DISTRICT OF COLUMBIA
DEPARTMENT OF MENTAL HEALTH

REPORT TO
THE COUNCIL OF THE DISTRICT OF COLUMBIA
REQUIRED BY THE

FISCAL YEAR 2009 BUDGET SUPPORT ACT OF 2008,
Title V, Subtitle I, Sec. 5022

IMPLEMENTATION PLAN FOR THE TRANSITION AND CLOSURE OF THE DISTRICT OF COLUMBIA COMMUNITY SERVICES AGENCY

December 31, 2008

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l.0 Introduction and Background

The Department of Mental Health ("DMH") submitted on October 1, 2008 to the Council of the District of Columbia its recommendations for a new governance structure for the District of Columbia Community Services Agency ("DC CSA") as required by the Fiscal Year 2009 Budget Support Act of 2008, L-17-219, (the "Budget Support Act"). In further compliance with the Budget Support Act, DMH is now submitting its plan for implementation of its recommendations (the "Implementation Plan"). The Implementation Plan is outlined below.

1.1 Background

In 1974, a lawsuit was filed against the federal and District of Columbia governments on behalf of a class of individuals civilly committed to Saint Elizabeths Hospital, demanding community based treatment alternatives to hospitalization. The class included former, current and future patients. The lead plaintiff was William Dixon. The case is now captioned as ***Dixon, et al. v. Fenty***, et al. (the "*Dixon* case"). On October 1, 1987, Saint Elizabeths Hospital was transferred from the federal government to the District of Columbia. As a result of the transfer, the District Government became the sole defendant in the *Dixon* case. In 1997, the U.S. District Court appointed a receiver to operate the District's public mental health system. The District's mental health system remained in receivership until 2002.

In 2000, the U.S. District Court appointed a Transitional Receiver to work with the District and the plaintiffs' counsel on a plan to transition the daily operation of the public mental health system back to the District. On April 2, 2001, the U.S. District Court adopted the Transitional Receiver's Final Court Ordered Plan (the "Court Ordered Plan"). Among other things, the Court Ordered Plan required the District to enact legislation establishing the Department of Mental Health as a cabinet-level agency reporting directly to the Mayor. The Court Ordered Plan recommended that DMH function primarily as a state mental health authority, with responsibility for managing and monitoring the provision of community-based services. At the same time, the Court Ordered Plan considered whether the government itself needed to operate mental health services. It outlined a three-part test (the "*Dixon* Test") for assessing the need for direct government operation. Specifically:

▪ Is the private sector willing and able to provide a given service;

▪ Can these services be provided more efficiently through the private sector, and

▪ Is there adequate capacity in the community to provide the necessary volume of quality services in the community.

Based on the *Dixon* Test, the Transitional Receiver (now the Court Monitor) concluded that there was a lack of capacity in the community or viable alternatives to contract through the private sector to provide the needed mental health services. As such, the Court Ordered Plan mandated that DMH deliver direct government-provided services through a core service agency that would be responsible for a range of adult, child and youth services. The government–run core service agency was to operate under the same rules and conditions as the certified private providers under contract with the government. The DC CSA was established as the government run service agency. At the same time, the Court Ordered Plan recommended an evaluation of the necessity for a government run service agency.

Legislation enacted by the Council in 2001 to establish the Department of Mental Health mirrored the language in the Court Ordered Plan and required that DMH "directly operate a core services agency for three years from the effective date of this act, or longer as needed, to address the community mental health needs of the District."

It has been seven years since the adoption of the Court Ordered Plan and the enactment of the DMH enabling legislation. Beginning with his July 2005 report, the *Dixon* Court Monitor continually has raised concerns about the viability of the DC CSA business model and strongly recommended that DMH review the service delivery model.

1.2 Review of October 1, 2008 Report to the Council

In April, DMH retained KPMG LLP ("KPMG") to assist with an analysis of options and alternatives for the governance and future operation of the DC CSA. Based on the findings and recommendations in the KPMG Report, DMH applied the original *Dixon* Test outlined in the Court Ordered Plan to determine whether government should continue to provide services directly through the DC CSA.

