REPORT TO THE COURT

Court Monitor
Dennis R. Jones

January 22, 2010

Executive Summary

The fifteenth Report to the Court shows that the DC CSA transition is now into its final phase and has gone well – considering the multiple changes that had to be managed. March 31, 2010 is still the target date for official close-out, but as of this Report only 167 consumers remain to be transferred (out of the 4,100 total originally projected as requiring continued service). The new hospital is planned for full occupancy in May 2010. DOJ progress continues, but with continued concern about the pace of compliance. DMH has absorbed $21.8 million in budget cuts; there is concern that the FY 2011 budget may target cuts of an additional 10%.

Highlights of this Report include:

1. Implementation of Exit Criteria

   Six of the nineteen (19) Exit Criteria are in active status. DMH has submitted one additional Exit Criterion (ACT # 11) for consideration to move to inactive status. DMH has also proposed different indicators to measure performance on Exit Criterion #9 (Supported Housing). Both of these recommendations are under active review by the Court Monitor.

2. Transition and Closure of DC CSA

   As of December 23, 2009, 3,006 consumers had been transferred to a new CSA and 94% have had at least one appointment. The District-run Mental Health Services Division (MHSD) is fully operational and is providing specialized services (e.g. multi-cultural) as well as medical management only services for consumers (as desired) through the core of available psychiatrists. The full phase-out of the DC CSA is still on track for March 31, 2010.

3. Budgetary Issues

   DMH has already absorbed $21.8 million in budget cuts during FY 2009. Every effort to date has been to absorb cuts in areas that will not reduce consumer services. Unfortunately, there are now instructions for DC agencies (including DMH) to prepare FY 2011 budgets assuming an additional 10% reduction in local funding. This $18 million cut – if it happens – will no doubt directly impact service areas, including Dixon-related services.

4. St. Elizabeth Hospital

   The 293-bed Hospital is complete and is scheduled for occupancy in May 2010. The latest DOJ Report reflects notable progress on many fronts but also the reality that the overall pace of achieving substantial compliance is behind

schedule. DMH reports there is at least partial compliance on 83% of the requirements in the Settlement Agreement (SA).

5. Use of Local Hospitals to Provide Acute Care

   DMH has continued its progress in utilizing acute care beds in the community. United Medical Center (UMC) was closed to admissions for nearly 2 months during this period, but otherwise there continues to be a minimum number of direct acute admissions to SEH – less than 3 per month. In FY'09 14.4% of acute care admissions went to Saint Elizabeths Hospital as compared to 44% in FY'08. There is continued concern about the financial viability of UMC.

6. Community System Redesign

   The DMH has constituted a Mental Health System Redesign Workgroup, which is meeting on a monthly basis. The intent is to have an initial draft of recommendations by April 2010. The budgetary issues may impact the scope and pace of redesign efforts.

7. Integrated Service Delivery for High Risk Children and Youth

   DMH continues its leadership efforts to develop cross-agency agreements and common practices for SED children/youth who are at-risk of placement in Psychiatric Residential Treatment Facilities (PRTF's). There is progress noted for CFSA and DMH children/youth in terms of diversions into community-intensive services. The Court Monitor believes now is the time to pursue legislation that would require all child-serving District agencies to participate in a common way.

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

   A. DMH, in conjunction with the SEH, should develop a budgeting model that factors in the multiple factors at play (e.g. DOJ requirements, reduced census, new Hospital, etc.). This model should be agreed to before the FY 2011 budget presentation.

   B. DMH should pursue the development of legislation via the District Council that mandates the participation and the process for assessment, diversion, placement and monitoring of all SED children who are referred for potential PRTF placement.

I. Current Situation

In October 2009, the Federal Court approved the Monitoring Plan for October 1, 2009 through September 30, 2010. 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 fifteenth formal Monitoring Report.

II. Findings Regarding Exit Criteria

This Report utilizes the same format as previous Reports. Table 1 in part II. C. presents the current status of all nineteen (19) Exit Criteria and discusses specific progress and concerns.

The Exit Criteria fall into three categories: (1) review of demonstrated use of consumer satisfaction method(s) and consumer functioning review method(s); (2) the implementation of year eight 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) quantifiable Exit Criteria.

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

There continues to be concerted effort on both of these Exit Criteria. The DMH has sharpened its focus on the long-standing issues regarding the Exit Criteria on Consumer Satisfaction. One of the issues has been the reliability and significance of data as obtained

through the three (3) approved consumer satisfaction methods. The Internal Quality Council (IQC), the Consumer Satisfaction Workgroup and the Quality Council have made recommendations to improve data from the MHSIP, the convenience surveys and the focus groups; the Convenience Surveys and Focus Groups are conducted by the Consumer Action Network (CAN). Right Source, LLC was retained to conduct the 2009 MHSIP survey and code the responses. The Applied Research and Evaluation (ARE) team of the Division of Organizational Development revised the survey methodology and will provide a concise analysis with recommendations concerning how to utilize this data. The major methodologic change for the 2009 MHSIP was to supplement the telephonic survey with mail surveys – in an effort to improve the poor response rates from past MHSIP surveys. Gift cards in the amount of $10 were also given as an incentive for consumers to participate in the survey. The 2009 MHSIP data will be analyzed across multiple variables – including length of service and agency – to provide for more targeted interventions. The 2009 MHSIP report has not been completed at the time of this Report.

The DMH has met regularly with CAN to address concerns regarding the focus groups and convenience sampling methodology. As a result of these discussions and subsequent changes, DMH now reports that it is receiving useful consumer data from the focus groups. Despite the data concerns, the Consumer Satisfaction Work Group has identified six (6) priority areas from CAN's May 2009 Focus Group Report and the 2008 MHSIP Report. These six (6) include: 1) housing; 2) medication education; 3) employment resources and community; 4) continuity of care between physical health and mental health; 5) expansion of consumer-run programs; 6) improvement of consumer participation in treatment planning. The Court Monitor is pleased to see that DMH has identified a discrete set of consumer-driven priorities and has developed and implemented strategies to address these areas. The next step is for DMH to be able to measure improvement from baseline performance.

The implementation of LOCUS/CALOCUS, as a measure of consumer functioning has continued to move forward. DMH has completed its major round of "train the trainers" so that all provider agencies now have qualified trainers on staff. Compliance with DMH policy regarding the use of LOCUS/CALOCUS is being monitored by the Office of Accountability (OA). The first monitoring reviews were conducted last spring. Of the 15 agencies that did not meet the 85% compliance level, all but one (1) have submitted documentation to show that they have implemented their corrective action plans. The next major compliance-related task is to determine whether local providers are in fact using the LOCUS/ CALOCUS scores in

formulating or reformulating treatment plans. ARE and OA have worked with IT and Deerfield Behavioral Services, Inc. to revise the LOCUS/CALOCUS metrics to make them more useful and relevant for reporting purposes, including modifying response options, developing a MHRS service crosswalk, and investigating the development of reports that integrate ECura data. Variance reports to measure the reasons a level of care was increased or decreased began as of November 30, 2009. ARE and OA staff ran variance reports from the web-based system during the week of November 30, 2009. These reports were not viable due to ongoing technical difficulties with the web-based system. A meeting is scheduled with the system developer (Deerfield Behavioral Health Services, Inc.) and DMH IT on January 12, 2010 to correct these problems.

