UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

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

COURT MONITOR'S NOTICE OF SUBMISSION OF REPORT

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

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that copies of the foregoing COURT MONITOR'S NOTICE OF SUBMISSION OF REPORT and the Court Monitor's REPORT TO THE COURT were served by first class mail, postage prepaid, this 4th day of August 2008 upon:

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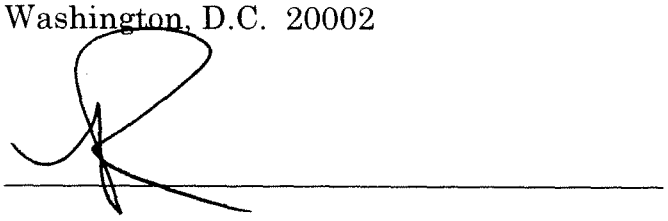

REPORT TO THE COURT

Court Monitor
Dennis R. Jones

July 31, 2008

EXECUTIVE SUMMARY

The twelfth Report to the Court details continued progress in critical areas. One additional Exit Criteria (#18—Community Resources) is recommended for inactive status. Implementation of the recommendations in the Crisis Emergency Services Planning Workgroup Report is moving forward with the creation of mobile crisis teams for adults. The Phase 1 rehabilitation of the existing CPEP building is scheduled for completion in October, 2008. The new Hospital is 73% complete as of June 30, 2008. The DC CSA evaluation and decision making process is targeted for resolution by October 1, 2008, with an implementation plan ready by December 31, 2008.

1. Implementation of Exit Criterion

Sixteen (16) of the seventeen (17) quantifiable data measures have been verified for data integrity by DMH and the Court Monitor. The Court Monitor is recommending that one additional Exit Criteria (#18—Community Resources) be moved to inactive status. There are five (5) additional criteria for which progress is noted and eleven (11) that still require significant additional effort to achieve the Court-required levels. For the first time, it is evident that all nineteen (19) Exit Criteria have clear "ownership" within DMH and concerted attention.

2. Comprehensive Psychiatric Emergency Services

The recommendations contained in the Crisis Emergency Services Planning Workgroup Report are being implemented. A new Court Urgent Care Clinic (CUCC) at the DC Superior Court opened on June 23, 2008. The mobile teams for adults have been funded and the intent is to have this service fully operational by October, 2008. As required by the Amended Implementation Plan in the LaShawn case, the contract for child/youth crisis was awarded to Catholic Charities; the expectation is that 2 mobile crisis teams and 4 crisis beds will be operating by September, 2008. The Phase 1 rehabilitation of the existing CPEP building is scheduled to be completed by October, 2008. This renovated space will allow for adequate and separate areas for visitors, staff, and eight (8) extended observation beds.

3. St. Elizabeths Hospital

The construction of the new 292 bed Hospital is 73% complete as of June 30, 2008. Early 2010 is the planned occupancy date. The Phase 1 RMB project—which separates out the energy source for the new Hospital—is scheduled for completion in the Spring of 2009.

Compliance with the DOJ Settlement Agreement continues to be the major focus and challenge. The first DOJ follow-up report was revised on April 16, 2008. The compliance officer will submit a report to DOJ by the end of July, 2008 regarding the levels of compliance under the settlement agreement. The major focus—in terms of measuring progress—will be on those twenty-nine (29) areas that were targeted for improvement by June, 2008. Staff hiring has improved and the new IT System (Phase 1) is scheduled to go live on July 22, 2008. Overall, there is still a tremendous amount of concerted work needed to achieve desired results.

4. Use of Local Hospitals to Provide Acute Care

The inappropriate use of SEH for acute care continues to be a major concern. The successful negotiation with Providence Hospital for ten (10) additional acute beds (starting in September, 2008) should help. There is also potential for the addition of acute beds at Greater Southeast. Additional dollars ($1.4 million) are budgeted for 2009 to expand acute care capacity in the community.

5. Budgeting/Provider Payment Issues

The FY09 budget is pretty flat as compared to FY08. Though it appears to drop significantly, $15.2 million of the $17.1 million will be transferred to MAA to pay the 70% MHRS claims for 2009. The 2009 budget will be tight but should allow continued progress on Dixon mandates.

The MAA transition has had a couple of significant IT snags since the November, 2008 switchover. These have been successfully resolved—albeit with renewed concern by affected providers as to the predictability of the payment system.

The DMH has decided not to pursue analysis of an Administrative Services Organization (ASO) pending further discussions with the City Administrator's Office about how they ASO analysis would be affected by the newly-created Health Care Finance Administration. This issue may resurface at a later date.

6. Planning for DC CSA

DMH has contracted with KPMG to analyze governance and service delivery options. Initial options and recommendations are to be completed by mid-August 2008. These time frames will require the Court Monitor to submit a supplemental Report to the Court in early October, 2008 on this specific issue. The District Council has also required a recommendation by October 1, 2008 and an implementation plan by December 31, 2008.

7. Evaluation of Independent Personnel Authority

KPMG has been contracted to review and analyze HR resources, processes and procedures. This process will begin July 16, 2008. In addition, KPMG will review HR policy and underlying regulations—with an eye to needed changes. This overall process will take at least ninety (90) days.

Overall, there continues to be progress on critical areas. It is encouraging to see movement on some of the core infrastructure systems. (e.g., IT, HR and procurement). Longstanding deficiencies and inefficiencies in these areas erode confidence and reduce organizational capacity. DMH leadership appears to be increasingly cohesive and productive under the overall leadership of Mr. Steve Baron. Critical issues—e.g., DC CSA, expansion of acute care, quality improvement at SEH, and initiation of mobile teams—will all come to a head this Fall.

Based on the findings in this Report and previous Reports to the Court, the Court Monitor makes the following priority recommendations:

A. Although less frequently, the District should continue to submit progress reports to the Court regarding priority areas. At a minimum, these priority areas should include: a) status of implementation of Exit Criteria; b) status of Crisis Emergency Services Planning Work Group Recommendations; c) status of quality care performance at SEH—including priority DOJ compliance measures; d) use of local Hospitals to provide acute care; e) provider payment performance; f) status of DC CSA governance and services plan; g) status of independent personnel and procurement assessments and improvements; h) status of new PRTF/RTC Commission (or equivalent structure). In an effort to reduce administrative burden and balance report periods, it is recommended that these Reports be filed twice per year—beginning on April 1, 2009 and every six months thereafter.

B. The District/DMH should complete its review of the new Commission for PRTF/RTC (or ICSIC alternative) placements and make this new cross-agency structure a reality.

C. The DMH should complete its analysis of the DC CSA governance and service options as currently scheduled with a Report to the District Council and the Court Monitor by no later than October 1, 2008. The Court Monitor

will review these findings and recommendations and prepare a supplemental Report to the Court in early October, 2008.

I. Current Situation

In October 2007 the Federal Court approved the Monitoring Plan for October 1, 2007 through September 30, 2008. The Monitoring Plan included three primary areas for review during this period:

A. Implementation and performance for each of the nineteen (19) Exit Criteria;

B. Continued implementation of critical administrative and service functions as outlined in the Court-Ordered Plan; and

C. Events which may significantly impact the implementation of the Court-Ordered Plan and/or the achievement of the required performance levels for the Exit Criteria.

This Report provides updates on the status of each of the above-identified areas, highlights any barriers to progress, and makes recommendations for future actions. The May 23, 2002 Consent Order requires a Monitoring Report to the Court twice per year. This is the twelfth formal Monitoring Report.

II. Findings Regarding Exit Criteria

This Report utilizes the same format as previous Reports. Table I in part II.C. presents the current status of all nineteen (19) Exit Criteria and discusses specific progress and concerns.

The Exit Criteria fall into three categories: (1) review of demonstrated use of consumer satisfaction method(s) and consumer functioning review method(s); (2) the implementation of year six Consumer Service Reviews (CSR's) for both adults and children/youth; and (3) the demonstrated implementation of data collection methods and performance levels for the fifteen (15) Exit Criteria.

A. Consumer Satisfaction Method(s) and Consumer Functioning Review Method(s)

There has been limited movement on these two Exit Criteria since the Monitor's Report of January, 2008 The major concern of carrying out the compliance requirements remains the same. The DMH has completed the MHSIP survey for 2007. This survey was done via contract with the House of Sharon, a consumer-run organization. Three separate nationally-normed instruments were used—the MHSIP (adults), the ROSI (supplemental survey for adults) and the YSS-F (children and youth). All of these surveys were done by telephone during the late summer and fall of 2007. As in prior years there were major issues in the surveyors being able to reach the sample selected due to inaccurate phone numbers. The overall participation rate was 25% for adults (279 out of 1110 in the sample) and 17.3% for children and youth (175 out of 1008). DMH staff indicate that the large majority of the non-participation was the direct result of inaccurate phone numbers. The intent is to correct this problem before the 2008 survey. Despite the access problems, the MHSIP, ROSI and YSS-F provide a set of satisfaction

indicators that could help to inform both the areas and the degree to which consumers are satisfied. The DMH intent is for this method, together with the convenience sampling and focus groups to serve as the basis for an overall analysis of consumer satisfaction trends, the development of a prioritized improvement plan and then the implementation and measurement of that plan. Though DMH structures are now in place to do this type of systems review via the Internal Quality Committee (IQC) and the external Quality Council (QC), the needed work on this issue has not yet occurred. One of the keys will be regular communication and collaboration with Consumer Action Network (CAN) regarding the expectations and reporting of the convenience sampling and focus groups that are part of the CAN contract. Once the Office of Accountability and the IQC receive regular summary reports of focus group results and convenience survey results, trending analysis will occur on a regular basis. It is hoped that quality improvement initiatives will be developed in response to that trending analysis.

There has finally been some movement on the consumer functioning method. The IT area has been able to add staff and some of the priority eCura issues are under better control. Although the Avatar hospital system go-live is currently a primary focus for IT, an additional resource is now available to work on the first of two major IT issues. These are: 1) migrating from Citrix to secure Web-based access so all providers can access LOCUS and CALOCUS to input data; and 2) reactivation of the interface between the LOCUS/CALOCUS and eCura for automated propagation of demographic and treatment information. The second issue includes: (a) short-term redesign of interface to accommodate updates to eCura database and (b) cleanup of client and facility data integrity issues. It is anticipated that these two projects can be completed by the end of the 2008 calendar year. The second phase of the interface redesign is scheduled for 2009. This will improve performance and stability by eliminating potential issues with remote transactions. The Office of Accountability is prepared to begin using the data via the QI Council to inform itself and its providers as to areas for improvement. The Court Monitor will review this area in more detail in the January 2009 Report to the Court.

B. Implementation of Year Six (6) Consumer Service Review (CSR's) for Adults and Children/Youth

As in previous years the Court Monitor contracted with Human Systems and Outcomes (HSO) to conduct year six (6) reviews for both child/youth and adults. The same basic protocols were utilized and CAN provided excellent logistical support in obtaining consents, coordinating schedules and providing assistance to both DMH and HSO reviewers. The changes that were agreed to for this year were fully implemented, namely: 1) sample cases were significantly increased; 2) HSO reviewers conducted approximately two-thirds of the reviews and DMH conducted one-third; 3)

HSO provided a case judge function for all DMH-reviewed cases; and 4) maximal effort was given to doing reviews for the selected sample—with careful scrutiny on any needed replacement cases.

The advance planning period was lengthened. HSO provided on-site staff during much of the review period and worked closely with DMH and CAN in dealing with the myriad of issues that inevitably surface. Overall, the logistics and the cooperation for these reviews was the best ever.

1. Summary of Children/Youth Findings

The Children/Youth Review was conducted from March 3-14, 2008. The target was to review 85 cases out of the total 1475 children who received a billable service between April 1 and October 31, 2007. The final completed sample was 73—with 53 cases reviewed by HSO personnel and 20 by DMH. The reviewed cases came from eleven different CSA's of which 62% had involvement with both DMH and CFSA. CFSA staff participated directly in seventeen (17) of the CFSA cases to allow a "co-review" under both CFSA and Dixon protocols. This cross-agency participation has grown each year. Despite diligent efforts by DMH, CFSA was unable to provide consent for six (6) children receiving foster care services, whose biological parents could not be located. This is an ongoing issue that the District needs to resolve.

