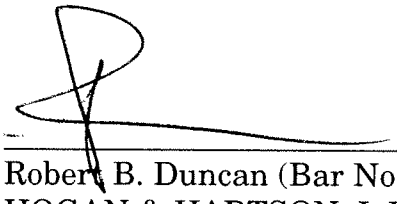
UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

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

COURT MONITOR'S NOTICE OF SUBMISSION OF REPORT

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

Respectfully submitted,



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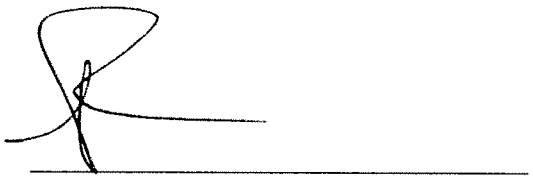
CERTIFICATE OF SERVICE

I certify that on January 28, 2009, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system, which will send notification to all counsel of record.



REPORT TO THE COURT

Court Monitor
Dennis R. Jones

January 27, 2009

Executive Summary

The thirteenth Report to the Court indicates solid progress on multiple fronts. The DMH has moved forward to implement key elements of its overall crisis and emergency services planning for both adults and children/youth. The creation of distinct mobile teams is a major step forward. The CPEP building has been completely renovated. The new Hospital is now 85% complete as of December, 2008. Major unresolved DOJ compliance issues remain at SEH. The DMH has created a new Integrated Care Division to target the movement of patients out of SEH into community care. The District has developed a Comprehensive Implementation Plan which is intended to phase out the DC CSA and transfer all consumers by no later than March 31, 2010.

1. Implementation of Exit Criterion

   One Exit Criterion (ACT #11) still needs to be verified for data integrity. The other sixteen (16) quantifiable measures have all been verified by both DMH and the Court Monitor. In addition to the three current inactive measures, three additional Exit Criterion have been recommended by the Court Monitor for movement to inactive status. These include #8 – Penetration for Adults with Serious Mental Illness – and #13 and #16 – Services to Adults and Children/Youth who are Homeless, plus a Comprehensive Strategy.

2. Comprehensive Psychiatric Emergency Services

   The DMH has made excellent progress in this area. The adult mobile crisis teams began operating as of November 1, 2008. The new Court Urgent Care Clinic (CUCC) at the DC Superior Court began on June 23, 2008. The child and youth mobile teams are contracted to Catholic Charities, which began providing its mobile teams as of late October, 2008. The renovation of the CPEP building was completed as of December 18, 2008 – allowing for well-designed and functional space for its site-based services, an office home for adult mobile teams and eight (8) extended observation beds as of February 17, 2009.

3. St. Elizabeth Hospital

   The construction of the new Hospital is now 85% complete – with planned occupancy in early 2010.

   Per the DOJ Settlement Agreement, staff hiring in key clinical areas has improved significantly. Phase 1 of the new IT system went live as planned On July 22, 2008. However, SEH remains out of compliance in all of the sub provisions that were to be in place by June, 2008. The DOJ review team gives credit for the major hiring efforts and the beginning creation of needed policies and processes. However, there is a need to put in place multiple and substantive changes before the next DOJ visit in the spring of 2009.

4. Use of Local Hospitals to Provide Acute Care

   There has been some progress on this issue – with the addition of six (6) contract beds at Providence Hospital and the potential use of up to 10 beds. The United Medical Center (UMC) has also added ten (10) acute beds as of January, 2009. Despite progress, this area is still not in accord with the Court-Ordered Plan – with approximately 25 admissions per month going to SEH that should be handled in the community.

5. Budgeting/Provider Payment Issues

   The FY 2009 budget for DMH has been reduced mid-year by $3.349 million due to revenue shortfalls for the District. There is major concern about additional budget cuts for FY'09 and FY'010 due to the volatile economic climate.

   The additional major budget concern for FY'09 is at SEH – with major challenges to manage contract expenditures and overtime within the appropriated budget of $97 million.

   The MAA transition for Medicaid payments has continued with the apparent resolution of all of the unanticipated snags as discussed in the July 2008 Report to the Court. Providers are submitting claims more quickly and DMH indications are that providers are getting paid on a predictable and more timely basis.

6. Planning for DC CSA

   The District has completed its Implementation Plan for DC CSA and submitted it to the Council on January 15, 2009. The Plan provides a multi-faceted approach to the transition of over 4000 consumers from DC CSA over a twelve month period (March 2009 to March 2010). The large majority (approximately 3350) of consumers would have the option to choose an alternative CSA with a voucher payment to the new provider to pay start-up costs. The remaining 650 consumers would be served through specialized programs managed directly out of the Authority.

7. Evaluation of Independent Personnel Authority

   The KPMG has completed a very detailed report to DMH regarding the restructuring of its HR functions to achieve improvements in both efficiency and effectiveness. This report provides DMH with a very specific HR manual that details all of the core elements of policy and process flow. The next step is for DMH to develop a work plan that will hopefully move to full implementation over the next 12 months.

   Based upon the findings in the Report, the Court Monitor makes the following priority recommendations:

   A. The DMH should proceed to implement the multiple tasks outlined in the Implementation Plan. Necessary mid-course corrections will need to be

made.

B. The DMH should proceed concurrently with the overall redesign of the public mental health system as soon as possible. To the degree possible, the Implementation Plan should reflect the principles of the redesigned system.

C. The DMH should develop specific targets for bed reduction at SEH. These targets should reflect both reduced acute admissions and accelerated discharges.

I. Current Situation

In November 2008 the Federal Court approved the Monitoring Plan for October 1, 2008 through September 30, 2009. 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 thirteenth 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 seven 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 Method(s)

There has been some discernible progress on both of these Exit Criteria since the time of the last Report to the Court. As regards consumer satisfaction, DMH has completed its 2008 MHSIP telephone survey. DMH contracted with the Family Alliance to conduct these telephone interviews for both children/youth and adults. Unfortunately, the results were not completed in time for this Report.

The Office of Accountability (OA) has used the Internal Quality Council (IQC) to review data from all three consumer satisfaction methods. The IQC has had multiple discussions regarding sampling and other significant methodological concerns for MHSIP and the convenience surveys. These concerns are of sufficient magnitude that it will likely mandate changes to the MHSIP and convenience sampling design. The Court

Monitor has encouraged the IQC to formally communicate these concerns and recommendations. The Court Monitor has continued to communicate that acceptable performance on this Exit Criterion will require: a) a clear description of consumer information utilized via the three approved methods; b) overall analysis of the data to inform action steps; c) specific organizational actions to make improvements; and d) tracking of improvement after action steps are taken. Given the methodological concerns, it is not yet clear how quickly OA staff will move to accomplish these tasks – although the process for doing so seems to be clearly in place.