The Dixon-related requirement to show "demonstrated use" of the data is still in the early stages. The Applied Research and Evaluation (ARE) team of the Division of Organizational Development continues to have the task of working with providers to systematically analyze the data and make program and services improvements. The ARE – as of the fall of 2009 – has begun to provide technical assistance to providers on data analysis, report generation and outcome-focused utilization. Hopefully, DMH overall and individual providers will continue to develop specific ways from the LOCUS/CALOCUS to improve the quality of care. DMH also intends to develop a data cross-walk between the eCura system (which captures services utilization) and the LOCUS/CALOCUS (which measures consumer need). The target date for building this capacity is uncertain given the IT issues referenced above.

B. Implementation of Year Eight (8) Consumer Service Reviews (CSR's) for Children/Youth and Adults

The process and protocols for Year Eight (8) of the Consumer Service Reviews (CSR's) will remain very similar to prior years. Human Systems and Outcomes (HSO) will again oversee the individual case reviews; ensure necessary training of reviewers; provide case-judging; and complete aggregation, analysis and findings for the Court Monitor and the parties. CAN will again provide logistical support in the form of obtaining consents, coordinating schedules and ensuring timely communication between DMH and HSO reviewers.

The target dates for reviews have been set – with the child/youth reviews in March 2010 and the adult reviews in May 2010. The CSR unit within DMH will take on an expanded role for this review. This unit will be primarily responsible for coordinating DMH's role and resources for the implementation of both adult and child reviews. They

will work closely with HSO in providing new reviewer training and refresher training, selecting the sample, and collaborating with partnering agencies; they will coordinate the selection and development of all DMH reviewers and shadows; and will implement reviews. Of the 85 (approximate) sample for children/youth, DMH staff will be the lead reviewer on one-third of the cases and likewise for the adult sample of approximately 88. All DMH staff who do reviews will have case-judging via HSO. The results and recommendations for both child/youth and adult reviews should be completed in time for the July 2010 Report to the Court.

The internal CSR unit has been extremely active since their inception, and has implemented their own agency and focused reviews which began in August of 2009. The CSR unit implemented agency-based reviews with First Home Care and Green Door in the fall of 2009, using the CSR protocol that is used for the reviews conducted by HSO.

In addition, the CSR unit conducted retrospective qualitative analyses of CSR data and reports from the 26 consumers who participated in 2009 Adult Dixon CSR Reviews, and were transitioning from the DC CSA to new core service agencies. These analyses, based on research questions of key stakeholders in the transition process, were written up in a report that was presented to the DC CSA implementation and transition steering committees. The results of this report have been used to inform the implementation of a new review of the 26 consumers, which began in December 2009, and is scheduled to be completed by January 31, 2010.

In their role as practice development specialists, the CSR Unit has provided technical assistance to several core service agencies on team formation and functioning guidelines. They have also developed and disseminated practice briefs and resource aids in this area based on the results of the Child CSR Dixon Teaming Workshop held in June of 2009, and have coordinated an internal team formation and functioning workgroup that has developed training, technical supports and other action steps for improving this area of practice. Finally, the CSR is in the process of finalizing a template and guidelines for the development of service and process-related practice guidelines. These templates will provide the architecture for the District's clinical practice guidelines, several of which will be developed over the next two quarters.

C. Performance on Court-approved Exit Criteria

Table 1 shows the current status on all nineteen (19) Exit Criteria

Table 1
Exit Criteria
Current Status

Aggregate Data for October 1, 2008 through September 30, 2009

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 computed. Utilization in process.
2. Consumer Functioning Method(s)	Yes	N.A.	N.A.	N.A.	Methods + Demonstrated Utilization of Results	Methods computed. Utilization in process.
3. Consumer Reviews (Adult)	Yes	Yes	Yes	Yes	80% for Systems Performance	70%
4. Consumer Reviews (C/Y)	Yes	Yes	Yes	Yes	80% for Systems Performance	48%
5. Penetration (C/Y 0-17 Years)	Yes	Yes	Yes	Yes	5%	3.07%
6. Penetration (C/Y with SED)	Yes	Yes	Yes	Yes	3%	2.52%
7. Penetration (Adults 18 + Years)	Yes	Yes	Yes	Yes	3%	2.75%
8. Penetration (Adults with SMI)	Yes	Yes	Yes	Yes	2%	2.63% (inactive)
9. Supported Housing	Yes	Yes	Yes	Yes	70% Served Within 45 Days of Referral	9.4%
10. Supported Employment	Yes	Yes	Yes	Yes	70% Served Within 120 Days of Referral	92.14%[1]
11. Assertive Community Treatment (ACT)	Yes	Yes	Yes	Yes	85% Served Within 45 Days of Referral	85.76%

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
12. Newer - Generation Medications	Yes	Yes	Yes	Yes	70% of Adults with Schizophrenia Receive Atypical Medications	87.4% (inactive)
13. Homeless (Adults)	Yes	Yes	Yes	Yes	150 Served + Comprehensive Strategy	227 Served + Strategy (inactive)
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%.	74.23%
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%.	93.09%
16. Homeless C/Y	Yes	Yes	Yes	Yes	100 Served + Comprehensive Strategy	179 (inactive)
17. Continuity of Care a. Adults b. C/Y	Yes	Yes	Yes	Yes	80% of Inpatient Discharges Seen Within 7 Days in Non-emergency Outpatient Setting.	a. 50.2% (adult) b. 34.06% (child)
18. Community Resources	Yes	Yes	Yes	Yes	60% of DMH Expenses for Community Services	FY '07-59% FY '08-57% (inactive)
19. Medicaid Utilization	Yes	Yes	Yes	Yes	49% of MHRS Billings Paid by Medicaid	FY '09 - 51.8% (inactive)

[1]Recent discussions with DMH have raised questions about how this percentage is calculated for new referrals. There will be ongoing discussions to resolve this matter.

The above data is for FY 2009 (October 1, 2008 – September 30, 2009). Data reported for Exit Criteria 5 – 8, 11, 12, 13, 14, 15 and 17 was extracted from eCura on December 18, 2009. The exception is #18 (Community Resources)

which reflects data for FY 2008. It should be noted that many of the Exit Criteria are calculated using data extracted from the MHRS claims; due to claim lag past the end of the fiscal year (September 30, 2009), these Exit Criteria percentages will likely increase after all claims for the fiscal year are processed. This is especially true for #19 (Medicaid utilization); this percentage is built on claims that have been fully processed as of December 11, 2009. The validation for #11 (ACT) was completed by DMH and the data consultant for the Court Monitor effective November 19, 2009. As noted below, DMH has received MCO data for Criteria 5-8 (penetration rates) and has forwarded said data and the proposed data reporting metrics to the Court Monitor for necessary validation. This process is still occurring at the time of this Report but should, once completed, have a positive impact on penetration rate performance. The DMH has completed is analysis and made recommendations for modification of the indicators for measuring performance for #9 (Supported Housing) on October 26, 2009. The next step is for the Court Monitor to fully evaluate this proposal before a recommendation is made to the Court.

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

1. Exit Criteria Met – Inactive Monitoring Status

   There are six (6) Exit Criterion that have moved to inactive status:
   - Prescribing New Generation Medications (#12) – This Criterion was moved to inactive status as of the July 2007 Report to the Court.
   - Medicaid Utilization (#19) and Community Resources (#18) – #19 was moved to inactive status in January, 2008; #18 in July, 2008.
   - Penetration – Adults with SMI (#8) – This Criterion was moved to inactive status as of January 2009.
   - Homeless Services for Adults and Children/Youth (#13 and #16) – These two Exit Criteria were moved to inactive status as of January 2009.

2. Under Current Review for Inactive Status
   - There is one Exit Criterion (ACT) (#11) that has been referred to the Court Monitor for potential inactive status. This issue is being reviewed by the Court Monitor with the parties before a recommendation is made to the Court.

