

DIXON SETTLEMENT AGREEMENT QUARTERLY REPORT – FY 2012 THIRD QUARTER

Pursuant to the terms of Paragraph 74 of the Settlement Agreement (“SA”), the District reports the following information:

I. Child and Youth Services

a. Community Services Reviews

- (1) Results of FY 2012 or FY2013 CSRs, as applicable (SA, ¶¶ 55 and 58).

The FY2012 Child/Youth CSR was completed during May of 2012. There were 89 children/youth reviewed, and almost 600 interviews conducted during the reviews. DMH worked closely with the Child and Family Services Agency, and the Court Monitor for the *LaShawn v. Gray* case, the Center for the Study of Social Policy, to jointly review the cases of children served by both systems. The joint reviews provided comprehensive information about children served by both systems, and will serve as a model for ongoing cooperation between the two agencies.

DMH achieved its FY 2012 goal of an overall system performance score of 65% for the FY2012 CSRs. We anticipate achieving a score of 70% system performance by the FY2013 reviews. We achieved a 71% score for consumer status, and a 67% score for consumer progress.

- (2) Status of Human Systems and Outcomes (“HSO”) consultation (SA, ¶¶ 56 and 57), including:

HSO participated in the FY2012 CSRs by conducting training for targeted providers; providing contracted reviewers; supplying case consultation services; and running the group debriefing sessions. HSO has been responsible for compiling and preparing all data from the CSRs, and has issued a final report on the FY2012 reviews. HSO has also been working to prepare DMH to assume oversight of the reviews after the FY2013 CSR.

The data from the FY2012 CSRs will be presented and discussed in detail with focus CSAs during October 2012. HSO, in consultation with DMH CSR unit, has developed trainings for work with targeted CSAs prior to the FY 2013 CSR. These trainings will focus on the weaknesses in clinical case formulation identified from the 2012 CSR data.

b. Psychiatric Residential Treatment Facilities (“PRTFs”) (SA, ¶ 59)

PRTF Total Bed Days Baseline Data¹		
Baseline Period: 05/01/11 –04/30/12		
Placing Agency	# Served with SED	Total # of Bed Days
Department of Youth Rehabilitation Services (DYRS)	155	37,999
Child and Family Services Agency (CFSA)	44	17,910
Department of Mental Health (DMH)	14	4,648
Office of the State Superintendent of Education (OSSE)	5	1,811
D.C. Public Schools (DCPS)	13	7,883
HSCSN	9	2,436
Total Bed Days Baseline Number	240	72,687

c. Reduction PRTF Usage(SA, ¶ 59)

PRTF Bed Days		
Comparison Period: 05/01/12 –04/30/13² (as of 6/30/12)		
Placing Agency	# Served with SED	Total # of Bed Days
Department of Youth Rehabilitation Services (DYRS)	61	13,165
Child and Family Services Agency (CFSA)	20	4,940
Department of Mental Health (DMH)	8	1,900
Office of the State Superintendent of Education (OSSE)	4	1,827
D.C. Public Schools (DCPS)	4	4,715
HSCSN	1	171
Total Bed Days (05/01/11 – 06/30/12)	98	26,718
Total Percentage Reduction from Baseline Number of Bed Days ([insert number])		

¹The District will report a running total of number of children served with SED in a PRTF and bed days until the baseline period is complete. The date of the reporting will also be included in the chart underneath the line describing the baseline period. An example of the language is as follows “Data reported below is as of 12/31/11.”

²The District will report a running total of number of children served with SED in a PRTF and bed days during the comparison period until it is complete. The date of the reporting will also be included in the chart underneath the line describing the baseline period. An example of the language is as follows “Data reported below is as of 12/31/11.”

d. PRTF Discharges and Community Services (SA, ¶ 60)

There were 40 youth discharged from PRTFs during the third quarter of FY 12. Seven (7) youth were discharged from PRTF and did not spend any time in the community because they went directly into non-community placements (hospitals and correctional and residential facilities) and remained for the duration of the 90-day period. There were 33 youth who were discharged and spent time in the community.