There continues to be progress on the consumer functioning review method. The IT staff have provided needed resources to migrate from Citrix to secure Web-based access for all providers who need to input LOCUS/CALOCUS data. The "go-live" on this transition will be February 1, 2009 to correspond with the introduction of provider trainings later that month. The Director of Organizational Development has taken on the role of business owner for this initiative. Specific timelines have been delineated to ensure that all providers are adequately trained on how to use LOCUS/CALOCUS. The "train the trainer" phase was completed in early November, 2008 with internal DMH super users. These super users will then provide training to designees from provider agencies so that they can train and request access for their personnel. The next big phase is to ensure that all local provider staff are fully trained. A training curriculum is currently in development for use by super users and agency-based trainers. The training is scheduled to take approximately four (4) hours; DMH estimates a 3-6 month process to accomplish this for provider staff throughout the system. The still unanswered question is how this data will be aggregated and utilized as part of an ongoing process for improving quality on a macro level by DMH but also at the individual provider level. The LOCUS/CALOCUS data should provide rich opportunities for data analysis and specific areas for improvement. The Court Monitor assumes that the leadership on this task would come through the Office of Accountability as part of its overall quality improvement efforts.

B. Implementation of Year Seven (7) Consumer Service Review (CSR's) for Children/Youth and Adults

The Court Monitor has again contracted with Human Systems and Outcomes (HSO) to conduct year seven (7) reviews for children/youth and adults. The Consumer Action Network (CAN) will again be providing logistical support, e.g., obtaining consents, coordinating schedules and coordinating with both DMH and HSO reviewers. The schedule for the 2009 reviews has been set – with child/youth reviews in March 2009 and adult reviews in May 2009.

The major issue for the 2009 reviews is the impending closure of the DC CSA (see IV A for full discussion). The CSR reviews will be occurring

right at the time of highest turmoil in the system in terms of a downsizing workforce at DC CSA, impending or very recent consumer transfers, and overall organizational churning at the DC CSA. In consideration of this reality, the Court Monitor and the DMH reached an agreement that DC CSA children/youth would be excluded from the 2009 sample cases. A smaller sample of cases will be reviewed and the review will be used as a developmental opportunity for the Choice providers and the internal CSR team (discussed below). This agreement is conditioned on the understanding – in the event that DMH achieves an 80% systems performance score – that this score would not result in movement to inactive status under the terms of the Consent Order. While the same issues are at play for adults, no agreement on adults has been made at the time of this Report.

The DMH has taken a very positive step regarding CSR performance by creating an internal CSR team. This team of three (3) staff is in a training/development mode, but has targeted June 2009 as the point at which it intends to "go live" with its initial reviews of selected cases. In the meantime, this team will have the opportunity to participate fully in the official Dixon reviews and receive training and consultation from the HSO staff. The Court Monitor is very encouraged with this development. The building of internal capacity to measure CSR performance at the DMH and individual provider level is seen as the ultimate key to improved systems performance. The DMH also intends to tie CSR results to its revitalized Training Institute initiative (see July, 2008 Report for discussion of Division of Organizational Development).

C. Performance of Court-approved Exit Criterion

Table 1 indicates the most recent annual performance on all nineteen (19) of the Exit Criteria.

Table 1
Exit Criteria
Current Status

January 2009

Aggregate Data for October 1, 2007 Through September 30, 2008

Exit Criteria	Policy in Place	Data Methods in Place	DMH Validated Data System	Court Monitor Validated Data System	Court Required Performance Level	Current Performance Level
1. Consumer Satisfaction Method(s)	Yes	N.A.	N.A.	N.A.	Methods + Demonstrated Utilization of Results	Methods Completed. Utilization in Process.
2. Consumer Functioning Method(s)	Yes	N.A.	N.A.	N.A.	Methods + Demonstrated Utilization of Results	Method Completed. IT System Completed.
3. Consumer Reviews (Adult)	Yes	Yes	Yes	Yes	80% for Systems Performance	74%
4. Consumer Reviews (C/Y)	Yes	Yes	Yes	Yes	80% for Systems Performance	36%
5. Penetration (C/Y 0-17 Years)	Yes	Yes	Yes	Yes	5%	2.79%
6. Penetration (C/Y with SED)	Yes	Yes	Yes	Yes	3%	1.75%
7. Penetration (Adults 18 + Years)	Yes	Yes	Yes	Yes	3%	2.45%
8. Penetration (Adults with SMI)	Yes	Yes	Yes	Yes	2%	2.09%
9. Supported Housing	Yes	Yes	Yes	Yes	70% Served Within 45 Days of Referral	10.4%
10. Supported Employment	Yes	Yes	Yes	Yes	70% Served Within 120 Days of Referral	92.9%
11. Assertive Community Treatment (ACT)	Yes	Yes	Yes	In Process via Consultant for Court Monitor	85% Served Within 45 Days of Referral	64.95%

12. Newer -Generation Medications	Yes	Yes	Yes	Yes	70% of Adults with Schizophrenia Receive Atypical Medications	86.24% (Inactive Monitoring Status)
13. Homeless (Adults)	Yes	Yes	Yes	Yes	150 Served + Comprehensive Strategy	157+Draft Strategy Developed
14. C/Y in Natural Setting	Yes	Yes	Yes	Yes	75% of SED With Service in Natural Setting. Must Have SED Penetration Rate of 2.5%.	47.74%
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%.	93.93%
16. Homeless C/Y	Yes	Yes	Yes	Yes	100 Served + Comprehensive Strategy	111+ Draft Strategy Developed
17. Continuity of Care a. Adults b. C/Y	Yes	Yes	Yes	Yes	80% of Inpatient Discharges Seen Within 7 Days in Non-emergency Outpatient Setting.	a. Adults-54.17% b. Youth-50.49% Total-53.83%
18. Community Resources	Yes	Yes	Yes	Yes	60% of DMH Expenses for Community Services	60.45% (FY06) (Inactive Monitoring Status)
19. Medicaid Utilization	Yes	Yes	Yes	Yes	49% of MHRS Billings Paid by Medicaid	50.6% (Inactive Monitoring Status)

The measurement period is for October 1, 2007 to September 30, 2008, and reflects claims activity as of November 28, 2008, for Exit Criteria numbers 5-8, 11-15, and 17. Data reported for Exit Criterion 16 is for the period from January 1, 2008 through October 31, 2008. It should be noted that #18 is for FY '06 due to the fact that a full analysis of FY '07 has not yet been completed. DMH and the Court Monitor have resolved all the validation issues except for ACT (#11), which still requires additional verification as to specific metrics before the consultant to the Court Monitor can complete her analysis. The penetration rates are still a work-in-progress

as it relates to the potential inclusion of MCO data. It should also be noted that there is on-going discussion between the Court Monitor and DMH regarding the appropriate performance metrics for supported housing. The DMH has engaged a supportive housing consultant to assist in this project.

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

1. Exit Criteria Met – Inactive Monitoring Status.

    - Prescribing Newer Generation Medications (Criteria #12): This Criterion was moved to inactive status as of the July, 2007 Report to the Court.
    - Medicaid Utilization (Criteria #17): This Criterion was moved to inactive status as of the January, 2008 Report to the Court.
    - Community Resources (Criteria #18): In the July, 2008, Report to the Court, the Court Monitor found that this Criterion had met the Court-established compliance level for FY 06 and was moved to inactive status. The DMH must continue to Report to the Court on this (and all inactive measures) and demonstrate its ability to verify data.

