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Report to the Chairman, Committee on Government Reform, House of Representatives

March 2004

DISTRICT OF COLUMBIA

Status of Reforms to the District's Mental Health System

GAO-04-387

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GAO Accountability • Integrity • Reliability

Highlights

Highlights of GAO-04-387, a report to the Chairman, Committee on Government Reform, House of Representatives

Why GAO Did This Study

Since 1975, the District of Columbia has operated its mental health system under a series of court orders aimed at developing a community-based system of care for District residents with mental illnesses. Placed in receivership from 1997 to 2002, the District regained full control of its mental health system in 2002 but has been ordered to implement a court-approved plan for developing and implementing a community-based mental health system. Additionally, the District must comply with exit criteria, which must be met in order to end the lawsuit. The court expects that it will take the District 3 to 5 years to implement the court-ordered plan and begin measuring performance against the exit criteria, with year 1 beginning in July 2001.

GAO was asked to report on the current status of the District's efforts to develop and implement (1) a mental health department with the authority to oversee and deliver services, (2) a comprehensive enrollment and billing system that accesses available funds for federal programs such as Medicaid, (3) a consumer-centered approach to services, and (4) methods to measure the District's performance as required by the court's exit criteria.

www.gao.gov/cgi-bin/getrpt?GAO-04-387.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen at (202) 512-7118.

What GAO Found

The District created the Department of Mental Health (DMH) in 2001 to oversee the provision of mental health services. DMH methods of oversight have included establishing certification and making use of licensing standards for participating providers and beginning to monitor provider compliance. DMH also continues to deliver direct services, acting as the primary provider for 55 percent of all consumers enrolled in the mental health system as of October 2003, and operating over 500 beds at St. Elizabeths Hospital, the District-run institution specializing in inpatient care for people with acute, intermediate, and long-term mental health needs.

DMH has also implemented a comprehensive enrollment and billing system designed to coordinate clinical, administrative, and financial processes. The system links payment to consumer treatment and increases access to federal funds by providing mental health rehabilitative services through the District's Medicaid program, which reimbursed DMH $17.5 million in federal Medicaid funds in fiscal year 2003. Providers have faced challenges managing cash flow in a fee-for-service system where service demand varies throughout the year. Also, because provider contracts were tied to the fee-for-service billing projections, DMH could not pay claims for providers who were exceeding their projections until their contracts were changed, and providers did not always receive timely claims payments in fiscal year 2003. DMH senior officials noted that DMH has a plan in process to prevent this problem from recurring.

DMH activities to increase the involvement of consumers in their own treatment and recovery process are evolving. While DMH has established a number of requirements in two key areas—consumer choice and consumer protection—its initial review of providers' records showed gaps in documentation of consumer participation in treatment planning for 41 percent of the records reviewed. Consumer protection policies are also evolving, as DMH instituted a consumer grievance policy that provides a uniform process for ensuring that all consumer grievances are tracked.

DMH is developing data collection methods for 17 performance targets aimed at determining the system's performance against the court's exit criteria. Although the court monitor expects DMH to both measure and improve its performance in fiscal years 2004 and 2005, DMH faces major challenges in accurately measuring its performance, including establishing methods to collect electronic data, correcting known data deficiencies, and working with providers to submit accurate data.

In its comments on a draft of the report, DMH indicated that the report did not reflect the entire spectrum of progress made since the creation of DMH. While the progress cited by DMH is important, GAO believes that focusing on DMH's status in meeting the exit criteria is an appropriate gauge of its overall compliance with the Dixon Decree.

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Abbreviations

CSA	Core Services Agency
DMH	Department of Mental Health
FFS	fee-for-service
OCFA	Office of Consumer and Family Affairs
RTC	residential treatment center

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G A O
Accountability * Integrity * Reliability

United States General Accounting Office
Washington, DC 20548

March 31, 2004

The Honorable Tom Davis
Chairman
Committee on Government Reform
House of Representatives

Dear Mr. Chairman:

In 1997, the U.S. District Court for the District of Columbia found that the District had failed over the previous 22 years to comply with a 1975 court determination, known as the Dixon Decree,[1] that District residents with mental illnesses have a statutory right to community-based treatment under the least restrictive conditions when that treatment is clinically appropriate. Consequently, the court placed the District of Columbia Commission on Mental Health Services in receivership and appointed two successive receivers, one in 1997 and one in 2000. Both receivers were charged with implementing the transition from treating consumers in an institutional setting, specifically in the District-run St. Elizabeths Hospital, to delivering a broader array of mental health services—including counseling, supported employment, and housing—in the community. Both receivers introduced initiatives intended to enhance the District's community-based mental health system. In response to congressional concerns, we previously examined the second receiver's plan to comply with the Dixon Decree. In October 2000, we reported that compliance with the Dixon Decree would require a fundamental shift in the District's approach to providing and financing mental health operations, including (1) assuming the more traditional oversight responsibilities of a mental health department and (2) increasing access to federal funds for Medicaid, the joint federal-state program for low-income families and aged, blind, and disabled people, to expand the scope and number of covered community-based mental health services.[2] We also reported on challenges remaining to comply with the Dixon Decree.

[1]See *Dixon v. Weinberger*, 405 F. Supp. 974 (D.D.C. 1975).

[2]U.S. General Accounting Office, *District of Columbia: Receiver's Plan to Return Control of Mental Health Commission Is Evolving*, GAO-01-157 (Washington, D.C.: Oct. 30, 2000).

In 2002, the District regained full control of its mental health system from the second receiver. However, the District remains under court order to implement a plan and comply with exit criteria for ending the Dixon lawsuit including meeting specific performance targets. The final plan, which was completed by the second receiver in 2001, provides an overall framework for developing and implementing an effective and integrated community-based system of mental health care for the District of Columbia.[3] Within this framework, the District is responsible for establishing certain components, including a new department of mental health capable of overseeing and delivering mental health services and developing and implementing a comprehensive enrollment and billing system for community-based providers. The final plan also highlights the need for consumers of mental health services to be offered choices from providers about the services they receive. In December 2003, the court approved a set of exit criteria, which provides a basis to measure the District's performance in a number of areas, such as consumer satisfaction and system performance. One exit criterion, for example, requires the District to demonstrate that it is providing continuity of care for consumers moving from an inpatient to a community-based setting. Until the exit criteria are fulfilled, the Dixon lawsuit remains open. Overall, the court expects that it will take the District 3 to 5 years to implement the court-ordered plan and begin measuring its performance against the exit criteria, with year 1 beginning in July 2001.

In keeping with your oversight responsibilities with regard to the District of Columbia, you asked us to report on the status of the District's effort to establish a community-based system of mental health care, particularly the District's steps to develop and implement (1) a mental health department with the authority to oversee—through regulation and monitoring—and deliver mental health services, (2) a comprehensive enrollment and billing system that accesses available federal funds, (3) a consumer-centered approach to services, and (4) methods to measure the District's performance as required by the court's exit criteria.

To review the District's actions to implement the final plan, we analyzed court orders, including the final plan and exit criteria; policies; reports; and evaluations regarding the District's implementation of a community-based mental health care system. We interviewed the court monitor, who

[3]See *Dixon v. Williams*, C.A. No. 74-285 (D.D.C. March 28, 2001) (Final Court Ordered Plan).

was also the second of the two receivers and was charged with monitoring implementation of the final plan. Additionally, we interviewed District officials, consumer advocates, and providers. We reviewed available data on mental health programs and services in operation in the District for fiscal year 2003, including data on District residents with mental illnesses who are enrolled consumers of the mental health system. We corroborated data and information received from the District with available data and information from the court monitor, providers, and advocates. We performed our work from July 2003 through March 2004 in accordance with generally accepted government auditing standards.

Results in Brief

As the first step in implementing the final court-ordered plan to establish a community-based mental health system, in 2001 the District passed legislation that created the Department of Mental Health (DMH). As articulated by the final plan, DMH has taken on the responsibility of overseeing the provision of community-based services, including setting regulations and monitoring provider compliance with them. DMH has centralized oversight of mental health service providers under its authority, established certification standards and made use of licensing standards for participating providers and facilities, and is beginning to implement a monitoring framework to ensure that services are meeting quality and safety standards. In addition to its oversight of community-based providers, DMH continues the District's historic role as a significant provider of services, acting as the primary provider for 55 percent of all consumers enrolled in the mental health system as of October 2003, and operating over 500 beds at St. Elizabeths Hospital. While the number of occupied beds at St. Elizabeths Hospital has declined about 18 percent, from 628 in 2000 to 513 in 2003, the absence of additional community acute care beds, services, and supports has limited further reductions in the number of occupied beds at the hospital.

DMH has developed and implemented a comprehensive enrollment and billing system designed to coordinate clinical, administrative, and financial processes. Under this system, a Core Services Agency (CSA), which is a DMH-certified provider, enrolls eligible consumers in the District mental health system and develops treatment plans, provides and coordinates services, and bills DMH on a fee-for-service (FFS) basis. As stated in the final plan, this system has two key attributes. First, it links payment directly to treatment planning and services provided. Second, it increases access to certain community-based mental health services, with a significant share of the costs reimbursable by federal Medicaid funds for community-based mental health services. For fiscal year 2003, DMH

received $17.5 million in federal Medicaid funds, and DMH expects further growth in Medicaid revenue. In transitioning to FFS, however, providers have faced challenges managing cash flow in a system that no longer guarantees revenue regardless of performance. Additionally, because provider contracts were tied to the FFS billing projections, DMH could not pay claims in 2003 for providers who were delivering more services than had been projected until their contracts were changed. As a result, providers did not always receive claims payments on a timely basis in fiscal year 2003. By August 2003, DMH made the necessary contract changes to allow providers to be paid for the remainder of the fiscal year and, according to senior officials, had a plan in process for fiscal year 2004 to prevent this problem from recurring.

The District's new mental health system is taking steps to increase the involvement of consumers in their own treatment and recovery process through a number of provider requirements, such as having policies in place that (1) inform consumers of their right to choose providers and participate in their treatment planning and (2) establish protections for consumers. Although DMH has established requirements related to consumer choice, its initial review of provider records, completed in January 2003, showed gaps in documentation of consumer participation in treatment planning for 41 percent of the records reviewed. Consumer protection policies are also continuing to evolve, as DMH instituted a consumer grievance policy in October 2003 that provides a uniform process for ensuring that all consumer grievances are tracked.