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

There are eight (8) Exit Criterion that required improved performance, are dependent upon meeting penetration rate thresholds, and/or require additional verification:

- Consumer Satisfaction Method(s) (#1) – DMH has made concerted efforts to improve its data sources on two of the three consumer methods. It has also created a discrete list of quality improvement areas based on consumer feedback to date. The next step is to document the utilization of data to improve services.
- Consumer Service Reviews (CSR) for Adults (#3) – The June 2009 CSR results for adults were at 70% - with a requirement of 80%. The May 2010 CSR review will hopefully reflect improvement into the acceptable range.
- Penetration Rates (#5-#7) – The MCO data and corresponding metrics need to be validated by the consultant to the Court Monitor. This should happen within the next 30 days.
- Supported Employment (#10) – The DMH continues to believe it has achieved inactive status on this Criterion. The Court Monitor continues to need verification that CSA's are making referrals as required per DMH policy. There has been agreement by DMH and the Court Monitor to utilize the eCura quarterly event screen for all adult consumers to determine the degree to which supported employment referrals are being considered (per DMH policy) and made. DMH plans to complete the revised screen by February 28, 2010 and pilot the new screen with providers in March 2010. The goal is to have the process fully implemented in April 1, 2010.
- Children/Youth in Natural Settings (#14) – The reported data for the last two reports is not necessarily reflective of actual performance. During the reporting of data for this report, DMH discovered a problem with the approved code for the reporting metric, which may have contributed to underreporting in prior periods. However, as with Exit Criterion #15, DMH may not submit evidence of compliance with this target until achieving a penetration level for SED children/youth of at least 2.5% (Exit Criterion #6).
- Children/Youth in Own (or Surrogate) Home (#15) – Performance continues to be above the Dixon-required level. The Court Monitor believes that there are two (2) outstanding issues: 1) DMH must achieve a penetration level for SED children/youth of at least 2.5% (Exit Criterion #6); 2) DMH must reasonably assure the Court

Monitor that SED children who are in out-of-home placements are enrolled in the DMH system.

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

   There are four (4) Exit Criterion that will require considerable continued work to achieve the required performance level:

   - Consumer Functioning Method (#2) – DMH has implemented the LOCUS/CALOCUS, has trained CSA staff and is monitoring utilization compliance. The required major step remaining is to show "demonstrated use."
   - Consumer Service Reviews (CSR) for Children/Youth (#4) – The 2009 systems performance score of 48% is indicative of the amount of work to be done in the child/youth system. Hopefully, the DMH focus on this area will begin to show improvement.
   - Supported Housing (#9) –DMH proposed new indicators to measure performance with regard to the provision of supported housing on October 26, 2009. The Court Monitor and the parties will be reviewing this proposal prior to a recommendation to the Court.
   - Continuity of Care (#17) – The DMH has recently begun to focus specific staff energy on this major area – both in the adult and the child/youth area. There has also been an effort to clarify and tighten the data system that measures this criterion. Specific efforts in the child/youth area include the creation of an eCura event screen to collect post-discharge data for children and youth discharged from acute care facilities. DMH will also provide ongoing training to child and youth serving core service agencies on the continuity of care guidelines. Training will begin in January with the Choice Providers and will be facilitated to all child and youth serving agencies shortly thereafter on a quarterly basis. The Integrated Care unit recently hired a fourth care manager who will be tracking every discharge from Saint Elizabeths Hospital. DMH believes that this tracking process, along with the discharge planning work that is being done for high utilizers will positively impact on performance with regard to Exit Criterion 17.

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

A. Review of the Development and Implementation of Crisis/Emergency Services

1. Overall Progress on Implementation of Crisis/Emergency Services Plan

The DMH continues to use as its template for action the comprehensive Crisis/Emergency Services Plan for adults that was completed in late 2007. The work group that developed the Crisis/ Emergency Services Plan continues to meet on a quarterly basis to review progress. A few highlights of the five (5) critical areas from the 2007 plan include:

- Access – DMH staff report that the upgraded telephone system that was installed in June 2008 has produced significant improvement in both telephone access and data/reporting accuracy. (See III A2. for further discussion.) The implementation of the Crisis Intervention Officer (CIO) training for MPD officers can also be viewed as a critical access/diversion effort. As of December 11, 2009, one hundred eight (108) MPD officers have now been trained and certified. (See July 2009 Report [P. 20] for discussion of this effort.)

- Walk-in or Urgent Care – The Court Urgent Care Clinic (CUCC) began in June 2008 and continues to operate via a DMH contract with the Psychiatric Institute of Washington (PIW). The first year of activity shows a total of 343 people were referred to CUCC with Pre-trial Services Agency (PSA) having 155 referrals (49% of total) and the Traffic and Misdemeanor Court with 77 (20.9%). Of the 343 total referrals, 201 persons became active recipients of services during the year. The remainder were triaged out or refused services. DMH has revised its contract with PIW to provide that the child psychiatrist who serves adults in the CUCC is available half-time to serve children and youth in the courthouse.

  The other major issue regarding walk-ins/urgent care is availability via free-standing mental health clinics.

- Mobile Crisis Outreach Teams – As discussed in III. A.3 of this Report, DMH has now completed (as of November 1, 2009) the first full year of operating the

adult Mobile Crisis Team. This team has added a level of responsiveness that has been extremely valuable for District residents, their families, sister agencies (like MPD) and the community-at-large.

- Crisis/Respite Residential Services – DMH continues to fund two (2) agencies to provide a total of 15 crisis/respite beds. (See III. A.5 for discussion.)

- Comprehensive Psychiatric Emergency Program (CPEP) – DMH continues to move toward a model of CPEP as a comprehensive entity. The most recent development is the organizational restructuring to place the Homeless Outreach Program under CPEP. (See P. 16) for discussion of this action.)

  Beyond the adult services, DMH continues to contract with Catholic Charities to fund crisis team(s) and crisis beds for children/youth. (See III. A3 for discussion.)

  Overall DMH has stayed true to its commitment to develop and implement a comprehensive and multi-pronged approach to crisis/emergency services. These efforts are certainly still a work in progress, but are highly consistent with the requirements for a public mental health system and the intent of the Court-ordered Plan.

2. Access Helpline

   The Access Helpline (AHL) continues to function as an integral part of the care coordination team. Key functions for the AHL continue to include: 1.) telephone assessment and triage for consumers – with needed linkage or transfer for non-emergency consumers to a CSA of choice; 2.) notification and coordination with both adult and child/youth mobile crisis teams. Outside callers now have the option of either calling AHL or the mobile teams directly; 3.) provision of care coordination functions – which includes prior authorization for requested acute inpatient admissions, ACT services, CBI services or day services.

   The AHL is a team of seventeen (17) staff plus the director. It is available on a 24/7 basis to handle both crisis and routine calls. This unit also provides specific care coordination for CFSA consumers who may need mental health services. This 3-person clinical team includes two staff physically located at CFSA and

one who is at DMH. The CFSA-based staff work as an integral part of the CFSA intake process – providing initial assessments, triage and referral for mental health services as needed. The AHL staff stay involved with any referred children/youth and families to ensure that appropriate services are being provided. This inter-agency agreement is a component of the Amended Implementation Plan (AIP) under LaShawn. DMH staff indicate that this arrangement is working well for both CFSA and DMH.

