.]

b) Clinician interview.

- *"How often do you close cases because they refuse treatment or you lose track of them?"*
- *"What factors does the team consider when closing a case?"*

Item Response Coding:

FORMULA: (# CLIENTS DISCHARGED, DROPPED, MOVED WITHOUT REFERRAL)/ TOTAL # CLIENTS

If 95% or more of the caseload is retained over a 12-month period, the item is coded as a "5."

S3. Assertive engagement mechanisms

Definition: Program uses street outreach, legal mechanisms (e.g., probation/parole, OP commitment) or other techniques to ensure ongoing engagement

Rationale: Clients are not immediately discharged from the program due to failure to keep appointments. Retention of clients is a high priority for ACT teams. Persistent, caring attempts to engage clients in treatment helps foster a trusting relationship between the client and the ACT team. Assertive outreach is considered a critical feature of the ACT team.

Sources of Information:

a) Team leader interview

- Ask the team leader to think about 2-3 clients who have been hard to engage or who have refused services. Review these with team leader.
- *"What did the team do to reach out to each of these clients?"*
- *"Was there anything more you could have done to retain them in services?"*
- *"What methods does the team use to keep clients involved in ACT?"*
- *"Which, if any, of the following methods, does the team use? Representative payee services, outpatient commitment, contacts with probation or parole officers, street and shelter outreach after a client is enrolled in ACT, or other mechanisms [please name]."*
- *"How many clients receive each of the above services?"*

b) Clinician interview.

- *"What happens if a client says he or she doesn't want your services?"*

c) Client interview

- *"What happens if a person says they don't want ACT services anymore?"*

Item Response Coding: If the program demonstrates consistently well-thought-out strategies and uses street outreach and legal mechanisms whenever appropriate, the item is coded as a "5."

S4. Intensity of service

Definition: High amount of face-to-face service time as needed.

Rationale: In order to help clients with severe and persistent symptoms maintain and improve their function within the community, high service intensity is often required.

Sources of Information:

a) Chart review (See "During Your Visit" on Page 7 for instructions how to choose charts)

- Using the same charts as used for Item S1, calculate the mean amount of service hours per client, per week, over a month-long period. (If applicable, the charts should proportionately represent the number of clients who have "stepped down" in program intensity.) Include only face-to-face contacts in your tally. From the mean values over a 4-week period, determine the median number of service hours across the sample (average of the 5th and 6th values when the mean service hours per week are rank-ordered – see worksheet). Remember to use the most complete and up-to-date time period from the chart. Ask the

team leader, clinicians, or an administrative person for the most recent, but complete period of documentation.

b) **Review of management information reports,** if available.

Item Response Coding: *See general instructions at beginning of Services Section.* **In scoring this item, count face-to-face contacts with clients. Do not count phone calls and do not count contacts with collaterals or family members.** The fidelity assessors should ask the team leader for the best data source to obtain this information, but the default is chart review, unless they can make a case for a better source. If the median value is two or more hours per week, per client, the item is coded as a "5."

S5. Frequency of contact

Definition: High number of face-to-face service contacts as needed.

Rationale: ACT teams are highly invested in their clients, and maintain frequent contact in order to provide ongoing, responsive support as needed. Frequent contacts are associated with improved client outcomes.

Sources of Information:

a) Chart review (See "During Your Visit" on Page 7 for instructions how to choose charts)

- Using the same charts as used for Item S1, calculate the mean number of face-to-face client-ACT service contacts, per week, over a month-long period. From the calculated mean values, determine the median number of service contacts across the sample average of the 5th and 6th values when the mean service contacts per week are rank-ordered – see tally sheet). Remember to use the most complete and up-to-date time period from the chart. Ask the team leader, clinicians, or an administrative person for the most recent, but complete period of documentation.

b) Review of internal reports/documentation, if available.

c) Client interview

- *"How many times have you seen ACT staff during the past week?"*

Item Response Coding: *See general instructions at beginning of Services Section.* **In scoring this item, count face-to-face contacts with clients. Do not count phone calls and do not count contacts with collaterals or family members.** The fidelity assessors should ask the team leader for the best data source to obtain this information, but the default is chart review, unless they can make a case for a better source. If the program averages four or more contacts per week, per client, the item is coded as a "5."