2. Recommended for Inactive Monitoring Status.

    Based on documentation provided by DMH, the Court Monitor has recommended three (3) additional measures for potential movement to inactive status:

    - Penetration – Adults with Serious Mental Illness (SMI) (Criteria #8). The DMH has demonstrated a FY '08 penetration rate of 2.09% for persons with serious mental illness (as a percentage of all adults in the District). The Court required percentage is 2%.
    - Homeless Services for Adults and Children/Youth. (Criteria #13 and #16) The DMH has addressed the 2-pronged criteria for each of these Criteria. First, it has met the annual service requirement – 157 for adults versus the Court requirement of 150 and 111 for children/youth versus the Court requirement of 100. DMH has also developed a comprehensive strategy for serving these vulnerable populations.

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

There are six (6) Exit Criteria that require additional verification and/or improved performance to achieve inactive monitoring status. These are summarized as follows:

- Consumer Service Reviews (CSR) for Adults (Criteria #3):
  The June 2008, CSR results were at 74% for systems performance. While this is below the 80% requirement, it indicates continued progress in the overall adult system.
- Penetration rates (#5-#7):
  The DMH has negotiated a new MOU with MAA which will include a delineation of DMH's role vis a vis the MCO's. The potential inclusion of MCO data in these Exit Criteria could go a long way toward the District's meeting these performance levels. Acceptance of the MCO data will require the same level of detail and data integrity as was developed for the current metrics.
- Supported Employment (#10):
  The DMH continues to perform above the established Court level. However, the ongoing and unresolved issue is the verification of referrals at the provider level. DMH has implemented proxy measures through the OA quarterly claims audit process beginning with the first quarter FY 08 claims audit. Regular dialogue with the Court Monitor continues.
- Children/Youth in Own (or Surrogate) Home (#15):
  DMH's ability to move to inactive status on this issue is dependent upon first achieving a penetration rate of 2.5% for children/youth with SED. The current penetration rate is 1.74%.

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

   There are seven (7) Exit Criteria that have seen progress but still have major challenges ahead:

   - Consumer Satisfaction Methods (#1):
     The three consumer satisfaction methods are being actively reviewed by the Internal Quality Council (IQC). The IQC has determined that there are serious methodological problems in two of the three. These issues will need to be addressed in order for DMH to have valid consumer data upon which to construct an improvement plan.
   - Consumer Functioning Methods (#2):
     The DMH has fully implemented its web-based system for providers to input data for LOCUS/CALOCUS. It has also

undertaken a comprehensive training effort for all providers. Still remaining is the development of a plan to utilize data to improve quality.

- Consumer Service Reviews (CSR) for Children/Youth (#4). These CSR scores remain very low, but DMH has committed staff resources toward an internal CSR team. The new DMH director for child/youth services also brings new vitality and leadership to the array of cross-agency programs for children, youth, and families.
- Supported Housing (#9):
  The DMH consultant on permanent supportive housing has helped to crystallize key issues and is working with DMH staff to make recommendations on key metrics to the Court Monitor.
- ACT (#11)
  DMH has undertaken multiple initiatives related to ACT. These include: increased ACT payment rate; completion of an independent fidelity audit; development of supported employment capacity in ACT teams; creation of new ACT teams via private providers; and active assessment of SEH consumers for potential ACT referrals (see III B4 for discussion of integrated care initiative). These efforts should begin to see payoff over the next 12 months.
- Children/Youth in Natural Settings (#14):
  Due to the roll-up of claims for billing purposes, DMH is not capturing same-day services of some of the care being provided in the home. It is not yet clear what solution DMH will propose for this data collection problem, but the deteriorating score on this measure does not appear to reflect accurately on where services are being provided.
- Continuity of Care (#17):
  DMH has shown improvement on this measure for both adults and children/youth. It is also tracking the time frames (beyond seven days) when consumers are seen and those who are never seen. Hopefully, this data will lead to new DMH initiatives to improve performance on this measure.

Overall, the Court Monitor is pleased to see the level of attention and activity on all of the Exit Criteria. For the first time, it can be reported that there is both clear ownership on each Criteria and active efforts to make improvements. Obviously, much work still remains.

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

In late 2007, DMH completed a comprehensive Crisis/Emergency Services Plan for adults. The planning process included a wide cross-section of persons who are knowledgeable about needed crisis/emergency services in the District. That plan has served as the framework for priority investment of energy and resources over the past year. A summary of progress in the five critical areas identified in the plan include:

- Access – The DMH has completely upgraded its telephone system for the Access Helpline. The new system allows staff to identify and respond immediately to crisis calls, which are approximately 8% of all calls.
- Walk-in or Urgent Care – DMH has funded and opened a Court Urgent Care Clinic (CUCC) as of June 23, 2008. The Psychiatric Institute of Washington (PIW) is contracted to provide immediate on-site mental health evaluations and referrals for individuals who come before the Court on a variety of charges. The DMH – as part of its overall redesign efforts – intends to promote a variety of urgent care points for mental health needs – both in free-standing mental health clinics and through the medical primary care system.
- Mobile Crisis Outreach Teams – DMH has moved to fund, staff and implement mobile crisis capacity for adults via CPEP. This will be discussed fully in III A 3.
- Crisis/Respite Residential Services – DMH has continued to contract for the 15 crisis beds it has had for the past several years.
- Comprehensive Psychiatric Emergency Program (CPEP) – DMH has moved aggressively to put a truly comprehensive CPEP in place. In addition to the mobile team(s), the newly renovated space will provide eight extended observation beds for consumers that need overnight stays to stabilize and evaluate their condition.

The DMH has also contracted with Catholic Charities to fund crisis team(s) and crisis beds for children/youth. This will be discussed more fully in III A 3.

The DMH should be commended for its leadership in developing and implementing a comprehensive approach to crisis/emergency services. The

past year has witnessed major steps forward in mobile teams for both children/youth and adults, plus the full renovation of CPEP.

2. Access Helpline

The Access Helpline (AHL) (as part of the overall Care Coordination Team) continues to provide key DMH functions as part of the entry to the system. These functions include: 1) telephone assessment and triage for incoming calls and requests for mental health services; 2) notifying and dispatching mobile crisis teams for both adults and children/youth; 3) linking or transferring non-emergency consumers to a CSA of choice and; 4) providing care coordination functions, including prior authorization for any acute inpatient admissions, ACT services, CBI services or Day services.

The Care Coordination Team continues to have responsibility for specific care coordination for CFSA consumers who are in need of mental health services. One of the two positions for this function is currently vacant; the person in the other position is scheduled to transfer to the new CSR unit but will not do so until a replacement is hired (target date of February, 2009). These positions are a part of the Amended Implementation Plan (AIP) under LaShawn. The intent is to provide onsite support to CFSA to ensure the appropriate and timely linkage of CFSA referrals for mental health services.