DMH asked KPMG to consider options for the governance and future operations of the DC CSA. These options were not mutually exclusive. The options were:

1. Continue to operate the DC CSA or parts of it as a core services agency;
2. Create a new non-profit organization to assume responsibility for operating some or all of the DC CSA;
3. Transition the DC CSA to a public benefit corporation;
4. Expand services currently purchased through the current service delivery system and dissolve the DC CSA, and
5. Privatize the DC CSA operations.

In addition, DMH posed several questions to KMPG and asked KPMG to address those questions within the context of options. The questions were as follows:

1. Is there any difference in the populations served by the DC CSA and private providers?
2. Is there any difference in the service array offered by the DC CSA and private providers?

3. Is there any difference in access to care and timeliness of services between the DC CSA and private providers?
4. What are the safety net functions performed by the DC CSA and whether they can be replicated by the private providers?
5. Are there any services performed by the DC CSA that need to be retained?
6. Would a change in governance structure result in cost savings?
7. Should the DC CSA continue in its current structure?

Finally, KPMG was asked to analyze the data collected and make recommendations in the context of the following considerations:

1. Access to care;
2. Clinical;
3. Programmatic Issues;
4. Population(s) served, and
5. Costs.

Key Observations from the KPMG Assessment

KPMG made ten (10) observations regarding the DC CSA. See KPMG Report pages 5 – 6. These observations are based on the data analysis completed and consideration of the five areas identified at the outset of the analysis. The observations are as follows:

1. The consumer population served by the DC CSA is similar to the consumer population served by the private provider network. There is no appreciable difference between the demographics or clinical presentation of consumers served by the DC CSA when compared to those served by the private provider network. *See* KPMG Report, Section 5.1, page 37.

2. The services delivered by the DC CSA are similar to the services delivered by the private provider network**.** *See* KPMG Report, Section 5.1, page 37.

3. Although the capacity of the provider network is enhanced by the DC CSA, the current fee-for-service payment structure and funding mechanism of the DC CSA were reported to create an impediment to private providers creating additional service capacity. Private providers have a difficult time competing with the DC CSA to retain clinicians. *See* KPMG Report, Section 5.1, pages 37 – 38.

4. The source of funding for DC CSA services is not as predominantly non-Medicaid as presumed by most stakeholders. In fact, the DC CSA uninsured population is only 10% larger than the uninsured population served by the private provider network. *See* KPMG Report, Section 5.1, page 38.

5. The timeliness of service provision by the DC CSA is similar to the timeliness of service provision by the private provider network. *See* KPMG Report, Section 5.1, page 38.

6. The DC CSA and the private provider network served clients whose location, based on address zip code, and were similarly distributed across the District**.** *See* KPMG Report, Section 5.1, page 38.

7. The DC CSA tended to deliver more services in an office based setting. *See* KPMG Report, Section 5.1, page 38.

8. The DC CSA provides several unique services that are not delivered through the private provider network. Specifically, these services are: pharmacy, ACT to the extent they are the predominant ACT provider[1]; multi-cultural services, psycho-education in school based settings and outpatient competency restoration services. The DC CSA also operates a Residents Clinic, staffed with psychiatry residents (third year) from the Saint Elizabeths Hospital psychiatry residency program. *See* KPMG Report, Section 5.1, page 38.

9. The current funding model for the DC CSA has a negative impact on the functioning of the overall provider network.[2] The DC CSA is not subject to the funding constraints applicable to the rest of the MHRS provider network, because the overhead costs for operating the program are built into DMH's base budget. Therefore, the DC CSA is currently able to impact the professional labor pool available to private providers by retaining staff at a higher rate, paying staff higher salaries and providing a larger benefit package. On a general level, the current funding model for the DC CSA impacts the private provider community by decreasing the overall funds available for local reimbursements. *See* KPMG Report, Section 5.1, pages 38-39.

10. Services are being delivered by the DC CSA at significantly greater cost to the District**.** The same services delivered in FY 2007 by the DC CSA could have been purchased through current fee-for-service arrangements with the private network for approximately $11-$14 million less. *See* KPMG Report, Section 5.1, page 39.