S6. Work with informal support system

Definition: Program provides support and skills for client's informal support network (i.e., persons not paid to support client, such as family, landlord, shelter staff, employer or other key person).

Rationale: Developing and maintaining community support further enhances client's integration and functioning.

Sources of Information:

a) Team leader interview

- Review the client roster with the team leader. Determine for how many clients the ACT team has made at least one contact with an informal support network. Focus the discussion on this subgroup.
- *"Among clients with whom you have had at least one contact with their informal network in the last month, how frequently does the team work with his or her informal support network (including family, landlord, employer, or other key person)?"*

b) Review of internal reports/documentation, if available.

c) Clinician interview.

- *"How often do you work with the family, landlord, employer, or other informal support network members for each client, on average?"*

d) Client interview

- *"How often is there contact between the ACT team and your family? Your landlord? Your employer?"*

Item Response Coding: Use team leader as primary data source. Include contacts with family, landlord, and employer; exclude persons who are paid to provide assistance to the client, such as Social Security Disability or Department of Human Services representatives.

Tabulate the rate for the subgroup for which the team has at least some contact. From this, calculate the rate for the entire caseload.

Example: Suppose there are 100 clients on the team and the team has some contact with the network for 50 clients. The average contact with this subgroup is 2 contacts a month. Therefore the rate for the entire caseload is:

$$2 * 50/100 = 1 \text{ time per month}$$

If the program makes four or more contacts per month, per client, the item is coded as a "5."

S7. Individualized substance abuse treatment

Definition: One or more members of the team provide direct treatment and substance abuse treatment for clients with substance use disorders.

Rationale: Substance use disorders often occur concurrently in persons with SMI; these co-occurring disorders require treatment that directly addresses them.

Sources of Information:

a) Team Leader AND Substance Abuse Specialist interviews

- *"How many clients have a substance use disorder?"*

- *"Of these clients, how many received structured individual counseling for substance use from the substance abuse counselor on the team or another ACT team member this last month?* The counseling can be in the office, at the clients home, or elsewhere, but it must be more than informal queries or "nagging."
- *Ask the nature of the counseling.* Ideally, the counseling should follow integrated DD counseling principles – see item S9, but for this item, the criterion is more lenient. It must relate specifically to substance use, it cannot be generic counseling. If the person providing the counseling is not a substance abuse counselor, then you should interview the staff providing this counseling to gauge whether it qualifies as appropriate substance abuse counseling. To count for this item, the interventions must be structured and in accordance with the client's goals/treatment plan.
- *"For each client who received substance abuse counseling in the last month, how many sessions did he/she have? How long were the sessions?"*

Item Response Coding: The substance abuse counselor interview is the primary data source. Calculate the total number of sessions for the clients receiving substance abuse treatment. Calculate the total number of minutes per month for each of these clients. Multiply the number of sessions by the number of minutes per month. Divide this product by the number of clients with substance use problems. Divide by 4 (weeks/month).

Example: 20 clients with DD. 10 receive 50-minute counseling sessions every other week.

(10 * 100 /20)/4 = 12.5 minutes per week per DD client.

If clinicians are providing DD counseling in the car and in the course of home visits, then this more informal contact can be coded at level 3 if it roughly meets the time requirement. To score a 4 or 5, there must be more formal structure than simply counseling embedded within home visits.

S8. Dual disorder treatment groups

Definition: Program uses group modalities as a treatment strategy for people with substance use disorders.

Rationale: Group treatment has been shown to positively influence recovery for persons with dual disorders.

Sources of Information:

a) Team leader interview

- *"How many of the clients with DD* (identified in S7) *attended at least one treatment group in the last month?"*
- *"How many groups are offered?"*
- *"Who offers these groups?"* **[Do not count groups offered by organizations that have no connection to the ACT team. Only groups led by ACT staff or by staff who are integrated with the ACT team, i.e., have regular contact with the ACT team count.]**
- *"How many clients attend these groups?"*

b) Substance abuse counselor interview

- Repeat same questions as above.

Item Response Coding: Use substance abuse counselor interview as primary source of data. If 50% or more of all clients with substance use disorders attend at least one substance abuse treatment group meeting during a month, the item is coded as a "5."

S9. Dual disorders (DD) model

Definition: Program uses a stage-wise treatment model that is non-confrontational, follows behavioral principles, considers interactions between mental illness and substance abuse, and has gradual expectations of abstinence.