April 2012: There were 9 youth discharged after having appropriately completed treatment. These 9 youth entered the community upon discharge. Five (5) youth were discharged after refusing to comply with treatment.

May 2012: There were 10 youth discharged after having appropriately completed treatment. These 10 youth entered the community. Also, one youth was discharged after having reached maximum benefit and entered the community, and another youth was discharged after it was determined that the PRTF was unable to meet her clinical needs.

June 2012: There were 9 youth discharged after having appropriately completed treatment; all entered the community. One youth was discharged after refusing to comply with treatment and entered a non-community placement (an RTC); one youth was discharged after it was determined that the PRTF was unable to meet his clinical needs and entered a community placement; one youth had the PRTF review committee deny his LOC and went into a non-community placement (an RTC); and two youths were discharged against medical advice ((one youth was discharged due to a legal charge in Maryland (entered a non-community placement – a jail) and another youth signed himself out after turning 18 years-of-age (entered a community placement)).

Quarter	Total Number of C/Y Discharged	Avg. LOS (Length of Stay)	Reasons for Discharge	Community-Based Services After Discharge
1QFY12	(29) Discharged	365.15 days	(25) Approximately Completed Treatment (1) Abscondance (3) Discharged but went directly into non-community	Billed MHRS Services CBI Level II: CBI Level I – MST: Med/Som: Community Support: Diagnostic Assessment: Behavioral Health Screening Other Agency Self-Reported Non-MHRS Services Mentoring Academic Support

			placements (correctional facility or RTC)	Tutoring Job/Work Problem Workforce Development Substance Abuse Counseling
2QFY12	(21) Discharged	305.11 days	(18) Appropriately Completed Treatment (1) PRTF Review Committee denied the LOC (2) Refused to Comply with Treatment	Billed MHRS Services CBI Level II: CBI Level I – MST: Med/Som: Community Support: Diagnostic Assessment: Behavioral Health Screening Counseling Onsite Individual Crisis/Emergency Other: ³ Agency Self-Reported Non-MHRS Services Mentoring Academic Support Tutoring Workforce Development Substance Abuse Counseling Gang Prevention Individual Therapy (via Sasha Bruce) Intensive Third Party Monitoring Physical Activity Youth Parenting Class
3QFY12	(40) Discharged	292.38 days	(28) Appropriately Completed Treatment (1) PRTF Review Committee denied the LOC (6) Refused to Comply with Treatment (1) Reached Maximum Benefit	Billed MHRS Services CBI Level II: CBI Level I – MST: Med/Som: Community Support: Diagnostic Assessment: Counseling Onsite Individual Crisis/Emergency Other: ⁴ Agency Self-Reported Non-MHRS Services Mentoring Academic Support Tutoring Workforce Development Substance Abuse Outpatient Gang Prevention Individual Therapy (via Sasha Bruce)

³ The District will amend this report to reflect additional services as they are added to the service taxonomy.

⁴ The District will amend this report to reflect additional services as they are added to the service taxonomy.

			(2) PRTF Unable to Meet Clinical Need (2) Discharge Against Medical Advice	Intensive Third Party Monitoring Summer Youth Employment Parenting Class
4QFY12				
1QFY13				
2QFY13				
3QFY13				
4QFY13				

e. PRTF Discharges and Outcomes (SA, ¶ 60)

- (1) Narrative summary of outcomes for children/youth discharged from PRTFs during the most recent quarter and for the end of the fiscal year, if applicable.

The services youth received while in the community are listed above in Table d. and show both billed claims received for MHRS services, as well as non-MHRS services and support self-reported by agency staff to DMH. Youth received therapeutic and clinical services as well as academic and professional assistance. There were 6 disruptions. Four were incarceration disruptions and two were hospitalization disruptions. The four Incarceration disruptions were DYRS youth and occurred on days 69, 135, 136, and 137 after discharge from PRTF. The Hospitalization disruptions were one DMH and one CFSA youth, 24 and 119 days after discharge from PRTF respectively.