To comply with the exit criteria that the District must meet prior to ending the Dixon lawsuit, the court monitor, in conjunction with DMH and others, developed methods of measuring compliance, which were approved by the court on December 11, 2003. These methods included two qualitative requirements relating to consumer satisfaction with services and consumer functioning, the latter of which assesses consumers' clinical, social, and other conditions. In addition, the court approved performance targets for 17 exit criteria measures relating to system performance. For example, DMH will be required to measure the percentage of DMH expenditures allocated to community-based services. DMH is in the initial stages of developing the capability to collect data to measure its performance against these exit criteria. While the court monitor expects DMH to both measure and improve its performance in fiscal years 2004 and 2005, DMH faces several challenges in collecting and verifying the accuracy of the performance data, such as establishing methods for electronically collecting the information, correcting known data deficiencies, and working with providers to submit accurate data.

In its comments on a draft of the report, DMH indicated that the report did not reflect the entire spectrum of changes and progress made since the creation of DMH. In assessing the status of DMH's steps to establish a community-based system of care, we focused on four key areas of reform central to meeting the exit criteria for the Dixon Decree. While we believe that the other reform initiatives and services are important, we believe that DMH's status with regard to meeting the exit criteria is an appropriate gauge of compliance with the Dixon Decree.

Background

In 1974, a class action suit filed in the U.S. District Court for the District of Columbia on behalf of individuals with mental illnesses alleged that the practice of treating the District's mental health patients in an institutional setting violated the statutory rights of individuals. Specifically, the plaintiffs asserted that patients at St. Elizabeths Hospital had a statutory right to appropriate care in alternative care facilities when less restrictive settings were clinically appropriate. In a ruling known as the Dixon Decree, the court ruled in favor of the plaintiffs in 1975, ordered the District to build a system to facilitate the provision of community-based treatment for these individuals, and continued oversight of the District's progress in developing this system. In 1997, finding that the District was no closer to complying with the Dixon Decree than it had been 22 years earlier, the court placed the D.C. Commission on Mental Health Services in receivership and appointed a receiver to implement the transition to a community-based mental health system.[4] This receiver introduced initiatives that sought to change the way the District delivered services, but implementation was slow and the first receiver made little progress in implementing these initiatives during his 2-year oversight of the commission. Thus, a second or "transitional" receiver was appointed on April 1, 2000, to facilitate the transition from court receivership to District control. (App. I summarizes the major court actions related to the Dixon Decree.)

The transitional receiver was charged with developing a comprehensive plan for the District to achieve compliance with the Dixon Decree and resume full control of its mental health system. The court approved a final

[4]A receiver is a person, usually appointed by a court, who takes control of and conserves assets or property that is the subject of litigation and manages the assets or property in accordance with court orders. In the Dixon case, the court granted the receiver broad powers, including the authority to hire and fire personnel, negotiate or renew labor contracts, and establish a budget.

plan in April 2001 and required the District to implement it; however, before the receivership could be ended, the court required the transitional receiver to certify that the District had the capacity to implement—and was implementing—the final plan. Although the court originally anticipated this certification in late 2001, in December 2001 the transitional receiver recommended extending the date, characterizing the implementation delay as largely unavoidable because of (1) additional time needed for recently hired senior DMH managers to begin major initiatives, and (2) the unexpected need for crisis services to respond to September 11, 2001, terrorist events. Following this extension, the transitional receiver reported to the court that the District had made sufficient progress and, as a result, the court terminated the receivership and appointed the former transitional receiver as a court monitor to oversee the District's continued implementation of the final plan in May 2002. (See table 1.)

Table 1: Key Events in Court Oversight of the District's Mental Health System, 2001-2002

Date	Event
2001	
March 28	The transitional receiver issued the final court-ordered plan.
April 2	The court approved the transitional receiver's final plan and required the District to implement it.
May 21	The District regained operational control of mental health services (transitional receiver still in place).
Oct. 21	The District emergency legislation creating the Department of Mental Health (DMH) went into effect.
Dec. 15	The transitional receiver recommended extending the receivership.
Dec. 18	Permanent legislation creating DMH became effective.
2002	
May 15	The transitional receiver provided the court with updated findings and recommendations on the extended receivership.
May 22	The court • found that the District was capable of implementing the final plan, • terminated the receivership, • appointed the former transitional receiver as a court monitor of District compliance with the final plan, and • approved exit criteria for the Dixon case.
Oct. 23	The court approved the court monitor's monitoring plan for fiscal year 2003, which included reporting to the court twice in that year.

Source: GAO summary of documents from U.S. District Court for the District of Columbia.

District Mental Health System Prior to the Approval of the Final Plan

When the transitional receiver was responsible for overseeing the District's mental health system, the District was the largest provider of mental health services to its residents, treating approximately 10,000 consumers annually and employing close to 2,000 staff in fiscal year 2000. The focal point of the mental health system was St. Elizabeths Hospital, which was the major point of entry for all consumers in the system.[5] St. Elizabeths Hospital provided a wide range of mental health services in an acute care setting, including more than 600 beds divided among two types

[5]St. Elizabeths Hospital specializes in inpatient care for people with acute, intermediate, and long-term mental health needs. Patients typically have symptoms that are so severe or intense that they need the security and structure of a hospital to assist in their recovery from mental illness. On October 1, 1987, the hospital passed from federal control to become part of the District's mental health system.

of inpatient consumers, forensic and civil,[6] for adults and children and youth.[7] The District also directly provided services through outpatient facilities in the community, including two community mental health centers and five mobile community outreach treatment teams.

In addition to providing inpatient and direct services in the community, the District contracted with private community providers for housing, employment, case management, and other community-based services. In its contracts with private community providers, the District often used a "slot" system to allocate a defined number of consumers to providers and paid them a fixed daily rate per consumer. Under this system, providers did not compete to attract consumers and were paid regardless of performance, consumer satisfaction, or the actual delivery of service.

The District and its providers focused primarily on treating the medical symptoms of the consumer without focusing as much on whether the individual was participating in his or her recovery from mental illness and successfully living in the community.[8] Furthermore, the system did not have many safeguards in place, such as uniform provider standards, to involve the consumer in key aspects of service delivery, such as choosing a provider and developing a treatment plan based on the consumer's goals. The transitional receiver identified the need for a restructured mental health system that had the flexibility to meet individual needs and allow consumers to successfully obtain treatment and live in the community, maximizing principles of accessibility, recovery, and consumer choice.

[6]DMH treats mentally ill individuals referred through the criminal justice system. DMH provides a range of forensic mental health services, such as caring for and treating an individual found not guilty by reason of insanity. Federal agencies may also refer persons to St. Elizabeths Hospital who, if admitted, would be housed in the hospital's forensic division. For example, the U.S. Secret Service may refer a person who has made a threat against a federal official.

[7]For purposes of this report, children and youth refer to a single category of individuals aged 0 to 17.

[8]The President's New Freedom Commission on Mental Health, which was created to study and make recommendations about the nation's mental health service delivery system, defines "recovery" as the process in which people with mental illnesses are able to live, work, learn, and participate fully in their communities. See *New Freedom Commission on Mental Health*, *Achieving the Promise: Transforming Mental Health Care in America. Final Report*, Pub. No. SMA-03-3832 (Rockville, Md.: Department of Health and Human Services, 2003).

In 2001, the federal share of Medicaid, an entitlement program in which states and the federal government are obligated to pay for covered services provided to an eligible individual,[9] accounted for 8 percent of District mental health system revenue as compared to the national average of 22 percent.[10] The transitional receiver identified the need to better utilize Medicaid as a major funding source. The District's access to Medicaid funds had been limited because Medicaid did not cover most of the services provided at St. Elizabeths Hospital, considered under the Medicaid statute as a larger psychiatric institution.[11] This effect was exacerbated by the limited capacity in the developing community-based system to support inpatients ready for discharge. For example, in October 2000, District officials estimated that approximately 60 percent of individuals in acute care units at St. Elizabeths Hospital could be moved into the community where outpatient services covered by Medicaid would be available, if stable alternative housing were available.

A second limit to the District's accessing federal funds was that the District had not taken advantage of optional community-based mental health services that could be reimbursed through the Medicaid program. The transitional receiver required the District to implement a strategy adopted by at least 40 other states to expand the services reimbursable by Medicaid through an option to cover rehabilitative services, thus expanding the scope of eligible services and providers beyond that of the program's traditional focus on services delivered by physicians and psychiatrists who work at hospitals, clinics, and other facilities. Rehabilitative services include crisis and emergency care, medication treatment, and community-based interventions. The variety of rehabilitative treatments and services covered by this Medicaid option is

[9]In the District of Columbia, the federal government contributes 70 cents of each Medicaid dollar spent. This ratio is set in statute and does not change with fluctuations in the District's per capita income. States' federal funding rates are determined through a statutory matching formula based on a state's per capita income in relationship to the national average, with the federal share ranging in fiscal year 2004 from 50 to approximately 77 percent. In the period April 1, 2003, through June 30, 2004 each state and the District of Columbia can receive an additional 2.95 percent in the federal share.

[10]See National Association of State Mental Health Program Directors Research Institute, Inc., *Funding Sources and Expenditures of State Mental Health Agencies: Fiscal Year 2001* (Alexandria, Va.: May 2003).

[11]Medicaid will cover inpatient services provided to individuals in mental health facilities with 16 or fewer beds, but the Medicaid statute specifically excludes coverage provided in larger psychiatric institutions for adults aged 21 to 64.

intended to facilitate a consumer's recovery from mental illness, including restoring a consumer to his or her best possible functional level.

Final Plan and Exit Criteria

The court-approved final plan broadly outlines the mental health system's direction, philosophy, major roles, and governance. It represents a major shift in the District's mental health system on several fronts, including the system's structure and organization, method for enrolling consumers and paying providers, and involvement of consumers in their plan for recovery. For example, the final plan

- identifies the need to create a new mental health department with the additional responsibility of oversight along with continuing the District's historic role as provider;
- envisions a significant change in enrollment and billing systems, such as linking payment to the delivery of services, and developing new funding strategies that increase federal reimbursement; and
- articulates that the new system have a built-in capacity to measure itself in key performance areas and to translate any findings into continued system improvements.