One of the major challenges for AHL in the past year has been the installation of a new phone system as of June 26, 2008. As noted in previous Reports to the Court, the prior phone system was a source of major frustration for AHL staff in terms of its inconsistent performance. AHL staff report that the new AVAYA telecom system is a major improvement in terms of reliability and reporting capacity. Telephone-related complaints are markedly reduced. The two major challenges for AHL/Care Coordination Team are to get fully staffed and fully trained in the new AVAYA system. Overall, out of 17 total staff, the AHL/Care Coordination Team is down two positions (including one of the CFSA positions noted above). Both have been approved to be filled and interviews are taking place. The initial reports from the new phone system (December, 2008) show call abandonment rates of approximately 6% and initial average phone-answering time of 35 seconds. The Care Coordination Director wants to get to performance levels of 3% or less for call abandonment and 24 seconds or less for average call answering. The goal is to get all vacant positions filled by February, 2009. It is believed this will provide major improvement to the current poor performance levels on telephone-answering capabilities. Ongoing training regarding the new phone system should also help.

The DMH is also actively exploring the possibility of taking on responsibility for District residents who currently are accessing the National Suicide Prevention Lifeline Network for suicide-related calls. Currently these calls are being routed to Maryland or Virginia. While the number of

such calls is relatively small (average of 3-4/day), DMH believes this is an appropriate function to be handled by the AHL. This is further reinforced by the fact that some of the current users of this Lifeline Network are known to the DMH system. DMH submitted its application for center status in November 2008. The application has been approved by the Substance Abuse and Mental Health Services Administration. The initial agreement for this service has been received and is currently being reviewed by DMH's legal department. Once the agreement has been approved and executed by the parties, DMH will have provisional certification for up to two years to provide these services. DMH intends to obtain full accreditation from the American Association of Suicidology which accredits suicide prevention hotlines.

Overall, the AHL remains committed to carrying out the multiple functions that are part of its front door and care coordination tasks. It has been hampered by an inadequate phone system (now fixed) and staff vacancies. Hopefully the next couple of months will see this team back at full capacity to carry out its critical role in the DMH system.

3. Capacity and Utilization of Mobile Teams

The DMH is at the end of a 90-day transition period for the delivery of adult mobile crisis services. As of November 1, 2008 the new mobile crisis team at CPEP was operational – providing mobile response capacity 16 hours/day and 365 days/year. The hours are 9AM-1PM. This 19-member team will provide a range of crisis stabilization services onsite – including not only initial visits but also follow-up contacts, dispensing of medications, assessment for voluntary and involuntary hospitalizations and any linkage to other needed services.

For children, youth and families, the system is likewise in transition. As of October 28, 2008, the new Child and Adolescent Mobile Psychiatric Service (ChAMPS) began operating by Catholics Charities under contract with DMH. This 12-member team has a very similar philosophy to the adult CPEP model. The goal is to provide onsite crisis stabilization via rapid response (within one hour of call), but also to provide whatever follow-up visits are needed to stabilize the family situation and/or connect the family to needed support services. This team will have staff physically present from 7:30AM to 10PM but will also be available on-call after 10PM for emergencies. Catholic Charities has the availability of crisis/respite beds as needed for children/youth via Sasha Bruce, St. Anne's or specialized foster homes. One of the goals of this new team is to reduce the percentage of children who end up in emergency rooms or in inpatient care (voluntary and involuntary). In order to find out if this goal is being met, the Court Monitor and DMH have agreed that DMH staff,together with ChAMPS, will collect key performance data to measure against baseline data.

As part of this expanded mobile service, DMH has developed a new set of protocols with MPD which it has memorialized in an inter-agency memorandum of understanding (MOU). This MOU clarifies that, when MPD encounters an individual (adult or child) for whom a mental health intervention is needed the MPD will contact the appropriate mobile teams for onsite response. In like kind, if mental health mobile teams are the first responders, MPD will provide backup assistance as requested to secure a location if potential weapons are observed or provide transportation to CPEP for adults or Children's National Medical Center for children when needed. The ready availability of these mobile teams will hopefully provide crisis stabilization in the home as opposed to the current model of bringing most individuals directly to CPEP or CNMC.

For FY08, the adult mobile services were provided as a part of the overall duties of the Homeless Outreach Team (HOT). DMH data indicate a significant increase in adult mobile services for FY08 – with 787 face-to-face contacts by HOT and an additional 90 by the Mobile Urgent Stabilization Team (MUST). This represents an average of 73 mobile visits per month – as compared to 35/month for FY07 and 32/month for FY06. The number of FD 12's also rose from 9/month in FY07 to 11/month in FY08. It is evident that the HOT has performed a very valuable mobile service during this interim three-year period. However, it continues to be clear that the multiple demands on the HOT do not allow the team to focus exclusively on outreach to homeless consumers. In order to enable the HOT to better perform its central duty, it is important that the new mobile teams continue to focus on crisis and emergency response.

For children and youth, mobile crisis for FY08 was provided exclusively by the MUST team. The average number of children/youth served per month was 9 – which is consistent with the FY07 averages of 8/month but well below the 20/month average of FY06. The FY08 data continue to show a large number of inpatient hospitalizations (33). As noted above, one of the goals of the new ChAMPS team is to reduce inpatient stays through enhanced home-based services.

The Court Monitor is very encouraged with the reality of new and dedicated mobile teams for both adults and children/youth. While it will inevitably take some time for these teams to come up to full potential, it is clear that the philosophy and commitment of these teams tracks the DMH Crisis/Emergency Services Plan of 2007 and also the intent of the Court-Ordered Plan. It will be interesting to see how these new services reshape current practice protocols (e.g., MPD) and key performance measures (e.g., use of inpatient care for children and youth).

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

CPEP has continued as the adult program to provide site-based services. The overall volume of persons seen has continued to creep upward, averaging nearly 10/day for FY08 as compared to 9.5/day for FY07 and 9/day for FY06. The percentage of persons evaluated at CPEP and subsequently admitted to an inpatient unit was 35%, which is very consistent with FY07 (35.2%) and FY06 (34%). The number of admissions from CPEP to SEH continues to drop slightly; FY07 CPEP direct admissions to SEH were 30.4/month compared to 31.8 for FY07 to 40.4 for FY06. CPEP continues to make consistent use of the 15 crisis residential beds, averaging 11 per month – as compared to 14 month for FY07. Indications are that the collaboration between CPEP and the crisis residential providers continues to be strong. A notable statistic for FY08 is that 259 individuals seen at CPEP were subsequently referred to substance abuse programs – almost always to an APRA detoxification program.

CPEP has continued to provide some overnight observation service through its limited extended observation beds. Even in cramped space, CPEP has had 815 consumers in FY08 who stayed at CPEP longer than 23 hours. This represents fully 22.5% of all persons seen. This number has grown significantly from 563 in FY07; it points to the continued need for dedicated extended observation beds.

After many years of false starts regarding adequate space for CPEP, it is very noteworthy that the entire CPEP has now been renovated and occupied as of December 18, 2008. The old building was essentially gutted during two phases of rehabilitation. The functional and visual impact of the new space (as compared to the old) is dramatic. The space is well-designed with inviting colors, art work, and distinctly functional areas. The new space provides eight extended observation beds – which were staffed and will be operational as of February 17, 2009.

The Court Monitor is very pleased to see the new CPEP space including dedicated space for extended observation beds, visiting families and professional staff. The full functioning of the mobile crisis team also represents a major step forward in the overall development of a comprehensive crisis/emergency system. DMH should be commended for its perseverance and commitment on both of these major FY08 accomplishments.