The findings for year six were similar to prior years. The overall children/youth status was 79%—which compares favorably to 2007 at 75% and 2006 at 81%. The children/youth status showed acceptable results among several indicators, e.g., safety of the child (88%), health/physical well-being (90%), lawful behavioral (77%) and home and school placement (85%). Scoring less well were academic status (67%) and stability (67%).

The Dixon measure is on system performance. In this category the score for 2008 was 36%—a drop from 48% in 2007 and 54% in 2006. This drop in system performance may well be a function of the case judging process that served to tighten inter-rater reliability. Nevertheless, the same issues that predominated in prior years continue. These include very poor scores in critical areas, e.g., service team functioning (26%), service team formation (47%), functional assessment (48%), goodness-of-service fit (51%), and service coordination and continuity (32%). The focus groups that are conducted as part of the CSR reviews corroborate the point that there has been good progress at the leadership level in developing cross-system relationships, common philosophy and commitment to a family-centered system of care. These commitments, however, have not been translated into every day practice. As the HSO report delineates: "there is not sufficient and timely conversation and team work across child-serving providers" . . . "there are still not sufficient quality assurance mechanisms in place that are focused on practice improvement" . . . and . . . "there are few performance,

feed back loops to help front line staff improve the quality and consistency of practice." The HSO report recommends (and the Court Monitor agrees) that the upcoming year should focus on one major goal—to increase the quality of teamwork and communication for each child served across all of the necessary providers, family members and agencies.

2. Summary of Adult Findings

The sixth year of the Adult CSR was conducted during the first two weeks of June, 2008. The same basic protocols that were used for children/youth were also used for adults. The total number of cases reviewed was 88—which hit the target for statistically acceptable numbers.

Year six results show that 74% of the cases reviewed were in the acceptable range for individual consumer status. This compares favorably to year five (5) results at 69% and year four (4) at 65%. Year six showed very positive results in areas of safety (82%), economic security (84%) and overall satisfaction (88%). Scoring poorly were areas of education/career preparations (39%), work (44%) and recovery activities (54%).

Year six results for system performance were also at 74%. While lower than the year five mark of 80%, this score represents a stable pattern of performance in the overall adult system. High performance areas continue to be: engagement efforts by staff (83%), culturally appropriate practice (95%), and medication management (80%). The systems areas that scored low (as with children/youth) were service team formation (53%) and service team functioning (51%). It was very evident from the adult debriefings that consistent efforts to communicate and collaborate among the core practitioners would bring this performance level above the Court-required standard of 80%.

C. Implementation of Court-Approved Performance Criteria

Table 1 reflects the current status of performance on all nineteen (19) Exit Criteria.

July 2008

Table 1
Exit Criteria
Current Status

Aggregate Data for April 1, 2007 Through March 31, 2008

Exit Criteria	Policy in Place	Data Methods in Place	DMH Validated Data System	Court Monitor Validated Data System	Court Required Performance Level	Current Performance Level
1. Consumer Satisfaction Method(s)	Yes	N.A.	N.A.	N.A.	Methods + Demonstrated Utilization of Results	Methods Completed. Utilization in Process
2. Consumer Functioning Method(s)	Yes	N.A.	N.A.	N.A.	Methods + Demonstrated Utilization of Results	Method Completed. No Evidence of Utilization
3. Consumer Reviews (Adult)	Yes	Yes	Yes	Yes	80% for Systems Performance	74%
4. Consumer Reviews (C/Y)	Yes	Yes	Yes	Yes	80% for Systems Performance	36%
5. Penetration (C/Y 0-17 Years)	Yes	Yes	Yes	Yes	5%	2.62%
6. Penetration (C/Y with SED)	Yes	Yes	Yes	Yes	3%	1.62%
7. Penetration (Adults 18 + Years)	Yes	Yes	Yes	Yes	3%	2.36%
8. Penetration (Adults with SMI)	Yes	Yes	Yes	Yes	2%	1.99%
9. Supported Housing	Yes	Yes	Yes	Yes	70% Served Within 45 Days of Referral	10.1%
10. Supported Employment	Yes	Yes	Yes	Yes	70% Served Within 120 Days of Referral	94%
11. Assertive Community Treatment (ACT)	Yes	Yes	Yes	In Process via Consultant for Court Monitor	85% Served Within 45 Days of Referral	48.05%

12. Newer -Generation Medications	Yes	Yes	Yes	Yes	70% of Adults with Schizophrenia Receive Atypical Medications	85.6% (Inactive Monitoring Status)
13. Homeless (Adults)	Yes	Yes	Yes	Yes	150 Served + Comprehensive Strategy	142 Draft Comprehensive Strategy Developed
14. C/Y in Natural Setting	Yes	Yes	Yes	Yes	75% of SED With Service in Natural Setting. Must Have SED Penetration Rate of 2.5%.	66.2%
15. C/Y in own (or surrogate) home	Yes	Yes	Yes	Yes	85% of SED in Own Home or Surrogate Home. Must Have SED Penetration Rate of 2.5%.	94.3%
16. Homeless C/Y	Yes	Yes	Yes	Yes	100 Served + Comprehensive Strategy	88 Draft Comprehensive Strategy Developed
17. Continuity of Care a. Adults b. C/Y	Yes	Yes	Yes	Yes	80% of Inpatient Discharges Seen Within 7 Days in Non-emergenc y Outpatient Setting.	Adults 45% Child/Youth 34.8% Overall 44.2%
18. Community Resources	Yes	Yes	Yes	Yes	60% of DMH Expenses for Community Services	FY '06— 60.45%
19. Medicaid Utilization	Yes	Yes	Yes	Yes	49% of MHRS Billings Paid by Medicaid	FY '07— 41% (Inactive Monitoring Status)

Table 1 reflects the most recent status of the District's performance on all nineteen (19) of the Exit Criteria. The measurement period is for the most current twelve months (April 1, 2007-March 31, 2008) and reflects claims activity as of July 8, 2008 for Exit Criteria numbers 5-8, 11-15 and 17. Data reported for Exit Criterion #16 is for the period from January 2008 through July 2, 2008. Community resources (#18) reports an in-depth analysis of FY06 expenditures. The Court Monitor and DMH have resolved nearly all of the outstanding validation issues regarding current reporting methods. The ACT (#11) metrics continue to be reviewed by the consultant to the Court Monitor. These issues should

be resolved very soon. However, in the event that DMH wishes to include MCO data in the penetration rates at some future period, there will need to be another round of validation at that time. It should also be noted that work is ongoing between DMH and the Court Monitor regarding Supported Housing. Any changes in the structure of the Exit Criteria will obviously trigger new validation tests.

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

1) Exit Criteria Met—Inactive Monitoring Status
   - Prescribing Newer Generation Medications (Criteria #12):
     In the July 2007 Report to the Court, the Court Monitor found that this measure met the Court-approved level and should move to inactive status.
   - Medicaid Utilization (Criterion #19):
     In the January, 2008 Report to the Court, the Court Monitor determined compliance on this criteria. It has also moved to inactive status. As required by the terms of the December 12, 2003 Consent Order, DMH is currently reporting on performance for FY'07. DMH is still collecting federal funds for FY'07 and is currently reporting a 41% collection rate (#19).

2) Recommended for Inactive Monitoring Status
   Based on submitted documentation and full review, the Court Monitor finds that one additional measure has been met and recommends that this move to inactive status.
   - Community Resources (Criteria #18):
     The DMH contracted with KPMG to do a detailed analysis of all expenditures for FY 2006. These expenditures were reviewed and allocated for 254 different index codes (cost centers). Based on this analysis, 60.45% of total expenditures were for community-based services and activities. Given that this exceeds the Court-imposed compliance level of 60%, the Court Monitor recommends that this Exit Criterion move to inactive status. The Court Monitor will continue to ask that DMH verify that it is meeting the 60% requirement in future years. This is especially important in light of the increased resources being devoted to SEH and the expected changes to DC CSA.

3) Progress Noted but Exit Criteria Not Met—Not Recommended For Inactive Status

There are five (5) Exit Criteria that need additional verification and/or performance before inactive monitoring can be achieved. These five are summarized as follows:

- Consumer Service Reviews (CSR) for Adults (#3):
  The Adult CSR reviews were completed in June, 2008. The final system performance score was 74%. While this falls below the required 80% level for compliance, it represents very solid performance in the adult system. The 2008 Adult Review included 88 cases which met the sample size requirements for a confidence level of 95% (+/-10%).
- Supported Employment (#10):
  The DMH has submitted a letter to the Court Monitor indicating its belief that it has met the compliance level. The major unresolved issue is verification of referrals at the provider level. Ongoing discussions will occur between the Court Monitor and the parties as to resolution options. There is further discussion about DMH activities with regard to supported employment in section III. C. 1.c of this Report.
- Children/Youth in Own (or Surrogate) Home (#15):
  The DMH continues to perform above the Court—required level. However, this Exit Criterion requires a penetration rate of 2.5% in order to be considered for inactive status; the current penetration rate is 1.62%.
- Homeless Services for Adults and Children/youth (#13 and#16):
  The DMH has made significant progress on both of these Exit Criteria. The comprehensive strategy has been developed as required and is being reviewed by Plaintiff's counsel. The number of adults served (via Pathways alone) stands at 142 —very near the 150 court requirement. The Homeless Outreach Program (HOP) has employed a full-time person to visit homeless shelters and assess the need for mental health services in children/youth. The performance level for the children/youth criterion is not measured by obtaining provider data; it is measured by counting the number of children/youth that this staff person has "engaged"--88 as of July 1, 2008. There is a further discussion about the HOP and services to the homeless in section III.C.1.c of the Report.

4) Significant Progress Not Noted/Major Progress Remains—Not Recommended for Inactive Status

There are eleven (11) Exit Criteria with significant progress still to be accomplished:

- Consumer Satisfaction Methods (#1):
  The consumer satisfaction methods have been in place for several years but there is not an overall plan to utilize data and demonstrate improvement.
- Consumer Functioning Methods (#2):
  The DMH is planning to migrate from the Citrix Platform to secure web-based access. This should make the process of aggregating data easier. A plan for utilizing this data to improve quality still remains.
- Consumer Service Reviews (CSR) for Children/Youth (#4):
  CSR scores remain low. DMH recognizes that significant additional cross-agency work needs to be done in order to show progress on this measure.
- Penetration Rates (#5-8):
  The DMH is collecting data from the MCO's but has not yet validated it. DMH has also negotiated a new MOU with the MAA regarding DMH's role vis a vis the MCO's. All of this is in anticipation of DMH requesting the inclusion of MCO data in the penetration calculations.
- Supported Housing (#9):
  DMH is working with a consultant to identify the full range of its supported housing efforts—most of which it does not currently capture with the current data collection metric. There is a further discussion about DMH activities with regard to supported housing in section III.C.1.b of this Report.
- ACT (#11)
  DMH is actively reviewing its ACT model via an outside fidelity audit. The intent is to make notable improvements over the next year. There is further discussion about DMH activities with regard to ACT in section III.C.1.d of this Report.
- Children/youth in Natural Settings (#14)
  Services on this measure appear to have slipped from previous reporting periods, as a result of the transition of claims payment from DMH to MAA. Providers are required to roll-up all claims for the same services provided at different times during the day for submission to MAA. If services are provided at multiple locations, the claim is submitted using a 99 place of service code. DMH is not reporting claims with a 99 place of service code as being provided in a natural setting. DMH will be

examining this issue during the remainder of FY08. This measure must also achieve a 2.5% penetration rate before it can be considered for meeting compliance.

