IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

WILLIAM DIXON, et al. Plaintiffs, v. ANTHONY A. WILLIAMS, et al. Defendants.	Civil Action Number 74-285 (TFH) Next Scheduled Event: Status Hearing January 19, 2007 at 10:30am

STATUS REPORT OF DEFENDANTS
REGARDING COURT MONITOR RECOMMENDATIONS

Come now the defendants, by and though counsel, the Office of the Attorney General for the District of Columbia, responding to the Court's Order of August 2, 2006.

I. INTRODUCTION

The purpose of this status report is to provide the Court with the fifth monthly report on high priority issues, as recommended by the Court Monitor and ordered by the Court on August 2, 2006. This status report addresses the six (6) areas ordered by the court and one area requested by the Dixon plaintiffs' counsel. Specifically: (1) payments to providers; (2) planning for the Comprehensive Psychiatric Emergency Program ("CPEP"); (3) construction status of the new Saint Elizabeths Hospital building; (4) quality of care issues at Saint Elizabeths Hospital; (5) implementation status of KPMG recommendations; (6) status of utilizing acute care beds as alternatives to Saint Elizabeths Hospital; and (7) status of exit criteria validation.

II. PAYMENTS TO PROVIDERS

A. Payments to Providers for FY 05 Claims Pursuant to August 1, 2006 Consent Order (the "FY 05 Consent Order").

On August 7, 2006, DMH distributed MHRS Bulletin #5, Instructions for Obtaining Expedited Payment for FY 05 Claims to MHRS providers, which explained the process that providers must follow to obtain expedited payment for remaining FY 05 claims. As of December 18, 2006, DMH has received signed declarations regarding expedited payments from eighteen (18) providers that have been processed for payment. DMH has not received signed declarations from three (3) providers. A copy of a spreadsheet showing the status of payments under the FY 05 Payments Consent Order is attached and marked as Exhibit A.

B. Payments to Providers for FY 06 MHRS.

As of December 28, 2006, DMH has received MHRS claims in the amount of $43,310,153.00[1] for FY 2006 services. DMH has processed payments in the amount of $26,646,836.00. $6,946,399.00 in claims were denied[2] and $ 8,914,079.00 in claims were rejected and returned to the providers on exception reports. A copy of the provider position report dated December 28, 2006, which is an updated version of the report submitted to the Court during the status hearing on October 13, 2006, is attached and marked as Exhibit B.

[1] $34,396,074.00 in unduplicated claims. This means that approximately 6.0 million dollars of the total claims submitted are claims that have been corrected by the providers (that were originally rejected and returned on exception reports or denied) and resubmitted for payment. These are claims that are included in the total listed as either denied claims or claims that were returned to the providers on exception reports and never processed.

[2] DMH estimates that $1,809,449.00 of the denied claims will be eligible for payment after rework by DMH. The remainder of the denied claims are either valid denials or denials that must be reworked by the provider to qualify for payment.

Providers are required to submit all initial claims for services rendered during FY 06 to DMH by December 31, 2006. Providers were notified about the claims submission deadline via MHRS Bulletin # 3, effective July 31, 2006 and again via MHRS Bulletin # 17, effective December 1, 2006. Copies of MHRS Bulletin # 3 and MHRS Bulletin # 17 are attached and marked as Exhibit C.

C. Payments to Providers for FY 07 MHRS.

As of December 28, 2006, DMH has received MHRS claims in the amount of $2,496,306.00[3] for FY 2007 services. DMH has processed payments in the amount of $1,681,475.00. $439,229 in claims were denied[4] and $ 238,041.00 in claims were rejected and returned to the providers on exception reports. A copy of the provider position report for FY 07 payments, dated December 28, 2006, is attached and marked as Exhibit D. On or about December 22, 2006, DMH distributed a letter from the Acting Deputy Director of Finance and Administration regarding the status of FY 07 contract approvals and task orders. A copy of the letter is attached and marked as Exhibit E.