KPMG made the following eight (8) recommendations:

1. Discontinue the delivery of all direct services through the DC CSA with the exception of pharmacy services, outpatient competency restoration, psycho-educational services[3], multi-cultural services coordination and the Residents Clinic. Consumers should be transferred to the private provider network on a phased basis, under the prevailing fee-for-service schedule. The specific services

[1] The DC CSA is one of three providers of assertive community treatment or ACT. Currently, the DC CSA operates three (3) ACT teams. DMH increased the reimbursement rates for ACT, counseling, community-based intervention ("CBI") and medication management services effective November 1, 2008. DMH anticipates that the rate increases will result in increased capacity by private providers. One of DMH's planned FY 2009 initiatives is the increase of ACT capacity in the community through the issuance of an RFP.

[2] The DC CSA is subject to the District's requirements regarding salaries and benefits.

[3] DMH believes that it may be more cost effective to contract with a private provider for psycho-educational services. This option will be explored during the development of the Implementation Plan.

to be transitioned to the private provider network include ACT, rehabilitation/day services (adults), community support (adults, children & youth), medication management (adults, children & youth), counseling (adults, children & youth) and community-based intervention (children & youth only). *See* KPMG Report, Section 5.2, page 40.

2. Continue direct government provision of the pharmacy,[4] the psycho-educational program,[5] the outpatient competency restoration program and the Residents clinic, which are unique, specialized services currently provided by the DC CSA**.** These specialized services, which are provided only by the DC CSA, should be maintained as direct government provided services. They should be linked to, and incorporated into a direct services entity under the direction of the DMH Authority that could also include current Authority functions/programs such as Comprehensive Psychiatric Emergency Program ("CPEP") and school based services. *See* KPMG Report, Section 5.2, page 38.

3. Broaden the provision of multicultural services across the private provider network. The multicultural mental health services provided by the DC CSA are the same as those delivered by the private provider network to a unique set of consumers. This function should be transitioned to private providers based on the common service set, in conjunction with establishing a stronger language access co-ordination and cultural competency function at the Mental Health Authority. *See* KPMG Report, Section 5.2, page 40.

4. Develop increased capacity to deliver ACT services to adults. *See* KPMG Report, Section 5.2, page 41

5. Utilize the resources that will become available from the DC CSA transition to properly fund aspects of the mental health system redesign**.** Significant resources will become available to be reallocated to the initial transition and then the strengthening of the overall public mental health system. *See* KPMG Report, Section 5.2, page 41.

6. Develop and implement a detailed transition plan to support the termination of services currently provided by the DC CSA. The transition plan needs to move consumers, by team, on a staggered or staged basis, to new clinical homes. The

[4] Stakeholders across all groups identified the DC CSA Pharmacy as an important service for which there is no equivalent structure in the private provider network. In fact, it provides an important support to both private provider consumers without Medicaid or other insurance as well as DC CSA consumers. In addition, the Department of Defense ("DOD") contractual mechanism through which the DC CSA acquires medications is available only to governmental entity. As a result, the DC CSA Pharmacy provides an important service to District mental health consumers that should be maintained.

[5] The Psycho-Educational team provides counseling and diagnostic assessments to children and youth enrolled in the DCPS Psycho-Educational program.

transition should be staged in accordance with plans to implement any redesign of the public mental health system. *See* KPMG Report, Section 5.2, page 41.

7. Establish enhanced accountability mechanisms to sustain and increase private provider accountability and monitoring. These mechanisms should include regular fidelity reviews of District funded mental health programs. *See* KPMG Report, Section 5.2, page 41.

8. Establish contractual mechanisms and obligations to solidify the public mental health system safety net. These requirements should be incorporated into provider agreements. *See* KPMG Report, Section 5.2, page 41.

1.2.1 Outreach and Interview Process

As part of its analysis, KPMG conducted thirteen (13) focus groups that included over eighty (80) participants, including consumers, DC CSA managers and employees, DC CSA union representatives, community members, advocates and other interested persons. Two were held with consumers and family members only, and another two were held with consumers, advocates and the DC CSA advisory board.