- Continuity of Care (#17):
  DMH is putting increasing focus on this Exit Criteria—examining the details of performance by provider (CSA) and by point of discharge (individual hospitals). This analysis should lead to refined strategies. It should be noted that DMH has submitted a letter to the Court Monitor requesting a change in the Court-required standards for this measure. This request is based on DMH's comparison of D.C.'s mental health system to recent benchmarking analysis of national data from Medicaid insurance providers. Though the request is under review and discussion by the Court Monitor and the Parties, the Court Monitor believes that any modification of this criterion is premature.

Overall, there continues to be concerted levels of activity on most of the Exit Criteria. Community Resources, Homeless Services, CSR Reviews, Supported Employment, ACT and Continuity of Care are examples of high activity levels over the past six months. In each case there is clear ownership for the program and leadership support for improved results.

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

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

1. Quality Improvement and Provider Oversight

The Office of Accountability (OA) has demonstrated considerable progress over the past year. Areas of particular note include:

a) Claims Auditing of MHRS Providers

OA staff have revised the process and protocols for conducting retrospective claims audits for all MHRS providers. This has been an area of major focus over the past year—with considerable work done in catching up on prior year audits, enlarging the audit sample for each agency to ensure statistical validity and negotiating clear protocols and agreements with both providers and MAA. The OA has completed the FY05, FY06, and FY07 claims audits. According to the steps outlined in the MOU signed by DMH and MAA for purposes of recoupment and repayment, DMH will deliver batches of failed claims to

MAA; MAA will review the failed claims data and overpayment analysis, make repayment to CMS accordingly, and then DMH and MAA will issue demand letters to the relevant DMH providers in order to recover the identified overpayments. The first recoupment letters are due to be issued by mid-July. Given that over 50% of the providers had error rates over 15% (for 2007), it underscores the importance of DMH and individual providers improving the underlying causes for audit failure. These include: invalid or missing treatment plans; progress notes that do not support the claims; inadequate supervision; and lack of agency controls over the treatment and documentation processes.

The OA has now completed its auditing for prior years and is conducting audits for the first quarter of 2008. It is very encouraging to see that the auditing process is now current and will be able to work with providers around current performance issues. Beginning in April 2008, monthly medical chart reviews have been performed by OA at St. Elizabeths Hospital, on a unit by unit base, in order to review medical care and follow-up for patients with co-morbidity (mental illness and physical illness). Beginning in September 2008, a quarterly report will be issued summarizing the findings of these chart reviews.

b) Compliance Committee

It is also noteworthy that the DMH has created a Compliance Committee, which generally meets on a monthly basis. The Compliance Committee has membership from key DMH offices (e.g., Fiscal, Legal, HR, and Provider Relations) and serves in an advisory capacity to the OA Director on a variety of compliance issues. As part of the overall compliance rollout, DMH has now instituted mandatory compliance training for DMH staff—including the DC CSA. All of the key elements of current compliance issues will be addressed, including whistle-blower provisions. The Compliance Committee reviews and makes recommendations on agency-specific issues as these are identified via the auditing process. The DMH will in the next year also be auditing providers to evaluate the presence and viability of internal compliance efforts.

On June 1, a Compliance Hot Line was instituted by the OA for the entire DMH. The hot line is operated by an

independent vendor, and will take reports of suspected fraud, abuse, or unethical behavior by DMH staff or by DMH providers. Callers maintain their anonymity and the information reported is sent directly to the Office of Accountability for investigation. The phone number for the hot line has been posted throughout DMH work areas and is also posted on the DMH website.

c) Quality Improvement

The OA has made major efforts in developing needed infrastructure for quality improvement for both DMH-run organizations and for the community provider system overall. The Internal Quality Committee (IQC) has been meeting on a monthly basis for the past year. It is composed of key leadership (clinical, medical and Q.I.) from the DMH Authority, DC CSA and SEH. Its mission is to identify priority QI issues for both the DMH-run facilities as well as the broader system. Among the current areas of focus are: major unusual incident (MUI) trending—with compression of MUI reporting codes from 53 to 14; mortality reviews; MHSIP survey—with recommendations to the Quality Council (see II A for MHSIP discussion); review of the high–end utilization of community support services; and the review of the current required treatment plan format—with an eye to needed revisions.

The Quality Council (QC) is made up of external community providers and has also been meeting on a quarterly basis. The QC receives recommendations from the IQC. Major areas of focus in the next year will include: review of medical co-morbidity at SEH—with focus on follow-up of needed medical services; process and timeliness for DMH mortality reviews, and review of the utilization of community support services.
The QI office is also heavily involved in the development of a set of quality and process-related performance indicators that could (and would) be measured for all providers. This "score card" would include a variety of measurable components of overall compliance efforts at the local level. Once completed, it would be publicly available and would hopefully prompt providers to build more comprehensive and timely compliance programs. The OA hopes to have this effort completed by the summer of 2008.

d) Integrated Data Bases

One of the goals for OA has been to build interactive databases for all key OA functions. While there has been progress in data development, this core goal has not been achieved. The current data sets within OA are disparate—with each section or function maintaining its own data base, e.g., licensure, certification, major unusual incidents (MUI's), investigation, audits, etc. The OA has put forward a proposal to buy a comprehensive software system that would allow full integration and analysis of data across areas. Given the current budgeting constraints on the 2009 budget, it appears unlikely this $300,000 project will be funded. Alternative options include some combination of buying existing software (which would likely need to be modified) or engaging a DMH or OCTO programmer to develop the needed software.

Overall, the Court Monitor is very pleased to see the amount of progress that has occurred in OA over the past year. Most of the core functions have not only been developed but are now current. This is a commendable accomplishment. Major challenges remain in training all DMH staff and engaging providers in the development of comprehensive compliance programs. The lack of an adequate information system is still a major constraint, but hopefully the overall DMH focus on this area will show progress in the next six to twelve months (see III.C. for discussion).

2. Consumer and Family Affairs

After a national search, DMH successfully hired a new Director for the Office of Consumer and Family Affairs. The new Director started in April 2008 and comes with a rich background in legal training, advocacy and direct services to consumers. The initial transition to new leadership is in full swing at the time of this Report.

One of the major activities for the up coming year will be the support of the newly-funded Wellness and Resource Center (WRC), which held its grand opening June 25, 2008. The successful applicant for the new RFP was the Ida Mae Campbell Foundation. The primary purpose of this new activity center is to provide self-help, mutual support, advocacy, education and referral assistance for interested consumers. As such, there will be numerous start-up tasks to include the hiring of peer specialists, marketing the center to consumers and

assuring that there are open linkages to both the service system and to policy-makers.

In addition to the WRC and the grievance process (as detailed below) the new OCFA Director has identified several other priorities for the upcoming year. These include the active representation of DMH and its consumers on the newly created Olmstead Planning Council for the District. The Director also plans to create a steering committee for the OCFA—with external representatives advising on issue of OCFA priorities and other consumer-related issues. The Director also plans to meet regularly with the Consumer Leadership Forum and with CAN to open the communication channels to other consumer-focused entities. Overall, it is good to see new leadership in place. Hopefully, the next year will see enhanced opportunities for consumers to be engaged as full partners in the work of OCFA and DMH.

3. Enforcement of Consumer Rights

The consumer grievance process continues to be managed by OCFA. For the twelve-month period between April 1, 2007 and March 31, 2008, there were 106 grievances filed. This is comparable to the prior year, for which there 106 over a thirteen month period (April 1, 2006 through April 30, 2007). However, DMH staff pointed out that 55% of the total grievances were filed by just 16 consumers—with five consumers having filed a total of thirty-one grievances. It is unclear as to reasons for these multi-grievance filings, but DMH staff express concern that a small minority of consumers are using (and re-using) the grievance process for issues that are inherently not resolvable (e.g., legal status) or should more appropriately be handled via a complaint process. The concern is that the grievance system has gotten "too protracted and legalistic" and is not working efficiently as a means to resolve legitimate issues on a timely basis. It should be noted, however, that the largest number of grievances (26) continue to be in the area of treatment rights, which normally is about the kind of services received or the way consumers were treated. The grievance system also continues to suffer from the lack of an adequate information system and the lack of any real enforcement for providers to resolve grievances within the prescribed ten-day period. Work is underway to better define when and how the grievance process should be used. In order to improve the timeliness of grievance responses as well as improve the understanding of the grievance process, OCFA provided training to SEH senior staff on June 10, 2008.

In sum, there are many intersecting issues regarding the grievance system that need attention. It is encouraging that the DMH

Grievance Committee has been reactivated. Currently this group includes only Authority staff, but the plan is to broaden the group to include staff from SEH, DC CSA, CAN and the University Legal Services (ULS). It would appear that, with the new OCFA Director in place, now is the time to reassess the strengths and weaknesses of the current grievance system and make recommendations for improvement.

The OCFA also continues to have responsibility for the tracking and monitoring of the Periodic Psychiatric Exams (PPE's) for committed patients. Of the twelve providers that have committed patients, eight met the threshold of 80% or better compliance rate. However, two of the agencies below 80% have shown improvement over the past year and are now at 72% and 73% compliance levels. OCFA sends out monthly reports to all providers regarding their performance.

As part of the PPE, individual physicians must complete a Certificate of Physician Form 90 days before the end of the commitment period if there is a clinical determination that the patient needs to re-committed. The DMH Chief Clinical Officer sent out a letter in March, 2007 that outlined the legal requirements for the process. This letter appears to have had a positive outcome in improving physician understanding and compliance. The total number of committed patients as of May 2008 was 168—of which 113 were outpatients and 56 inpatients. This total compares to 129 in May, 2007. It is also noteworthy that the Office of the Inspector General (OIG) recently did a follow-up review to the audit that was done two years ago. The OIG indicated that the monitoring and implementation of these legal requirements was now in acceptable performance range due to the implementation of multiple improvements over the past two years.

4. Information System Development

Developing an adequate information system has been one of the major challenges for DMH since its inception. Significant progress has been identified for SEH (see III.D.2) and in prior reports regarding the DC CSA. The DMH Authority has been forced to use its limited information technology (IT) resources on the most pressing issues, e.g., support for the enrollment, authorization and payment functions that plagued DMH for several years. On the encouraging side, DMH has begun to roll out its Dashboard Technology project. This project will allow DMH Authority managers to create key metrics for their specific area—with the ability to access data that is stored electronically. These metrics can be displayed in easily readable formats that allow for aggregation as

well as "drill downs" on specific metrics. DMH has developed performance metrics in six general areas. They are: (1) claims processing; (2) consumer enrollment; (3) service authorization; (4) provider funding; (5) Medicaid reimbursement, and (6) call center statistics. This technology has wide replicability within the DMH authority and for DMH-run organizations—SEH and DC CSA.

DMH leadership recognizes, however, that the Dashboard project is only the start of building an integrated electronic information system. Senior DMH leadership intend to prioritize staff resources to building a more adequate IT system. The DMH has developed a preliminary IT structure that is intended to support the multiple IT needs of the system. This structure would do some consolidating of current IT applications to create efficiencies. Most importantly it would create a new Business Intelligence Unit under the CIO. It is this unit which would take on direct responsibility for Dashboard, Share Point and MS-Reporting Services. This unit—with a full time Director reporting to the CIO—would interface with the respective program units to create data support as well as growing reporting and analytic capacity.

It is encouraging that DMH is now placing a high priority on the growth of IT services. As pointed out by DMH, the current IT budget (as measured by FTE's) is at 1.5%. In today's information-driven world, that is exceedingly low. The DMH intends to review any and all vacancies with the Authority and DC CSA. Positions (and dollars) will be evaluated against priority needs. It is clear that growing the IT infrastructure is one of the top DMH priorities.