Underpinning these structural changes is a refocusing of the mission of the District's mental health system toward involving the consumer in treatment decisions and incorporating changes that facilitate the consumer's recovery from mental illness and away from focusing primarily on treating the individual's medical symptoms.

The court also approved exit criteria for the Dixon lawsuit, which provide a basis for measuring the performance of the District's mental health system and which must be met in order to end the Dixon case. The criteria cover four areas:

1. consumer satisfaction, which assesses consumers' satisfaction with mental health services provided;

2. consumer functioning, which tracks consumers' clinical, social, and other conditions upon entry into the mental health system and again after receiving services for a specified period of time;

3. consumer service delivery, which assesses the adequacy of the mental health system's overall performance for consumers in a range of areas including treatment planning, coordination of care, and response to emergent and urgent needs; and

4. system performance, which demonstrates how well the community-based system of care is serving particular populations.

The first two areas require DMH to develop and implement methods for reviewing and measuring consumer satisfaction and consumer functioning and to use the data to refine the system. To fulfill the remaining criteria, DMH is required to meet 17 performance targets, many of which measure activities identified as national best practices in the field of mental health.[12]

According to the court monitor, implementing the final plan, including developing the ability to measure DMH's progress against the exit criteria, will take 3 to 5 years, with year 1 beginning July 1, 2001.[13] In general, efforts for years 1 and 2 were expected to center on planning, laying the basic infrastructure for the system, and beginning to provide community-based services. By the end of year 3, which began October 1, 2003, DMH is expected to be stabilizing and improving performance within the system, and in years 4 and 5 DMH is expected to be actively measuring performance outcomes. (See table 2.) In addition to developing performance targets for the exit criteria, the court monitor is required to provide the court with semiannual reports on the District's progress in meeting all of the exit criteria. The court monitor's first two reports, submitted to the court in January 2003 and July 2003, respectively, focused primarily on DMH's status in implementing the final plan and also included an update on the status of meeting the exit criteria to end the Dixon case.

[12]For a discussion of best practices in mental health, see *Mental Health: A Report of the Surgeon General* (Rockville, Md.: Department of Health and Human Services, 1999).

[13]While years 1 and 2 associated with implementing the transitional receiver's final plan did not follow a consistent 12-month cycle (year 2 was extended from 12 to 15 months), years 3 and beyond are linked to the District's fiscal year cycle, with year 3 representing the time period October 1, 2003, to September 30, 2004.

Table 2: Status of Meeting Court Expectations for the District's New Mental Health System

Phase and time period	Expected results for time period	Status
Planning and developing infrastructure and beginning data collection. July 2001 – Sept. 2003	Enact enabling legislation	●
	Hire DMH director	●
	Hire and train key leadership	●
	Develop and implement regulatory and monitoring functions	●
	Begin delivering Medicaid rehabilitative services	●
	Design and implement enrollment and billing systems	●
	Certify and license community-based providers	●
	Issue consumer protection rules	●
	Design and implement hotline and crisis supports	●
	Review adult and child and youth consumer services and establish performance targets	●
	Define system performance measures and establish performance targets	●
	Develop consumer functioning review methods	⦿
	Develop consumer satisfaction review methods	⦿
Stabilizing, evaluating, and measuring system performance. Begin Oct. 2003 (no specific end date)	Meet 2 performance targets for adult and child and youth services	○
	Submit performance target data for 15 measures of system performance to court monitor on quarterly basis	○
	Meet 15 system performance targets for measures such as: • Penetration rates[a] • Specialized services for adults • Specialized services for children and youth • Continuity of care • Efficient use of resources	○
	Use consumer functioning review data for quality improvement	○
	Use consumer satisfaction review data to improve the availability and quality of care	○

Source: Court monitor, DMH, and documents from U.S. District Court for the District of Columbia, March 2004.

Legend

● - step is completed

⦿ - step is in process but not completed

○ - step is in planning

[a]Penetration rates measure the percentage of District populations, such as adults aged 18 and over, who are served by the mental health system (defined as receiving at least one provided service).

DMH Has Assumed Oversight Authority and Responsibility for Providing Direct Care

In accord with the transitional receiver's final plan, the District restructured its mental health system by creating DMH to oversee the provision of mental health services, including the authority to set regulations and monitor compliance—a shift away from the structure of its predecessor office, which was primarily a provider of services. Under this structure, DMH also continues the District's historic role as a provider of mental health services. In its oversight role, DMH has developed certification standards and made use of licensing standards to enroll a network of providers to deliver an array of mental health services, which DMH continues to expand to ensure adequate capacity for community-based mental health services. DMH is in the early stages of implementing its new monitoring framework to ensure that services are complying with existing and newly established quality and safety standards. DMH remains the largest provider of community-based services and continues to provide inpatient mental health care for the District at St. Elizabeths Hospital.

Oversight Responsibilities Include Setting Regulations and Monitoring Provider Compliance

In 2001 the District took the first step toward implementing the final plan by passing legislation establishing DMH and giving it new oversight responsibilities, including setting regulations and monitoring community-based provider compliance.[14] The significant organizational change accompanying the addition of oversight responsibilities required hiring new leadership and redeploying and retraining a large portion of existing staff. For example, of DMH's 270 administrative and oversight staff positions, which represent approximately 14 percent of all budgeted staff for fiscal year 2003, the majority of positions were new and required either redeployment of existing staff or hiring new staff. Consistent with the final plan, DMH established a training institute to provide staff training and development, among other services. As of December 2001, a court report indicated that key leadership positions had been filled, including that of the director of DMH, who was hired by the mayor in April 2001. Subsequently, however, one key leadership position, DMH's chief financial officer, experienced turnover, with four individuals serving in the role since April 2001. DMH has also hired two chief executive officers with experience in other systems undergoing reform, to run its community-based services agency and St. Elizabeths Hospital, respectively. (See table

[14]The District legislation creating DMH—the Mental Health Service Delivery Reform Act of 2001, 49 D.C. Reg. 985 (2002)—assigned DMH the duty and authority to develop systems of care for adults and for children and youth, purchase and reimburse for services, regulate services and supports, investigate allegations of abuse and neglect, and operate an inpatient hospital and a CSA. See D.C. Code Ann. § 7-1231.04 (2003 Supp.).

3 for a summary of DMH's functional responsibilities, including oversight, by office.)

Table 3: Summary of Functional Responsibilities of DMH, as of January 2004

DMH office	Functions of office
Office of Fiscal and Administrative Services	• Prepares and oversees DMH's operating and capital budgets. • Plans for and manages DMH's facilities and information systems. • Operates DMH's contract management system and develops enrollment and eligibility processes for services provided directly or by contractors. • Administers human resources and labor management.
Office of Accountability	• Certifies mental health rehabilitative services providers, freestanding mental health clinics, residential treatment centers for children and youth, and Medicaid day treatment programs. • Licenses community residential facilities for persons with a mental illness. • Oversees unusual incident review, grievance, and consumer complaint processes. • Develops and implements quality improvement, program evaluation, and compliance functions, such as audits of provider records. • Develops and implements policies.
Office of Delivery Systems Management	• Develops program requirements for DMH's service contracts and arranges for community-based mental health service delivery through agreements with community providers. • Develops and monitors acute care contracts with community hospitals. • Develops discharge planning and diversion programs for adults and children and youth. • Operates the Access Helpline, a telephone hotline providing crisis emergency services, enrollment assistance, and information and referral 24 hours a day, 7 days a week. • Collaborates with other public agencies, including the District's Youth Services Administration and Department of Health, to develop operational arrangements for service delivery with other public systems of care.
St. Elizabeths Hospital	• Provides inpatient care for adults with acute, intermediate, and long-term mental health needs. • Provides mental health evaluations and recommendations to courts as to a person's competence to stand trial. • Treats adults with forensic status, meaning the court has found the patient not guilty by reason of insanity or the patient has been moved to St. Elizabeths Hospital from a correctional facility for temporary treatment in a secure environment.
D.C. Community Services Agency	• Delivers a broad range of mental health services for adults and children and youth, including mental health rehabilitation, crisis response, and homeless outreach, in a variety of settings, such as homes, schools, neighborhood sites, and in the agency's 17 locations throughout the District. • Operates three pharmacies, which provide free medication to consumers; three medical clinics; and a reform school for adolescents.

Source: DMH.

DMH became the primary entity for overseeing a mental health system that is focused on community-based systems of care. (See table 4.) DMH's regulatory responsibilities include developing standards and certifying providers of services, such as rehabilitative services and supported housing at independent living facilities, and licensing community residential facilities. As of January 2004, DMH had certified 22 mental health rehabilitative services providers, licensed more than 148 community residential facilities, and was in the process of implementing a certification program to oversee more than 400 supported independent living facilities.[15] DMH addressed rehabilitative services standards by developing and publishing specific provider certification standards that took effect on November 9, 2001.[16]

[15]In addition, there are other providers, including residential treatment centers for children and youth, day treatment programs, and free-standing mental health clinics, certified by DMH on behalf of the District Medicaid office. These providers can serve DMH consumers; however, they are paid directly by the District's Medicaid office.

[16]According to a DMH official, as of December 2003, in addition to the 22 certified rehabilitation providers, 17 additional providers had applied for certification to deliver rehabilitative services. As part of DMH's effort to increase capacity for serving children and youth, many of the 17 providers specialize in serving these populations.