1.2.2 DMH Findings regarding the Dixon Test

In its October 1 report to the Council, DMH made the following findings regarding the *Dixon* Test to gauge the necessity for a government run service agency to continue to provide needed mental health services:

1. *Is the private sector willing and able to provide a given service?*

The private sector is willing to provide the services required by consumers currently enrolled in the DC CSA. This is supported by the results of the stakeholder interviews and based upon the clinical and demographic profiles of the consumers currently receiving services from the DC CSA.

2. *Can these services be provided more efficiently through the private sector?*

Services can be provided more efficiently through the private sector. Cost analysis completed by KPMG shows that the same MHRS services provided to DC CSA consumers in 2007 could be provided more cost efficiently through the private sector.

3. *Is there adequate capacity in the community to provide the necessary volume of quality services?*

A transfer of DC CSA consumers to the private providers will require that the current public mental health system be restructured to ensure the provision of both the volume and quality of needed services.

In the October 1 Report, DMH proposed to take three steps. 1) Restructure the existing public mental health service delivery system by reallocating existing resources. The goal is to create a comprehensive, community-based public mental health system that increases accessibility and is administratively unified. 2) Discontinue the delivery of direct services by the DC CSA that can be provided by the private provider network and transition the majority of the DC CSA services to a network of private providers. 3) Continue direct government provision of only those unique services currently operated by the DC CSA. Specifically, those services are the pharmacy, the residency outpatient clinic and the outpatient competency restoration program.

DMH projects that transitioning DC CSA consumers to the private provider network will yield about $11 to $14 million in savings that can be reinvested in the public mental health system to increase the number of individuals served and expand the range of services.

2.0 Overview of DMH Implementation Plan

In the October 1 Report to the Council, DMH stated that it would cease the delivery of direct services by the DC CSA that can be provided by the private provider network and transition the majority of DC CSA consumers to private providers. Based on the DC CSA treatment teams and a records review, DMH determined that as of December 19, 2008, the DC CSA actively serves 4,174 consumers—3,696 adults and 478 children/youth.

DMH recognized in the October 1 Report that a transfer of this size—nearly 40% of the total number of consumers in the public mental health system—to the private providers would require an assessment that the capacity exists to provide both the volume and quality of needed services. Further, DMH recognized that government assistance would be required to build the needed capacity. Working with the private providers, DMH assessed the level of resources and amount of time required to build capacity to transition 4,000 consumers. To ensure that proper capacity exists, the transition of DC CSA consumers will take place in two phases: 1) transition 2,500 consumers during Fiscal Year 2009, and 2) finalize the transition and close the DC CSA by March 31, 2010.

About 650 individuals now served by the DC CSA with unique needs including language access and multicultural requirements; children enrolled in the psychoeducational school; individuals on outpatient commitment orders; consumers who are deaf or hearing impaired; consumers with mental illness and mental retardation, and consumers in the outpatient restoration program will have their services transitioned to the Authority.

The DC CSA will be revamped as outlined in section 5.0 to reflect the reduced numbers of consumers and to meet the imperatives of the transition until its closure in 2010.

2.1 Guiding Principles of the Implementation Plan

DMH has developed a set of guiding principles to measure our performance throughout the implementation plan. These principles are derived from our mission and developed through further discussions with our partners.

Principle 1. DMH's core purpose must guide the Implementation Plan. Our core purpose is to increase the capacity of the public mental health system to meet its goal of providing high quality community based interventions and supports to improve the quality of life for residents in need of public mental health services.

Principle 2. Consumers are active participants in their recovery and consumer choice will drive the selection of a new service provider. DMH is committed to ensuring that consumers are involved in the transition, will have an opportunity to choose a new service provider, and will continue to receive the services that are necessary to meet their needs.

Principle 3. The public mental health system will maintain its strong safety net function. The District's public mental health system is designed to ensure that individuals can receive services when needed regardless of their ability to pay. All DC CSA consumers whether insured or not will continue to be served by the public mental health system. No DC CSA consumer currently receiving care will be denied service due to inability to pay.