5. Organizational Development

The DMH has created an Office of Organizational Development as part of the overall scope of the Office of Programs and Policy. An energetic and capable Director has been hired into this organizational development position. One of the major tasks is to reconstitute the role and focus of the DMH Training Institute. The Training Institute was envisioned in the March 2001 Dixon Court-Ordered Plan as a dynamic entity that would "develop strong working relationships with local universities and other professional resources and provide a continuous learning environment for consumers, community stakeholders, staff and providers". While the Training Institute has been in existence since August 2001, now is clearly an opportune time to reassess training needs, training priorities and training methods. The new Director has developed an ambitious agenda under three major goals: a) institute a training program that is standards-based, results- focused and guided by the

learning and competency needs of the population served; b) institutionalize training norms, processes and procedures that support continuous quality improvement efforts and ensure compliance with federal, local and departmental regulations; and c) embrace both intra-agency and inter-agency communication, collaboration, and coordination in the planning and delivery of workforce development activities. Underlying these broad goals are a series of specific objectives that have already been articulated and are beginning to be implemented.

A Training Committee has been established and is meeting on a monthly basis for the near term. This committee is broadly composed of the target groups identified in the original Court-Ordered Plan (i.e., providers, consumers, DMH staff and stakeholders). This committee will conduct a system-wide training needs assessment, offer advice on training policies, priorities and resource coordination. With the help of this committee, the intent is to develop an annual training implementation plan.

In addition, the OD Director has begun a process of assessing the data gathering activities and needs of OPP managers. The immediate task is to scan current data collection processes within OPP and ultimately to develop a more comprehensive list of key performance indicators in each area (and overall). The goal is to create organizational support for data collection, data analysis and internal problem-solving that is truly data-informed. This project obviously intersects with the overall development of IT as discussed in III.A.4. It will be critical that the program and the administrative arms of DMH actively collaborate on this key effort.

The Court Monitor is very pleased with the recent organizational development efforts at DMH. The initial reception by DMH Authority staff has been exceedingly positive—in large measure due to the well-conceptualized approach and high level of focused activity. The Training Institute and other organizational development efforts ultimately rise or fall based on leadership, managerial and front-line staff buy-in. Clearly the effort is off to a good start, but with much work to be done. The cultural shift to a data-driven, self-analytic, quality improvement orientation is critical but will obviously not be easy.

B. Review of Independent Authority for Key Functions

1. Independent Personnel Authority

DMH has engaged KPMG a review human resources (HR) processes and procedures with the kickoff scheduled for July 16,

2008. The major tasks of this engagement are to evaluate current staffing patterns for HR functions and then to develop and/or improve standard HR processes and procedures. This engagement will include a detailed review of basic policy and process requirements, current staffing and skill sets as a first step. The next task will be to define what should be in terms of HR processes, organizational design, staffing patterns, and policy gaps. A revised Procedures Manual is one of the concrete outcomes of the engagement. The Court Monitor is supportive of the review. There is no doubt that a significant amount of "process reengineering" is needed and will help to clarify and streamline the HR system.

In addition, KPMG will review existing HR policy and underlying regulations and make recommendations for needed changes. Some of these changes may require new District legislation or new rules. KPMG will assist in the drafting of these new rules or policies. KPMG is particularly well-suited to take on this task – as it has recently done a similar project for the District of Columbia Public School System (DCPS). This overall review will take at least 90 days to complete. The Court Monitor is very pleased to see this effort underway.

2. Independent Procurement Authority

In October, 2007, the DMH contracted with Thompson, Cobb, Bazilio and Associates (TCBA) to do an independent review of the DMH's contracts and procurement administration with an eye toward the objective of developing a best practice unit with new procurement operating procedures (POP's). A copy of the draft consulting report has been provided to the Court Monitor for review. The Report identifies shortcomings of the existing contracting processes and includes recommendations for improvements. DMH has advised the Court Monitor that it has begun to implement some of the proposed recommendations, although the Report is not yet final. The major findings of this draft Report can be summarized as follows:

Some of the general recommendations included in the TCBA report are: 1) standardizing the policies and procedures for contracting and procurement; 2) increasing the number of contract specialists; 3) developing specialized training for both contracts and procurement staff and program managers; 4) developing clear protocols for communication between the program units and the contracts office regarding e.g., legal requirements for a given contract, statements of work, current status, projected timelines, etc.; 5) improving accountability and internal controls; and 6) significantly improving the access, training and use of the information technology

tools available via the District's Office of Contracting and Procurement (OCP).

It is clear that DMH has considerable work to do in improving its contracts and procurement function. For the first time in many years there is stable DMH contracts and procurement leadership in place and a desire to make needed improvements. Given the resource limitations, there is an open question as to how many of the recommended staff additions will happen. However, many of the recommendations can be accomplished within the resource constraints—namely the enhanced training, improved communication and development of standardized operating procedures. It will be key for DMH to take this report and articulate a clear set of achievable priorities for the next year.

The consultation report did not really address the issue of using its independent authority to develop new procurement rules—other than to note that the DMH view was that the goal should be to establish a more stable procurement operation before taking on the possibility of new rules. While this appears reasonable, the Court Monitor is still uncertain as to whether the root causes for current delays can be fixed within the current system.

C. Review of Systems of Care Development

1. Review of Adult Systems of Care

a. Organizational Efforts to Develop Adult Systems of Care

The DMH has continued to expand and focus its systems of care philosophy for adults with serious mental illness. Those areas of adult services that have a unique Exit Criteria will be detailed below; these include Supported Housing, Supported Employment, Assertive Community Treatment (ACT), Homeless services, and Continuity of Care. Other areas of significant cross-agency planning and services will also be discussed, as follows:

- Forensics: In January 2008, the DMH, the Criminal Justice Coordinating Council (CJCC) and the Substance Abuse and Mental Health Services Taskforce collaborated in the development of a multi-year strategic plan for persons with SMI or co-occurring mental health/substance abuse disorders who are involved with the criminal justice system. This planning effort was supported by a $50,000 grant from the Bureau of Justice Assistance (BJA). All of the planning efforts are framed around the Sequential Intercept

Model—which seeks to connect (and divert whenever possible) persons with mental illness/substance abuse who are entering the criminal justice system. In FY08, the DMH Director and the Pre-Trial Services Director will co-chair the Substance Abuse and Mental Health Taskforce. Some of the major areas of focus include:

1) Oversee and support the development of the newly-started Urgent Care Clinic at the D.C. Superior Court. The Urgent Care Clinic is further discussed in section IV.A.1 of this Report.
2) Develop an improved system to assess, treat and refer persons with SMI and co-occurring disorders at the D.C. Jail and move them to community based services on discharge from jail.
3) Increase opportunities for crisis intervention and treatment alternatives (vs. arrest) through the new DMH mobile crisis teams and working with the Homeless Outreach Team.
4) Target specific populations for treatment and diversion opportunities through data analysis to determine needs.
5) Improve data and information sharing among criminal justice agencies by exploring a mechanism to create a comprehensive data base with the technology for "real time" access to consumer records that would include access to important medical, psychiatric and criminal justice information. The goal would be that all stake holders should have access to appropriate, available information to improve service delivery.

The DMH has maintained the Outpatient Competency Restoration Program (OCRP). This is a low-volume but critical program that attempts to restore competency for individuals in the community instead of hospitalizing them at SEH. Prospective referrals have a screening and full competency evaluation prior to being Court-Ordered to participate in this unique program at the DC CSA. During the past year, there were twenty four (24) referrals to OCRP. There have been seventy one (71) total referrals since the start of the program in July 2005.

The D.C. Linkage Plus also began in 2005 and has continued to implement the Sequential Intercept Model in a variety of ways. This program focuses on serious and persistent mental illness

(SPMI) and co-occurring disorders who are in the criminal justice system as well as consumers who are in the community but have frequent contacts with MPD, Fire and Emergency Medical Services (FEMS) or CPEP. The specific points of intercept are at four distinct points:

1) Pre-booking—this service is performed via CPEP, the Homeless Outreach Program (HOP) and the expanding collaborations with MPD.
2) Post-booking—DMH provides screenings for the Pre-trial Services Agency (PSA) and recommends release conditions and referrals for mental health services. Referrals can be made to the Linkage Plus program or to the Options program. Services are done via contract with a designated CSA. It has capacity for 35 consumers—with ten short-term residential beds also available. The Options program served 120 consumers in FY07.
3) Jail-based Linkage—DMH continues to have a full time Jail liaison coordinator. The goal continues to be to track all individuals with SPMI and to re-connect them to a CSA upon release if they have one or to connect them with a CSA if they do not. The CSA's with a forensic program have designated criminal justice liaisons whose job it is to meet with jailed consumers within 48 hours and ensure that linkage to mental health services occurs upon release. DMH has linked 399 consumers to the D.C. Linkage Plus
4) Re-entry—The DMH continues to have a mental health coordinator on site at 609 H St., N. E. to both provide mental health screenings / assessments and accept referrals from the Court Services and Supervision Agency (CSOSA), the Office of Ex-Offender Affairs and the Bureau of Prisons. This program provided 634 screenings and assessments from April 1, 2007 to March 31, 2008. Of these 164 were identified as having primarily mental health issues that needed referral with the majority of the remainder having substance abuse disorders.

Overall, the DMH continues to support and intensify its working relationships with the criminal justice system. The evolution of the new mobile crisis teams should take this partnership to another level—as will the new Urgent Care Clinic at the D.C. Superior Court. DMH has hired a forensic psychiatrist at the

Authority—who can help provide additional leadership and psychiatric support. This person began employment on July 7, 2008.

- Disaster Services: The Office of Disaster Mental Health Services was started at DMH in 2007. As part of the city-wide emergency preparedness effort the DMH disaster plan is to ensure that DMH can quickly mobilize needed mental health services in the event of a disaster or major community emergency. This plan includes strategies to ensure the continued operations of core mental health functions in case of a disaster, e.g., SEH and DC CSA. The DMH is planning to expand the number of Emergency Response Teams from seven to twelve. These teams would all be trained (as would be the DMH Senior Executive Staff) so as to be familiar with the Incident Command System (ICS) and the National Incident Management System (NIMS). The DMH expects to be NIMS compliant by the end of calendar year 2008.
- Co-Occurring Mental Illness and Substance Abuse: The DMH has continued its national "best practice" model for the planning and delivery of integrated services for persons with both mental illness and substance abuse. The DMH and Addiction Prevention and Recovery Administration (APRA) continue to provide joint support of this federally-funded effort. The four major objectives of this effort are as follows:

    1) System Supports for Integrated Service Delivery: The focus is on aligning both agencies rules, policies and processes to promote an integrated "no wrong door" model. A key cross-agency initiative is the Youth Work Group, which has identified a significant funding source for youth (EPSDT) and is working to engage, train and certify local providers to serve co-occurring youth.
    2) Universal Screening: Both DMH and APRA have now adapted standards that require all consumers seeking service to be screened for co-occurring disorders. Given the historic issues of under-identification of COD, this is a major step forward.
    3) Expand Workforce Competencies in COD: The DMH has developed a comprehensive 100-hour training program which certifies its graduates. This training manual will soon be available in final form to DMH, APRA and community agencies either as a comprehensive training

package or for specific modules. The training effort for clinical staff has been ongoing over the past one and a half years and is on track to meet its goal of training 150 professionals by August 2008.

4) CQI Supports for Consumer Outcomes: With the assistance of George Washington University, the DMH has developed a Clinically Informed Outcome Management (CIOM) project. This project is currently being piloted with several DMH and APRA providers. CIOM collects consumer self-reports on treatment effectiveness on a continuous basis and provides immediate feedback to treatment teams.

The COD project is finishing year three of its four-year grant cycle. It has clearly proven itself as an innovative and successful effort—uniting DMH and APRA in ways never before imagined. It will be critical that DMH find ways to support this effort at the end of the grant period.