III. PLANNING FOR CPEP

As reported in the December 2006 report, the Council of the District of Columbia (the "Council") enacted the Comprehensive Psychiatric Emergency Program Long-Term Ground Lease Emergency Amendment Act of 2006, Bill No. B16-0984 on November 14,

[3] $2,258,264.00 in unduplicated claims. This means that approximately $240,000.00 of the total claims submitted are claims that have been corrected by the providers (that were originally rejected and returned on exception reports or denied) and resubmitted for payment. These are claims that are included in the total listed as either denied claims or claims that were returned to the providers on exception reports and never processed.

[4] DMH estimates that $309,434.00 of the denied claims will be eligible for payment after rework by DMH. The remainder of the denied claims are either valid denials or denials that must be reworked by the provider to qualify for payment.

2006. The legislation authorizes the District to negotiate the terms of a long-term ground lease with Greater Southeast Community Hospital ("GSCH") for a newly constructed building, built to the District's specifications, that would house CPEP. The Office of Property Management is working with the Office of Attorney General to negotiate the specific terms of the lease and construction of the CPEP building with the owners and mortgage holders of the Greater Southeast Community Hospital property.

IV. CONSTRUCTION OF THE NEW SAINT ELIZABETHS HOSPITAL BUILDING

As previously reported in the December 2006 status report, the Council of the District of Columbia approved the terms of the contract between DMH and Tompkins Builders, Incorporated ("Tompkins") for the construction of the new Saint Elizabeths Hospital building (the "Tompkins Contract") on November 14, 2006. DMH obtained all the necessary permits to commence construction. On November 17, 2006, DMH issued a notice to proceed to Tompkins. Tompkins began work on December 4, 2006. Construction activities include digging out the new sewage line, preparing the temporary parking lot for employees to use during construction, and actual moving of earth for the site work. Landscape crews are working to move various trees that will be in the building footprint.

The official groundbreaking ceremony was held on December 19, 2006 at 1:30 pm. The total time for construction is expected to be thirty-six (36) months, and includes demolition of the John Howard Pavilion, construction of the exercise yard and construction of the parking lot.

V. QUALITY OF CARE ISSUES AT SAINT ELIZABETHS HOSPITAL

Effective January 2, 2007, Dr. Patrick Canavan, Psy.D. was appointed as the chief executive officer of Saint Elizabeths Hospital. Dr. Canavan previously served as the Director of the District of Columbia Department of Consumer and Regulatory Affairs and as director of the District's Office of Neighborhood Services. He began his career in District government as a clinical administrator at Saint Elizabeths Hospital. Dr. Canavan is a licensed clinical psychologist and a qualified expert in forensic psychology. Dr. Canavan earned his Doctor of Psychology degree from the Illinois School of Professional Psychology, a Master of Education from the University of Delaware, and a Bachelor of Arts from Villanova University. He is a certified public manager, trained at The George Washington University, and he has also completed the Program for Senior Executives in State and Local Governments at Harvard University's John F. Kennedy School of Government.

A. Budgetary Issues.

DMH has developed a spending pressures report for the Office of the Chief Financial Officer identifying gaps in the FY 07 budget that will affect the Hospital's ability to address areas of concern identified in the Department of Justice report. On December 19, 2006, the Council of the District of Columbia enacted the Fiscal Year 2007 Operating Cash Reserve and Revised Revenue December Allocation Emergency Act of 2006, which included ten million one hundred fifty-five thousand dollars ($10,155,00.00), eight millions six hundred thousand dollars ($8,600,000.00) is for costs associated with meeting DOJ requirements for hiring additional staff, maintenance contracts and supplies for the

Hospital. The legislation also requires DMH to use one million five hundred thousand dollars ($1,500,000.) for strategic management evaluation (see discussion in section VI below regarding implementation of KPMG recommendations). A copy of the Fiscal Year 2007 Operating Cash Reserve and Revised Revenue December Allocation Emergency Act of 2006 is attached and marked as Exhibit F.