Table 4: Examples of Services in the Community-Based System of Care Overseen by DMH, as of January 2004

Mental health service	Description
Counseling	Individual, group, or family face-to-face services to help consumers develop, restore, and enhance the skills necessary to access community resources and support systems and restore or enhance the family unit.
Community support	A broad range of activities to enable consumers to recover from mental illness, such as participating in the development and implementation of their treatment plan, providing assistance and support for consumers in crisis, offering support for consumers' family members, and assisting consumers with the self-monitoring and self-management of symptoms.
Medication/somatic treatment	Medical interventions such as physical examinations; prescription, supervision, and direction for administration of mental health medications; and monitoring results of laboratory diagnostic procedures for mental-health related medications.
Crisis response	Site-based services, which allow extended observation to stabilize a consumer and prevent hospitalization as well as critical incident and stress debriefing capacity, and mobile services. Services are available 24 hours a day, 7 days a week.
Supported housing	Personal care support for adult and older youth (18 to 21 years of age) consumers living alone or with others, including assistance with maintaining a safe and sanitary living environment, maintaining personal hygiene and health, and identifying community resources for education, employment, and recreation.
Homeless support and outreach	Intermittent and long-term support services for individuals who are homeless, including outreach and initial evaluation as well as supportive counseling, medication management, and housing assistance.
Consumer advocacy	Information on consumers' rights and the procedures for resolving complaints and individual advocacy for consumers who seek assistance with specific rights violations.
Peer support	Self-help services, including self-help groups, health education, and nutrition services. In addition, services include assistance to maintain a supportive network and an advocacy program.

Source: DMH.

In addition to its regulatory responsibilities, DMH must monitor providers' compliance with existing and newly developed quality and safety standards. DMH's oversight division, the Office of Accountability, has direct responsibility for monitoring compliance with standards. DMH has developed a monitoring framework that is in the early stages of implementation, with DMH beginning to use information from some monitoring efforts to assess provider compliance and continuing to adjust other efforts. The following are examples of DMH monitoring efforts:

- Safety inspections, which are surveys of the sites where licensed providers offer services, are used to ensure health and safety standards are met. In the first 11 months of 2003, DMH conducted at least 150 inspections of 148 eligible facilities. When DMH conducts site inspections, it can issue notices of infractions for violations of the standards. According to DMH, from April 2002 through January 2004, it issued 46 notices to 22 providers and issued more than $29,000 in fines for identified deficiencies, including

items such as insufficient staff on duty, failure to report unusual incidents, inaccurate personnel records, and exceeding maximum capacity. Increasing the number of site inspections of facilities that serve DMH consumers is one of the goals included in the DMH annual "scorecard" submitted to the District Mayor's office, which tracks commitments and deadlines set for DMH.

- Provider audits, which are record reviews of certified rehabilitative services providers, are used to analyze trends across providers and to ensure that providers are meeting documentation and service standards. In January 2003, DMH completed its first round of audits for the 12 providers certified at that time. As expected by DMH for the first year of applying standards, the audit found that providers were not in compliance with certain documentation requirements, such as having the approving practitioner sign the authorized treatment plan, and, as a result, all 12 providers were to implement corrective action plans. While these initial audits focused solely on provider documentation compliance, the second round of audits of all certified providers, which DMH expects to complete in early 2004, will examine how well specific services (such as medication treatment) are being provided.
- Routine, biennial recertification reviews for rehabilitative services providers, which include evaluations of recorded complaints, audits, and public comment, are used to ensure that individual providers are complying with certification standards. With the first round of recertification applications, begun in December 2003, DMH will be able to use data from these reviews to make decisions regarding providers' recertifications.[17]
- Investigations of unusual incidents, which are conducted by the Office of Accountability and providers, are used to ensure consumer safety and reduce the occurrence of future incidents.[18] DMH is expected to investigate any major unusual incident, such as consumer deaths, adverse drug reactions, and allegations of abuse or neglect. Providers are expected to investigate other, less serious incidents, defined as any events that occur outside the normal routine of care, and they are required to report

[17]As a condition of Medicaid reimbursement, DMH is required to certify any willing provider who meets the business and clinical policy requirements for rehabilitative services. The first rehabilitative services providers were certified for 2 years in the spring of 2002.

[18]DMH has the authority to investigate unusual incidents reported by all providers who deliver services to District of Columbia residents. These providers include DMH certified or licensed providers, community residential facilities and their employees, all DMH mental health services and support contractors, St. Elizabeths Hospital, and other mental health providers serving children and youth located in and outside of the District.

to DMH all unusual incidents and action taken to respond to them. Unusual incidents, which vary widely in severity, were reported 1,259 times in calendar year 2003, including 336 reports of major unusual incidents. Of the 1,259 unusual incidents reported for 2003, DMH resolved 528 cases, including 161 major unusual incident cases. The remaining 731 cases usually required additional information from providers or other District agency investigators before DMH could take action. According to a DMH official, on average, a case remains pending for between 30 and 90 days before a disposition is reached.

DMH Continues the District's Historical Role as a Direct Provider of Mental Health Services

Through DMH, the District remains a direct provider of a significant portion of mental health services. DMH's own community services agency is the largest provider of community-based services in the District, acting as the primary provider for 55 percent of all consumers enrolled in the District mental heath system as of October 2003. In addition, it is the sole provider of a number of services, including crisis response services for adult consumers through its Comprehensive Psychiatric Emergency Program and free pharmacy services for uninsured consumers. The number of consumers receiving community-based services directly from DMH grew from 4,191 in October 2002 to 6,971 in October 2003. In addition, the total number of consumers served by the 13 other community-based providers increased from 2,612 in October 2002 to 5,631 in October 2003.[19]

As envisioned by the transitional receiver's final plan, DMH has also taken steps to reduce the number of beds at St. Elizabeths Hospital, but reductions have been limited by the lack of community-based services and agreements with community hospitals for acute care.[20] The intent of the plan was for St. Elizabeths Hospital to be primarily a forensic hospital and a safety net facility for the community-based system of services and for

[19]DMH officials told us that its enrollment data are inflated because the system does not actively disenroll consumers who are no longer receiving services. Thus, the enrollment counts could include individuals who have left the District and no longer receive services.

[20]In addition to increasing the care provided under the least restrictive conditions, the transitional receiver outlined a reduced role for St. Elizabeths Hospital in order to maximize access to Medicaid funds. Medicaid does not reimburse for most psychiatric admissions to large institutions.

community hospitals.[21] While neither the final plan nor the exit criteria for the Dixon Decree specify goals for the reduction in the bed census at St. Elizabeths Hospital as a condition of ending the Dixon case, the exit criteria specify that 60 percent of DMH's annual expenditures must be directed to community-based services. In DMH's 2004 proposed budget, 41 percent of funds, approximately $80 million, are allocated for community-based providers and 42 percent, approximately $81 million, are allocated for St. Elizabeths Hospital. The remaining 17 percent, approximately $34 million, are budgeted for administration, oversight, delivery systems management, and other direct service costs, some of which represent fixed costs for community-based services.[22] DMH has decreased the number of occupied beds at St. Elizabeths Hospital—from 628 beds in October 2000 to 513 beds in October 2003. In July 2003, the court monitor reported that the current model of continued reliance on St. Elizabeths Hospital was not financially viable, did not promote the concept of community-integrated care, and was not in compliance with the court-ordered plan. However, DMH stated that the hospital's budget cannot be reduced without an additional decrease in the number of occupied beds. The chief executive officer of St. Elizabeths Hospital said that the census would not decrease until the community can support patients upon discharge, including providing access to affordable housing. The court monitor estimates that for the community-based system to adequately meet the needs of District residents, DMH would have to double the current capacity.

[21]The final plan states that acute care services will also be provided under agreements with a number of willing and qualified acute care hospitals in the community that have unused capacity. The establishment and effectiveness of these agreements is an area identified in the court monitor's July 2003 report to the court as an area of concern for continued monitoring. We recognize that such agreements are difficult and often complex to negotiate and local hospitals must be willing and able to contract for such services.

[22]According to the court monitor, the method for counting fixed costs for community-based services is still being negotiated by the parties to the Dixon case; the court monitor expects this to be finalized by July 2004.

Enrollment and Billing System Is Designed to Coordinate Clinical, Administrative, and Financial Processes

In its first 2 years, DMH developed and implemented a comprehensive enrollment and billing system that coordinates clinical, administrative, and financial processes. Two key attributes of this system that were described in the final plan are that it (1) links payment with planning for individual treatment and the provision of services and (2) increases access to federal funds through the development of mental health rehabilitative services, which are community-based mental health services that a state's Medicaid program can choose to provide. DMH has developed and implemented a system to link payment to authorized treatment plans, enroll consumers, reimburse providers, and bill Medicaid for rehabilitative services provided. However, moving to an FFS billing system for services has resulted in difficult adjustments, including managing cash flow, for some DMH providers.

Enrollment and Billing System Links Payment to Treatment

DMH's enrollment and billing system that links payment to treatment, as envisioned by the final plan, is in place and operating. Consumers can enter into the mental health system through a variety of points in the community, including calling DMH's Access Helpline, visiting a DMH-certified community-based service provider, receiving treatment in hospitals or emergency rooms, and receiving mental health assistance through other DMH outreach efforts.[23] All District residents needing mental health services are eligible to receive them regardless of insurance coverage.[24] The Access Helpline—which is a telephone hotline that provides crisis emergency services, enrollment assistance, and information and referral 24 hours a day, 7 days a week—or a certified CSA[25]—which is responsible for acting as a clinical home and therefore assessing consumer needs and coordinating care—will enroll eligible

[23]For example, DMH's homeless outreach program has five full-time staff who visit homeless shelters throughout the District to help encourage contact with the mental health system. Outreach staff members maintain close contact with organizations for the homeless to remind them of DMH's Access Helpline and offer training to providers on a range of topics, including how to link homeless individuals with DMH services.