- Co-Occurring Mental Illness and Mental Retardation:

DMH and the Department of Disability Services (DDS) have had a memorandum of understanding (MOU) since October, 2004. This cross-agency effort is intended to provide intensive tracking and intervention for individuals in the DDS system who also have an Axis 1 mental illness. Administrative changes at the DDS have made this an up and down project in terms of cross-agency collaboration. However, DMH staff indicate that the process is now working again and 118 consumers are currently enrolled—with 25 in ACT services and 25 receiving community support services as of June, 2008.

b. Supported Housing Capability

The DMH over the past year has strengthened its collective efforts to provide "safe, decent, affordable and permanent housing." The demand for housing continues to be one of the highest priorities for DMH consumers. The DMH goal—via its supported housing efforts—is to help consumers with SMI obtain affordable housing that is directly linked to flexible support services. The prioritization of limited resources continues to be for consumers who are homeless, discharge-ready from SEH, released from jails/prisons or other institutions, living in a CRF, living in substandard housing or who require special needs

assistance.

The DMH housing strategy is intended to use DMH housing dollars to help leverage housing resources from other agencies—most notably the D.C. Housing Authority and the Department of Housing and Community Development (DHCD). In November, 2007, DMH signed an agreement with DHCD to develop 300 affordable housing units for DMH consumers by September, 2009. DMH has transferred $14 million in capital funds for this effort which will be awarded as grants to developers. These funds will also be leveraged with other local and federal funds to increase affordable housing for low income individuals. There are currently 97 new housing units for DMH in the pipeline.

The DMH has also continued to build its partnerships with the D.C. Housing Authority (DCHA). The DMH has multiple MOU's with the DCHA. These MOU's set aside specific federal housing choice vouchers for DMH. The DMH attempts to utilize its limited dollars as "bridge" housing subsidy with the hope that permanent housing vouchers can eventually be accessed. Under either program the consumer pays 30% of their income for rent.

The overall current DMH capacity for supported housing is 1,584. This includes 1,133 DMH bridge housing subsidy slots and 451 federal vouchers. This 1,584 compares to a capacity of 1,572 one year ago. DMH has currently budgeted $6.1 million for its overall supported housing program.

The Court Monitor has had ongoing discussions with DMH staff regarding the specific Exit Criterion for Supported Housing (see July 2007 Report to the Court). Despite the overall DMH efforts, the scores for this criterion continue to be very low (10.1% for recent year vs. required 70% of SMI served within 45 days of referral). The DMH has recently undertaken an in-depth review of this issue. A Dixon Supportive Housing Work Group has been created and an outside consultant from the Corporation for Supportive Housing (CSH) has been engaged. The beginning steps are to create an inventory of all supported housing programs/units within DMH and analyze the current ability of DMH to capture complete data on individuals referred to housing within provider agencies. While it is too soon to predict where this effort will lead, the Court Monitor is pleased with this concerted analysis.

c. Supported Employment Capability

The DMH has continued to support and grow its Supported

Employment program. The DMH has in the past year added a seventh contracted provider. It has also increased the current hourly rate to providers from $45 to $65. As a result of these efforts the number of consumers enrolled has grown from 402 in July 2007 to 477 as of this report.

The Supported Employment program continues to do annual fidelity audits for each of its providers. Of the six providers surveyed in the most recent audit, five had scores that placed them in the range of "good" supported employment. One sixth was in the "fair" range. Of the 477 individuals currently enrolled, 224 are employed—working an average of 25.7 hours per week and earning an average of $8.92 per hour. Every effort is made to match an individual's unique skills and interest with an available job. Part of the success of this evidence-based program also comes from the follow-along services that are provided by job coaches to both consumers and employers. Job retention is enhanced by early identification of any employment, personal, social or treatment issues.

The DMH Supported Employment Director has also undertaken an aggressive marketing effort in the past year. Multiple presentations and training efforts have been directed to consumers, providers, advocacy organizations and other D.C. agencies. A cursory review of referral patterns suggests that these efforts are beginning to pay off. For example, DMH data show an average of thirty seven (37) referrals per month for the time period of 9/2/07 to 12/2/07. This is up considerably from previous periods and hopefully reflects the fact that more providers and consumers are becoming aware of this critical service.

The Court Monitor continues to be very pleased with the quality and momentum of the program. The central question regarding Dixon compliance pertains to the lack of validation that DMH providers are in fact following the DMH policy on Supported Employment. The current utilization rate (477 out of 8,832 persons with serious mental illness served from April 1, 2007 through March 31, 2008)) is 5.4%. This low percentage stands in contrast to high expressed interest in employment by DMH consumers and growing research literature that supports the notion that consumers can and should have employment as a central goal in their overall recovery plan.

d. Assertive Community Treatment (ACT) Services

DMH has demonstrated some progress in its ACT program during the past year but clearly has a long way to go. Notable

developments include:

- The initiation of an ACT Advisory Committee in January, 2008. This group is meeting monthly and will advise on the full gamut of issues regarding ACT—including areas of access, role and functioning of ACT services, fidelity measurement, etc.
- The DMH ACT policy was finalized in November, 2007.
- The ACT Coordinator position was filled in February, 2008, following the elimination of the previous position due to its being one of the discontinued Public Health Service jobs.
- Monthly meetings with ACT Teams to review progress and discuss common issues.
- Active tracking of all requests for ACT admissions, transfers or discharges—resulting in a more accurate data base of active ACT consumers. The major goals for the coming year include:

  1) Complete a baseline fidelity assessment of all ACT teams. This assessment has been contracted to the National ACT Institute and will be completed by the end of July, 2008. This assessment will provide the basis for much of the agency-specific training and consultation to be done in the next year.

  2) Initiate Supported Employment as a core service within the ACT teams. Initial discussions have occurred with the DMH Supported Employment Director.

  3) Increase the census of ACT Teams by 25%. In review of DMH data, the Court Monitor noted that current ACT Teams (in the aggregate) are only at 65% capacity. This is in part due to cleaning out the rolls but also reflects the continued low level of referrals to ACT services.

  4) Improve the compliance percentage of ACT referrals under the Dixon Exit Criteria. As noted in II C, this compliance percentage currently stands at 48.5% versus the Court-mandated requirement of 85% of ACT referrals receiving services within forty five days.

It is good to see renewed commitment to ACT within DMH. The fidelity baseline should serve as a useful start point for improvements in the quality of ACT services. There are major issues in terms of access and perception of ACT services in DMH. These have been there for many years with limited progress noted.

Hopefully the next 12 months will see some concrete evident of improvement in access, capacity and quality of this key service.

e. Services to the Homeless

DMH continues to work toward the reality of a comprehensive strategy for serving homeless individuals who also have mental health problems. The Homeless Outreach Program (HOP) continues to implement the various programs described in the comprehensive strategy and perform key functions for the DMH and District. The ten HOP staff are all trained in trauma, cultural competence, co-occurring issues and crisis services. Among the ongoing services provided by this team are:

- Short-term case management to homeless consumers who are unconnected to services or poorly connected.
- Travelers assistance to stranded consumers with mental illness.
- Mobile crisis services to homeless and non-homeless individuals. The HOP will transfer the mobile crisis to non-homeless as soon as the new CPEP mobile teams are prepared to take this on.
- Active collaboration with the D.C. jail diversion efforts.
- Direct operation of the Sobering Station during each hypothermia season for intoxicated men and women who refuse or are unable to handle the structure of a traditional shelter. This program has 374 bed nights and 185 unduplicated consumers served in FY08.

Among the program expansions that began in FY '07 and are continuing in 2008 are:

1) Enhance outreach to children and youth who are homeless or at risk of homelessness. The HOP has hired on a full time staff member who is visiting shelters to engage children, youth and families who need mental health services.
2) HOP sponsors a monthly Emergency Rounds meeting to review the status of high-risk individuals who are mentally ill and homeless. These meetings are facilitated by the DMH psychiatrist and include an array of street outreach workers. This program has been accepted to be presented as an "Innovative Program" at the American Psychiatric Association's annual meeting for community psychiatry in October, 2008.
3) MPD and DMH have piloted a program that is intended to provide quick linkage by MPD to the Homeless Outreach Program (HOP). The initial pilot has been modified and now

includes 2 police stations. The HOP does weekly walk-arounds in these targeted areas—with close linkage and communication to local police stations and officers.

4) HOP has begun to contract with two local mental health providers to provide mental health services in one of the larger local emergency shelters and also to expand day socialization services for individuals who are mentally ill and homeless.

The other major development of the past year is the visible role of the Interagency Council on Homelessness (ICH). By District law, the ICH is the governmental interagency group responsible for planning and coordinating services to the District's homeless—including housing and various emergency services. This group is the Mayor's focal point on policy and implementation for all services to the homeless. The DMH Homeless Services Coordinator is also leading the Focused Improvement Area Initiative which is a District-wide effort to reduce crime through collaboration between government agencies that provide infrastructure and social services support to residents of the District of Columbia.

Overall, the Court Monitor is pleased with the growing breadth of DMH's homeless services. The transfer of mobile crisis services should further enhance the HOP's ability to carry out its mandates. It is especially encouraging to see the recent focus on services to children, youth and families. The HOP makes over 2000 contacts annually to some 900 different people. Clearly this is a vital team in DMH's overall array of community-based services.

2. Review of Child/Youth Systems of Care

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

The overall system of care planning between DMH and CFSA continues to be at a high level. The February 2007 LaShawn A. v. Fenty Amended Implementation Plan (AIP) continues to serve as the focal point for much of the interagency work. The specific DMH initiatives under the AIP are discussed in detail in III.C.2d. In general these initiatives are on track, although time lines have slipped on some due largely to the contractual processes within DMH.

Beyond CFSA, it is encouraging to see the beginnings of potentially strong partnerships between DMH, DCPS, the Executive Office of the Mayor (EOM) and the Office of State

Superintendent Education (OSSE). The Blackman Jones case regarding students in special education has specific mental health components required. Previously, DMH's involvement with children/youth in special education has been limited, so this represents an opportunity for DMH to broaden its child/youth service array. The specific wraparound project for 100 students (as discussed in III C 2c) should be a good beginning. The DMH has had an ongoing working relationship with DYRS and the MCO's, the other two key partners in creating an integrated and effective system of care. The establishment of the DC Commission on Coordination of Residential Facility Placements (see III C 2c) will create further opportunities to strengthen intra-agency coordination and collaboration as well as the establishment of a standardized process for placing children and youth in residential facilities. The respective leadership of these agencies embrace a common philosophy and commitment to a family-centered and community-based approach to care. The challenge that remains is to reduce barriers and is to build in the kind of reinforcers that cause this philosophy to actually be practiced. To date, this remains an elusive challenge as measured by the CSR system performance score of 36%.

The DMH has completed its federally-funded SAMHSA Systems of Care grant. While this grant did not achieve the ambitious goals originally conceived, it has helped to build a foundation for future development. The Family Team Conference (FTC) model is one of the major legacies of the SOC grant. This model has been fully embraced by DMH, DYRS and CFSA. The requirement is for family participation and full cross-agency participation for all children who are fee-for-service Medicaid with multiple complex needs and being considered for out-of-home placement. This model has been in place since October 1, 2006. Children who are diverted from PRTF's (approximately 50%) are then monitored for up to a year. Approximately 250 children/youth were followed under the SOC model in FY 2007. The SOC has also begun to track key timeline indicators for access to services—including the average time from the initial referral to SOC until the FTC and the average time from FTC to the beginning of service by a provider. Against the standard of 14 days for the FTC to occur, the average was 25.4 days (or 22 without the outliers). From FTC to services received, the average delay was 56 days (40 excluding the outliers) against the DMH expectation of 7 days. This data shows clearly there is much work to be done in the child/youth system, but at least DMH now has the personnel and technology to track data on key system performance indicators.