Principle 4. **Open communication and transparency with consumers and their families, employees, providers, advocates and the public. DMH will make available timely information to outside parties through different venues, including its website, public meetings, and newsletters.** Since the October 1 Report was submitted to the Council, DMH has conducted a widespread internal and external/public information initiative about the planned closure of the DC CSA. The Department posted its October 1 Report on its website along with a series of regularly updated Frequently Asked Questions. DMH has sponsored 18 consumer meetings since October. The Director has held four all staff meetings with DC CSA employees to discuss the plan and to outline a strong employee assistance program for job placement, and is in ongoing dialogue with collective bargaining representatives.

In addition, the Director has participated in community meetings and forums with our partners and interested parties, including National Alliance on Mental Illness (NAMI), DC; the Mental Health Association, DC Chapter; the Heath Care Finance Department's Medicaid Advisory Board; the Coalition of Housing and Homeless Organizations; the DMH Partnership Council, and the Behavioral Health Association.

Starting in January, DMH will hold meetings with interested parties to review the Implementation Plan.

Principle 5. Monitor continuity of care for transitioned consumers. The Implementation Plan includes established processes for transferring consumers from the DC CSA to other providers, including written protocols and a mechanism to track transitioned consumers to ensure that consumers are engaged with the new providers and are receiving the necessary level of services.

Principle 6. Strengthen accountability in the mental health system. DMH continues to be responsible for monitoring, certifying, and regulating private providers. The Office of Accountability recently has established enhanced accountability mechanisms to sustain and

increase provider accountability and monitoring with a vigorous system of certification, audits and quality reviews.

2.2 Strategies to ensure consumer choice and participation of consumers and their families

DMH will perform assertive outreach and education activities to ensure that DC CSA consumers are aware of their right to choose a new provider and to participate in the selection process. This includes face-to-face meetings, consumer forums to explain the process and answer questions, and a series of consumer/provider fairs for consumers to learn about and interview prospective providers. DMH through its Office of Consumer and Family Affairs already has held a series of meetings with DC CSA consumers and their families. And, meetings have been held with consumers and consumer advocates. Targeted materials have been translated in several languages: Spanish, Amharic and Vietnamese. Frequently Asked Questions focused on consumer concerns were developed and posted on our website.

DMH has developed a process outlined below that allows the consumer to drive the selection process with a transition voucher that gives the consumer "purchasing authority". A consumer will be able to select a new provider by using either a written form or by calling the Access Helpline to facilitate the transition. No consumer will lose coverage because of inability to pay.

3.0 Assessment of Current Capacity of Private Provider Network

According to the KPMG findings, private providers serve a similar consumer population and offer similar services as the DC CSA Further, KPMG found that while the capacity of the provider network is enhanced by the DC CSA, the current fee-for-service payment structure and funding mechanism of the DC CSA were reported to create an impediment to private providers creating additional service capacity.

As part of its ongoing assessment of its capacity to absorb more than 4,000 DC CSA consumers, DMH issued a formal Request for Information to its private provider network to gather specific information about current capacity and the type and level of assistance needed from DMH, if any, to build needed capacity.

Providers were asked to identify their ability to provide increased capacity within the following service areas and delineate the capacity based on serving adults or children:

1. Assertive Community Treatment
2. Community support
3. Med Somatic (Psychiatrist time)
4. Community based intervention for children

The following questions were in the Request for Information:

- What is each agency's ability to developed increase capacity to serve children and adult consumers?
- What is each agency's consumer to psychiatrist ratio? How much additional psychiatric time will be required to serve the transitioning consumers?

- To what degree can providers serve special populations such as consumers with dual diagnoses, hearing impairment, individuals with HIV/AIDS, children and youth with a history of trauma, specific multicultural populations or individuals involved with the criminal justice system?
- What additional space is required to provide additional services?
- What are the projected start-up costs to expand services?
- What kind of support is needed from DMH to reduce the fiscal impact on each organization?