The DMH continues to utilize the Children's National Medical Center (CNMC) to provide site-based services. The DMH is getting daily data regarding admissions, but is working with CNMC as well as Psychiatric Institute of Washington (PIW) to develop a more comprehensive data set. Both institutions will be required to report on these data on a monthly basis. The goal is to have the protocol developed and in use by the first quarter of calendar year '09. This has been a long-standing gap at DMH in terms of collecting, analyzing and trending this data. Now that the child and youth

mobile teams are in place, it will be even more critical to monitor and evaluate the overall use of emergency services.

5. Development and Utilization of Crisis Residential Beds

DMH continues to contract for 15 crisis residential beds (Crossing Place has 8 beds and Jordan House has 7). Jordan House for FY08 had an average utilization rate of 80% while Crossing Place was at 65%. The two main sources of referrals to crisis beds are CSA's (50% of total) and CPEP at 27%. This suggests a healthy working relationship with other CSA's and with CPEP. Average lengths of stay were at 6.5 days for Crossing Place and 8.5 for Jordan House.

The DMH conducted its third fidelity audit of the crisis providers in March, 2008. In general, DMH found that both programs continue to make practice changes to ensure that admissions are consistent with crisis bed admission criterion. There has also been continued work to improve treatment documentation and ensure continuity of care with both DMH providers and non-DMH providers – even when providers were difficult to engage. While there are some program differences between the two programs, both programs are functioning as true crisis residential providers, with limited provision of "step-down" services for persons leaving an inpatient unit. DMH again noted that there is a need to re-evaluate the system's need for not only crisis beds but also step-down beds. This has been a recurring theme for several years, but has not yet been accomplished.

B. Review of DMH Role as Provider

1. Planning for New/Consolidated Hospital

As of December 1, 2008, the overall construction of the new 292 bed hospital stands at 85%. The exterior finishes for the building are almost complete. The major work is currently on interior framing and build out. The current estimate for occupancy is early 2010. It is exciting for all to see the new hospital take shape. Regular tours for staff and patients are being conducted.

The RMB phase one project continues. Phase one ($13.2 million) involves the separation of the energy source for the new hospital from the existing campus buildings. The projected completion date for phase one is now fall of 2009. As noted in the January, 2008 Report to the Court, the 2009 DMH capital budget will provide for the design phase of the RMB building only – which could provide up to 100 beds beyond the 292 in the new hospital. The DMH will request approximately $3M in the FY '10 budget to do basic rehabilitation work on RMB. It has been decided not to proceed with any design or rehab of CT 7 and 8. The ongoing planning and budgeting question is what the census of SEH will be by the time of

occupancy (see III B 2 and III B 4 for discussion of hospital census). Given current assumptions, an additional 100 beds should be adequate to meet demand.

2. Quality of Care Issues at SEH

The May 2007 DOJ Settlement Agreement is the primary framework by which to measure progress on quality of care issues at SEH. Consultants for DOJ conducted their second site visit to SEH on September 22-26, 2008. In its December 18, 2008 letter and Report to the District, DOJ has continued to highlight priority concerns in four major areas:

- Protection from Harm and Risk Management - There is great concern by DOJ over the lack of progress in this critical area. Specifically highlighted are:

  1) There is a critical need to develop and implement a mortality review system that ensures timely and complete reports with specific recommendations and documented actions.
  2) Revise the patient incident database so as to identify repeat aggressors and victims–with the expectation that treatment teams will review this data and develop needed treatment responses.
  3) Ensure that staff are trained and monitored to report all abuse and neglect with disciplinary action to occur when this does not happen.

- Nursing Care – The Report commends SEH for the positive improvements noted in filling nursing positions. However, there is considerable work to be done to ensure that "quality and competent nursing care" is delivered. Priority recommendations include the need for increased competency training for all nursing staff–including specific training regarding medication administration and potential errors and the role of nursing interventions with specific high-risk patients who have co-morbid health conditions, e.g., patients prone to choking, incontinence, MRSA infections.

- Treatment Planning and Psychiatric Care – The Report identified a number of priority recommendations in this area – with recognition that there has been good progress in hiring psychiatrists and licensed clinical psychologists. As with nursing, the thrust is to ensure that these professionals are performing as required under the settlement agreement. There is a specific need to ensure that psychiatrist assessments for new patients are done in a timely way–including adequate risk assessments for specific behaviors, e.g., suicide, physical aggression, self-injury, etc. There is also a need for corrective actions to ensure that patients receiving higher-risk medications are carefully monitored and that any

medication errors are captured and analyzed–with necessary corrective action taken.

- Behavioral Management and Psychological Care – Priority recommendations in this area include the need for SEH to modify its progress note template for all treatment mall programs to show specific objectives as well as progress. There is also a continued priority to develop and implement discipline-specific audits for the assessments that are conducted.

Overall, the latest Report shows that SEH has not reached compliance on any of the sub provisions of the settlement agreement that were to be completed by June, 2008. The Report, however, does recognize the "enormity of the task" and "the broad process and infrastructure changes that must occur for lasting substantive change." The report gives credit for substantive efforts in hiring staff, creating policies and hiring consultants to assist in training and implementation. However, the challenge for the next three-six months is to turn all of this work into substantive and discernible changes toward improving the quality of care.

The DOJ consultants will conduct their third visit in the spring of 2009.

This report will also summarize progress and barriers on those key areas that have been discussed in prior reports to the Court.

1) Human Resources (HR)

Hospital leadership continues to point positively to the DMH decision to delegate HR authority to the Hospital. They believe that this continues to allow vacant positions to be filled more quickly. The data support the fact that SEH has had continued success in filling vacant positions. From April 16, 2008 through November 12, 2008, (approximately seven months) SEH has hired 132 individuals, of which 115 were clinical positions. Throughout this period, the official vacancy rates averaged around 11% - which is about 110 positions at any given point in time out of a workforce of 1001 total positions. There appears to be a downward trend in the vacancy rate since October, 2008, which may reflect the end of the departure of staff who have taken the retirement incentive (a total of 47 since April, 2008). The most recent period (12/11/08-12/19/08) shows an overall vacancy rate of 8.34% and the net vacancy rate at 5.86% (vacancies minus committed positions). Overall, there has been a net gain of 28 positions since April, 2008, all of which are in the clinical area. This compares favorably to the net gain of only four for

the period of October, 2007 to April, 2008. Particularly encouraging is the net gain since April of 47 nursing positions.

SEH has also recently filled the vacant Medical Director position with a very experienced Psychiatrist Administrator. The leadership from this position is obviously key to many of the changes that are needed to ensure consistency and quality medical and psychiatric care per the DOJ settlement. SEH has also filled a new position for Chief Administrative Officer as of December 8, 2008. This person will add administrative capacity with particular early attention to managing SEH's budgetary issues (see budget discussion for SEH in III C).

2) Contracts and Procurement

It is difficult to assess progress in this area due to the fact there have been far fewer contracts recently than at the time of the July, 2008 Report to the Court. Indications are, in general, that contracts and procurement are moving more smoothly. The other major issue (as discussed in III C) is that all SEH contracts are being prioritized in light of the severe budget shortage. It does not appear there has been any further work on creating service level agreements between DMH and SEH that would establish different protocols dependent upon the dollar value of the contract.