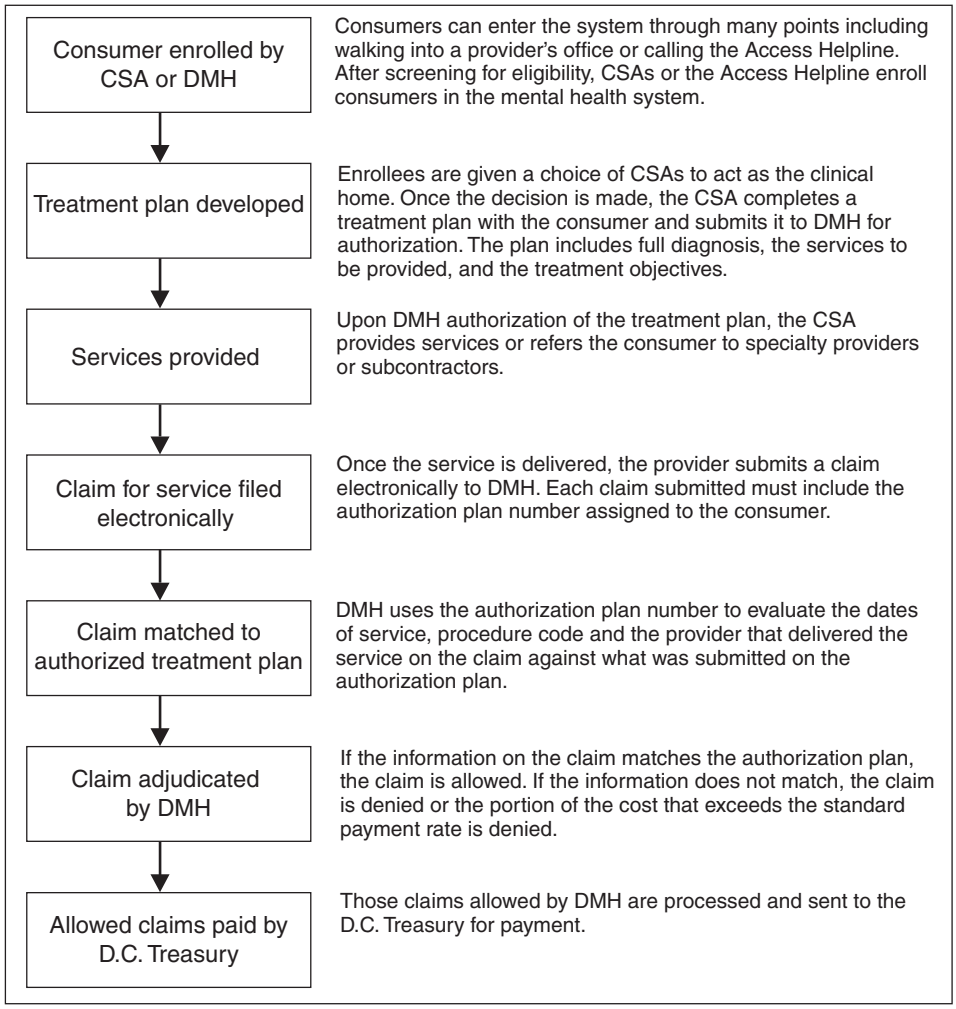
[24]Homeless individuals are considered residents if they are in the District while receiving services and express their intent to continue to stay in the District.

[25]CSAs are DMH-certified rehabilitative services providers responsible for assessing consumer needs, working with consumers to develop treatment plans, providing and/or coordinating services to meet objectives of the treatment plans, and billing DMH for services.

consumers within 3 days of initial contact.[26] When enrolling in the system, the consumer chooses a CSA as a clinical home based on a number of preferences such as location and treatment specialties. (See fig. 1.) After choosing the CSA, a consumer meets with a clinical manager to develop a treatment plan, which includes objectives and a plan of services, called an individualized recovery plan for adults and an individualized plan of care for children and youth. Once a clinical manager and a consumer develop a treatment plan, it is submitted by the CSA to DMH for authorization. Upon authorization of the treatment plan, a consumer can begin accessing the approved services. These services must be provided by a CSA or by another DMH-certified provider; once services are delivered, the providers then bill DMH on an FFS basis for reimbursement. Screening consumers for eligibility to receive mental health services and billing DMH for services rendered are new responsibilities for providers. Providers will be paid only for services delivered that are identified by the treatment plan and authorized by DMH.

[26]The Access Helpline and CSAs are the only entities that can enroll a consumer. As of January 2004, there were over 15 CSAs, one of which is DMH's community services agency. Other providers can, however, work with the Helpline to help a consumer enroll.

Figure 1: Overview of Enrollment and Billing System, as of October 2003



Source: GAO summary of DMH documents.

As of December 2003, DMH had transitioned 12 of its 27 community-based services to the FFS enrollment and billing system, including all nine rehabilitative services, but 15 other services, such as consumer advocacy and peer support, had yet to be added. Services that have not been transitioned to the FFS system do not have to be identified in an authorized treatment plan; however, community-based providers must deliver these services according to their contractual agreements with DMH.

In order to develop a system that links payment to services provided, DMH purchased management information systems that coordinate clinical, administrative, and financial processes for mental health services. These systems allow CSAs to enroll consumers in the mental health system, submit claims electronically, and retrieve their consumers' demographic data. These systems also streamline DMH's administrative efforts by allowing DMH to electronically enroll consumers, authorize services, adjudicate claims, and generate payment reports for providers. The system further helps DMH monitor how much individual providers are billing, which helps DMH project expenditures. DMH received the first batches of claims in June and July 2002, and as of October 2003 it reported that its mental health system had 12,602 consumers enrolled.[27] However, DMH could not report the number of consumers who received services within a 90-day period, which is consistent with the court's definition of provision of services to enrolled consumers. As of January 2004, DMH had paid rehabilitative services providers $30.4 million for claims submitted in fiscal year 2003.[28] DMH projects that it will have paid these providers a total of $35 million to $40 million for claims submitted in fiscal year 2003.[29]

DMH Has Increased Access to Federal Funds through a Medicaid Mental Health Rehabilitation Services Option

In December 2001, the Centers for Medicare & Medicaid Services approved the District's request to add the mental health rehabilitation services option to its Medicaid program.[30] (See table 5.) Approval of the option increased both the number and scope of mental health services reimbursable by Medicaid. Under the option, DMH certifies and contracts with community providers to deliver covered services. DMH pays providers for any DMH-authorized service and, on behalf of contracted providers, files claims with the District Medicaid office for reimbursement of the federal share of the cost of Medicaid-covered services. Thus, there is no relationship between the District Medicaid office and the local providers for these services, nor is payment to providers contingent upon

[27]This enrollment number represents any individual who enrolled in the District's mental health system and selected or was assigned a CSA.

[28]DMH's fiscal year 2003 covers the period October 1, 2002, through September 30, 2003.

[29]Under the standard contract between certified rehabilitative services providers and DMH, providers have up to 1 year from the date a service was delivered to submit a claim for reimbursement from DMH. According to a DMH official, there is generally a 30- to 60-day lag between the date of service and the submission of the claim.

[30]The Centers for Medicare & Medicaid Services oversees states' Medicaid programs at the federal level.

reimbursement by Medicaid. Other District community-based service providers that do not contract with DMH bill the District Medicaid office directly for their services.

Table 5: Overview of District Medicaid Mental Health Rehabilitative Services Coverage, as of January 2004

Covered services	Coverage criteria	Qualified practitioners
• Diagnostic/assessment • Medication/somatic treatment[a] • Counseling and psychotherapy • Community support • Crisis/emergency • Day services[b] • Intensive day treatment[c] • Community-based intervention • Assertive community treatment[d]	**The service should be:** • medically necessary **The service should be delivered:** • by a DMH-certified provider • by a qualified practitioner (associated with a DMH-certified provider) • in accordance with a treatment plan • in accordance with service standards[e]	• Psychiatrist • Psychologist • Clinical social worker • Social worker • Registered nurse • Licensed professional counselor • Addiction counselor

Source: GAO analysis of DMH Medicaid information.

[a]Medication/somatic treatment services are medical interventions such as physical examinations, prescription, and supervision or administration of mental health medications; and monitoring results of laboratory diagnostic procedures for mental health-related medications.

[b]Day services are structured to restore community living, socialization, and adaptive skills.

[c]Intensive day treatment is a coordinated acute treatment program that serves as a step-down service from inpatient care.

[d]Assertive community treatment is an intensive integrated rehabilitative, crisis, treatment, and mental health community support service provided by an interdisciplinary team with coverage 24 hours a day and 7 days a week.

[e]Service standards include, among other things, staffing ratios, levels of availability, and location of service delivery.

DMH built mechanisms into the enrollment and billing processes to help providers and DMH work together to obtain Medicaid reimbursement. Access Helpline counselors work with providers to identify consumers who are eligible and enrolled in the Medicaid program using eligibility data from the District Medicaid office.[31] Before transmitting Medicaid-reimbursable claims to the District's Medicaid office, DMH checks each claim to ensure that the consumer is currently enrolled in Medicaid, that the provider is eligible, and that the covered service has been paid by

[31]The District's Medicaid office is the only agency in the District that can enroll individuals in Medicaid. However, it is a DMH priority to identify its consumers who are eligible for Medicaid coverage and assist with enrollment in Medicaid. DMH-certified providers are encouraged to refer and/or assist potentially eligible consumers in applying for Medicaid.

DMH. Upon submittal for reimbursement to the District's Medicaid office, DMH tracks the status of claims, receiving reports that detail the claims paid, waiting to be paid, and denied payment. The report also provides reasons that claims were denied.

DMH is improving its overall enrollment and billing system to decrease the time providers spend on administration and to increase the time they spend serving consumers. For example, in October 2003, DMH changed a component of the billing system that delayed providers from offering services. The system had required providers to electronically update treatment plans every 90 days. To reinforce this requirement, the information system prevented the provider from entering any other consumer data, such as claims data for a service provided, until the plan was updated. DMH realized that requiring providers to do this was burdensome and prevented them from serving consumers. As a result, DMH removed the requirement to update the treatment plan from the electronic billing system and is monitoring compliance with the 90-day requirement through an alternative mechanism.

DMH projects that as the enrollment and billing system improves and the provision of community-based services continues to expand, mental health rehabilitative services will eventually generate approximately $36 million to $38 million annually in federal Medicaid funds. As of November 2003, the District's Medicaid office had reimbursed DMH $17.5 million for fiscal year 2003—over 50 percent of the amount DMH paid to providers for rehabilitative services. As one condition of ending the Dixon case, federal Medicaid funds must cover at least 49 percent of all mental health rehabilitative services provided. Although DMH expects future growth in Medicaid revenue, many individuals served by the District's mental health system, especially adults, are not eligible for Medicaid.