3.1 Summary of Findings

Twenty-four providers responded to the Request for Information. The survey provided DMH with valuable insight into the size and type of resources, i.e., additional staff, space, and financial support, needed to expand provider capacity and complete the transition of DC CSA consumers. The private providers reported that they would require transition start up funds to reach appropriate staffing levels and to secure adequate resources necessary to serve more than 4,000 new consumers. Further, nine of the 24 respondents reported that they would need additional office space and several proposed the possibility of using government owned facilities. Other capacity issues identified are described below:

Limited Ability to Provide Multicultural Services

The providers indicated limited capacity to serve Limited English Speaking multicultural populations from Ethiopia, Vietnam, and Mexico, Latin America or other Spanish speaking countries now served by the DC CSA.

Insufficient Psychiatric Services for Medication Management

According to the results of the Request for Information, the average ratio of psychiatrists to child/youth consumers is 1:200, which is consistent with the accepted standard of care. However, the average ratio of psychiatrist to adult consumers is 1:443, which is inconsistent with the acceptable industry standard of 1:300.

3.2 DMH Support to Build Capacity within the Private Provider Network

Based on the information provided by the private providers, DMH assessed the level of resources and amount of time required to build capacity to transition nearly 4,000 consumers. It concluded that a 12-month transition schedule is required to build the needed capacity at the appropriate pace to minimize disruption in consumer care. In addition, DMH conducted an analysis of the costs to support capacity building and ongoing support for consumers and determined that sufficient resources are available within its appropriated Fiscal Year 2009 budget for the first phase of the transition, and funds will be included in the Fiscal Year 2010 budget to complete the transition by March 31, 2010.

3.2.1 Consumer transition rate to support transition costs

DMH developed a formula to determine the appropriate level of support required to build sufficient capacity within the private provider network. DMH set a transition rate for the average service cost per consumer based on an assessment of the service cost for DC CSA consumers in the three highest usage months during the last calendar year. The transition rate will cover the cost of additional staff, training and space requirements for providing services for DC CSA consumers.

A set transition rate establishes an equitable process to allocate support and ensure that the funds are used to support building capacity. Providers who are not selected by DC CSA consumers will not receive transition start up funds. Further, a provider will receive transition start up funds only after it has been selected by a consumer.

An added benefit of the voucher system is that it strengthens consumer choice and provides an incentive for providers to actively engage transitioning consumers. It will be up to each provider to show that it can meet the needs of a consumer and to conduct outreach to retain the consumer once enrolled.

3.2.2 Increased local funds

All private providers currently certified by DMH serve both Medicaid and uninsured consumers. DMH transition costs include additional local support required to cover the required Medicaid match and the costs for DC CSA uninsured consumers.

3.2.3 Psychiatrist services support

The private providers reported that they will require assistance from the DMH to increase the availability of psychiatrist services. To address this issue, DMH is planning to retain government-operated psychiatric services in the form of a psychiatric practice group consisting of current DC CSA psychiatrists who will provide services on-site at private provider locations.

4.0 Transition of Consumers

4.1 Methodology for completing consumer transfers

DMH recognizes that the transition will work best when consumers are able to choose their new provider. DMH will facilitate the ability for a consumer to self-select in a number of ways, including organizing consumer forums, identifying peer support outreach staff, holding consumer/provider fairs and encouraging provider open houses.

DMH is committed to transitioning 2,500 consumers by August 1, 2009. The staging of the transition process will be based upon a number of factors including the date a consumer chooses a new provider, the clinical needs of the individual, and the pace at which the private providers are able to receive new clients.

4.2 Transfer protocols

DMH has developed with the private providers a set of mutually agreed upon written transfer protocols. This will include processes for consumer choice, enrollment, records to be transferred, and appropriate authorizations. At the same time, the DC CSA treatment teams will conduct an evaluation of clinical needs of individual consumers to identify any concerns that might affect the timing of the transition.

In addition, DMH has identified consumers who receive employment and housing supports to ensure these services are uninterrupted during the transition.

4.3 Oversight and treatment monitoring structure for transferred consumers

A mechanism will be put in place for aggressive outreach to consumers deemed high risk to make the transition by themselves, and for those individuals who may not have been considered high risk initially, but did not make and/or keep the first appointment following the transfer. This outreach will include the establishment of a consumer transition team which will consist of peer support specialists, DC CSA mental health counselors, and other DMH staff including members of the mobile crisis team and the homeless outreach program.