3) Information Technology

Phase I of the new hospital information system (AVATAR) did "go live" as planned on July 22, 2008. Phase I is the practice management module which includes all data for admissions, discharges and billing, plus laboratory and pharmacy orders. There was an eight week training period for all staff that needed to be trained on all three systems. While the technical aspects of the conversion went largely as planned, there have been several early-on implementation snags. Among the most frustrating for SEH has been the staffing and accountability of the Help Desk. The split accountability for Help Desk staff between SEH and the Authority added to the learning curve for front-line staff. There was also a need to add second-shift Help Desk capacity. These issues have subsequently been resolved and overall AVATAR Phase I seems to be moving apace. Other critical issues involved medication ordering and administration, which resulted in use of a paper back up system. These issues

are being systematically addressed using a process on issue identification and prioritization.

The Hospital continues to run a separate database until AVATAR is fully implemented. This database attempts to include basic demographic information, diagnosis, medications, risk assessments, and co-occurring disorder assessments. This database has severe limitations in that it is dependent on the manual entering of data and there is no capacity to review the quality of data input short of a chart review. Nevertheless, it does give the hospital some ability to trend data on key demographic and clinical areas.

Phase 2 of AVATAR is the clinical workstation module, which will include patient assessments, treatment planning and care notes. Phase 2 will establish an electronic medical record for all patients and will hopefully eliminate the need for SEH to maintain a separate clinical and demographic database. It appears likely that Phase 2 will be implemented in distinct phases over a six to nine month period.

4) Training

SEH has recently been successful in recruiting a Training Director who began in early January, 2009. The issue of training of staff has been a major one for DOJ. SEH has contracted with an outside group to provide Person-Centered Treatment Planning throughout the Hospital. There were initial delays in starting this training due to contract delays. However, the current status shows five units as having completed this training, five more to start in January, 2009 and all 20 units to be trained by March, 2009. This training package has been well-received by staff. The Hospital is also piloting a targeted behavioral management model in its intensive behavioral unit to determine its efficacy before expanding to other units or specific patients.

5) Quality Improvement

The Hospital continues to produce an integrated management report on a periodic basis. This report includes a variety of information including patient census trends, demographics, clinical profiles, treatment mall participation, medication errors, etc. This report is intended to provide senior management a single report in which to analyze trends, target problem areas and prioritize actionable strategies. This

report is still limited in that data inputted prior to AVATAR (July 22, 2008) was largely manual and hence is not fully reliable.

SEH has successfully filled its Performance Improvement Director position as of January, 2009. The first set of priorities for this position will be to track the multiple quality improvement recommendations that came from the DOJ Report.

Overall, it appears that some of the basic infrastructure elements are now in place, i.e., a workable information system and key leadership. It is also evident that concerted and tangible quality improvement needs to happen in key treatment areas before the time of the next DOJ visit in the spring of 2009.

6) Discharge Planning

The whole area of discharge planning from SEH has been targeted as a part of the Integrated Care Division (as discussed in III B4). Indications from SEH leadership is that this initiative has been well-received by staff at SEH. The Hospital continues to maintain a "barriers to discharge" list and an overall tally of patients determined to be ready to leave. These numbers tend to average in the mid-50's, but will likely grow with the broader focus of the Integrated Care Division.

3. Review of Progress in use of Local Hospitals for Acute Inpatient Care

The progress on the acute care front is that Providence Hospital is now providing acute services for DMH under a negotiated agreement. This arrangement for up to 10 beds began in August, 2008, although the current utilization is only for six beds due primarily to limited psychiatric time. The other positive development in terms of bed capacity, is that United Medical Center (UMC) (the former Greater Southeast Community Hospital) is intending to expand by 10 additional acute beds in January, 2009. There is also discussion that UMC might grow by an additional eight beds in the not too distant future. Hence the January 2009 total available acute bed capacity (not counting PIW) should be 36. There are early indications that the additional acute beds are having a positive impact in terms of reduced numbers of admissions to SEH – which is now handling approximately 1/3rd of total acute inpatient admissions. This compares very favorably to several years ago when acute admissions to SEH were 1/2 to 2/3rds of total admissions. Clearly progress is being made.

Despite these gains, it is clear there is still considerable room for

additional progress. An analysis of the last 3 months of FY08 shows that there is an average of 43 admissions to SEH per month. This includes both direct acute admissions (34 average/month) and persons admitted to SEH after 14 days in an acute unit (9 average/month). DMH tracks and categorizes those admissions for which SEH is the only real option. For the last quarter of FY08, the average number of persons for which SEH was the only option was 18/month. Hence there are still an average of at least 25 admissions/month that could and should be handled in local acute hospitals.

The same concerns regarding acute care still remain. SEH is not intended under the Court-Ordered Plan to be a primary acute care facility. Providing unnecessary acute care beds at SEH adds to the staffing and budgeting concerns at SEH (see III C). It is also clear that acute care stays in the community are much shorter and more likely to keep consumers integrated into existing housing, families and other community support systems. The Court Monitor is hopeful that the next six months will see the full reality of adequate community acute beds. The Court Monitor believes that now is the time for DMH to begin to set clear performance targets for community acute admissions versus SEH.

4. Development and Implementation of the Integrated Care Initiative

In the fall of 2008, DMH created a separate unit at the Authority to focus exclusively on individuals at SEH who are in need of intensive care management. The Integrated Care Division builds on the earlier discharge planning efforts implemented in 2005. The Integrated Care Division, however, is more comprehensive and outcome-specific in its focus. The focus of the Integrated Care Division's efforts toward the population at SEH includes: a) consumers who are discharge ready but are reluctant to leave and/or have complex needs; b) consumers who are discharge ready and have been at SEH six months or more; and c) consumers who have been admitted to an inpatient setting three (3) or more times in the past 12 months. The overall goal is to reduce the census at SEH by both avoiding admissions and re-admissions to SEH and facilitating discharge for the targeted populations to appropriate community services.

This small team of five staff has been hired and have developed specific protocols and timelines for implementing the discharge planning and care management process. There is a clear sense of urgency given the census, length of stay, recidivism rates and budget concerns at SEH. One of the specific high priority projects–the Integrated Community Care Project–will provide intensive wraparound services and support to consumers in SEH who were previously discharged but unable to maintain their community tenure. Thirty people will be served through a contract with a community provider. Responses to the Request for Proposal (RFP) have been received and evaluated. The goal is for this project to be under way by April 1, 2009. Beyond these 30, the goal is to assist in the expedited discharge of 150

consumers from the targeted populations. This unit will monitor discharged persons for up to two years to ensure that community placements are working effectively. It is anticipated that this unit will carry a "caseload" of approximately 300 consumers. It is important to note the intensity of services provided to individual consumers will depend upon their unique needs. It is also anticipated that this unit will be actively involved in the needed assessment of SEH consumers who should be referred to community-based ACT teams. This has been an area of ongoing concern by the Court Monitor. The Division of Integrated Care has already begun this process which includes actively reviewing individual cases, and working closely with the CSAs assigned to those cases to make placement decisions. Since October 1, 2008, 14 consumers have been placed in ACT through this effort.