B. Quality of Care Issues.

Dr. Fields and two teams of surveyors visited the Hospital on December 4, 5 and 6, 2006. Dr. Fields is expected to issue his report on or about January 7, 2007. A copy of Dr. Fields' report will be provided to the Court and to the Court Monitor upon receipt.

C. Discharge Planning for Patients.

The plan for discharging patients to the community has been completed, pending a name for the plan[6]. A project manager will be appointed in January 2007.

D. Hospital Census.

The average census for the month of November 2006 was two hundred seven (207) patients on the civil units and two hundred six (206) patients on the forensic units. There were forty-five (45) admissions and thirty-six (36) discharges from the civil units. There were twenty-six (26) admissions and twenty-five (25) discharges from the forensic units.[7]

As of December 27, 2006, the average census for the month of December 2006 was two hundred seven (207) patients on the civil units and two hundred six (206) patients on the forensic units. There were twenty-nine (29) admissions and twenty-six (26) discharges

[6] The plan will be named by the Office of Consumer and Family Affairs.
[7] The number of admissions and discharges reported in this section of the report includes both voluntary and involuntary admissions to civil units as well as court-ordered admissions to the forensic units. The admissions reported in section VII of this report are only involuntary commitments to the civil units (a subset of the total reported in this section).

from the civil units. There were twenty-six (26) admissions and eighteen (18) discharges from the forensic units.

VI. IMPLEMENTATION OF KPMG RECOMMENDATIONS

As previously reported, DMH worked with representatives from the provider community, internal staff and an external consultant, to prioritize the recommendations contained in the KPMG report. DMH requested and has received a proposal from KPMG to assist DMH in several high priority, concrete tasks recommended in the KPMG report. DMH has been negotiating the terms of a contract with KPMG that will address four areas. Specifically: (1) project management of the MHRS operations for the next six to eight months; (2) assistance in and evaluation of DMH's recovery effort of the federal match dollars (70% federal financial participation) from Medicaid from MHRS claims paid by DMH over a 27-month period; (3) evaluation of the transition of the MHRS provider claims processing to the Medical Assistance Administration (the District's Medicaid agency); and (4) development of a Request for Proposals for an Administrative Services Organization to handle several functions (claims processing, consumer intake and authorizations, provider relations and some information technology functions). DMH has negotiated the terms of a contract with KPMG to perform the work identified in the proposal and expects to have the contract signed by January 15, 2007, with an immediate start date for the engagement. (See discussion in section V.B. above regarding funding for implementation of recommendations for organizational changes.)

VII. USE OF ACUTE CARE BEDS AS ALTERNATIVES TO SAINT ELIZABETHS

As previously reported, the renovated unit of twenty (20) beds on 4 West at GSCH began accepting involuntary patients in late September 2006.[8] The data collected by the Access Helpline for November 2006 shows that twenty-three (23) involuntary patients were sent to GSCH. As of December 15, 2006, nineteen (19) involuntary patients were sent to GSCH.

For the same periods, the data collected by Access HelpLine for November 2006, shows that forty-five (45) involuntary patients were sent to Saint Elizabeths Hospital in November 2006.[9] As of December 15, 2006, Access HelpLine's records showed that twenty (20) patients had been referred to Saint Elizabeths Hospital for involuntary hospitalization in December 2006.[10]

Recently, DMH entered into an agreement with Amerigroup, a managed care organization with experience in public mental health in the District and in several states, to provide utilization review of the involuntary inpatient admissions to GSCH. In addition to the utilization review of inpatient admissions, Amerigroup will also assess readmission

[8] There was an error in the October 2, 2006 report regarding the opening date of the renovated unit.