Rationale: The DD model attends to the concerns of both SMI and substance abuse for maximum opportunity for recovery and symptom management.

Sources of Information:

a) Team leader interview

- *"What is the treatment model used to treat clients with substance abuse problems?"* [Probe for whether confrontation is used]
- *"Do you refer clients to AA? What about detox programs?"*
- *"Do you see the goal as abstinence?"*
- *"How does your team view abstinence versus reduction of use?"*
- *"Does your team employ harm reduction tactics?"* [if "yes"] *"What are some examples?"*
- *"Are you familiar with a stage-wise approach to substance use treatment?* [if "yes"] *"Give some examples of how your program uses this approach."*

b) Clinician (Substance Abuse Counselor) interview.

- Repeat same questions as above.

Item Response Coding: Use Team leader interview as primary data source. If the program is fully based in DD treatment principles, with the team providing treatment, the item is coded as a "5." A program can receive full credit for this item if it includes self-help (e.g., AA) referrals as additional support, rather than in place of team-based interventions.

S10. Role of consumers on treatment team

Definition: Consumers are members of the team who provide direct services.

Rationale: Some research has concluded that including consumers as staff on case management teams improves the practice culture, making it more attuned to consumer perspectives.

Sources of Information:

a) Team leader interview

- *"How are consumers involved as members of your team? (e.g., employed, volunteer, not at all, etc.)"*

- *If they are paid employees, are they full time?*
- *Are they considered full-fledged clinicians? (Alternatively, are they considered aides?)*

b) Clinician interview.

- Ask similar questions as for team leader.

c) Client interview

- *"How are consumers involved as members of your team? (e.g., employed, volunteer, not at all, etc.)"*

Item Response Coding: This item refers to disclosed mental health consumers who have received treatment for a psychiatric disorder. If consumers are employed as clinicians with equal status as other case managers, the item is coded as a "5." If they work full time but at reduced responsibility, code as "4." If part time, but providing clinical activities (e.g., co-lead a group) code as "3." If their participation is "token" involvement on team, code as "2." (If consumer staff does not attend/participate in treatment team meetings, for instance, this would likely be coded as a "2.") Also code the item as a "2" if the consumer works in a position such as driver or administrative assistant.

ACT Fidelity Scale Cover Sheet

Date:_____ **Rater(s):** _____

_____

Program Name (or Program Code): _____

Parent Agency: _____

Address: _____

Contact Person: _____

Telephone: _____

E-mail: _____

Sources Used:

_____ Chart review

_____ Team Leader interview

_____ Program Staff Interview(s) (# interviewed)_____

_____ Consumer Interview(s) (# interviewed)_____

_____ Family Member Interview(s) (# interviewed)_____

_____ _____

_____ _____

_____ _____

Number of clinicians: _____ **Number of consumers served last year:** _____

Funding source: _____ **Urban or rural?** _____

Date program was started: _____

DACTS Score Sheet

Program: _____ Date of Visit: _____ Rater 1 initials:_____ Rater 2 initials ___

		Rater 1	Rater 2	Consensus	ACTUAL VALUE
H1	Small Caseload				
H2	Team Approach				
H3	Program Meeting				
H4	Practicing Team Leader				
H5	Continuity of Staffing				
H6	Staff Capacity				
H7	Psychiatrist on Staff				
H8	Nurse on Staff				
H9	Substance Abuse Specialist on Staff				
H10	Vocational Specialist on Staff				
H11	Program Size	*	*	*	
	HUMAN RESOURCES MEAN:				
O1	Explicit Admission Criteria				
O2	Intake Rate				
O3	Full Responsibility for Treatment Services				
O4	Responsibility for Crisis Services				
O5	Responsibility for Hospital Admissions				
O6	Responsibility for Hospital Discharge Planning				
O7	Time-Unlimited Services				
	ORGANIZATONAL BOUNDARIES MEAN:				
S1	In-Vivo Services				
S2	No Drop-Out Policy				
S3	Assertive Engagement Mechanisms				
S4	Intensity of Service				
S5	Frequency of Contact				
S6	Work with Support System				
S7	Individualized Substance Abuse Treatment				
S8	Dual Disorder Treatment Groups				
S9	Dual Disorders (DD) Model				
S10	Role of Consumers on Treatment Team	*	*	*	
	NATURE OF SERVICES MEAN:				
	TOTAL MEAN SCORE				