New System Presents Challenges to Providers

According to DMH officials, moving to an FFS system represented a major change in business operations for DMH providers and has presented challenges for them; however, DMH has offered assistance to all certified rehabilitative providers. DMH offered training for providers on service and billing requirements and grants for building the infrastructure required to participate in the system. In addition, consultants funded by DMH can work with providers on developing sound business practices, including cash flow analysis, budgeting in an FFS environment, staff assignments and productivity, record keeping, and billing.

Even with assistance, providers experienced challenges since beginning to bill DMH on an FFS basis. Two providers reported that there are considerable investments of time and money necessary to be certified as a CSA. According to one provider, the new system requires more "business savvy" and planning by providers for revenue peaks and valleys because providers are no longer guaranteed revenue regardless of the level of services provided. Thus, as stated by the same provider, they must plan ahead to ensure they can meet payroll in months like December and February, when fewer consumers seek services because of holidays and winter weather.

Problems managing cash flow were exacerbated because provider contracts with DMH were tied to the billing projections, which meant that DMH could not pay claims for providers who exceeded their projections until their contracts were changed.[32] The Mental Health Coalition, whose members are primarily DMH-certified providers, wrote to DMH several times in fiscal year 2003 listing a number of concerns with the billing process, and its primary concern was the lack of timely payment on a consistent basis. By August 2003, DMH made the necessary contract changes to allow providers to be paid for the remainder of the fiscal year and, according to senior officials, had a plan in process for fiscal year 2004 to prevent this problem from recurring. DMH provided data showing that in fiscal year 2003 it adjudicated—that is, made a decision to pay or deny—79 percent of submitted claims within 30 days; however, after adjudication, the District of Columbia Treasury must then pay the approved claims, which, according to DMH, took an average of 15 additional days. The court monitor has identified claims payment as an area of concern that will continue to be monitored. DMH did not provide the court monitor with a measure of timely reimbursement in 2003, but, according to the court monitor, in fiscal year 2004 DMH will be required to report the percentage of claims being paid within 30 days of submission.

[32]At the beginning of each fiscal year, DMH and each individual provider sign a contract, which includes the projected amount to be billed for each rehabilitative service that the provider is certified to deliver. DMH submits the agreed-upon projections to the District contracting office to reserve funding at the agreed-upon level for the specified service and provider. When billing exceeds the amount of funds reserved for the designated fiscal year, the providers are no longer reimbursed for the services unless the projected billing amount is adjusted.

Consumer-Centered Approach Blending Choice and Protection Is Evolving

Also central to DMH's new mental health system is facilitating consumers' participation in their recovery from mental illness, an approach that is consistent with the final plan,[33] as well as national trends.[34] Consistent with this focus, DMH has established requirements in two key areas, consumer choice and consumer protection. With regard to consumer choice, DMH has requirements in place to ensure that consumers participate in the selection and receipt of services. However, DMH's initial review of rehabilitative services provider records showed gaps in documentation of consumer participation, such as a lack of documentation of the consumers' participation in—and agreement with—their treatment plans for 41 percent of the records reviewed. DMH is addressing these gaps with providers to ensure that their practices comply with these requirements and adequately involve consumers in their treatment. Consumer protection policies are also evolving, with DMH publishing a uniform consumer grievance policy in October 2003. DMH officials emphasized that moving to a consumer-focused model is a long-term change that will take place gradually.

With Requirements in Place, DMH Is Addressing Gaps in Consumer Choice

Consumers entering the District's mental health system are faced with important choices that help shape the provision of care they receive, including the choice of a CSA as a clinical home that will provide and coordinate care, choice of other DMH-certified providers, and choice of services through involvement in treatment planning. As part of the enrollment process, both the CSA and the Access Helpline are required to present consumers with the option to select any DMH-certified CSA to serve as the clinical home, a choice typically made based on their preferences, such as location and treatment specialties provided. Every CSA that serves as a consumer's clinical home is required by DMH's certification standards to have a policy in place to inform consumers about these and other choices available to them. For example, each CSA's

[33]The final plan highlights developing a recovery-based system that is integrated and community based. A recovery-based system moves beyond treating the consumer's mental health symptoms to also measuring the success of his or her ability to live and function in the community.

[34]SMA-03-3832, page 5. The July 2003 report of the President's New Freedom Commission on Mental Health cites two basic principles for successfully transforming a mental health service delivery system: (1) services and treatments must be consumer and family centered and (2) care must focus on increasing consumers' ability to successfully cope with life's challenges, on facilitating recovery, and on building resilience, not just on managing symptoms.

consumer choice policy must also inform consumers about the availability of peer and family support services—such as transportation, education, nutrition services, and recreation activities—as well as how to access the services. DMH's certification standards also require CSAs to coordinate the treatment planning process for their consumers and to document consumer participation. For example, CSAs are required to develop a diagnostic assessment and treatment plan for each consumer that follows the consumer throughout the service delivery and reimbursement systems. Each CSA acting as a clinical home is required to obtain a consumer's written consent to treatment as well as provide all consumers with a statement outlining their rights and responsibilities during the enrollment and treatment process.

To assist consumers in obtaining mental health services, the Director of DMH's Office of Consumer and Family Affairs (OCFA) told us that DMH employs 15 to 20 mental health consumers as enrollment specialists who are available to other consumers as a resource in making these choices. DMH also offers training, some of which is conducted by other mental health consumers, that is available to consumers and their families on selecting providers and planning treatment. In addition, DMH's enrollment handbook for new consumers summarizes aspects relating to the enrollment process, such as the types of mental health services available, range of consumer choices, and activities a consumer can expect during enrollment. Intended for use in the second quarter of 2004, DMH is developing a provider report card that contains specific information about each rehabilitative services provider to better facilitate consumer choice. For example, the provider report card will give providers a numerical score in areas, such as consumer access, billing and claims, and consumer complaints, that would enhance the consumers' basis for selecting a provider. Finally, OCFA is also responsible for overseeing the development and implementation of the consumer satisfaction review required in the Dixon exit criteria, an initiative that DMH envisions as expanding the role of consumers in measuring the quality of services they receive in the District's mental health system.

The court monitor and District mental health advocates have highlighted areas relating to consumer choice that need attention and that are consistent with DMH's plans for additional development. In a January 2003 report to the court, the court monitor recommended that DMH develop a system for tracking consumer choice to help determine whether choices

truly are available.[35] The Director of OCFA told us that DMH would begin addressing this issue by identifying concerns relating to choice through consumer focus groups planned for each CSA in 2004. In addition, University Legal Services, the designated protection and advocacy program for the District,[36] told us that consumers do not have enough information about how to access providers in the mental health system, and therefore it has published its own consumer rights manual. For example, an official with this organization told us that District consumers often do not have a choice among the full range of providers because many CSAs have limited capacity and have had to develop waiting lists. University Legal Services also cited a delay for consumers in receiving community-based services who are discharged from St. Elizabeths Hospital. While DMH is not required to report current baseline data regarding the receipt of community-based services for consumers following a hospital discharge, one condition for ending the Dixon case will be to demonstrate that 80 percent of known discharged inpatients receive services in a non-emergency, community-based setting within 7 days of a hospital discharge.

DMH's initial audits of documentation practices of each of its certified rehabilitative services providers showed gaps in documentation of consumer participation in development of their treatment plans. Of the 740 unique consumer records DMH reviewed in its audit completed in January 2003, 38 percent did not have a consumer's signature on the treatment plan and 41 percent did not document the consumer's participation in and agreement with the treatment plan. Each of the 12 providers reviewed by DMH was asked to develop a self-audit program and implement staff training to address areas of deficiency in the audits, which, according to DMH, were to be expected in the first year of applying provider standards. Concerns raised by other stakeholders were consistent with the results of DMH's audits of provider documentation practices. For example, in a July 2003 letter to DMH, University Legal Services noted systemic problems with treatment plans relating to consumer participation and accuracy,

[35]See *Dixon v. Williams*, C.A. No. 74-285 (D.D.C. January 13, 2003) (*Report to the Court*, Dennis R. Jones, Court Monitor).

[36]University Legal Services is a private, nonprofit organization that is the District of Columbia's federally mandated protection and advocacy system for the human, legal, and service rights of people with disabilities. Protection and advocacy organizations are congressionally mandated disability rights agencies that have the authority to provide legal representation and other advocacy services, under all federal and state laws, to all people with disabilities.

such as being unsigned, lacking consumer preferences, and failing to reflect consumer medical needs. DMH's written response to University Legal Services highlighted the provider documentation audits completed by DMH as evidence that the department is identifying treatment plan issues but acknowledged that these problems will take time to resolve.

Consumer Protection Mechanisms Are Evolving

In October 2003, DMH published a consumer grievance policy, required by the legislation creating DMH,[37] which strengthened the basic consumer protection provisions in DMH's provider certification standards. Prior to publication of this policy, CSAs and other mental health providers were required to establish written complaint and grievance policies and procedures but did not have to include specific criteria consistent with an overall and uniform DMH policy. For example, the DMH policy published in October 2003 required providers to review, investigate, and respond within 5 business days to grievances alleging abuse or neglect or denial of a service. While consumers can continue to file grievances with CSAs or DMH, the new policy also specifically outlines the conditions under which consumers can request an external review of a grievance that can result in a fact-finding hearing or mediation process.[38] The new policy also requires DMH to facilitate and fund peer advocacy programs that are independent of providers to assist consumers throughout the grievance process. In addition, providers are required to take specific steps to increase consumer awareness about their grievance policies, such as posting the various options and procedures for filing a grievance and documenting that the consumer received a copy of the provider's policy.

DMH's monitoring of consumer complaints and grievances is also evolving. As of January 2004, DMH had contracted with an organization to create a database that will allow OCFA to track consumer grievances and identify systemic issues. OCFA expects that the database will be developed in the first few months of 2004. The new grievance policy also specifies that DMH will periodically review the implementation of the provider policies and publish a semiannual report on the types and

[37]This legislation also required DMH to implement a variety of other consumer protection mechanisms, such as durable power of attorney, informed consent for administration of medications, freedom from seclusion and restraint, and information privacy.

[38]DMH is required to select and contract with one or more external reviewer(s) to provide timely, neutral, and impartial review of grievances that have not been resolved to the consumer's satisfaction.

dispositions of all grievances filed as well as highlight noteworthy trends, patterns, and other statistical information. Prior to this policy, DMH could not ensure that grievances were being tracked and did not review the extent to which providers were implementing their grievance procedures.