In terms of the volume of calls, AHL for FY 2009 (October 1, 2008 – September 30, 2009) averaged 3,160 incoming calls per month. 75% of these calls were answered via the primary AHL line; the remainder were received as calls from providers (typically for authorizations) or as special services calls, i.e. children/youth or families in acute crisis, any disaster-related calls or persons who need special language assistance.

For the year, the abandonment rate for incoming calls was 4.63%; this continues to run higher than the established goal of 3.0%. However, the average phone answer time has dropped to 18-20 seconds, which is a significant improvement over historic levels of over 25 seconds. Indications from DMH staff are that the Avaya telecom system (as installed in June 2008) continues to be effective. The DMH would still like to see its phone abandonment rate at 3.0% or lower. It appears that it will take a careful review as to the reasons for the abandonment, frequency by hours of day, etc. in order to make strategic improvements.

The DMH (through the AHL) assumed responsibility for District residents who call the National Suicide Prevention Lifeline (NSPL) Network. DMH obtained provisional certification from the NSPL in June 2009 and officially opened this service in October 2009. It is still too early to know what the volume of calls will be; while it is likely the numbers will be small, it is nevertheless an important service for DMH and the AHL to provide. DMH has two years to obtain official certification as a suicide prevention hotline from the American Association of Sociology.

3. Capacity and Utilization of Mobile Teams

   a. Adult Mobile Crisis

   The new adult mobile crisis team began operation on November 1, 2008. This 17-member team is housed at the renovated CPEP building and provides mobile response 16 hours/day (9am-1pm) on a 7 day/week schedule. The

primary mission of this team is to provide on-site crisis/emergency response via a 2-person team. However, mobile teams also do a signification amount of pre-crisis and post-crisis work. During its first 11 months of operation (November 1, 2008 – September 30, 2009) the mobile team served 1,489 different consumers with a total of 2,976 contacts. The immediate crisis response involved 1,089 contacts (36.6% of total contacts) with crisis follow-up at 727 contacts (24.4%) and discharge/connecting activities at 566 contacts (19%). Of the 1,089 crisis contacts, 428 ended up in acute inpatient admissions – with an even number (214 each) voluntary and involuntary admissions. It is very noteworthy that of the 1,089 contacts, over 80% of the cases involved persons with some combination of decompensating psychiatric status, suicidal status and/or homicidal concerns.

In addition to direct referrals, the mobile team has also reached out to the community in unique ways. The mobile team attempts to connect with family and/or other impacted persons whenever there is a suicide, homicide or other tragedy in the District. The effort is to engage, assess and support people through the range of emotional and practical needs. This is a unique service in the District and has served to further strengthen the relationship with MPD and other District agencies.

It is clear that the mobile team has already established a strong and vital role in the District. Its philosophy is to not only help stabilize a crisis situation but to ensure that people are linked to a CSA and other needed services. Mobile team staff, for example, routinely transport people to other settings (e.g., crisis beds, home, etc.) as part of its transfer/connecting function. These are the kinds of behaviors that often make the difference in whether consumers stay (or get) connected to needed services.

b. Child and Youth Mobile Crisis

As of October 28, 2008, the new Child and Adolescent Mobile Psychiatric Services (ChAMPS) began operating via DMH contract with Catholic Charities. Hence there has been 11 full month of operation via ChAMPS for FY 2009. The basic model of providing on-site crisis stabilization via quick response is very consistent with the adult mobile crisis team.

The team is staffed with 12 front line workers – which include six masters-prepared and six bachelors level staff. One masters and one bachelors person are paired on the 2-person response teams. The team has staff physically present from 7:30am to 10:00pm, Monday through Friday. Throughout FY 2009, ChAMPS also staffed weekends, but due to low volume, it has gone to an on-call response on weekends as well as after 10:00pm. However it is important to note that on-call response still prompts an on-site visit; the expected response arrival time for both "live" staffing and on-call is one hour.

For FY 2009, ChAMPS served a total of 338 youth (unduplicated count). Of the 687 calls received, teams were deployed 396 times (58% overall deployment rate). For the other 42% of the calls, telephone consultation was deemed the appropriate intervention. The average response time for the year was 25 minutes. Of the total of 338 children/youth, 150 were involved with CFSA. The ChAMPS staff have reached out to foster parents as one target group – encouraging both foster parents and CFSA social workers to call CHAMPS for crisis situations rather than 911 or the police (unless there is a clear and immediate safety concern). The outreach/community education efforts appear to be paying off.

For FY 2009, there were 67 total acute care hospitalizations of which 39 were FD 12's (involuntary admissions). Hence hospital admissions occurred 16.9% of the time for the 396 deployed calls. Overall, ChAMPS staff indicate they were successful in maintaining the pre-existing placement for 75% of the deployed calls. Unfortunately neither ChAMPS nor DMH staff has been able to look at pre-existing baseline data for key performance indicators (e.g., acute hospital admissions, FD 12's, etc.) to evaluate the impact of the new mobile team. It appears that the best that can happen is to take the first year data and use that as a baseline for future measurement. The Court Monitor continues to encourage the explicit development and measurement of key outcomes.

It should also be noted that the standard protocol for the team is to provide follow-up contact with children/youth and families. The first follow-up typically happens within 48 hours – with another follow-up within one to two weeks after that. In FY 2009, follow-up contacts were primarily conducted via telephone, although sometimes they occurred

on site. For FY 2009, ChAMPS provided a total of 446 follow-up contacts, with 23 in person and 443 by phone. ChAMPS mobile teams' goal for FY 2010, is to conduct a face to face follow up visit within 72 hour from the initial crisis response, followed by a phone contact within 2-3 weeks.

The crisis/respite bed model has been modified for FY 2010, because there were problems in trying to incorporate children/youth in crisis into existing programs operated by Sasha Bruce or specialized foster homes. The new plan is for Catholic Charities to directly operate a 4-bed crisis home for children ages 10 and older. Catholic Charities has secured the facility, hired staff and are awaiting licensure from CFSA. The hope is to have this new facility operating by early 2010.

The Court Monitor believes that these specialized crisis beds could provide for further diversion from acute inpatient beds and perhaps some FD 12's.

Overall, the ChAMPS program has had an impressive first year. It has stayed true to its mission and appears to be operating in a way that will continue to grow family and community support. The major over-riding concern is the future status of Catholic Charities as a provider in light of the same-sex marriage legislation in the District. Hopefully there can be successful resolution to this issue so that Catholic Charities can continue its critical role in mobile crisis services and other outreach mental health programs.

4. Development and Utilization of Site-Based Psychiatric Emergency Services

CPEP continues to provide the site-based psychiatric services for DMH. The overall data for FY 2009 (for what is called Psychiatric Emergency Services (PES) includes the site-based as well as the new mobile team. Not surprisingly, the number of persons seen has increased. The overall daily average is now 11.7/day – as compared to 10/day for FY 2008 and 9.5/day for FY 2007. There has been a significant drop in the numbers and percentages of persons seen at CPEP and subsequently admitted to an inpatient unit. Even including the 2.2% admitted to a medical inpatient unit, the overall percentage of inpatient admissions fell to 29.4% - as compared to 35% for FY 2008. Even more dramatic was the drop in direct admissions to SEH; for FY 2009 there were a total of 99

direct admission to SEH (or 8.25 per month). This contrasts sharply to an average of 30.4 for FY 2008 and 31.8 for FY 2007. The major reason appears to be the increased utilization of community psychiatric hospitals. (See III. B3 for discussion.) The overall decrease in inpatient utilization (as a percentage of total persons seen) would also argue for the efficacy of the mobile crisis team and the use of Extended Observation Beds (EOB's). The percentage of people discharged to self-care is up by nearly 10% from FY 2008. CPEP continues to make use of the 15 crisis residential beds – although at a reduced rate of 7 referrals per month as compared to a FY 2008 rate of 11 per month. Referrals to substance abuse programs (usually detox) continues to average nearly 20 persons/month – which is very consistent with FY 2008 data of 21/month.