[9] According to the Access Helpline records, of the forty-five (45) patients sent to Saint Elizabeths Hospital, in the case of thirteen (13) admission, Saint Elizabeths Hospital was the only option for involuntary inpatient treatment because six (6) patients were committed outpatients; three (3) patients were involuntary transfer requests from inpatient medical/surgical units or a psychiatric unit in a community hospital; two (2) were voluntary admissions of uninsured consumers who presented to CPEP; and two (2) were transferred from GSCH after fourteen (14) days of inpatient treatment, because further inpatient treatment was required, in accordance with DMH's agreement with GSCH.

[10] According to the Access Helpline records, there was no other option for inpatient treatment for twelve (12) of the twenty (20) involuntary patients admitted to Saint Elizabeths Hospital. Three (3) were committed outpatients; five (5) were transfers from GSCH after fourteen (14) days of inpatient treatment; one (1) was an involuntary transfer request from an inpatient medical/surgical units or psychiatric unit in a community hospital; two (2) were involuntary inpatient requests from community emergency rooms; and one (1) patient was an AMA return to Saint Elizabeths Hospital.

patterns and follow consumers released from both GSCH and Saint Elizabeths Hospital to track continuity of care and appropriateness of community treatment.[11] DMH will provide a report on the work done by Amerigroup during December 2006 in an upcoming status report.

VIII. EXIT CRITERIA VALIDATION

In December 2003, the District and the plaintiffs reached agreement on nineteen (19) individual performance measures or exit criteria. Seventeen (17) of the nineteen (19) exit criteria are measurable criteria that require validation.[12]

Exit Criteria # 1 requires DMH to conduct consumer satisfaction surveys and to use the results of those surveys in program planning and quality improvement activities. During the summer of 2006, a group of consumers conducted a telephone survey of consumers, utilizing three survey instruments. The first instrument was the Mental Health Statistics improvement program ("MHSIP"), which is used for adults. The second instrument, which is used in tandem with the MHSIP is the Youth Services Survey for Families. The third survey instrument, is the Recovery Oriented System Indications ("ROSI"). The ROSI survey was conducted for the first time, with a subgroup of persons who respond to the MHSIP survey and includes more detailed responses regarding

[11] In addition to the work regarding the inpatient and aftercare provided to involuntarily committed patients, Amerigroup will be reviewing the services provided in the community by the four largest core services agencies: the District of Columbia Community Services Agency, Community Connections, Inc., Green Door and Anchor Mental Health. Amerigroup will review a random sample of thirty (30) records each month for a 4 month period. This review will focus on appropriateness of level of care; timely access; quality of care; and a determination whether services meet diagnostic need. Data from these reviews will be used to plan for the future. The thirty (30) consumers whose records are reviewed each month, will be randomly selected; over age 18; fee-for-service Medicaid or uninsured, but not a member of a DC Managed Care plan. The reviews will be conducted using medical record reviews.

[12] Exit Criterion #1, demonstrated use of Consumer Satisfaction methods, and Exit Criterion #2, demonstrated use of Measures of Consumer Functioning, are not measurable, although DMH is required to demonstrate that the information gathered from activities relating to both is used in improving and expanding services to mental health consumers.

recovery-oriented services within the DMH system. These three surveys are collectively referred to as the "Consumer Surveys." DMH expects to complete preparation of a report on the 2006 Consumer Surveys in January 2007. The report will be circulated among DMH staff, posted on the DMH website and made available to the public. It will be reviewed by the DMH Quality Council and the recommendations of the Quality Council will be used to inform planning and policy initiatives.

Exit Criteria #2 requires DMH to demonstrate use of consumer functioning methods as part of the DMH Quality Improvement System for community services. DMH has required the use of the LOCUS (Level of Care Utilization System for psychiatric and addiction services adult version) and CALOCUS (Child and Adolescent Level of Care Utilization System) for the initial and ongoing evaluation of consumer needs since April 2005 (DMH Policy 300.1). LOCUS and CALOCUS assessments are required to obtain pre-authorization of certain services, such as Assertive Community Treatment and Community-Based Intervention.