DMH Faces Challenges in Developing the Capability to Measure Performance against Exit Criteria

The court monitor worked with DMH and others to develop performance targets to measure compliance with the Dixon exit criteria. On December 11, 2003, the court approved qualitative requirements for two exit criteria measures relating to consumer satisfaction with services and level of functioning. In addition, the court approved 17 performance targets for 17 exit criteria measures relating to system performance. Although the court monitor envisioned fiscal years 2004 and 2005 as the appropriate time frame for DMH to both measure and improve its performance, DMH faces major challenges to collecting and verifying the accuracy of the performance data, including developing methods to electronically collect the data, correcting known data deficiencies, and working with providers to submit accurate data.

Methods to Measure Performance against the Exit Criteria Approved in December 2003

In working to measure the District's compliance with the exit criteria, the court monitor, in conjunction with an outside expert and the legal parties to the Dixon case, developed two qualitative requirements and 17 performance targets, which were approved by the court in December 2003.[39] The qualitative requirements address two of the exit criteria measures—consumer functioning and consumer satisfaction. For these two measures, DMH is required to develop and implement consumer satisfaction and functioning review methods and begin using the data obtained by these methods to make refinements to service delivery. DMH has contracted with a consumer organization to build a consumer satisfaction initiative patterned after model programs around the country. As of December 2003, OCFA had conducted a telephone survey of consumers to help DMH develop this consumer satisfaction review. In addition, DMH officials told us that they are testing the effectiveness of a tool for assessing consumer functioning. According to the court monitor, DMH will provide a progress report in early 2004 on the status of these two reviews, but is not likely to submit the methodologies to the court

[39]The December 2003 court order replaced an earlier set of exit criteria measures. The prior measures, which had been approved in May 2002, had methodologies for measuring performance but did not contain performance targets, qualitative requirements, or definitions.

monitor—which is required to comply with the exit criteria—for several more months.

The court also approved 17 exit criteria measures, each with a specific performance target. (See table 6.) Two of the 17 measures articulate overall system performance targets that DMH must meet in annual reviews of the services provided to adult and child and youth consumers. For example, DMH's system must perform positively for 80 percent of the adults who are sampled and reviewed. The remaining 15 measures define specific system performance targets that DMH must meet in the aggregate for 4 consecutive quarters, such as demonstrating the timely receipt of supported housing services for a specific percentage of persons referred to supported housing. Once DMH meets these targets for the specified time frame, the court monitor ends active monitoring of the measure. However, according to the court order, DMH is required to continue to submit data to the court monitor for all exit criteria measures regardless of their monitoring status, giving the court the ability to require that DMH meet the performance targets for any exit criteria measure showing a substantial drop in performance. The Dixon case can be dismissed when the court monitor submits a report to the court affirming that the District has achieved compliance with all required performance targets and qualitative requirements for all of the exit criteria, and the court accepts that finding.[40]

[40]Alternatively, under its December 11, 2003, order, the court also allowed the District to request a dismissal of the case after demonstrating "substantial compliance" with all required performance targets and qualitative requirements and the court determines that the case, in the interest of fairness, should be dismissed. In either scenario, the District would have to demonstrate a level of compliance with all of the exit criteria measures, including the 17 with performance targets and the consumer satisfaction and consumer functioning measures with qualitative requirements.

Table 6: Summary of 17 Exit Criteria Measures with Performance Targets, December 11, 2003

Exit criteria measure	Description of methodology	Performance target
Consumer services reviews		
Acceptable services— • children and youth (0-17) • adults (18 and over)	Aggregate score of overall service system performance from stratified random sample of subpopulation of consumers who have received services	• Children and youth: DMH will receive aggregate scores of 80% for acceptable services for children and youth sampled and reviewed[a] • Adults: DMH will receive aggregate scores of 80% for acceptable services for adults sampled and reviewed[a]
System performance		
Penetration rates for adults— • adults (18 and over) • adults with serious mental illness	Percentage of District population aged 18 and over served by the system (defined as receiving at least one provided service)[b]	• Adults (3%) • Adults with serious mental illness (2%)
Penetration rates for children and youth— • children and youth (0-17) • children and youth with serious emotional disturbances	Percentage of District population aged 0-17 served by the system (defined as receiving at least one provided service)[b]	• Children and youth (5%) • Children and youth with serious emotional disturbances (3%)
Specialized services for adults with serious mental illness— • supported housing • supported employment • assertive community treatment[c]	Number of persons in subpopulation served by DMH as a percentage of total number of adults with serious mental illness served in the community who have been referred to receive this service	• 70% of persons referred receive supported housing services within 45 calendar days • 70% of persons referred receive supported employment services within 120 calendar days • 85% of persons referred receive assertive community treatment services within 45 calendar days
Specialized services for adults with schizophrenia— • newer generation anti-psychotic medications for adults with schizophrenia	Number of persons in subpopulation served by DMH as a percentage of total number of adults with schizophrenia served in the community	• 70% of adults with schizophrenia will be prescribed newer generation medications
Specialized services for adults who are chronically homeless and seriously mentally ill— • homeless adults	Number of persons in subpopulation served by DMH identified as chronically homeless and seriously mentally ill	• 150 individuals will be "engaged" by a DMH Housing First provider[d,e]
Specialized services for children and youth with serious emotional disturbances— • in natural settings, including schools, churches, youth centers and recreational centers • in their own home or surrogate home	Number of persons in subpopulation served as a percentage of total number of children and youth with serious emotional disturbances served by DMH	• 75% will receive a service in a natural setting[f] • 85% will be living in their own home or surrogate home[f]
Specialized services for children and youth— • children and youth who are homeless	Number of persons in subpopulation served by DMH identified as homeless	• 100 individuals will be "engaged" by a DMH provider[d,e]

Exit criteria measure	Description of methodology	Performance target
Demonstrated continuity of care upon discharge from inpatient facilities— • adults and children and youth	Percentage of subpopulation discharged from an inpatient unit who are seen in a nonemergency outpatient setting within 7 days of discharge	• 80% of known discharges from an inpatient psychiatric hospital will be seen in a nonemergency outpatient setting within 7 days of discharge[g]
Demonstrated efficient use of resources— • increase in percentage of total resources directed toward community-based services	Dollars expended on community-based services as a percentage of the total DMH expenses	• 60% of total annual DMH expenditures will be directed toward community-based services
Demonstrated efficient use of resources— • maximization of Medicaid funding to support community-based services	Federal Medicaid reimbursement dollars as a percentage of total community-based billings for Medicaid approved services	• 49% of total billings for mental health rehabilitative services will be reimbursed by federal Medicaid dollars[h]

Source: U.S. District Court for the District of Columbia.

[a]This score is based on the results of the annual consumer services reviews conducted to comply with the exit criteria. According to the court monitor, this performance target means that 80 percent of sampled consumers receive an aggregate score indicating the receipt of acceptable services.

[b]The District population used to calculate the four penetration rate performance targets for adults and children and youth is defined as the U.S. Census Population Estimate for the calendar year (or latest data available). For example, the penetration rate performance target for adults with serious mental illness requires DMH to provide at least one service to two percent of the District's total adult population aged 18 and over.

[c]Assertive community treatment is an intensive integrated rehabilitative, crisis, treatment, and mental health rehabilitative community support service provided by an interdisciplinary team with coverage 24 hours a day and 7 days a week.

[d]According to the court monitor, the parties to the Dixon case chose to measure the number of homeless adults and children and youth "engaged" rather than "served," because "served" implies enrollment. Many of the homeless adults and children and youth who need DMH services may choose not to enroll in the system. According to the court monitor, the parties have not negotiated a definition for "engaged."

[e]In addition to meeting the performance targets for homeless services to adults and to children and youth, DMH is also required to implement a comprehensive strategy to engage and serve these subpopulations.

[f]DMH must first achieve a penetration rate of at least 2.5 percent for children and youth with serious emotional disturbances before DMH can meet this performance target.

[g]According to the court monitor, this performance target allows DMH to limit its measurement to "known" hospital discharges to account for potential difficulties in collecting comprehensive discharge data from local hospitals. For example, a consumer may seek care in a local hospital that does not typically report discharge data to DMH.

[h]According to the court monitor, the performance target of 49 percent is based on the assumption that 70 percent of mental health rehabilitative services provided will be received by consumers enrolled in Medicaid multiplied by the District's 70 percent federal match for the costs of those services.

Originally, the court expected the proposed performance targets submitted by the court monitor to be accompanied by baseline measures of performance. The proposal approved by the court in December 2003, however, did not include previous requirements for DMH to submit baseline measurement data along with the performance targets. According to the court monitor and a DMH official, baseline data were omitted because (1) historical data are generally incomplete because of problems with data systems as well as a general lack of reliable and consistent previous data, and (2) many of the performance targets require information that was not collected by DMH and its providers, such as the number of consumers referred to supported housing. In commenting on a draft of this report, DMH noted that it was unable to identify comparable baselines from other jurisdictions.

Developing the Capability to Measure and Meet Performance Targets Will Take Time

Meeting the exit criteria performance targets, and thus ending the Dixon case, is a multiyear effort that requires DMH to develop and carry out a plan that will satisfy the court on three levels: (1) developing policies and practices that address the requirements of the exit criteria and demonstrating that DMH monitors the extent to which these policies are implemented, (2) developing specific methods for DMH's collection and verification of the accuracy of the data, and (3) meeting the required performance targets for one full year as defined by the court. In November 2003, the court monitor anticipated that reviews relating to the first two requirements—policies and procedures and data collection and verification methods—will start in early 2004, but it may be a year before these two requirements are met for all of the exit criteria measures. The court monitor expects that DMH will concurrently develop and implement a plan to measure performance on all three levels that will allow the department to begin generating valid performance data in 2004. Although DMH began to collect data in July 2003 for some of the exit criteria measures based on the earlier methodologies approved by the court in May 2002, DMH officials told us in November 2003 that this data collection was preliminary and that they would not begin to develop a specific plan for meeting these three requirements until the court approved the final performance targets, which occurred in December 2003.