The Court Monitor is very pleased with the development and beginning implementation of the Division of Integrated Care. It brings together several critical strands within DMH and can be viewed as the unit whose job it is to actively monitor the system's performance for probably those at greatest risk for inpatient stays and hence need the highest levels of community support and attention. The Court Monitor views this new initiative as exceedingly positive in terms of potential impact on the issues underlying the Dixon case.

C. Review of FY 2009 Budget

The major issue for the FY09 DMH budget is the mandatory mid-year budget cuts for DMH (along with all other agencies). Two separate budget reductions since October, 2008 have totaled $3.349 million in reductions to DMH's total approved budget of $231.8 million. These mandatory cuts were apportioned to all District agencies due to real and projected revenue short falls. DMH has absorbed these cuts in a combination of ways. The largest reductions are in local match for MHRS services ($1.4 million), eliminations of the Franklin Shelter contract due to its closure ($425,000); reduction in Hospital acute care contracts due to delays in new beds at United Medical Center ($466,000); and contract reductions or delays in filling positions at child/youth and adult mobile crisis teams ($500,000). The DMH indicates that the $1.4 million in local match should not negatively impact its ability to provide MHRS services at the FY08 level. However, the larger question is what this reduction will do to DMH's ability to manage the FY09 closure of the DC CSA (see IV A for discussion of this issue).

The other major FY09 budget concern is at SEH. The DMH and SEH leadership are working through two large areas of budget shortfall for FY '09. The first is contracts – some of which were added in FY '08 but were not funded as part of the base budget for FY '09. The plan is to prioritize all contracts and temporarily fund those that are high priority and then look to reduce or de-obligate those that are not critical. The other major issue is staff overtime. The Hospital spent $6.3 million in overtime in FY '08 but was

budgeted for $1.9 million in FY '09. The question is what is a realistic target that would support critical clinical and support services. Managing overtime is a major current task with five major strategies to get overtime under control. It is too early to know the impact of all the budgeting efforts, but it appears that the Authority and SEH leadership are working very collaboratively. It is also clear there is no new money to solve the problem so SEH budgeted dollars ($97 million) will need to be maximized.

The unknown and looming question is whether there will be any additional FY'09 cuts and what the FY'10 budget situation will be. The District will be doing its next revenue estimate in January 2009. These estimates will have major impact on the construction and approval of 2010 budgets. As a proactive step, DMH has put together an internal team to look at any and all opportunities to further reduce expenses without negatively impacting its core mission and/or finding new revenue sources. Potential impact on reductions will be evaluated as either short-term (1 month), mid-range (1-4 months) or longer-term (4-12 months). The Court Monitor sees this step as highly prudent given the current volatility of the economy and the very real potential for further erosion in revenue streams. The Court Monitor will closely monitor the budget situation, including the development of FY'10 budget for DMH. There are major Dixon issues that are directly dependent upon adequate District budgetary support.

IV. Follow-up on Recommendations from Previous Court Reports

A. Planning for DC CSA

The DMH and the Mayor have submitted to the District Council the required Implementation Plan for the DC CSA. This plan (entitled Implementation Plan for the Transition and Closure of the District of Columbia Community Services Agency) was required by the 2008 Budget Support Act.

The Implementation Plan builds on the recommendations for a new governance structure that were included in the October 1, 2008, Report to the Council. The essence of the October 1, 2008 Report was that the District should:

1. Restructure the existing public mental health system by establishing designated comprehensive service providers.
2. Bring the full authority for free standing mental health clinics (FSMHC's) under DMH.
3. Phase out all services currently provided by the DC CSA in an orderly and consumer-friendly manner.
4. Continue direct government provisions of unique services that are not available via the contracted provider network (e.g., pharmacy, outpatient competency restoration and the

psychiatry residency outpatient program). The Court Monitor in his October 17, 2008 Supplemental Report to the Court supported these basic governance and service delivery recommendations.

The major questions for the implementation phase revolve around how much and how fast these recommendations can be accomplished. It is clear that the overall redesign of the public mental health system is a multi-year project. DMH has actively begun the planning process but the redesign of the system will not be in place before the necessary transitioning and closure of the DC CSA. A major issue for DMH is the assessment of the private provider's capacity to gear up services for the 4,174 consumers who are currently active with the DC CSA. (3,696 adults and 478 children/youth). DMH recently issued a Request for Information (RFI) to its providers about their current capacity and what type and level of assistance providers would need to build additional capacity. Twenty-four providers responded to the RFI. The anticipated responses were the need for transitional start-up funds and additional office space. The RFIs also highlighted significant limitations in being able to provide multi-cultural services and much difficulty in providing sufficient psychiatric services.

DMH also did a detailed analysis of the fiscal impact of different transition scenarios. The DMH-recommended timeline of a 12-month phase-out (March 2009 – March 2010) would require a total of $6.5 million in one time costs. These costs would be spread over FY '09 and FY '10. The one time costs are estimated at $2.7 million for start up costs to build capacity and $3.8 million to provide severance and terminal leave for DC CSA employers. These costs could be supported primarily through savings in the declining workforce at the DC CSA.

The major elements of the Implementation Plan are as follows:

1) The DMH would transition over 4,000 DC CSA consumers over a 12-month period starting in March, 2009 – with 2,500 persons to be transitioned by September 30, 2009 and an additional 850 to be transitioned by March 31, 2010. The remaining 650 (approximate) individuals would be served via on-going DMH-run specialty services out of the Authority. These would include pharmacy, psycho-educational program and therapeutic nursery, outpatient restoration program, resident's clinic, multi-cultural services, and services to the deaf who are mentally ill.

2) DMH would work proactively with individual consumers to select a new CSA. As a way of strengthening consumer choice and providing start-up funds, DMH is proposing a voucher system. Once selected by a consumer, each provider

would receive approximately $758 per individual to help cover transition and start-up costs.

3) DMH would retain current psychiatrists in the form of a psychiatric practice group. DMH would work out methods for individual CSA's to purchase needed psychiatric time from this group.

4) DMH has developed a set of written protocols regarding the transfer process–including consumer choice, enrollment, transfer of records, and needed authorizations. DMH also plans to put in place a consumer transition team to reach out to higher-risk consumers to help make the transition successful. This team will work closely with the DC CSA and private providers to provide necessary extra support to ensure a successful transition for all consumers and families.

5) The DMH will carefully monitor the performance and productivity of DC CSA staff during the transition to ensure that both quantity and quality standards are met.

6) DMH will plan for a reduction in force (RIF) in July 2009 for those DC CSA employees no longer needed. DMH has established a job assistance program to assist in the placement of employees into jobs inside or outside of government.

7) DMH is open to the possibility of a "legacy agency" that would presumably take on some portion of existing DC CSA consumers and employees. Any such new legacy agency or new program of an existing agency would have to operate within the overall framework of the transition plan, i.e., there would be no additional grants or start-up monies except as available under the Implementation Plan.