* denotes item not included in original DACTS; do not include in score summary

EXHIBIT C

DACTS Score Sheet 2010

		CC1	CC2	CC3	A	GD	FP	HC	P1	P2	P3	P4
H1	Small Caseload	**5**	5	**5**	5	5	5	5	5	4	5	5
H2	Team Approach	**5**	3	**5**	3	3	3	3	3	5	4	5
H3	Program Meeting	**5**	5	**5**	5	5	5	5	5	5	5	5
H4	Practicing Team Leader	**4**	4	**4**	4	5	3	5	5	5	5	5
H5	Continuity of Staffing	**4**	5	**5**	3	1	1	4	2	1	2	3
H6	Staff Capacity	**5**	4	**5**	5	4	4	5	4	3	4	5
H7	Psychiatrist on Staff	**3**	3	**3**	3	4	4	5	4	4	4	4
H8	Nurse on Staff	**3**	3	**3**	4	3	3	4	4	4	4	4
H9	Substance Abuse Specialist on Staff	**3**	3	**3**	5	1	5	5	4	4	5	4
H10	Vocational Specialist on Staff	**3**	1	**3**	1	1	3	1	5	4	5	5
H11	Program Size	**5**	4	**5**	4	5	4	4	4	4	4	4
	HUMAN RESOURCES MEAN:	**4.1**	**3.6**	**4.2**	**3.8**	**3.4**	**3.6**	**4.2**	**4.0**	**3.9**	**4.3**	**4.4**

		CC1	CC2	CC3	A	GD	FP	HC	P1	P2	P3	P4
O1	Explicit Admission Criteria	**5**	5	**5**	5	5	5	5	5	5	5	5
O2	Intake Rate	**5**	5	**1**	5	5	5	3	5	5	5	5
O3	Full Responsibility for Treatment Services	**3**	4	**4**	4	4	4	4	5	5	5	4
O4	Responsibility for Crisis Services	**2**	2	**2**	5	5	3	4	4	4	4	4
O5	Responsibility for Hospital Admissions	**4**	4	**4**	4	4	5	2	4	4	4	5
O6	Responsibility for Hospital Discharge Planning	**4**	5	**4**	4	4	5	5	4	4	4	4
O7	Time-Unlimited Services	**5**	5	**5**	5	5	5	5	5	5	5	5
	ORGANIZATIONAL BOUNDARIES MEAN:	**4.0**	**4.3**	**3.6**	**4.6**	**4.6**	**4.6**	**4.0**	**4.6**	**4.6**	**4.6**	**4.6**

		CC1	CC2	CC3	A	GD	FP	HC	P1	P2	P3	P4
S1	In-Vivo Services	**3**	4	**4**	2	4	5	1	4	4	4	4
S2	No Drop-Out Policy	**5**	5	**5**	5	5	5	5	5	5	4	5
S3	Assertive Engagement Mechanisms	**4**	4	**4**	4	3	3	3	3	3	3	3
S4	Intensity of Service	**5**	4	**4**	4	3	4	4	4	4	3	5
S5	Frequency of Contact	**4**	2	**3**	2	2	3	2	3	3	2	4
S6	Work with Support System	**4**	3	**3**	1	2	4	4	2	2	3	1
S7	Individualized Substance Abuse Treatment	**4**	5	**3**	4	3	4	2	4	4	3	4
S8	Dual Disorder Treatment Groups	**1**	1	**1**	1	2	1	1	3	3	3	2
S9	Dual Disorder (DD) Model	**4**	4	**4**	2	2	3	3	4	4	4	4
S10	Role of Consumers on Treatment Team	**1**	1	**1**	5	1	5	3	1	1	1	1
	NATURE OF SERVICES MEAN:	**3.5**	**3.3**	**3.2**	**3.0**	**2.7**	**3.7**	**2.8**	**3.3**	**3.3**	**2.9**	**3.3**

	CC1	CC2	CC3	A	GD	FP	HC	P1	P2	P3	P4
TOTAL MEAN SCORE:	**3.9**	**3.7**	**3.7**	**3.7**	**3.4**	**3.9**	**3.6**	**4.0**	**3.9**	**3.9**	**4.0**