The renovation of the CPEP allowed for the opening of a separate unit of eight (8) Extended Observation Beds (EOB's). This unit opened on February 17, 2009. From that date through the end of September 2009, there was an average of approximately 38 transfers/month to the new unit. The EOB is designed as a 72 hour maximum stay unit; the average number of hours for the 269 total transfers was at 40 hours prior to discharge. The EOB unit is staffed from a combination of dedicated staff and flex staff (depending on the census). CPEP has developed a set of procedures and protocols for the EOB unit that did not exist when the EOB was co-mingled and co-staffed with the rest of CPEP. Overall it appears to be functioning as planned – with greatly improved potency with new space and dedicated staff and programs.

There are three larger system planning issues that impact CPEP's role. First, in analyzing the issue of CPEP utilizers, there were 292 consumers in FY 2009 who utilized CPEP three or more times. This raises the question of whether the appropriate intensity of services is being provided (e.g., need for ACT services or other high intensity intervention). CPEP has taken the initiative in the past year to meet with CSA's serving consumers with three or more CPEP visits. Second, the data show that over two-thirds of the consumers seen by CPEP are linked to a CSA. While this would be viewed as a positive, it does raise the question of what the individual CSA's role can/should be in providing crisis/emergency services for its enrolled consumers. This issue was raised as part of the Crisis/ Emergency Services Plan and will hopefully be addressed as part of the redesign work. There is no doubt that a centralized CPEP will always be needed, but it would seem that at least the larger and established CSA's should take on

greater responsibility for outreach and after hours crisis services for enrolled consumers.

The third issue involves the organizational change that moved the Homeless Outreach Program (HOP) from a separate, service within the Office of Programs to being part of CPEP. DMH decided that the quality of care for individuals receiving this service would be enhanced if the HOP was placed under the overall purview of CPEP; this happened in late October 2009. The previous Director of the HOP program has been transferred to a new position at the Authority as Systems of Care Manager as of December 21, 2009. The rationale for the move was to create greater integration across outreach units (e.g. mobile crisis and HOP) and to strengthen the clinical capacity of the HOP. Unfortunately, this change was not well received and resulted in a significant amount of concern about the efficacy of the HOP in this new model. The Court Monitor will assess this change as part of the July 2010 Report to the Court.

The site-based services for children/youth continue to be provided by the Children National Medicaid Center (CNMC). Unfortunately the data that has been transmitted to DMH for the past year has not been aggregated or utilized in any meaningful way – in spite of multiple past discussions on this issue. As of the date of this Report, it finally appears that DMH has resolved these internal issues and has identified a person within the Child and Youth Services Division (CYSD) who is responsible for analyzing the data and preparing report for use by the CYSD managers. The Monitor will continue to monitor DMH's progress with regard to the use of this data and will assess the use of the CNMC emergency department data as part of the overall discussion about the Child/Youth system of care in the July 2010 Report to the Court.

5. Development and Utilization of Crisis Residential Beds

   DMH contracts for a total of 15 adult crisis residential beds – with eight (8) at Crossing Place and seven (7) at Jordan House. Due to renovations, however, Crossing Place operated with six beds from May 9, 2009 until early October 2009. For FY 2009, there were 394 admissions to crisis residential beds, with 342 unique consumers served (unduplicated). Jordan House had an average utilization for the year of 81% and Crossing Place was 69%. The average lengths of stay are – 11.0 days at Jordan House and 7.9 days at Crossing Place. DMH staff note there are some differences in the two programs – with Jordan House serving more complex

consumers due to the availability of an R.N. on staff. Jordan House also does more outreach to other mental health agencies – which may explain its higher levels of utilization. Of the 394 crisis residential admissions for the year, 84 (21%) came from CPEP and 248 (63%) came from CSA's. The remaining 16% of admissions came from local hospitals or other sources.

Unfortunately, DMH did not do any fidelity audits in FY 2009 due to staff shortages. These have proven to be very useful reviews in prior years – measuring the degree of consistency of admissions to admission criteria, treatment document action and continuity of care. DMH staff committed to doing audits for FY 2010 and perhaps also doing a FY 2009 review.

III.

B. Review of DMH Role as Provider

1. Planning for New/Consolidated Hospital

The new 293 bed Hospital is now complete. All of the interior work and exterior landscaping is completed. Furniture has been ordered and, according to the DMH procurement officer, is expected to arrive in April 2010 The final "punch list" is being worked and the "commissioning" of the Hospital is under way to ensure that all of the electrical, mechanical and other systems are fully working. The issue of adequate water supply and water pressure for the sprinkler system and fire hydrants is being addressed. In October 2009, DMH ordered a new telemetry system which, when installed, will provide controls over how much water is pumped to the new Hospital. DMH is hopeful that the DC Fire Marshal (and the DCRA) will agree to a certificate of occupancy by early 2010. Patient and staff moves are expected to begin on April 16th and occur over the course of three weekends in April, with the move completed by the first week of May 2010. DMH also intends to have a temporary supplemental pump station in place by September 2010 which will provide water pressure of 3,500 gallons per minute as requested by the Fire Marshall for the entire east campus. The temporary pump station will operate until WASA erects the new water tower to serve the entire area. There is current water capacity of 2,700 gallons per minute just for the new Hospital. DMH believes this is a safe and adequate level.

The utility consolidation for RMB (Phase 1) is now complete. Phase 2 ($3 million capital) has begun; the overflow dental suite has been removed from Phase 2 so that the only work of Phase 2 will be the reconfiguration of the lobby and modest bedroom and

bathroom work beginning in March 2010 – after most patients move to the new Hospital. This work will include two wards of 25 beds each (total of 50) in the first phase. Given the current census projection, this 50-bed renovation should be adequate to cover the census overflow for FY 2010.

Phase 3 involves the asbestos abatement and demolition of John Howard after John Howard is fully vacated. Phase 3 also involves the building of a new recreation yard for forensic patients and additional surface parking and landscaping. Phase 2 ($19.8 million capital) is estimated to take at least one year and is expected to begin in the spring of 2010.

2. Quality of Care Issues at SEH

The Department of Justice (DOJ) conducted its fourth visit since the Settlement Agreement (SA) was signed by Judge Hogan on June 25, 2007. Following the most recent visit (September 21-25, 2009), the DOJ provided a follow-up letter dated October 8, 2009 that outlined four (4) areas of priority concern – summarized as follows:

- Concern that the Chief Nurse Executive was also functioning as the Director of Performance Improvement – raising questions about the ability of one person to lead both areas. DMH reports that a Director of Performance Improvement was hired and began working on December 21, 2009.
- Concern about SEH coming into full compliance with the SA provisions regarding "Restraints, Seclusion and Emergency Involuntary Medications." DOJ raised questions as to whether SEH is under-reporting in the seclusion and restraint area – questioning the lack of reporting for usage of "quiet rooms."
- Continued concern regarding the area of treatment planning – with particular concern about the treatment team utilizing and adopting treatment plans based upon serious incidents.
- Concern that a few patient assessments (e.g. risk assessments, nursing assessments, and positive behavioral support plans) are still in "preliminary stages of implementation."

The general tone of the letter suggests that DOJ believes the Hospital has made progress but that the demonstrated improvements are not happening fast enough. This is consistent with the tone and content of prior reviews.