The Court Monitor is impressed with the overall scope and detail of the Implementation Plan. It would appear that all of the major elements necessary to be effective have been addressed. The voucher concept is innovative and strengthens consumer's choice while also providing needed start-up funds for providers. The major issue is how quickly all of this can occur. While there are legitimate arguments for moving more quickly, there are also two major constraining factors – resources available and private provider capacity. The operant assumption is that DMH will need to find the resources to do all of this from its own budget. This inevitably limits the resources that can be paid to private providers for start-up. The connected issue is how quickly

private providers can gear up to handle approximately 3,350 additional consumers. It strikes the Court Monitor that 12 months to accomplish this is not an unreasonable time period – given the inevitable unforeseen events and the magnitude and complexity of the task. It would be hoped that 12 months is an outside limit and that as the first 2,500 are placed, the remaining consumers can be placed more quickly so that the process can be finalized. However, a conservative planning cycle seems prudent at this point with the need for fine-tuning as experience dictates.

The Court Monitor understands the need for the Authority to play a role in providing specialized services after the closure of the DC CSA. However, the DMH should look for opportunities to contract out for these services where possible. For example, providing a psychiatric team may be necessary in the short-term, but can hopefully be phased out as private providers gear up their psychiatric capability. Each of the other specialized services should also be individually evaluated as to need and the potential for these services to be provided by other entities. The thrust of this is for the DMH Authority to increasingly focus its time and energies on Authority functions and decrease its time and energy on direct service provision.

The next several months will be key as the DMH moves toward a full implementation mode. The Court Monitor will continue to track progress closely.

B. Provider Payment and Service Authorization

The DMH has not closed out its FY '08 payments to providers. As with previous years, providers have 90 days after the close of the fiscal year (December 31, 2008) to have all claims submitted. DMH will then have 90 days to resolve any outstanding issues related to denials or rework before closing out the fiscal claims processing for FY '08.

As of the end of November, 2008, DMH shows unduplicated claims for all local providers of $42.7 million. This compares to a figure of $40.1 million for the same period last year and suggests that the final payout will be slightly higher than FY '07. The $5.1 gap between total claims submitted and approved claims ($37.5 million) are largely the result of duplicate billing or providers billing DMH at their full rate versus the approved Medicaid rate. Early projections are that the final payout for FY '08 MHRS claims for contracted providers (local only claims plus Medicaid supported) could be in excess of $37 million. This compares to the final payout for $35.4 million for FY '07. The percentages of payout of local dollars (versus maximum

allocation) are at 81% as of the end of November, 2008. This figure should increase with final claims to be processed.

The MAA transition continues to go well. DMH and the MAA (now renamed the Department of Health Care Finance (DHCF)) are continuing to meet regularly to resolve any and all issues. It appears that all of the unexpected issues that surfaced in FY '08 (as reported in the July 2008 Report to the Court) have been resolved. There are still some issues at the provider level, e.g., lack of rollup on same day services, which results in payment denials or delays. As an example of continued efficiencies in claims processing, DMH is showing that for FY '09, 98% of clean claims are being warranted for payment for non-Medicaid (Local), or pre-approved to forward to DHCF for final Medicaid adjudication within ten days. This compares to an 81.7% rate for FY '08. This report also shows that providers (on-average) are reducing the time it takes them to submit claims to DMH – from 56 days for FY '08 to 35 days thus far for FY '09. Despite notable progress in provider reimbursement some providers are still reporting significant delays in receiving payments. The source and reason behind payment delays appear to be varied, so it is important for DMH to maintain an active role in helping providers resolve these issues. Considering the impending closure of the DCCSA and the transfer of over 4,000 consumers to private providers, the viability of private providers is more important now than ever. Consequently, continued study and monitoring of provider capacity and related billing issues is needed.

C. Status of Cross-agency Review System for Placements for Children/Youth.

In the July, 2008 Report to the Court, the Court Monitor discussed the multiple cross-agency issues regarded residential placements for children and youth; the July report recommended that the process for establishing a clear structure needed to move to reality. While this has not yet happened, it does appear to be coming to a decision point. The DMH Director of Child/Youth services has been part of a special work group charged with reviewing this issue and making recommendations to the Subcommittee on Residential Placements (SRP), which is one of the standing subcommittees of the Mayor's Interagency Collaboration and Services Integration Commission (ICSIC). The work group will make a recommendation to the SRP on January 21, 2009, that a standing cross-agency team be appointed to review and approve all children/youth within the District of Columbia who are recommended for residential placement. This team would have full and final authority to make placement decisions and would be the cross-agency forum within which potential diversions into community-based alternatives would be considered. The cross-agency team would have standing membership from all of the child servicing agencies who currently place children/youth into residential treatment programs including DCPS, DYRS, DMH, CFSA and a representative of the MCO's.

There are multiple other issues that are also in play including: the accurate tracking of all children/youth in PRTF's or RTC's; determining readiness for discharge for the existing 473 in out-of-home placements; exploring cost models that would incentivize community alternatives; and growing the capacity of high-intensity wraparound services.

The Court Monitor is encouraged to see some movement on the placement issue and will explore all of these related concerns in detail in the July, 2009 Report to the Court.

D. Utilization of Independent Personnel Authority

The DMH engaged KPMG in July, 2008, to conduct a comprehensive review of all HR functions, policies and processes. The review was designed not only to look at what currently exists but to recommend what should be–including the development of a comprehensive HR manual that details all of the core elements of policy and process flow. KPMG has completed its work as of early January, 2009 and DMH leadership is in the process of reviewing this 700+ page report. All of the major HR functions have been included in separate chapters.

These include:

- Human Resources General Program Administration
- Recruitment, Retention and Selection
- Training and Special Programs
- Labor and Employee Relations
- Compensation, Benefits, and Retirement
- Information Systems and Record-Keeping

DMH officials–upon initial review–are very pleased with the work that has been done by KPMG. It will provide DMH with a clear template to establish a more stream-lined, consistent and less costly HR system. It is clear that one of the major transitions will be to move toward greater reliance on an electronic HR system versus the current model of part electronic and part paper. DMH officials indicate that the next step is to work out the details of how this new organizational and functional design will affect SEH HR functions. There is also the need to create a specific work plan for implementation. Estimates are that it will take all of calendar year 2009 to implement the multiple changes in policy and process flow. There will also need to be significant investment in staff training as new policies and processes are put in place.

The Court Monitor is very pleased with this comprehensive review of HR functions. The redesign is not fully dependent upon the DMH's having independent personnel authority – in that the proposed changes do not impact

overall District personnel rules. Rather it creates potency via the creation of consistent policy and process flow throughout all of the HR functions. It also enables DMH to be what was originally conceived – mainly to serve as a District model for having an efficient and effective HR system. The Court Monitor will continue to track progress as this implementation moves forward.

V. Recommendations

Based on the findings in this Report, the following priority recommendations are made:

1. The DMH should proceed to implement the multiple tasks outlined in the Implementation Plan. Necessary mid-course corrections will need to be made.

2. The DMH should proceed concurrently with the overall redesign of the public mental health system as soon as possible. To the degree possible, the Implementation Plan should reflect the principles of the redesigned system.

3. The DMH should develop specific targets for bed reduction at SEH. These targets should reflect both reduced acute admissions and accelerated discharges.