EXHIBIT D

Department of Mental Health
Assertive Community Treatment
Fidelity Report-Template
Spring 2010

Team:
Team Leader:
Fidelity Assessment Date:
Fidelity Team:
Caseload:
Timeframe for Chart Review:
Team Start Month:

On_____, 2010 the District of Columbia Department of Mental Health conducted a fidelity assessment of the XXXXX (XXX) Assertive Community Treatment Team using the Dartmouth ACT scale. This fidelity assessment is part of a planned assessment of the ACT system at DMH. This fidelity assessment process began in _____ 2010 and will be completed in _____ 2010. The XXX fidelity assessment is considered a second assessment. It is anticipated that the scores for a second assessment will be higher than the baseline assessment.

The DACTS is a 28 item scale that assesses the degree of fidelity to the ACT model along 3 dimension: Human Resources (caseload ratios, staffing patterns, team member specialties etc.), Organizational Boundaries (admission criteria, responsibility for admission and discharge from inpatient facilities, team admissions and discharges etc.) and Nature of Services (e.g. services provided in the community, intensity of services, frequency of contact etc.)

Data was gathered through the following mechanisms:

Site Visit
Morning Meeting Attendance
Staff Interviews of Team Leader, Substance Abuse specialist, SE/Voc Specialist and Consumer
Chart Reviews – 10 randomly selected charts
Reports submitted by Team Leader

Fidelity scores are listed below and include comments in each criterion.

DACTS Criterion/Scores/Comments

DACTS Criterion	Score	Comments
Human Resources		
H1: Small Caseload (Ratio 10:1)		

H2: Team Approach (Providers function as a team rather than as individual practitioners.)		
H3: Program Meeting		
H4: Practicing Team Leader		
H5: Continuity of Staff (Program Maintains same staffing over time)		
H6: Staff Capacity (Program operates at full staffing)		
H7: Psychiatrist on Staff (There is at least one full time psychiatrist per 100 consumers on the team)		
H8: Nurse on Staff (There are at least 2 FTE RNs assigned to work with 100 consumers)		
H9: Substance Abuse Specialist on Staff (There are at least 2 substance abuse specialists with 1 year of training/ experience in substance abuse treatment for 100 consumers)		
H10: Vocational Specialist (The program includes at least two staff members with 1 year training/experience in vacation and rehab support.		
H11: Program Size		

[Type text]

(The program is of sufficient absolute size to provide the necessary diversity of specialists and coverage)		
Subtotal		HR Score:
Organizational Boundaries		
O1: Admission Criteria (Program has clearly identified mission and operationally defined criteria to screen out inappropriate referrals.)		
O2: Intake Rate (Program admits consumers at a low rate to maintain a stable service environment)		
O3: Full Responsibility for Treatment Services (Psychiatric Services, Counseling/Therapy, Housing support, SA TX, Emp/Voc services)		.
O4: Responsibility for Crisis Services (Program has 24 – Hour responsibility for crisis services)		
O5: Responsibility of Hospital Admissions		
O6: Responsibility for Hospital Discharges		
O7: Time-Unlimited Services (Program rarely graduates		

[Type text]

consumers)		
SubTotal		
Nature of Services		
S1: Community-Based Services (Program monitors status, develops community living skills out of the office)		
S2: No Drop Out Policy (Program retains a high percentage of its consumers)		
S3: Assertive Engagement Mechanisms (Use of Street outreach, Visits to jail, special engagement strategies, use of legal mechanisms: commitment, payee ship, guardianship, Hours of operation)		
S4: Intensity of Services (High Total amount of face to face time)		
S5: Frequency of contact (Number of face to face service contacts)		
S6: Work with Informal Support System (Number of contacts with collateral sources)		
S7: Individualized Substance Abuse Treatment (One or more members of the staff provide direct treatment for consumers)		
S8: Dual Disorders		

[Type text]

Treatment Groups		
S9: Dual Disorders Model (Program uses a stage-wise model that is non-confrontational, follows behavioral principles, considers interactions of mental illness and substance abuse and considers gradual abstinence)		
S10: Role of consumers on Treatment Team		
Subtotal		
Total Team Score		