The official report from DOJ was received on December 19, 2009, and is summarized below for the Court's information and review:

> The cover letter to the full Report of 359 pages outlines continued priority concerns by the DOJ based upon the September 21-25, 2009 expert consultant's visit. Overall the letter continued to reflect the DOJ belief that SEH has not kept pace with compliance targets and timelines – including critical issues identified in the May 2009 visit. The four major categories of review identified the following priority concerns:

- Protection from Harm and Risk Management

  1) A carryover critical priority area required SEH to develop a data and tracking system for repeat victims and repeat offenders. The intent is that the interdisciplinary team – upon the timely receipt of this data – would develop responsive interventions. DOJ did not find evidence – based upon clinical record reviews – that these interventions had been developed or implemented.

  2) SEH has included the use of the preponderance of evidence standard overall in its Performance Improvement Department (PID) policies, but did not show evidence of using this standard in determinations regarding abuse, neglect and exploitation.

  3) SEH has adopted a standard face sheet for abuse, neglect and exploitation investigations. However, SEH staff must also show specific findings that would support the recommendations. SEH should also develop a system for compiling abuse and neglect recommendations and ensuring that appropriate staff follow through on recommendations and reporting this to PID.

  4) SEH should produce a history of an individual patient's incident history – prompting clinical review for persons whose behavioral or medical patterns warrant more intensive review and intervention.

- Nursing Care

  The DOJ commended the hiring of the new Chief Nurse Executive (CNE) in May 2009. Since that time, the CNE has made major improvements in nursing policies and practice – including new methods for evaluating nurse competencies and implementing a pilot program on RMB-3 that is designed to increase meaningful contact between staff and patients. The intent is to take this successful pilot to other Hospital units. DOJ also commended SEH for its Infection Control Program, which is now operating fully in line with accepted practice standards. Despite these areas of commendations, DOJ had major continued concerns regarding nursing overall. Some of the priority areas include:

  1) Provide competency training for all nurses in critical areas. The required training should be completed by February 2010.
  2) SEH needs to refine its medication administration policy and practice to help ensure the consistent and accurate administration of medications. All nursing staff who administer medications need to be retrained on these enhanced protocols.

  3) SEH needs to ensure that nursing staff are completing the new nursing assessment form and have adequate clinical knowledge to understand nursing care implications.

  4) SEH continues to be deficient in terms of having an RN on all units for all shifts. DOJ expressed particular concern about nursing coverage on the evening shift – when nursing staff provide the large majority of patient care.

  5) DOJ continues to be "deeply alarmed" that the IRP's lack meaningful nursing interventions. This appears to be an issue of training, role definition and the need for clear nurse practice guidelines.

- Treatment Planning and Psychiatric Care

DOJ noted that SEH has developed a number of policies and procedures in this area since the last DOJ visit but has not yet adequately implemented these; hence DOJ finds the Hospital noncompliant in this area. Some of the priority concerns include:

1) SEH needs to revise its IRP manual and training module to provide greater clarity and operational guidance for staff.

2) SEH needs to develop monitoring tools and clear clinical indicators for the use of high-risk medications. The concern is to have clear justification for those patients receiving long-term treatment on benzodiazepines and/or anti-cholinergic medications – given the known risks of these drugs.

3) SEH needs to develop processes to ensure the diagnostic accuracy of psychiatric assessments. DOJ noted some improvements in this area but deficiencies remain both in clinical documentation and the need to align diagnostic formulations with the progress notes.

- Behavioral Management and Psychological Care

  DOJ noted improvements in this area, which includes behavioral management plus discharge planning and community integration. Several sub-provisions have achieved substantial compliance. The following priority areas are highlighted:

  1) DOJ noted that IRP team meetings are now functioning in a "fairly organized manner" but there are still concerns that relate to the IRP manual and training (as referenced earlier).

  2) SEH needs to conduct a comprehensive needs assessment for rehabilitation treatment/therapy staff – with the intent of developing a clear staffing plan for rehabilitation staff.

  3) SEH needs to complete the formation of a Positive Behavior Support team. It should be noted that DMH has recently hired a Positive

Behavior Support team leader and interviewing for remaining PBS team positions is ongoing.

4) DOJ reflected that there have been "admirable" efforts to address issues of discharge and community integration, but believe that SEH is still not in compliance in this area. DMH, by way of response, notes the 20% reduction in patient census from October 2008 to December 2009 (408 to 326). The DOJ concerns point to the lack of discharge criteria in reviewed records and the lack of documented follow-up for individuals who have been discharged.

   DMH, in response to the latest Report, indicates that SEH has substantially or partially complied with 83% of the Settlement Agreement requirements that were originally targeted for compliance by this point. DMH also indicates it has now moved to substantial compliance in 23 categories – up from 11 in April 2009 – and has reduced the areas that are noncompliant from 40 to 23. This 83% compares to an 80% level for partial and substantial compliance as of April 2009.

   Despite the incremental progress, the general tenor of the letter reflects DOJ unhappiness with the pace of progress. The Court Monitor, in review of this Report as well as prior ones, has a couple of observations to make regarding the ongoing process. First, as reflected in the cover letter, it does appear prudent for the DOJ and DMH officials to have a sit-down meeting to discuss progress-to-date and going-forward options as it relates to the SA. The overall SA timeline is now past the half way point and much has been learned about the reasonable pace of change on many fronts; hence now appears to be a critical time to reassess. The second observation is that it would seem prudent for SEH to create a discrete list of true Key Performance Indicators (KPI's) against which to establish quantifiable performance targets. The SA includes 208 different areas of measurement; the organizational reality is that

the sheer magnitude of concurrent expectations leads to confusion and frustration as to what is most important. A discrete list of performance areas could help create a sense of focus and also help SEH management in its internal and external measurement of progress and expectations.

Other key support areas for SEH can be highlighted as follows:

1.) Human Resources

The overall vacancy rate at SEH has begun to creep back up – showing an 8.65 actual vacancy rate as of 12/1/09. This compares to rates of near 5% in mid-2009. The reasons for the increase appear to be multiple – including the process time required to review former DC employees who have been "displaced" and the PeopleSoft system requirement that specific budget dollars must be loaded and available for every vacant position before it can be posted.

2.) Information Technology

Phase 2 of the AVATAR system officially "went live" on November 9, 2009. Phase 2 is the clinical workstation module – including patient assessments, treatment planning and treatment clinical notes. The introduction of an electronic medical record involved a major challenge in creating electronic clinical forms (from old manual ones); this involved multiple iterations of work between the IT staff and the clinical staff. Phase 2 also has included a major training effort for all clinical disciplines; the nursing staff were the last to be completed. It is unclear how long it will take to work out all of the "bugs" from this new system. It is clear from discussions with SEH officials that there is considerable work still to be done in ensuring that data is accurate and that IT issues are dealt with in a timely way. Complicating all of this is the need to transfer and install new IT systems in the new Hospital. Given the April target for move-in, there is a major effort underway to install and test everything from new phone systems to new security card access. While much of the detailed work is contracted out, the IT staff (in

conjunction with SEH) have to manage and oversee all of this.

Phase 3 is now conceived as largely involving cleanup and optimization. Phase 3 will also likely involve a billing module.