One of the major current challenges for DMH is to find a new

Director for its child/youth division. The previous Director left in early 2008 and a national search has not yet been successful in finding a replacement. This is obviously a key leadership position in DMH—with its importance heightened by the number of projects and issues at hand. In the interim, the DMH Director for the Office of Planning and Programs (OPP) has taken on many of the cross-agency leadership tasks. It is hoped that DMH will soon be successful in filling this critical child/youth leadership position.

b. School-Based Services

The School Mental Health Program continues to provide an array of prevention, early intervention and treatment services. The number of schools involved has grown from 42 to 48 over the past year. In like kind, the volume of most services has continued to grow e.g., formal referrals have grown from 1017 for the entire 2006/2007 school year and are already at 787 for the first six months of the 2007/2008 school year. There has been corresponding growth in individual/group/family services, students sent in conflict resolution interventions, parent consultation, prevention groups, etc. It is noteworthy that an average of 3 children per month are admitted to psychiatric inpatient care based on SMHP assessment and referral.

The SMHP also provides regular in-service training for school staff and psycho-educational workshops for parents. The SMHP has provided crisis response services to nineteen different D.C. public and charter schools already this school year. These interventions for students and school staff are triggered by traumatic events, e.g., shootings, death of students or teachers.

The SMHP continues to evaluate the outcome of direct service interventions and overall school satisfaction with the program. Improvements continue to be noteworthy with children's anger, aggression and depression. Results from School Year 2006/2007 data indicate 36% of school administrators reported improvements in the school climate as a result of having a SMHP clinician in the school It is also worth noting that 52% of administrators reported a decrease in referrals to special education as a direct result of the SMHP.

The District Council and the Mayor's office continue to support the SMHP. The mandate is to expand into 58 schools for the upcoming year; however, there are no new funds to accomplish this so DMH will need to spread existing staff to meet this requirement. Seven of the existing SMHP schools are targeted for closure, so in reality the SMHP staff will be in seventeen different

schools for the upcoming year, which will be a major challenge.

The pilot program to utilize Medicaid funding for the SMHP started in January 2008. There are two contractors who are covering a total of 6 schools. Since 80% of the children/youth are MCO enrollees, DMH has had to negotiate with MAA to ensure that these school-based services are eligible under the MCO contracts. It appears that this issue has been resolved. It is also very noteworthy that DMH has recently learned that the core SMHP program (provided via the DMH Authority) could also be eligible for Medicaid reimbursement. This would be a major funding breakthrough, which would open up a revenue source for the direct clinical work done by the SMHP. It should be noted that the other critical work done by SMHP, e.g., prevention, training, crisis responses would continue to need local dollar support.

The SMHP continues to be a strong and viable program. The Blackman-Jones case (as discussed in III.C.2a) will undoubtedly put additional requirements on the SMHP to be more directly involved with the special education system.

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

The DMH continues to track data for all DMH and CFSA children/youth referred for placement in a psychiatric residential treatment facility (PRTF). For all of FY07, there were a total of 175 full reviews for PRTF's, of which eighty seven (87) were diverted to community service. This 50% diversion rate is very consistent with data for the prior year (51%). This number of referrals to PRTF's is reflective of the larger reality that the District continues to rely heavily on PRTF's for youth with the most intensive and complex needs. In the fall of 2007 the Office of the City Administrator estimated (via surveying each of the child-caring agencies in the District) that there are approximately 425 children/youth in PRTF's at any given time. These 425 youth are costing approximately $37.5 million per year—of which the District is paying nearly 75% out of local funds. All of this flies in the face of best practice across the country which suggests that the large majority of children/youth can be supported in the community and that the lengths of stay for those admitted to PRTF's can be significantly reduced. It should be noted that the District is actively working to refine this data and develop a discrete and reliable set of information for all child-serving agencies in the District who refer and place children/youth into PRTF"s. By any measure, however, this is a major policy issue that calls for a multi-pronged approach. Critical issues and

current actions include:

1) Need for Common Interagency Pathway for all PRTF/RTC Placements

Currently DMH and CFSA collaborate on all PRTF assessments and placements. Parallel placements occur via DCPS, DYRS, and the MCO's. The assumption of authority for DCPS by the Mayor creates a common authority base for all child-placement agencies. DMH under its statutory authority is charged as "the exclusive agency to regulate all mental health services and mental health supports, including but not limited to housing services and residential treatment centers for children".

DMH has proposed a draft Executive Order that would create this common pathway for all D.C. child-serving agencies. The proposed Commission on Coordination of PRTF/RTC placements would ensure a consistent assessment process as well as ensuring that treatment planning, lengths of stay and discharge planning are appropriately carried out. This Commission would also ensure the creation of a comprehensive database on all children/youth. This proposal was put forward in early April, 2008, and is being actively reviewed by all of the effected agencies. More recently, the thinking has been to use the existing legislative authority of the Interagency Collaboration and Services Integration Commission (ICSIC). Whichever mechanism is selected needs to include the core tasks identified and needs to move quickly to reality.

2) Need for Consistent Oversight and Monitoring of all Children Placed Into PRTF's

The assessment and placement process is parallel and inconsistent; so is the process for certifying and monitoring the care of the children who are placed. Each placement entity has its own unique standard and protocols for visiting and overseeing PRTF's. The DMH needs to be the lead agency in creating common standards and oversight rules for all PRTF's. The Commission could serve as a vehicle for ensuring cross-agency input and participation. The respective agency resources for this oversight either need to be pooled (under DMH) or clearly delineated and accountable in terms of standardized expectations.

3) Alternatives to PRTF's Need to be Developed

The inordinate use of PRTF's is a direct result of inadequate community-based services for this most complex set of youth. Nationally, the service technology has clearly demonstrated that

intensive Wraparound models are effective with this high-needs population.

The DMH, CFSA and DYRS have entered into a joint agreement to support a pilot High Fidelity Wraparound project for a minimum of 24 children/youth. An RFP has been awarded to Choices, Inc.—an entity that has a very successful 10 year track record in other states. The contract for this new pilot was signed on June 12, 2008 and should be ready to start by September 1, 2008. The intent is to use the local dollars to also leverage FFP, so that the total number of children/youth served in the first year should grow to at least thirty and beyond. This is an excellent beginning for a program that will hopefully expand quickly to meet the obvious unmet need.

By October 1, 2008, an additional flow of $1 million will come to DMH from the Office of the State Superintendent of Education (OSSE) to support the creation of an additional 100 children who are special education students in D.C. middle schools. This initiative is part of the Blackman Jones settlement agreement with the District. Choices, Inc. will also serve as the contractor for this effort, so in effect there will be a base of 124 wraparound slots. As with the twenty four mentioned previously, the ability for Choices, Inc. to become a CSA will open the door to MHRS billing and enable local dollars to be leveraged in order to serve more children.

DMH, OSSE and DCPS are developing an MOU for the $1 million dollars to enhance service capacity for children and youth in eight DCPS Middle schools undergoing restructuring. These schools will be called "full service" schools (combining academics, mental health, Positive Behavior Intervention Strategies (PBIS), and data-driven decision-making) and an intensive Wraparound Care Coordinator will be placed in each of 8 middle schools. Seven schools are restructuring and one is in improvement level two. DMH will have a clinician in each of these eight schools as well. One hundred slots from the eight schools will be dedicated to the Wraparound project based on referral and criteria determined by DCPS.

4) PRTF Applicants Need to Have a Clinical Home

One of the core principles of the Dixon Plan is that all consumers would have a core service agency (CSA) that would take leadership responsibility for the full gamut of needed services and the creation of an integrated services plan. This concept is only a partial reality today. Children/youth who are in PRTF's

need an aggressive community-based team that stays engaged with the child and family during any time in a PRTF. The obvious goal is to shorten lengths of stay and maximize family involvement and community readiness. The lack of this engagement is one of the reasons for the high lengths of stay (approximately twenty months) for DMH/CFSA youth currently. The lack of engagement is most critical during discharge planning ninety (90) days prior to discharge and immediately upon discharge. Without adequate community services and treatment, the child/youth has a greater chance of returning to residential, thus increasing the rate of recidivism for this population.

In addition to the District-wide issues discussed above, the DMH continues to manage—though the Child/youth Services Division—the Residential Treatment Center (RTC) Reinvestment Project. Part of this effort includes the management of the Assessment Center, which provides full mental health evaluations for Juvenile Justice youth and CFSA youth as well as any DMH youth who are being considered for PRTF placement. The issue of turnaround time for assessments continues to be an issue under the requirements of the Jerry M case. DMH indicates that for FY08 the average response time from Court-Ordered referral to completed report is 38.7 days. This compares favorable to the 47 days for FY07 and fifty eight days for FY06.

The DMH Associate Chief Clinical Officer has responsibility for authorizing all PRTF placements for DMH and CFSA youth and the DMH RTC Program has responsibility for monitoring their care once placed. The total number of DMH/CFSA children/youth placed was 109 at the time of this review. DMH staffs this effort with 4 clinical coordinators who have responsibility for roughly twenty five placements each. The PRTF's include both Medicaid and non-Medicaid funded placements—with Medicaid approximately 60% of the total. Nearly 90% of the PRTF's visited are over 100 miles from D.C.—making both staff and family visitation challenging. The DMH believes that the overall quality of its monitoring has gone up due to its consistent implementation of care standards, regular visitation, follow-up on any issues of concern and practice changes implemented by the provider in response to the clinical oversight and monitoring being provided by DMH.

d. Child Welfare/Foster Care

The framework for much of the DMH/CFSA collaboration continues to be on the implementation of the Amended Implementation Plan (AIP) in the LaShawn case. This AIP

requires a number of initiatives that are key to meeting the mental health needs of CFSA children/youth as well as other youth and families in the District. Major efforts include:

- Crisis Mobile Teams and Crisis Beds—This RFP has been negotiated. The proposed contract must be approved by the District Council, because it exceeds $1 million. The contract has been transmitted to the EOM for submission to the Council prior to the summer recess. Catholic Charities is the successful respondent. The functions are to provide, twenty-four hours per day, seven days per week, mobile crisis response services to children and families who are in DC—including children and youth in foster care placed in homes MD and VA. The goal is to stabilize the immediate crisis and avert unnecessary inpatient psychiatric hospitalizations whenever possible, through the utilization of the crisis beds which are accessible only through the mobile crisis respond teams. This project will hopefully begin by October 1, 2008.
- Wraparound Pilot—As discussed in III C 2c, this community based pilot initiative is funded through blended funds via an MOU signed by DMH, CFSA and DYRS. The contract was executed in June 2008 with a target start date of August 1, 2008.
- Choice Providers—The cost proposal submissions in response to this RFP were very inconsistent; as a result, DMH issued a revised budget format with a clarifying letter to the respondents within competitive range, requesting new cost proposals. These "best and final offer" responses were received June 9, 2008. DMH reviewed all the potential vendor's best and final offers and is currently holding individual negotiation meetings with each provider. The hope is that multiple Choice Provider awards will be made by the end of July, 2008.

Overall, the cross-agency collaboration among DMH, DYRS and CFSA continues to be high. The Blackman Jones Wraparound initiative and the PRTF/RTC Commission (or alternative) create the opportunity for DMH to actively partner with all the other DC Government child-serving agencies on key initiatives. The cross-agency coordination and collaboration is at its highest level since Dixon Court monitoring began. The obvious challenge remains to improve actual practice performance from its inconsistent (and overall low) current levels. The hope is that this

increased coordination will result in an improved system of care for children and youth in DC.

D. DMH's Role as Provider

1. Planning for New/Consolidated Hospital

The construction of the new 292 bed Hospital at SEH continues—with the overall completion at 73% as of the end of June, 2008. The masonry work is nearly complete and window installation is in full swing. There have been some delays due to heavy rains and changes in the handling of wall surfaces in public areas. The planned occupancy for late 2009 or early 2010 is still the target. As the new Hospital takes visible shape, it provides tangible impetus for not only new space planning but also new and upgraded opportunities for programs.