D.C. Department of Mental Health
Assertive Community Treatment
ACT Performance Improvement Workplan – FY 2011

Area of Concern	Strategy	Person Responsible	Timeline	Status	Documentation
Complete Annual Fidelity Assessment	1)Identify Fidelity Team 2)Provide Refresher Training to Fideltiy Team 3)Develop schedule 4)Provide refresher training to ACT teams	Eugene/Michele	Assessments to be completed 7/11-9/11	Not Done	Reports including recommendations will be finalized and circulated to all teams as of 10/1/11. Improvement plans will be submitted by each team by the end of December 2011. Status reports will be required as part of the monthly report process.
Improve Evidence based practice in Dual Diagnosis services	Provide and training and coaching to substance abuse counselors and ACT staff	Eugene/Michele/Providers	Second and Fourth Quarter	Not Done	
Improve Evidence based practice in SE services	Provide SE training and coaching to Voc specialists and ACT staff	Eugene/Michele/Steve Baker	First and Third Quarter	Not Done	
Improve Evidence based practice in peer specialists	1)Provide information to ACT Team Leaders on Peers 2)Provide training to Peers Specialists and ACT staff 3)Meet with office of consumer Affairs/Training Institute	Eugene/Michele/Vivi Smith	First and Second Quarter	Not Done	
Clarify role of psychiatrist on ACT service	1)Provide training to ACT psychiatrists and Team Leaders on role of psychiatrist.	Eugene/Michele/consultant	Second Quarter	Not Done	
Improve skills of ACT staff in	1)Provide/refer ACT staff to MI	Eugene/Michele/others	Ongoing through FY	Not Done	

MI	training.		2011		
Priority Cases	1. Develop criteria 2. Develop spreadsheet 3. Document actions	Eugene/Michele	Ongoing	Not Done	Follow-up form to be completed.
Site Visits to All Teams	Attend Morning Mtgs for all	Eugene, Michele, Steve Miller	Quarterly	All Meetings have been attended.	Follow up-Form to be completed.
Referral Sources	Track Referral Sources	Eugene	Twice Annually	Not Done	Ecura Reports
Reconvene Internal Stakeholder Group	1)Identify participants 2)Develop standing agenda items 3)Set meeting dates 4)Identify facilitator and note taker	Michele, Eugene, Provider Relations, Integrated Care, Care coordination, OA, SHE, CPEP	Quarterly	First Mtg 7/15/10	Agenda and Minutes
Establish ACT group billing rate	1) Prepare language for approval to Health care finance agency	Michele/Suzanne Fenzel	Done April 2010	In process	

Updated 6/29/10

EXHIBIT F

DMH
ACT Work Group
7/13/10
Minutes

Present: Venida Hamilton/Provider Relations; Steve Steury, MD/Chief Clinical Officer, Atiya Frame/Office of Accountability; Randy Raybon/ AccessHelpline-Care Coordination; Eugene Wooden/ACT Coordinator and Michele May /Adult Services. Not Present: Office of Integrated Care

I. ACT fidelity assessment scores were presented and the fidelity assessment process was described. Eugene and Michele apprised the group on the training provided to prepare Fidelity Assessment to complete assessments and specific scores were reviewed. Michele and Eugene highlighted area of strength for the ACT system and areas of weakness.

II. Michele and Eugene shared the FY 2011 draft ACT workplan with the group and the performance improvement plan required for each team score of 3 or below.

III. Work group members discussed experiences related to working with ACT providers. Dr. Steury stated that required documentation for ACT providers whose consumers were at CPEP seemed to be provided as needed and that teams were participating in rounds at CPEP when requested.

IV. Michele told the group that Suzanne Fenzel was working with Healthcare Finance to establish a group billing rate for the dual diagnosis groups required by the DACTS scale and for other groups the teams might like to do. It is anticipated that by the end of the fiscal year this rate will be in place.

V. Michele also stated that she and Eugene are working on some amendments to the MHRS language for ACT.

VI. Lastly, the group discussed needing to establish criteria and protocols for putting a team on probation and for determining when a team/provider should be recertified.

VII. The ACT workgroup will meet on a quarterly basis to 1) review progress and share information on ACT 2) plan for ACT system improvement.

Next Meeting: October 2010.