3.) Budgetary Issues

SEH continues to have significant spending pressures in its FY 2010 Budget. The confirmed budget cuts for FY 2010 resulted in a loss of approximately 58 FTE's – most in non-clinical areas. One of the major positive trends has been the overall census reduction from 399 in November 2008 to 332 as of the end of October 2009. This drop of 67 is the direct result of acute admissions being largely treated in the community and the work of the Integrated Care Division (see III B4). The Hospital has also reduced its overtime expenses by 40% from where it was a year ago. In spite of these efforts, it appears there are significant spending pressures for FY 2010 – perhaps as much as $1.5 million. This $1.5 million may be partially offset by unanticipated Medicare revenue ($993,000). The ability to load this revenue for FY 2010 is still being discussed at the time of this Report.

There are multiple budgetary issues at play – new Hospital, reduced census, DOJ staffing requirements, and overtime management to name some. It would appear that both DMH and SEH need to develop a budgetary/planning model that can forecast budgetary needs with much greater accuracy. The Hospital has begun this process; it will be critical that people at all levels understand and buy into the budget modeling so that outcomes are broadly supported. This will be particularly important if the FY 2011 Budget mandates an additional 10% cut (as discussed in III C).

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

The DMH has continued its strong efforts to provide acute care in local hospitals. For the six-month period of April 2009 through September 2009, there were a total of 40 acute care admissions to SEH – less than 7/month on average. This compares favorably to the first six months of the fiscal year (October 2008 – March 2009)

which showed an average of 13 acute care admissions to SEH per month. For April 2009 – September 2009, there were 19 occasions (3 per month) when a community bed was not available and hence resulted in an admission. It should be noted that 12 of the 19 occurred in July and August when United Medical Center (UMC) was going through changes in psychiatric management and leadership – resulting in nearly two months of no admissions to UMC and resultant pressure on the acute care system.

The total admissions to SEH for April – September 2008 was 131 (an average of 22 per month); this number is contrasted to prior years of 45-50/month on average. The result is reduced need for acute bed capacity at SEH, shorter lengths of stay and reduced costs for acute inpatient care. The primary bed support continues to be UMC (30 beds) and Providence Hospital (15 beds). Psychiatric Institute of Washington (PIW) is also available as a backup inpatient facility – but is not preferred because it is not eligible to collect Medicaid due to its IMD status.

There is ongoing concern about the financial viability of UMC – with indications that the Hospital is operating with significant losses (approximately $20 million) for the current fiscal year. This would argue that DMH needs to be aggressively looking for new hospital partners.

4. Development and Implementation of the Integrated Care Initiative

The Integrated Care Division (ICD) at the DMH Authority continues to provide intensive care management and care coordination to outplace difficult-to-place consumers at SEH and also avoid admissions/readmissions to SEH for those at higher risk.

One of the specific outplacement projects is via contract with Washington Hospital Center. DMH reduced the target for this initiative – called New Directions – for the first project year from 30 to 23, due to budgetary constraints. These 23 consumers from SEH are now all identified and enrolled; eleven (11) have actually been placed into the community as of January 7, 2010. Experience is showing that it takes 3-4 months of intensive work on the front end to engage the consumers and their families/guardians that this is the best course for them. DMH has funding to support four (4) additional consumers in its FY 2010 budget. The intent is to increase the target number to 27 as of March 25, 2010. It is clear that this project is targeting some of the most long-term and difficult-to-place persons at SEH so it is not surprising that this timeframe has expanded.

The ICD has set up specific outcomes for itself in key areas, e.g. access to care management for high-risk persons, reductions in hospital utilizations, and increase in community tenure for outplacements. Overall it appears that ICD is meeting its outcome targets. For example: 1) 100% of persons with three or more hospitalizations were identified and served in FY 2009; 2) of the 272 who were served by ICD in FY 2009, there was a reduction of 60% in the number of hospitalizations (from 302 to 181); 3) community tenure increased by 50% for FY 2009 over FY 2008 for these 272 consumers; and 4) 162 people were discharged from SEH in FY 2009 – as measured against the original target of 150.

The ICD added a fourth front line position as of the end of November 2009. This position will be focused on continuity of care for adults – one of the outstanding Dixon measures. The initial emphasis will be on monitoring all discharges from SEH, both civil and forensic, for a 90-day period.

Overall, the ICD is filling a critical void in the DMH system. Persons at all levels applaud the intensive "hands-on" approach that has been taken for this most difficult-to-serve population – many of whom have had extensive periods of time at SEH.

5. Phase-out of DC CSA and Implementation of the DMH-run Mental Health Services Division (MHSD)

The DMH has continued to carefully manage the phase-out and transition of consumers who were previously served by the DC CSA. The overall project was divided into two (2) phases – with the first goal of transferring 2,500 consumers (out of the 4,100 originally identified) by September 2009. This goal was met with 2,664 former DC CSA consumers having enrolled with a new CSA as of October 13, 2009. The second phase is the transfer of all remaining consumers between October 1, 2009 and March 31, 2010, and the full implementation of the DMH-run Mental Health Services Division (MHSD) for consumers who need specialty services not readily available via the private CSA's.

As of December 23, 2009, 3,006 consumers had transferred to other CSA's. DMH indicates that, as of that date, 167 persons remained to be transferred. The difference between the 4,100 and the total of 3,173 (3,006 transferred plus 167 remaining) are primarily made up of persons who will be served by the MHSD (approximately 843), persons who are deceased, persons who will or have disenrolled because they refused service or could not be

located and had not received any service in the last twelve months (273). DMH data indicate that 94% of persons have had a first appointment and 77 % have had a second appointment. The Continuity of Care Transition Teams (CCTT) are now down to two teams of three staff each. All of the specialty populations (e.g. children/youth, ACT, hearing impaired, multi-cultural, etc.) have been transferred either to a CSA or to the MHSD. March 31, 2010 continues to be the end date for the CCTT's and final close-out of the DC CSA transition.

The Mental Health Services Division (MHSD) is now fully operational out of two sites – 35 K Street for all adult services and 821 Howard Road, SE, for all child and youth services. The core services being provided by the MHSD include: 1) Saint Elizabeths psychiatric residents clinic; 2) multi-cultural services; 3) programs for consumers with dual diagnosis (hearing impaired or developmentally disabled); 4) outpatient competency restoration program; 5) consumers who present for same-day services 6) consumers who only require medication management services; and 7) pharmacy. Of the 15 psychiatrists who were retained to work at the MHSD, 2 subsequently retired, leaving 13 psychiatrists. The breakdown of the 13 remaining psychiatrists is 9 adult and 4 child psychiatrists. CSA's have also requested specific times of psychiatrists from this group; at the time of this Report, eight (8) different CSA's were using 1-3 days per week of psychiatric time. The MHSD psychiatrists bill Medicaid or other third parties directly for their services. It is anticipated other CSA's will add to the demand. The MHSD is beginning to evaluate its role going forward. While it is clear that centralized specialty services will need to exist, the open question is one of size and scope. Hopefully by the July 2010 Report to the Court, this issue will be easier to assess in terms of costs and efficacy.

Overall, the DC CSA transition has been very effectively planned and implemented. The earlier major delays in CSA's taking on transfers appears to have been largely resolved. The consolidation of sites has improved efficiencies and saved costs. The CCTT's have been an effective "hands-on" model for assisting consumers in the process. The private CSA's have ramped up their capacity and responsiveness. This has been a very complex and potentially volatile project; DMH should be commended for its broad planning but also the consistent attention to detail throughout the process.

C. Review of FY 2010 Budget and Planning for FY 2011 Budget

The July 2009 Report to the Court detailed the budget cuts that have been made for the FY 2010 DMH budget. In addition to earlier cuts, DMH absorbed cuts in July, 2009 of $9.0 million in local revenue (4.5% reduction). These cuts affected both the Hospital, the Authority, and contracted community services. Every effort was made to absorb cuts in areas that did not directly impact consumer services, e.g. increased efficiencies at SEH, targeted staff reduction at the Authority, etc. As of this Report, no additional cuts to the FY 2010 Budget have been made.