The RMB CT 7 and 8 phase one project continues in parallel fashion. Phase one will separate the energy source for the new Hospital from existing buildings for this $13.2 million project. The projected completion date for phase one is spring 2009. The DMH has requested capital funds in its 2009 capital budget for phase two—which would allow the rehabilitation of the interior space in RMB. The 2009 DMH capital budget will allow monies for the design phase of the RMB building—which would provide up to 100 additional beds. A decision has been made not to proceed with the design or rehab of CT 7 and 8. Given that the average census at SEH tends to run at 400 or higher, and without an improvement in the discharge rate or a reduction in the use of acute care beds, it appears unlikely that the 292 beds in the new Hospital will be adequate (see III D2 for discussion of census at SEH). If average census at St. Elizabeths continues to be 400 or higher, the rehabilitation of RMB will need to move forward.

2. Quality of Care Issues at SEH

The May 2007 DOJ Settlement Agreement continues to provide a comprehensive framework against which to measure quality of care progress at SEH. Consultants for DOJ made their first site visit to SEH since the Settlement Agreement and DOJ issued its initial report on findings on April 16, 2008. At the time of their initial review, four of the 206 total requirements (2%) were found in substantial compliance; 76 (36%) were found in partial compliance and; 125 (61%) were found in non-compliance. These findings are somewhat misleading given that the first measurement point for compliance is June, 2008. Hence, the truer test is the twenty nine (23%) of the non-compliant findings that are due by June, 2008. The

compliance officer will be filing a Report with DOJ by the end of July, 2008—unfortunately too late for this Report to the Court.

In addition to the specific findings of compliance (or non-compliance) the DOJ letter of April 16, 2008 highlighted four areas that need to be addressed on a priority basis and by the time of the next DOJ visit in the fall of 2008. A brief summary of these issues includes:

- Protection From Harm and Risk Management—There is deep concern regarding the adequacy of nursing and medical care. This concern was triggered by "the significant number of recent deaths at SEH". The deficiencies in the Hospital's mortality review system were also noted—specifically in terms of timeliness, thoroughness and specific recommendations that are monitored for implementation.
- Nursing Care—The Report commended the progress made in areas of monitoring and documenting medication administration and the beginnings of an infection control program. However, there is continued concern "with the insufficiency of nursing staff necessary to provide SEH patients with basic nursing care and services". The Court Monitor takes note—in support of this concern—that SEH data show that as of June 1, 2008, 292 (70%) of its inpatients had at least one significant medical condition that required monitoring and/or treatment.
- Treatment Planning and Psychiatric Care—The major concern is with the overall sufficiency of psychiatry staff needed. The Report commends SEH for "significant strides made in areas of psychiatric assessments and diagnoses."
- Behavioral Management and Psychological Care—The Report noted progress in the area of risk assessments but noted non-compliance in the "overall category of behavioral management and psychology, including discharge planning and community integration."

This Report will track the SEH efforts to respond to the DOJ findings overall—including in some cases a specific strategy related to the April findings. The major areas for tracking progress continue to be:

1) Human Resources

Hospital officials believe that the delegation of HR authority to SEH has had a very positive effect in being able to move more quickly to fill open positions. Since

October, 2007, SEH has filled 109 positions either through outside hiring or internal promotion—of which seventy four were clinical positions. It is encouraging to see that there was significant progress in the hiring of nursing positions; 61 nursing positions have been filled since October, 2007—including twenty five nurse managers and RN's. The nurse managers and RN's are especially critical to DOJ compliance issues. It is also noteworthy that SEH recently made offers to ten psychiatrists and six have accepted. At the same time that the new hiring has moved aggressively, there have also been losses in positions due to employees leaving and early retirements; during this same period for FY08 there have been eighty seven employee separations and thirty eight retirements. Thus the overall gain in on-board FTE's for FY08 is only four. A drill-down of nursing positions, however, reveals a net gain of forty eight, which indicates that critical clinical areas are in fact gaining ground.

Further complicating the picture is the fact that the District-wide decision to abolish select unfilled positions in D.C. government resulted in a loss of fifty two positions—eighteen of which are clinical positions. The DMH message to SEH is to continue aggressively recruiting to fill current vacancies, which at the end of May, 2008, stood at ninety positions. The DMH is working diligently with SEH to ensure that critical positions are identified and filled without delay.

Vacancies in the direct care area have contributed directly to the use of overtime—which is running almost 70% over budget for the first seven months of the year. The SEH has put a plan in place to carefully monitor overtime use, but the key to longer term success is the continued ability to fill front line clinical vacancies.

2) Contracts and Procurement

As discussed in III.B.2 there are still many staffing and operational issues at play in the area of contracts and procurement. For SEH, last year there were nearly 100 larger contracts involved in a revamped DMH effort to be in accord with District procurement regulations. This year should be much easier for SEH. However, there continues to be frustration with the inordinate delays in moving contracts through the process—often running

four months even for very low-cost straight forward contracts. One of the ideas that has surfaced is to create service level agreements between DMH and SEH that would define different protocols dependent upon the dollar size of the contract. This idea seems to have merit and should be pursued as part of the overall enhancements to the Office of Contracts and Procurement.

3) Information Technology

Phase 1 of the new AVATAR IT system is scheduled to "go live" on July 22, 2008. Phase 1 is the Practice Management Module and includes all data for admissions, discharges, and billing—plus laboratory and pharmacy orders. The eight-week training period was fully scheduled for all of the staff and shifts that need to be trained before July 22, 2008. The training logistics alone have been an immense task—needing to ensure unit coverage at the same time that intense training is occurring. The DMH has successfully obtained a commitment for an additional $2.223 million in supplemental funds that will be needed to pay overtime and contract for the needed expertise to assist staff and develop reports after the July 22 date. This $2.223 million also includes dollars to pay for the additional 92 PC's, twenty two laptop computers and twenty two printers that were not included in the original capital order. This order is in addition to eighty five systems already in the procurement cycle.

Phase 2 is the clinical workstation module and will include assessments, treatment planning and care notes. Phase 2 will bring up the electronic medical record (EMR) for all patients. Phase 2 is estimated at an additional six to nine months.

4) Training

SEH has not been successful in recruiting for a Director-level person for training. Round 2 of recruitment will focus more heavily on clinical areas in hopes of finding someone who can take on this critical position.

5) Quality Improvement

There is continued foundation-building effort in the whole area of quality improvement. Following the departure of the Quality Improvement Director in March, 2008, an internal candidate was recently promoted into this position. The Performance Improvement Director position is being actively recruited.

SEH has put together an integrated management report that it eventually intends to produce on a monthly basis; it is currently being done bimonthly. This report details key performance data on everything from patient census and demographics to treatment mall participation and seclusion and restraint. The major caution in the near term is that the source of data is built on the existing STAR system—requiring a great deal of manual input. Nevertheless, the report format and beginning management review should help create a context of data-driven analysis, accountability and decision-making.

In addition to the trend analysis report, SEH has also created a database that relates to discharge tracking and a clinical database that captures diagnosis and medication. There are also manual systems for the short-term until Avatar is fully in place. There are over forty auditing tools that are required by the DOJ compliance agreement. The treatment planning process monitoring tool is in the testing phase and the clinical chart audit will be piloted in late summer, 2008.

6) Discharge Planning

The DMH Mental Health Authority and SEH continue to work collaboratively to discharge patients who have been at SEH over thirty days and are determined to be ready for discharge. As of May 30, 2008 there were thirty one patients in this category. SEH tracks the barriers to discharge—which run the gamut of clinical, behavioral and family-related issues. There is the ever-present issue of adequate CRF or supportive housing available. The number of patients ready-for-discharge was 62 in mid-April, 2008—so it is encouraging to see the active out- placement in the past thirty days. Of the thirty one patients readmitted between January 2007 and May 2008, eight had been at SEH over 120 days. There are a couple of notable

steps that DMH has taken to deal with discharge-ready patients: 1) DMH has continued to work closely with Pathways regarding community placement. Pathways has the advantage of being able to provide both ACT services and supported housing via dedicated Choice voucher slots. The Court Monitor has encouraged DMH to engage other ACT providers as referral options for SEH. 2) DMH is developing an RFP that is targeted toward SEH patients who have had multiple admissions. For example, of the 245 total discharges from SEH that have occurred as part of the Discharge Plan, fifty four (54) have been readmitted during this period. This population becomes a special subset for this RFP—which is intended to provide intensive and flexible community supports for up to thirty patients. At the time of this Report, it is unclear as to how quickly this initiative will begin. The Court Monitor is highly supportive of this RFP and hopes that it can be expanded as quickly as possible.

In addition, the DMH Division of Care Coordination is beginning a tracking process on August 1, 2008 for all persons discharged from SEH. Two mental health staff in Care Coordination will conduct 30, 60 and 90 day follow-ups. The basic intent is to determine how the individual is doing—e.g., are they receiving services, any rehospitalizations or incarcerations, in need of additional services, etc. This tracking process could be useful in reducing current recidivism rates.

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

There has been some definitive progress on the use of local hospitals for acute beds. The DMH has negotiated an agreement with Providence Hospital that should become operational in September, 2008. This agreement will provide up to ten beds for DMH as part of an existing twenty five bed inpatient acute unit. The general contractual arrangements will be similar to Greater Southeast—namely that Providence will provide involuntary acute care to designated DMH patients for up to fourteen days. Providence has contracted with PIW to provide needed psychiatrist time for these ten beds. On the financial side, this arrangement is advantageous because Providence is not an IMD and hence, can bill for Medicaid patients.

The inpatient situation at Greater Southeast also appears to have stabilized under new ownership. Greater Southeast is running at full capacity on its existing 20-bed unit—with an average of 28 DMH admissions/month from DMH referrals for the six-month period October 1, 2007 to March 31, 2008. Greater Southeast would like to open an additional 18 adult psychiatry beds by the Fall of 2008, but this is dependent on several things—including an expanded contract with DMH, necessary rehabilitation to the unit and needed approval from the D.C. Department of Health.

The Providence development is encouraging—as is the potential for additional beds at Greater Southeast. An analysis of the data for the past six months shows a relatively stable pattern of acute admissions. SEH is getting a total of thirty nine admissions per month—of which approximately thirty three are true acute admissions and the other 6 are admitted at the end of the fourteen day period. This thirty nine total is up slightly from the thirty five average for the prior six-month period. The DMH separates out those admissions for which SEH is the only option. For the six-month period, this was an average of nearly fourteen per month—or 32% of the total admissions. Conversely, this means that 68% of the admissions to SEH should be handled via local acute hospitals. This is not a new phenomenon but it underscores the continuing reality that DMH is not in compliance with the requirements of the Court-Ordered Plan.

As the Court Monitor has discussed in multiple Reports, the appropriate utilization of SEH is a major ongoing Dixon issue. It is also very costly to the District to spend 100% local dollars for institutional care that can and should be provided in the community. SEH is currently operating forty six acute beds. If you extrapolate from the DMH data that two-thirds of the acute admissions should be served in the community, then thirty acute beds could be reduced. Adding to that the ready-for-discharge list (which has averaged fifty four since November, 2007) means that on any given day there are in excess of eighty patients at SEH who should not be there. At $240,000 per bed, this translates into a major DMH expense ($19.2 million) unnecessarily directed to institutional care. The DMH Director is clearly committed to rebalancing the system as reflected by the RFP and the 2009 additional dollars to support acute care beds in the community.

4. Management and Role of DMH-Operated CSA

The major issue for the DC CSA continues to be the analysis of alternative service delivery and governance options. There have been continued time lags in this process—the most recent revolving

around the 2008 KPMG contract to help DMH manage the assessment and final analysis of options. The work plan for this project shows the completion of the analysis and benchmarking phase by the end of June, 2008—with the development of options and recommendations by mid-August, 2008. While these time lines are later than hoped for, the Court Monitor believes that the process of involvement of key stakeholders (e.g., advocates, private providers, unions and DC CSA staff) is critical and should not be short-circuited.

The KPMG analysis of options appropriately tracks to the Court-Ordered Plan in identifying three major factors:

1) whether there is adequate capacity in the community to provide the volume of quality services needed;

2) whether the private sector is willing and able to provide a given service; and

3) whether these services can be provided more efficiently through the private sector.