There were 75 youth in community tenure at one time or another during Q3: 26 youth from Q1, 19 youth from Q2, and 30 from Q3.

- (2) Length of Community Tenure – Community tenure for children/youth is calculated beginning with the date of discharge and continuing up to and including the 180th day after discharge. For purposes of this report, a disruption in community tenure occurs when the child/youth is: incarcerated/detained for 14 days or more; hospitalized (in a psychiatric hospital) for 22 days or more; or re-admitted to a PRTF.

Summary of Community Tenure Data	
Total Youth Monitored in the Community at the beginning of 3Q	42
Total Youth Discharged from a PRTF to the Community during FY 12 3Q	33
Total Youth Completing Community Tenure	26
Total Youth Removed from Community Tenure due to removal from community (re-enrolled in PRTF, incarceration, etc.)	2
Total Youth Being Monitored at the end of the Quarter	50
Total Youth Without Disruptions in Community Tenure during FY 12 3Q	69
Total Youth With Disruptions in Community Tenure	6
Total Possible Maximum Number of Days (Total # of Days Between Date of Discharge for Each Youth to Last Day of Reporting Period)⁵	7,539
Actual Number of Days in Community	6,867
% of Actual Days of Possible Days in Community	91%

Disruption in Community Tenure Data⁶							
Type of Disruption	Total Applicable	<30 Days	31-60 Days	61-90 Days	91-120 Days	121-150 Days	151-180 Days
Incarceration More than 14 Days	4			1		3	

⁵ DMH will report the total number of days that the children discharged during a quarter could have been in the community. This accounts for the different discharge dates from a PRTF. For example: 20 children are discharged during the first quarter of FY 12 (October 1 – December 31, 2011). A child is discharged on October 3, 2011. The maximum days in the community for that child would be 89 (28 days in October + 30 days in November + 31 days in December). Another child is discharged on December 25, 2011 the maximum days in the community for this child would be 6.

⁶ Data will be reported cumulatively and will identify each placement disruption throughout the course of the 180 day tracking period. For example, a child who is hospitalized during days 31 – 60 and hospitalized again during days 151 – 180 will be shown in both columns of the chart.

Hospitalization More than 22 Days	2	1			1		
Readmitted to PRTF	0						

f. Evidenced-Based and Promising Practices (SA, ¶ 61)

Annual Service Utilization					
Type of Service	FY 2011 Unduplicated Number of C/Y Served	FY 2012 Unduplicated Number of C/Y Served As of 6/30/12	FY 2011 - 2012 Percent Increase	FY 2013 Unduplicate d Number of C/Y Served	FY 2012 - 2013 Percent Increase
FFT	82	173			
MST	129	90			
HFW	211	257			

Service Utilization by Quarter				
Services	# Served 1Q	# Served 2Q	# Served 3Q	# Served 4Q
FFT	61	128	173	
MST	54	71	90	
HFW	156	231	257	
Total Served	271	430	520	

Although the number of children served with MST by the end of the third quarter is less than anticipated by the Settlement Agreement, it should be noted that although the population for both MST and FFT can be children with similar issues, there are different requirements for the home environment. MST serves children and youth up to age seventeen who display the most severe and chronic externalizing behaviors, and requires that the child or youth be in a stable home

setting with a long-term caregiver. FFT serves children and youth up to eighteen years old who display behaviors ranging from at-risk to severe with the requirement that the child is in a stable setting with a caregiver willing to participate in the treatment. Thus far more children and youth meet the criteria for FFT, and are therefore receiving FFT rather than MST services.