The major concern is the early planning for the FY 2011 Budget. Budget directions to the agencies have been to prepare a FY 2011 Budget with a further reduction of 10% (excluding fixed costs) in local spending. If this becomes the reality, it would translate into approximately $16.8 million in local spending cuts. As noted above, the budget reductions to-date have largely focused on non-consumer efficiencies, consolidations, overhead positions, etc. Future cuts of this magnitude will inevitably impact direct services in a frontal way – including Dixon-focused service areas. The new District revenue forecast is due in January 2010, and will likely set the stage for FY 2011 budgeting. The Court Monitor will continue to closely track budget discussions.

IV. Follow-up on Recommendations

A. Planning for Community System Redesign

The DMH has put together a Mental Health System Redesign Workgroup which is made up of a cross-section of DMH Authority staff, providers, advocates, and consumers. The group is meeting on a monthly basis and is working within the seven (7) system redesign principles that were laid out by DMH in the October 2008 Report to the Council regarding the DC CSA. These principles center around the need to create a core of comprehensive providers and provide DMH with the full authority (and resources) for DMH to regulate the Free-standing Mental Health Clinic (FSMHC) program in the District. Today the FSMHC's are regulated directly by the Department of Healthcare Finance (DHCF). The workgroup is meeting monthly and intends to have an initial draft of its recommendations by April 2010. The Rand Corporation is continuing its work in a parallel fashion – with the intent of reviewing the public mental health system and providing recommendations about the investment of Tobacco settlement funds into capital improvements to enhance the District's public mental health system by September 30, 2010. It is not clear to the Court Monitor how and when these two major redesign efforts will intersect. It would seem prudent, if possible, to use the Rand study to help inform the work of the Redesign Workgroup. DMH continues to

recognize that redesign will be a multi-year process and will be directly impacted in its scope by the budgetary concerns.

B. Status of Share Point Information Technology System

The July 2009 Report to the Court recommended that DMH proceed with the approximately $300,000.00 expense to augment and develop its Share Point technology. This has not occurred due to budgetary restrictions. While DMH had the basic Share Point software available for approximately a year and a half, the issue is to develop and make this software available to DMH managers. While there has been modest enhancement of Share Point in a few places (e.g. SEH and the Office of Procurement), this tool is essentially undeveloped for DMH Authority managers. DMH's capacity during the past six months was further diminished by the departure of the single systems development person from the IT Department. This position is being recruited but with no viable candidates yet in view.

Given the current (and perhaps future) budget reductions, it does not appear hopeful that this IT upgrade will occur in the new future. As a result, managers are left with data systems that are largely stand-alones and not very "user friendly." The only glimmer of hope for resources would be to find specialized grant dollars that might be utilized for this purpose.

C. Status of Integrated Service Delivery for High Risk Children and Youth

The cross-agency integration process for District agencies serving high-risk children/youth continues to show positive results. DMH has focused on developing strategies to divert children/youth from Psychiatric Residential Treatment Facility Placements (PRTFs) with some success. In 2006 there were 132 youth who were either in the care and custody of either Child and Family Services or DMH in PRTF placements; today there are 88 which is a reduction of 33% over three years. Starting in January 2009, DMH began utilizing a Child and Family Team Process to divert children from PRTFs. These teams consist of representatives from the involved District agencies (including the schools), parents, youth and others working together to create plans that will allow the youth to be better served in the community. This practice has proven to be quite successful as in 2009, 98 (85%) of the 115 children who were previously identified as in need of a PRTF were diverted from such placements. This reduction in admissions to PRTFs has contributed to the overall reduction in PRTF placements for youth in the care and custody of CFSA and DMH. While this is a strong start, and represents about one third of the District youth in PRTF placements DMH needs to assert its role to better address the needs of youth served by DC Public Schools (DCPS), the MCOs and

other District agencies. This process has begun through the expansion of its wraparound initiative which involves a partnership between with DMH, CFSA, DCPS and the Department of Youth and Rehabilitation Services ("DYRS"). Wraparound is an intensive service for youth most at risk of PRTF placement, as well as those returning from a PRTF placement. Wraparound is a team-based services delivery planning process which integrates a network of formal and informal services and supports for children, youth and their families as they avoid or transition from institutional care to community-based care. Wraparound usually lasts for about a year; and, families and youth participate in all areas of planning and service delivery. The program data for FY 2009 (the first full year of operations) shows a 71% PRTF diversion rate for the 34 youth referred from the community and 100% for the 100 youth who are referred from DCPS. This is one significant part of the multiple strands that need to be in place if the District is to have a truly integrated, community-based system of care for this most at-risk population. In addition, to the current activities, there needs to be: 1) a common database for all out-of-home placements; 2) common standards and a single protocol for placement decisions; 3) common standards and practice for monitoring children who are placed; 4) the creation of financial incentives for alternative community placements and; 5) the creation of specialized community capacity for high needs children and youth. There is continued activity on all of these areas, with varying degrees of progress. One of the major current efforts is to create an agreed-upon Commission on Coordination of Psychiatric Residential Treatment Facility Placements. This Commission would have representatives from all of the child-serving agencies and would ensure that all referrals to PRFT's go through a common process. The draft of the proposed commission is being discussed with all of the agencies involved – with each agency looking at how this commission would work in light of its own rules and mandates. It is unclear at the time of this Report how quickly this process will proceed.

The Court Monitor observes that there is continued effort and intent by DMH staff. DMH staff report continued progress working through the interagency process. However, there is lingering concern on the part of the Court Monitor that the interagency process will get bogged down in the parochial interests of each agency. The Court Monitor believes that in order to ensure continued institutional structure for the process, now is the time for this issue to take the form of District legislation that would clearly create a mandate for all agencies to participate.

D. Status of Independent Personnel Authority

The DMH has moved forward with its restructuring and streamlining goals for Human Resources. Phase 1 included the downsizing of 13 H.R. staff based upon the KPMG report that was completed in 2008. The staff

reduction was completed on December 31, 2009, and was based upon a functional review of all positions.

Phase 2 will include the realignment and integration of core H.R. functions between the Authority and SEH. As of January 2010, the operational/hiring unit will be based at SEH – with responsibility for both SEH and the Authority. In like kind, the policy and program unit will be based at the Authority. The intent is to roll out this new plan in early January 2010, and actually relocate staff by the end of January 2010.

The third phase goes to the heart of the KPMG report – which is to consolidate forms and processes into a more streamlined and consistent H.R. system. H.R. has not yet prioritized the KPMG recommendations but will do so as part of Phase 3. Phase 3 should begin in February 2010. Concurrent and integral to all of this is to build a fully electronic H.R. system. For example, DMH implemented an eRecruitment module as of early November 2009. This will greatly streamline the process by which applicants and hiring managers can navigate the hiring phase. While the overall implementation of KPMG recommendations has lagged due to immediate H.R. demands (e.g. DC CSA closure and downsizing), hopefully the next six months will see discernible progress in this area.

V. Recommendations

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

A. DMH, in conjunction with the SEH, should develop a budgeting model that factors in the multiple factors at play (e.g. DOJ requirements, reduced census, new Hospital, etc.). This model should be agreed to before the FY 2011 budget presentation.

B. DMH should pursue the development of legislation via the District Council that mandates the participation and the process for assessment, diversion, placement and monitoring of all SED children who are referred for potential PRTF placement.