The primary function of the consumer transition team is to ensure that a successful transition occurs for all consumers. The consumer transition team will work closely with the DC CSA teams and private providers to provide the extra support including outreach and other activities to ensure that an individual is successfully linked to a new provider.

DMH staff will monitor the level of services provided at specific intervals after the enrollment with the new provider to identify consumers who need further outreach and/or support during this time of transition.

4.4 Timeline of Transition

DMH will begin transitioning consumers with consumer fairs in March 2009. The process of linking consumers to new providers will continue until 2,500 consumers are transitioned by August 1, 2009. The remaining consumers will be transferred by March 31, 2010.

5.0 Scale down the DC Community Services Agency

DMH will revamp the DC CSA to reflect the transfer of 2,500 consumers and to prepare for final closure in 2010. As a first step, effective November 17, 2008, DMH ceased enrollment except for the following specialty populations:

- referrals from the Court Services and Offender Supervision Agency (CSOSA), Family Treatment Court, DC Linkage Plus, and for restoration competency
- deaf/hearing impaired consumers
- consumers with co-occurring mental illness and developmental disabilities, and
- consumers with multicultural or language access needs

Further, a hiring freeze was imposed on October 1, 2008 except for temporary workers to ensure the proper level of care and supports is maintained during the transition.

Same Day Urgent Care Service

The DC CSA will continue to provide same day service for urgent care to increase access to care and to reduce the high number of missed first appointments.

The same day service program is staff by mental health professionals who are licensed to diagnose mental health disorders and prescribed services. Residents of the Saint Elizabeths psychiatry training program also staff the same day service program and are available to prescribe medications and provide short-term psychotherapy as needed. Upon completion of a same day service, the consumer in most cases will be transitioned to a private provider. As we build capacity in the private provider network, we will expect the private providers to provide same day service.

The DC CSA also will continue to serve consumers who are not transitioned in Fiscal Year 2009. This will number no more than 1,500 consumers including about 850 individuals for whom capacity does not yet exist and those individuals who receive specialty services defined below that will remain after the closure of the DC CSA.

5.1. Continue Specialized Services through the DC CSA

During the transition, the DC CSA will continue to provide certain specialized services: the pharmacy, the psycho-educational program and therapeutic nursery program, the outpatient competency restoration program, the Residents Clinic, multicultural services program and the deaf program. As indicated in the October 1 Report, these services will remain government operated after the closure of the DC CSA.

Pharmacy

DMH currently operates a pharmacy at two locations for consumers who are unable to pay for medications, including consumers who are serviced by the DC CSA and the private providers. These pharmacies are located at two DC CSA service sites—35 K Street NE and 1125 Spring Road, NW. The 35 K Street Pharmacy served 2,308 consumers patients and filled 16,829 prescriptions this past year. The 1125 Spring Road Pharmacy filled 25,389 prescriptions for 2,041 consumers. The pharmacy services are vital to medication compliance and continuity of care.

Psycho-educational program and the therapeutic nursery

The DC CSA provides counseling and diagnostic assessments for children and youth enrolled in the DCPS Psycho-Educational program at the Jackie Robinson School. The same psycho-educational team provides these services to the therapeutic nursery at Moten School.

Outpatient restoration competency program

Currently, the program operates two days each week providing a psycho-educational group and psychiatric services with some case management. The social worker and nursing services attached to the program are provided by DCCSA employees, and the program is run from the Spring Road site. In addition to the psychiatric services, the program utilizes the part-time services of a nurse and social worker with administrative support provided by other DC CSA employees.

The Residents Clinic

The Resident Clinic is a significant component of the Saint Elizabeth's Hospital training program. Also, psychiatric residents provide the critical same day/urgent care psychiatric service.

Multicultural services program and the deaf program

The DC CSA operates a highly developed multicultural services program that serves about 250 consumers who represent more than 20 languages. Outside of Spanish, there is limited capacity in the private provider network to serve this population as reflected in the responses to the Request for Information. DC CSA also is one of only two providers who serve deaf consumers.