EXHIBIT G

ACT RECERTIFICATION SCHEDULE

No.	Provider Name	Recertification Date
1.	Anchor Mental Health	09-14-2011
2.	Capital Community Services	04-30-2011
3.	Community Connections	09-10-2011
4.	Family Preservation	07-30-2012
5.	Green Door	07-14-2011
6.	Hillcrest Children's Center	03-30-2012
7.	Pathways to Housing	09-13-2011

EXHIBIT G

Exhibit G

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF MENTAL HEALTH

Office of Programs and Policy
Division of Integrated Care
Involuntary Hospital Admissions Monthly Report
Fiscal Year 2010

Actual Total Admissions By Facility	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Total
United Medical Center (UMC)	16	33	33	37	33	44	27	26	31	22	26		328
Psychiatric Institute of Washington (PIW)	3	3	0	0	7	3	3	1	2	4	14		40
Providence	36	32	38	27	25	28	32	26	34	36	36		350
St Elizabeths – Acute (SEH)	8	9	11	6	5	1	3	1	3	6	4		57
St Elizabeths – 15 Day Transfers (SEH)	8	7	13	10	6	7	9	6	10	8	13		97
Sub Acute (Inpatient Psychiatric Bed)	2	4	8	4	6	9	8	6	1	1	5		54
Total	73	88	103	84	82	92	82	66	81	77	98		926

Legal Status of SEH Admissions - All	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Total
Committed Outpatient	3	2	4	3	1	2	3	0	3	3	1		25
Involuntary	14	18	28	16	14	15	17	13	14	17	21		187
Voluntary	1	0	0	1	2	0	0	0	0	2	0		6
Admissions without Care Coordination Authorization	0	0	0	0	0	0	0	0	0	0	0		0

Referral Source of Admissions to SEH	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Total
Community Emergency Room	0	0	1	0	0	0	0	0	1	1	1		4
Inpatient Medical/Surgical Bed	0	0	0	0	0	1	0	1	0	0	0		2
Sub Acute (Inpatient Psychiatric Bed)	2	4	8	4	6	8	8	5	1	1	4		51
CPEP	6	9	10	6	5	1	3	1	2	5	3		51
UMC 15 Day Transfer	5	3	6	5	1	2	2	2	5	2	4		37
PIW 15 Day Transfer	0	1	0	0	0	0	0	0	0	0	0		1
Providence 15 Day Transfer	3	3	7	5	5	5	7	4	5	6	9		59
Unknown	0	0	0	0	0	0	0	0	0	0	0		0

Exhibit G

Involuntary Hospital Admissions Monthly Report
Page 2

Reasons Eligible Consumers Not Admitted to a Community Hospital	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Total
No Beds Available	0	0	1	0	0	3	0	1	1	2	0		8
Clinical Reason – Hospital Determined	6	0	0	0	0	0	0	0	0	0	0		6
Clinical Reason – DMH Determined	2	9	31	6	5	7	11	6	5	11	9		102
Administrative Reason	0	0	0	0	0	0	0	0	0	0	0		0
Other Reason	0	0	0	0	0	0	0	0	0	0	0		0
No Reason Listed	0	0	0	0	0	0	0	0	0	0	0		0

Acute Total Admissions by Facility	Oct		Nov		Dec		Jan		Feb		March		April		May		June		July		Aug		Sept	
Total Number/Percent of Total	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
United Medical Center (UMC)	16	25	33	41	33	40	37	50	33	43	44	52	27	37	26	43	31	44	22	32	26	31		
Psychiatric Institute of Washington (PIW)	3	5	3	4	0	0	0	0	7	9	3	4	3	4	1	2	2	3	4	6	14	16		
Providence	36	55	32	40	38	46	27	36	25	33	28	33	32	43	26	43	34	48	36	52	36	42		
St Elizabeths – Acute (SEH)	8	12	9	11	11	14	6	8	5	7	1	1	3	4	1	2	3	4	6	9	4	5		
St Elizabeths – Sub Acute	2	3	4	5	8		4	5	6	8	9	11	8	11	6	10	1	1	1	1	5	6		
Total	65		81		82		74		76		85		73		60		71		69		85			
St Elizabeths – 15 Day Transfers	8		7		13		10		6		7		9		6		10		8		13			
% of All Acute Community Admissions	15		10		16		16		9		9		14		11		15		13		17			