The analysis will include a reasonably detailed review of key issues including: access to care; clinical and program implications; community needs; personnel implications; legal and regulatory issues; and cost implications. The KPMG and DMH leadership identified five different options (or combinations of options) for future governance and service delivery.

1) Current State—Continue to operate the CSA, or parts of it, as it is now.

2) Not for Profit—Transform the CSA into a not-for-profit corporation.

3) Public Benefit Corporation- Transform the CSA into a Public Benefit Corporation (PBC).

4) Outsource Services—Transfer the delivery of components of the current CSA to private entities through the coordinated transfer of clients.

5. Private Acquisitions—External Private Entity Would Acquire the CSA

The District Council has also added its impetus to this process by including language in the Budget Support Act (BSA) that requires

the DMH to report to the Council on recommendations for a new governance structure for the DC CSA by October 1, 2008. The BSA further requires a plan for implementation by December 31, 2008 and full implementation of said plan by September 30, 2009.

The current timelines are for KPMG completion of options and recommendations by mid-August with DMH/District review to follow. While the Court Monitor intended to have a recommendation to the Court in the July, 2008 Report, this is clearly not possible. Hence, the Court Monitor will prepare a supplemental Report to the Court on this issue in early October, 2008. This Report will summarize the issues and recommendations as put forth to the District Council by October 1, 2008—together with a recommendation to the Court.

While all of the KPMG analysis has been going on, the DC CSA leadership has stayed focused on the immediate tasks-at-hand. It should be noted that the DC CSA continues to provide approximately 45% of the total MHRS services provided. Among the major activities of the past 6 months are the following:

- The successful organization of a new Community Advocacy Council made up of a mix of consumers, family members, agency representatives, and community-at-large members. The council's role is to advise on strategic ways to improve the quality of services.
- Hosted two community Round Table meetings and a focused meeting with local clergy. The goal is to enhance partnerships.
- Worked to implement some of the recommendations from the FY 2007 Business Practices review by KPMG. The central goal is to enhance revenue.
- Successfully implemented the Management Supervisory Service (MSS) conversion for all managers.
- Implemented an "early out" program for staff—with twenty three (23) individuals taking early retirement by the end of June, 2008.
- Implemented comprehensive compliance training—with 75% to 80% of staff having completed training.
- Successfully implemented a major access project for new consumers called Services Upon Request Enhanced (SURE). This program provides same-day access to assessment and enrollment at multiple DC CSA sites. It has increased new enrollments for the first 5 months (November 1, 2007 to March 31, 2008) by 58% over the same period for the prior year.

These initiatives are all reflective of the ongoing commitment to improve access, quality, consumer satisfaction and community partnerships. Needless to say, the kind of sweeping review being done by KPMG makes daily operations difficult at best. The DC CSA leadership team is to be commended for maintaining a positive attitude for the near-term, while remaining flexible about future options. A central focus has been around the question of what is ultimately best for consumers.

E. Review of FY 2008 Budget Issues and Status of FY 2009 Budget

The FY08 budget of $249 million should, according to DMH officials, be adequate to cover all of the planned and needed expenditures with the exception of the supplemental request for SEH. The $2.223 million (as discussed in III D 2) is related primarily to the Avatar installation—including overtime costs and time-limited consultants to assist with report writing and staff training and support.

The DMH is also looking to reprogram $3.6 million in 2008 budgeted (but unused) local dollars from MHRS-supported service to other priority initiatives. These new initiatives include $2.2 million total for the new consumer-run center, the urgent care clinic, additional acute care expenses, the mobile crisis teams and the discharge initiative at SEH. These funds will also pay $1.4 million to cover the MSS and non-union raises.

For FY09, at first it appears that DMH is taking a large budget cut in the Council-approved budget (from $249 million to $231.8 million). The large majority of this reduction, however, is the result of the MAA transition for claims payment. Of the $17.1 million reduction from 2008 budget to 2009, $15.2 million are funds for MHRS services that are now being directly appropriated to MAA instead of DMH. This $15.2 million represents the 70% FFP for Medicaid MHRS services. DMH will continue to be budgeted for the Medicaid match (30%-$9.2 million). The major reduction for 2009 is the loss of 80 vacant positions—valued at $5.4 million in expenditures. However, DMH argued successfully that there needs to be $5 million 2009 added back for DOJ initiatives at SEH plus $1.4 million for additional acute care capacity. The funds to support the other new initiatives (consumer center, urgent care clinic, mobile crisis and the SEH discharge initiative) will all be funded out of dollars redirected within the DMH budget.

Overall, the DMH net budget for 2009 is pretty flat as compared to FY 2008. Local funds actually increase from $209.9 million to $213.1 million. It appears that DMH should be able to move forward with its key initiatives—including Dixon mandates.

IV. Follow-up on Other Previously Identified Recommendations

A. Crisis Services Planning and Rehabilitation of CPEP

1. Crisis Services Planning

The January 2008 Report to the Court summarized the results of a 10-month process to develop a Comprehensive Plan for Crisis/emergency Services for adults. The original work group that oversaw the plan development has continued to meet on a quarterly basis. There are several noteworthy developments that are a direct result of this planning effort:

- The DMH issued an RFP for a Court Urgent Care Clinic (CUCC) to be located at the D.C. Superior Court—with the goal to provide on-site mental health evaluations and referrals for individuals coming before the court on a variety of charges. This RFP has been awarded to the Psychiatric Institute of Washington (PIW) and began operation on June 23, 2008.
- The DC CSA has implemented an initiative to provide same day evaluation and referral for adults needing more immediate interventions. The SURE initiative is discussed in detail in section III.D.4 of the Report.
- The Director of the new mobile crisis services has been recruited. The plan is to have five two-member teams to provide sixteen hours of coverage seven days per week. The goal is to have this service fully operational by October 1, 2008.
- The DMH has published proposed rules for certification of Officer-Agents. These rules establish a DMH officer-agent certification committee and clarify the eligibility and training required to become a DMH Officer-Agent. The final Officer-Agent rules were published in the District Register on July 11, 2008.
- The child/youth crisis RFP has been awarded to Catholic Charities. Catholic Charities has had considerable experience in providing crisis services for children/youth in other jurisdictions, e.g., Baltimore. They will be funding and providing four crisis beds and 2 mobile crisis teams at a total contract cost of $2.6 million. This service is expected to be in operation by September, 2008.

2. CPEP Rehabilitation

The DMH has engaged D.C. Housing Enterprises to do the construction management and project bidding for the renovation of the existing CPEP building at a cost of approximately 1.2 million. CPEP will continue to operate in roughly half of the building while

the other half is being rehabbed. The eventual 14, 000 square feet should provide adequate space for eight Extended Observation Beds plus waiting room space for families, office space for staff and evaluation areas for normal CPEP functions. The DMH will furnish the building via a separate arrangement ($250,000-$300,000).

The estimated timeframe for completion is approximately 9 months for Phase 1 from the beginning of the construction design to construction completion. Phase 2 will involve less intensive renovations to the currently occupied section of the building. Phase 2 should take an additional sixty days to complete. Phase 1 renovations began on July 14, 2008. Currently, DMH expects that Phase 1 of the renovation will be completed by October 5, 2008.

B. Provider Payments and MAA Transition

The DMH ended FY07 with a MHRS payout of $35.4m. This compares to a final payout of $32.7 for FY06. Of the $35.4 million, $31.8 million was billed to Medicaid for the 70% FFP. As of July 10, 2008, 73% of the potential FFP has been collected. These percentages represent the reality that DMH and MAA are now in relative sync on claims payment issues and FFP is being tracked and collected.

For FY08, the major payment issues have surrounded the move to MAA for all Medicaid claims as of November 1, 2007. There have been several major unanticipated payment snags along the way. The first occurred soon after the transition and took a couple of months before the editing inconsistencies were identified and the problems resolved. The most recent problem related to the required addition of a National Provider Identification (NPI) code. This switchover affected payments for four providers. In this case, the problem was discovered very quickly and the turnaround time for resolution was much shorter. DMH and MAA (through its fiscal intermediary-ACS) have also reformatted the remittance advices that go back to providers to allow them to reconcile to individual claims submitted. This has been a long-standing concern for providers.

During the transition of payment responsibilities to MAA, there was a realignment of eCura, which prohibited transmission of claims for telephonic services to MAA. As a result, DMH was holding claims for telephonic services rendered in FY08, which were not processed or paid from local funds. To resolve this issue, DMH issued a bulletin to providers, indicating that it will suspend payments for telephone services effective June 30, 2008. DMH has also agreed to pay current telephone charges (up to June 30, 2008) out of local funds. This will total in excess of $1 million. The whole issue of

telephonic payments will need to be resolved as part of an overall restructuring of MHRS rates. It would appear that telephonic charges are appropriate for certain services (e.g., emergency services) but for other services should be bundled into face-to-face rates. DMH is committed to a major review of the rates and has engaged a consultant to assist in this process. The earliest potential timeline for this process would be Fall 2008.

Overall, the MAA transition and provider payments have gone well. DMH and MAA (with ongoing KPMG assistance) continue to work collaboratively to identify and solve problems. MAA payments for MHRS services are predictably happening within twenty one days of adjudication at ACS. The editing inconsistencies that have impacted several providers (plus the telephone issue) continue to provide a certain level of "dis-ease" in the system. There continues to be a level of unpredictability and lack of common understanding in the payment system. Neither DMH nor providers are satisfied with the current status. DMH has committed to continue working with providers and MAA to understand payment-related issues and find lasting solutions. The analysis of the rate structure is both timely and critical.

C. Administrative Services Organization (ASO) Analysis

The Court Monitor recommended in the January, 2008 Report to the Court that DMH pursue an analysis of the ASO option as originally planned. DMH has decided not to move forward with this analysis. The primary reason is the creation of the new Department of Health Care Finance (DHCF) to replace the existing MAA. This transition, per Council legislation, is to occur by October 1, 2008. The DMH and City Administrator's concern is that a new DHCF may obviate the need for any ASO support. The Court Monitor continues to question the timeliness and overall capacity of a new agency to meet DMH's unique needs. The transition to MAA takes some of the pressure off of DMH as regards the MHRS payment function. Perhaps the best resolution is to temporarily suspend this issue until the new agency takes form and then re-evaluate at a future date.

D. Access Helpline Phone System Upgrade

The DMH has moved forward to purchase and plan installation of a new phone system for the AHL. As noted in the January 2008 Report to the Court, the previous telephone system has proven very unreliable. The new AVAYA telecom platform is the standard for the District and should provide greatly improved telephone consistency and reporting capability. DMH has successfully negotiated with the vendor to install this new system as

of June 26, 2008. All of the needed training occurred prior to the switchover date. DMH IT staff worked very diligently with OCTO to keep this project on track. The Court Monitor will re-evaluate the new phone system in the January 2009 Report to the Court.

V. Recommendations

Based on the findings in this Report and previous Reports to the Court, the Court Monitor makes the following priority recommendations:

A. The District should continue to submit progress reports to the Court, but on a less frequent basis. These priority areas should include (at a minimum): a) status of implementation of Exit Criteria; b) status of Crisis Emergency Services Plan implementation; c) status of quality care performance at SEH—including priority DOJ compliance measures; d) use of local Hospitals to provide acute care; e) provider payment performance; f) status of DC CSA governance and services plan; g) status of independent personnel and procurement assessments and improvements; and h) status of new PRTF/RTC Commission. In an effort to reduce administrative burden and balance report periods, it is recommended that these Reports be filed twice per year—beginning on April 1, 2009 and every six months thereafter.

B. The District/DMH should complete its review of the new Commission for PRTF/RTC (or ICSIC alternative) placements and make this new cross-agency structure a reality.

C. The DMH should complete its analysis of the DC CSA governance and service options as currently scheduled with a Report to the District Council and the Court Monitor by no later than October 1, 2008. The Court Monitor will review these findings and recommendations and prepare a supplemental Report to the Court in early October, 2008.