5.2 Serve first time, short term users of the District's public mental health system

During the transition period, DC CSA will be the primary referral for first time, short term users of the public mental health system who may be affected by the stressful economic times. Depression and anxiety are normal reactions to abnormal times or stress. With increased concerns about losing jobs, homes and savings, more people are showing signs of psychological distress.

5.3 A more effective, smaller DC CSA

5.3.1 Improve productivity

While DMH is transitioning DC CSA consumers, changes must take place at the DC CSA. The Court Monitor regularly has raised the viability of the business model. DMH recognizes that there are extremely talented and committed individuals working at the DC CSA However, a significant number of employees inconsistently meet the minimum annual performance standard. This period of transition will place greater demands on the DC CSA staff and require a higher level of attention to consumer care. DC CSA will establish new performance standards tied to productivity and vigorously enforce personnel actions to demand strict accountability. DMH also will enact new regulations if required to tie productivity to continued employment.

5.3.2 Impact on the DC CSA Workforce

A reduction in force will be implemented in July 2009 in accordance with District of Columbia Personnel Regulations. DMH has established a job assistance program to lessen the impact of a

reduction in force including identifying job opportunities for displaced employees inside and outside government and conducting training consistent with collective bargaining agreements. DMH is matching eligible employees for first consideration for vacancies within the Department. DMH also is working with private providers who need new staff to seek out DC CSA employees as their skills and existing relationships with clients will be extremely valuable. In addition, DMH is participating in the government wide incentivized early out retirement program for eligible employees.

In addition, a limited number of positions now projected to be from 100-125 will be required in Fiscal Year 2010 to serve the consumers outlined above who are not transitioned in 2009. DMH will offer appointments to these short-term positions first to DC CSA employees who are affected by the reduction-in-force.

6.0 Possible "legacy agency"

With the pending closure of the DC CSA, considerable interest has been expressed by current DC CSA employees about the possibility of establishing a new "legacy agency" to promote continuity of care. DMH will set up a process to receive and evaluate proposals from either a new provider agency with board members or key leaders who can demonstrate they represent current or former employees of the DC CSA or an existing organization that can demonstrate that it is partnering with current or former employees of the DC CSA. This entity must be able to operate within the current proposed DMH structure with no additional start-up costs, using only those described within this Implementation Plan.

7.0 Transition Budget

DMH projects that the total one time cost of the transition of the majority of DC CSA consumers over a 12 month period is $6.5 million. This includes a total of $3.8 million in Fiscal Year 2009 which consists of $2.0 million to build capacity and $1.8 million for severance and terminal leave costs associated with the Reduction-in-Force, and a total of $2.7 million in Fiscal Year 2010 which consists of $700,000.00 to build capacity and $2 million in severance and terminal leave costs. Funds to support the one time transition costs are available primarily due to savings from salary lapses at the DC CSA.

The local dollar cost to service the transitioned DC CSA consumers in the private provider network in Fiscal Year 2009 is $525,000.00 with a projected annual cost of $5.9 million once the transition is complete. The Fiscal Year 2009 appropriated budget for the DC CSA is nearly $36 million dollars with 286 full time equivalent positions. Any savings from the closure of the DC CSA will be used to help build a restructured public mental health system which was described in the October 1 report to the Council.

8.0 Conclusion and Next Steps

- Determine the staging process by which consumers will be transferred
- Set up the government operated psychiatrists group

- Finalize the number and job descriptions of DC CSA positions required in Fiscal Year 2010

- Set up a process to evaluate the ongoing capacity building

- Develop Facilities Plan that protects government owned property but supports capacity building within the private provider network

- Develop individual transition plans with our sister agencies, i.e., the Child and Family Services Agency (CFSA), the Court Services and Offender Supervision Agency (CSOSA), the Addiction Prevention and Recovery Administration (APRA), and the Courts for implementing changes resulting from the closure of the DC CSA

- Develop a process to evaluate the viability of a "legacy agency"

DMH looks forward to working with our partners as we move to strengthen our public mental health system.

Appendices

A. October 1 Report to the Council
C. KPMG Report