Exit Criteria # 3 and # 4 (community services reviews for adults and children, respectively) are measured by the community services reviews conducted by HSO, an organization under contract with the Court Monitor. The community services reviews for FY 2007 have been scheduled as follows:

January 30 – February 1, 2007	Training for Child/Youth Reviewers
March 19 – 31, 2007	Child/Youth Reviews
April 11- 13, 2007	Training for Adult Reviewers
April 16 – 17, 2007	Adult Reviews

DMH has been working to develop and implement data collection systems for the remaining fifteen (15) exit criteria. These data collection systems are also referred to as "performance metrics."

As reported in the Court Monitor's July 2006 report, DMH had completed the development of performance metrics for twelve (12) of the exit criteria. Specifically: (1) Exit Criteria # 5 - # 8 (penetration rates for services); (2) Exit Criterion # 9 (supported housing); (3) Exit Criterion # 10 (supported employment); (4) Exit Criterion # 12 (atypical medications); (5) Exit Criterion # 13 (homeless adults); (6) Exit Criterion # 14 (children/youth receiving services in a natural setting); (7) Exit Criterion # 15 (children/youth living in own or surrogate home receiving services); (8) Exit Criterion # 18 (community resources); and (9) Exit Criterion # 19 (utilization of Medicaid). Data was reported to the Court Monitor for the period April 1, 2005 through March 31, 2006 for twelve (12) metrics.

In November 2006, DMH met with stakeholders to review the data collection measures for Exit Criteria # 9, 10, 12, 13, 14 and 15. After considering the comments provided by stakeholders during the meeting regarding the data collection method established for Exit Criterion # 13 (homeless adults), DMH has elected to re-examine that data collection method in conjunction with the development of a data collection method for Exit Criterion # 16 (homeless children) to address the stakeholders comments. DMH expects to finalize the data collection method for Exit Criteria # 13 and 16 during the spring of 2007.

In addition, DMH determined that it could not replicate the data collection methods used to calculate the data reported for Exit Criteria # 18 and 19. As reported in the December report, the Dixon Court Monitor and DMH staff involved in claims met regarding the methodology for allocating certain over head and administrative expenses to be included in the data reported for Exit Criterion #18 (60% of the total DMH expenditures for one full fiscal year will be directed toward community – based services). The methodology introduced was Random Moment Sampling Technique ("RMST") and the District cost allocation methodology. The District cost allocation methodology is currently being worked out between the District's Office of the Chief Financial Officer and their consultants, Innovative Costing Solutions, LLC. Once the details have been decided, DMH staff will demonstrate how the two methodologies will work together to provide a consistent and repeatable process for allocating certain overhead and administrative costs for Exit Criterion # 18.

Accordingly, DMH has reported data to the Court Monitor for Exit Criteria # 5, 6, 7, 8, 9, 10, 12, 14 and 15 for inclusion in the January 2007 report. At the same time, DMH has been working to finalize the performance metrics for Exit Criterion # 11, Assertive Community Treatment and Exit Criterion # 17, Continuity of Care for Adults, Children and Youth. The performance metrics for Exit Criterion # 11 and Exit Criterion # 17 are expected to be completed shortly. DMH expects to begin reporting data to the Court Monitor on Exit Criterion # 11 and Exit Criteria # 17 in the first quarter of FY 2007 (October 1, 2006 – December 31, 2006). To the extent that reliable historical data is available, DMH will also provide that to the Court Monitor.

Respectfully submitted,

LINDA SINGER
Acting Attorney General for the District of Columbia

GEORGE VALENTINE
Deputy Attorney General, Civil Litigation Division

EDWARD TAPTICH
Section Chief, Equity II Section

_____/s/_____
DANIEL A. REZNECK
Senior Assistant Attorney General
D.C. Bar No. 31625
441 4TH Street, NW, Suite 600
Washington, D.C. 20002
(202) 724-5691
(202) 727-3625 (facsimile)
Email: daniel.rezneck@dc.gov