II. Supported Housing

a. Supported Housing Capacity (SA, ¶¶ 62, 63, and 64)

Supported Housing Capacity					
Program	Baseline Capacity (As of 09/30/11)	Capacity Quarter 1	Capacity Quarter 2	Capacity Quarter 3	Capacity Quarter 4
Home First Subsidy (HFS)	653	657	706	739 ⁷	
Local Rent Subsidy Program (LRSP)	93	93	93	93	
Shelter Plus Care (SPC)	159	159	159	159	
Federal Vouchers (Project- and Tenant-Based)	436	436	436	436	
Sub-Total	1,341	1,345	1,394	1,427	
Capital-Funded Units	55	35	28	28	
Grand Total	1,396	1,380	1,422	1,455	

⁷ This number includes eighty-nine (82) consumers who were issued subsidy awards in FY12-2Q and 3Q and were not leased up by the end of FY2012 3Q.

b. Supported Housing rules status (SA, ¶ 65)

Provide narrative of status of Supported Housing rules, including priority populations. Attach draft/final rules as applicable.

To ensure that the Housing Rules are in alignment with the Housing Plan, development of the Housing Rules will continue following completion of the Housing Plan.

The Housing Rules include language regarding priority populations where the Consumer is:

1. Pending discharge from Saint Elizabeths Hospital
2. In an emergency situation involving the health or safety of the consumer or the consumer's family
3. Moving from a more-restrictive living situation.

c. Enforcement of Supported Housing Rules (SA, ¶ 65)

- (1) Demonstrate that the Supported Housing rules are communicated to providers and that they are being enforced.

Once the Housing Rules have been finalized, they will be disseminated to the providers. DMH has monthly Housing Liaison and Clinical Director meetings where housing issues are discussed and information is exchanged. Additionally, DMH offers quarterly 'Housing 101' training through the DMH Training Institute for all CSA employees and housing stakeholders. There were fifty (50) attendees at the April 2012 Housing training session and fifteen (15) attendees at the July 2012 Housing training session. The next 'Housing 101' training session is scheduled for October 2012.

- (2) Demonstrate that available housing is assigned according to the priority populations in accordance with the Supported Housing rules. [Use table below in addition to any relevant narrative].

Consumers on the Housing Waiting List are candidates for housing opportunities as housing opportunities arise. Consumers in priority categories will be selected first for housing opportunities, followed by consumers on the Housing Waiting List, ordered by longest wait time to shortest wait time. Priority categories other than those listed above (b) are determined by the Director.

Priority Population Category	# Applied or Referred to SH	# Placed in SH 1Q	# Placed in SH 2Q	# Placed in SH 3Q	# Placed in SH 4Q
SEH Discharge	1	1	0	0	
Homeless w/SMI	145	12	14	33	
Consumer w/SMI Transfer to Less Restrictive Setting	1	6	2	4	
Other	39	1	1	6	
Total	186	20	17	43	

Housing opportunities, including Home First Program subsidies, are awarded first to consumers in priority categories. When the number of remaining housing opportunities exceeds the number of consumers in priority populations who are ready for independent living, consumers in other living situations such as Treatment Facilities, and residing temporarily with Family and Friends, will be offered a housing subsidy, beginning with those consumers with the longest tenure on the Housing Waiting List.

d. **Supported Housing Strategic Plan (SA, ¶ 66)**

Provide narrative of status of strategic plan, including efforts to consult with consumers and consumer advocates. Attach draft/final plan as applicable.

The completed DMH Supportive Housing Strategic Plan was finalized September 27, 2012. It is attached as Exhibit A, and is available for review at the following link:

<http://dmh1.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/Dixon%20Settlement%20Agreement%20Housing%20Plan%20September%202012.pdf>

III. Supported Employment Services

a. **Methodology to Assess Need (SA, ¶ 67)**

Provide narrative of status of the development of an objective methodology to assess the need for supported employment services. Describe how DMH is implementing this methodology and enforcing compliance.

DMH has revised its Supported Employment Policy (see Exhibit A, DMH Policy# 508.1A, Evidence Based Supported Employment Services, issued February 28, 2012) to require every CSA to assess all adult consumers with a Serious Mental Illness (SMI) or Axis II Personality Disorder for interest and eligibility in supported employment. If an interested person is eligible, the CSA is required to refer the individual to a Supported Employment Program. The CSA must complete an electronic performance event screen for each individual when completing the 180-day treatment plan (or more often when necessary) to confirm that consumers have been assessed, offered and referred for supported employment services authorization. DMH monitors the performance event screen data to insure that CSA's complete the process and offer the service. A centralized waitlist has been created at DMH for those individuals waiting for an available opening at a Supported Employment provider.

b. Assessment and Referral (SA, ¶¶ 67 and 68)

Assessment and Referral for Supported Employment Services ("SES")						
Measurement Period: April 1, 2012 through September 30, 2013						
	3QFY12	4QFY12	1QFY13	2QFY13	3QFY13	4QFY13
Total # w/SMI Assessed and Need SES	*					
Of those Assessed, Total # Referred to SES	*					
Percentage Referred to SES Services	*					

***The data for this category requires verification. The data is drawn from the performance event screen, as described above, but because it is essentially self-reported data from the CSAs, DMH has determined that it is necessary to compare the consumer files against the data to ensure accuracy. As a result, the actual data will not be available until December 31, 2012. DMH will keep the plaintiffs updated as needed.**

c. Service Delivery (SA, ¶ 69)

Delivery of Supported Employment Services					
	1QFY12	2QFY12	3QFY12	4QFY12	Total for FY 2012
Total Unduplicated Count of Adults with SMI who Received at Least One SES	369* Revised number due to re-calculation	194* Revised number due to re-calculation	100* Revised number due to re-calculation		
Percentage Increase Over FY 2012 Baseline [insert baseline]					

*These numbers are of individuals per quarter who did not receive services in the previous quarter.

Continuity of Care

d. Continuity of Care Delivery (SA, ¶¶ 70 and 71)

Continuity of Care – Adults					
	1QFY12	2QFY12	3QFY12	4QFY12	Total for FY 2012
Total Number of Adults Discharged	264	296	282		842
Number of Adults Receiving a Community Based Service within 7 days of Discharge	185	197	181		563
Percentage Receiving Service w/in 7 Days of Discharge	70.07 %	66.55%	64%	%	66.86%
Number of Adults Receiving a Community Service within 30 days of Discharge	205	231	204		640
Percentage Receiving Service w/in30 Days of Discharge	77.65 %	78.04%	73%	%	76 %

Continuity of Care – Children and Youth					
	1QFY12	2QFY12	3QFY12	4QFY12	Total for FY 2012
Total Number of C/Y Discharged	153	132	133		418
Number of C/Y Receiving a Community Based Service within 7 days of Discharge	89	81	68		238
Percentage Receiving Service w/in 7 Days of Discharge	58.17 %	61.36%	51.13%		56.94 %
Number of C/Y Receiving a Community Service within 30 days of Discharge	113	102	92		307
Percentage Receiving Service w/in 30 Days of Discharge	73.86 %	77.27%	69.17%		73.44 %

e. Performance Standards (SA, ¶ 73)

Continuity of Care outcome reporting continues. The Integrated Care Division (ICD) is working with the Office of Accountability (OA) to assist in monitoring and reinforcing the Continuity of Care requirements for the CSAs. ICD has also sent each Clinical Director the CSA-specific data on performance with requests for review and plans for improvement. This communication has highlighted the issue of consumers receiving non-crisis services from Medicaid providers who are not necessarily MHRS providers. DMH is currently working with DHCF to refine the data regarding these qualifying services and expects the quarterly percentages to improve. ICD continues to work to reconcile the CSA self report data with the data in eCura as self report data meets performance standards.

The language for amending the Human Care Agreements to include the Continuity of Care standards and requirements has been drafted; the DMH Contracting Office is working on adding the specific language to the Human Care Agreements.