Satisfying the court regarding DMH's demonstration of specific methods for collecting and verifying the accuracy of the performance data is likely to be challenging because of impediments to data collection as well as the fact that collected data may be incomplete or inaccurate. DMH and its providers face three major obstacles in collecting accurate data used to meet the actual performance targets: (1) establishing methods to collect

electronic data, (2) correcting known data deficiencies, and (3) ensuring the accuracy of information collected and reported by providers. A description of each of these challenges follows.

Data Not Collected Electronically

Although the final exit criteria measures and performance targets were not approved until December 2003, DMH began collecting monthly data nonelectronically for 8 of the 17 exit criteria measures from providers in July 2003.[41] For example, mental health rehabilitative services providers submit nonelectronic monthly reports to DMH on services provided to homeless consumers who are diagnosed with a serious mental illness. However, because the court approved revisions to some of the exit criteria measures in December 2003, providers will have to refine some of the information that they collect and report to DMH. In addition, the performance targets themselves, which did not exist prior to December 2003, will also affect the types of data collected. DMH officials told us that the department may be able to modify its enrollment and billing information system to collect some—but not all—of the data for the exit criteria measures, thus developing a central repository of information is still under discussion between DMH and the court monitor.[42] Beyond this, a related issue will be developing the capacity to appropriately factor in other data currently collected by DMH in a way that is not duplicative of the monthly data submitted by mental health rehabilitative services providers. For example, officials told us that DMH's school-based services program collects information that could be used as part of the calculation to meet the performance target requiring 75 percent of children and youth with serious emotional disturbances to receive services in a natural setting such as the home or school. However, the information collected through this program is not consumer-specific, nor is it linked to DMH's enrollment

[41]The eight measures requiring nonelectronic data collection, which were based on the earlier methodologies approved by the court in May 2002, include supported housing, supported employment, assertive community treatment, service to homeless adults, service to children and youth with serious emotional disturbances in natural settings, service to children and youth with serious emotional disturbances who live in their own home or a surrogate home, service to homeless children and youth with serious emotional disturbances, and continuity of care for children and youth. According to DMH officials, this information is entered into a separate database or compiled in a separate document. Under the new methodologies approved in December 2003, the court monitor expects DMH to establish an electronic process to ensure accurate performance data. However, the court monitor acknowledged that electronic data collection would be difficult for the two performance measures related to homeless consumers.

[42]As of January 2004, DMH was still determining the extent to which its enrollment and billing information system could be modified to collect this information and thus could not provide us with additional details.

and billing information system, which may, according to DMH officials, eventually be the primary mechanism for collecting data on many of the performance targets.

Deficiencies in Service Utilization Data

As part of the exit criteria requirements for the Dixon case, DMH conducted an initial consumer services review in the spring of 2003 that identified two major service provision gaps relating to services provided to children and youth that need to be addressed to ensure the accuracy of the performance target data collected by DMH. The court monitor's semiannual reports to the court have similarly highlighted these findings as areas requiring action. First, the review showed that many of the children and youth placed in residential treatment centers (RTC) do not have a clinical home at a CSA as intended and thus are not receiving DMH services. In addition to raising concerns about the coordination between DMH and RTCs, the lack of services for these individuals could also affect the accuracy of the data collected by DMH to meet a performance target that requires DMH to demonstrate that 85 percent of children and youth with serious emotional disturbances served by the system are living in their own or surrogate homes.[43] Second, according to the court monitor, the consumer services review also revealed a significant gap between the number of children and youth enrolled in DMH's system and the number who are actually receiving services. The court monitor's report acknowledged that the source of this gap, while unknown, could reflect flaws in DMH's data management system, its disenrollment policy,[44] or clinical standards, such as required follow-up with consumers who have missed an appointment. Since the four penetration rate performance targets are calculated using the number of enrolled consumers who received at least one service in the past quarter, DMH will need to determine the cause of this gap to ensure that its performance data are

[43]DMH officials recognize the need to address the gap between children and youth enrolled in RTCs and CSAs. While officials told us that DMH has put processes in place for ensuring that new children and youth placed in RTCs are linked to a CSA, the department is still working to develop a process for connecting children and youth already enrolled in an RTC with a CSA. However, according to DMH, addressing this gap requires coordination with other District agencies that typically have separate tracking mechanisms for children and youth referred to RTCs.

[44]As stated earlier, DMH officials told us that its enrollment data are inflated because the system does not actively disenroll consumers who are no longer receiving services. While inflated enrollment data resulting from do not directly factor into the exit criteria penetration rate calculations, it is an issue also identified by the court monitor that DMH needs to resolve. The court monitor stated in January 2004 that DMH is taking steps to implement a policy that would disenroll consumers no longer receiving services.

accurate. As of March 2004, DMH had not provided us with the number of consumers who were enrolled and receiving services within a 90-day period.

Accuracy of Information Reported by Providers

Beginning in July 2003, DMH began collecting unaudited monthly data from mental health rehabilitative services providers for a range of exit criteria measures, including the provision of supported housing and supported employment.[45] The department has also begun to collect preliminary discharge data from St. Elizabeths Hospital and local hospitals providing acute care to mental health care consumers. However, as of November 2003, neither the mental health rehabilitative services providers nor the local hospitals were required to track this information, and DMH did not have processes in place for verifying the accuracy of these data. DMH's Director told us in December 2003 that DMH is planning to incorporate reporting requirements as part of the recertification process for mental health rehabilitative services providers. As of January 2004, DMH was planning to collect quarterly discharge data from local hospitals but was still working out the details. Until these reporting processes are put in place, DMH will continue to collect discharge data from a combination of St. Elizabeths Hospital (for adults) and mental health rehabilitative services providers (for children and youth).[46] Even after hospital reporting processes are implemented, the court monitor and DMH expect some difficulties in collecting comprehensive discharge data. For example, a DMH consumer may seek care in a local hospital that does not typically serve DMH consumers and thus does not provide quarterly data to DMH. Recognizing potential challenges in collecting data from local hospitals, the court monitor proposed—and the court approved—as one of the 17 performance targets, a continuity of care performance target that allows DMH to limit its measurement against this exit criteria measure to "known" inpatient hospital discharges.[47] The court monitor expects DMH to include in its plan specific strategies for obtaining and verifying the accuracy of these data. The potential lack of accurate data—for example, from local hospitals—may mean that some discharged individuals are not factored into the data used to measure performance. In addition, the lack

[45]DMH officials told us that this information is self-reported and, aside from some site visits to providers in July and August 2003, the data are not separately verified by DMH.

[46]In July 2003, DMH collected discharge data from two hospitals that have agreements to serve DMH children and youth, but has not requested this information on a routine basis.

[47]According to DMH, hospitals have indicated a willingness to submit discharge data to DMH.

of consumer-specific data collected by DMH to meet the performance targets will also be a challenge. For example, because mental health rehabilitative services providers do not submit the names of each homeless consumer served, just the total number of these individuals served, information submitted is not consumer-specific and thus may be duplicative, compromising the accuracy of the measurement. The court monitor has also told us that DMH will need to verify that the performance target data are unduplicated.

Comments from DMH and the Court Monitor and Our Evaluation

DMH provided written comments on a draft of our report. DMH's comments are included, with our detailed responses, in appendix II. The court monitor provided technical comments, which we incorporated as appropriate.

In its comments, DMH stated that the court-ordered plan for the reform of the District's mental health system envisioned comprehensive and sweeping reforms, noting that accomplishing such reforms would result in over 50 percent of DMH's budget being redirected in a 5-year period. DMH described six broad changes to the District's mental health system in the court-ordered implementation plan. These changes included (1) implementing a mental health authority, (2) instituting systems of care, (3) developing a new set of accountability functions and changing the oversight and monitoring of mental health services, (4) incorporating consumer protections, (5) shifting the methods and operations for financing the delivery of inpatient and outpatient mental health services, and (6) creating a new Department of Mental Health with new responsibilities for operating within the city government. In addition, DMH stated that in spite of the District's failure to meaningfully participate in the last 20 years of mental health reform, DMH is moving aggressively to become a positive contributor to the health and well being of the community and to persons in priority service groups.

DMH commented that the draft report addressed several issues in depth while overlooking other reforms prominent in the final plan and the legislation creating DMH and other services such as Assertive Community Treatment, Supported Employment, and Supported Housing. The scope of our work was the status of DMH's efforts to establish a community-based system of mental health care, focusing on four key areas of reform central to meeting the exit criteria for the Dixon Decree. While we believe that the other reform initiatives and services are important, we believe that DMH's status with regard to meeting the exit criteria is an appropriate gauge of compliance with the Dixon Decree. We believe that making a

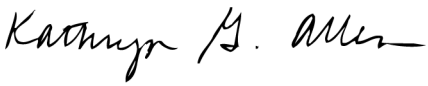
comprehensive assessment of the system's performance before DMH begins reporting on the exit criteria is premature.

DMH also provided specific comments that clarified, updated, or added information regarding its status in implementing the final plan (see app. II). Where appropriate, we incorporated these changes into the report.

As agreed with your office, we plan no further distribution of this report until 30 days from its date of issue, unless you publicly announce its contents. At that time, we will send copies of this report to the Director of the District of Columbia Department of Mental Health. We will also make copies available to others upon request. In addition, the report will be available at no charge on the GAO Web site at http://www.gao.gov.

Please call me at (202) 512-7118 or Carolyn Yocom at (202) 512-4931 if you have questions about this report. Major contributors to this report are listed in appendix III.

Sincerely yours,



Kathryn G. Allen
Director, Health Care—Medicaid
and Private Health Insurance Issues

Appendix I: Major Court Actions Related to District Compliance with the Dixon Decree

Date	Court action
1974	A class action lawsuit was filed in the U.S. District Court for the District of Columbia on behalf of District residents institutionalized at St. Elizabeths Hospital.
1975	The court determined that the District and the federal government had a joint responsibility to provide the plaintiffs community-based treatment in the least restrictive conditions. This ruling is known as the Dixon Decree.
1980	To comply with the court order, the involved parties drafted a final implementation plan that generally required an assessment of the plaintiff class members and periodic reports on progress in establishing a community-based system.
1984	Congress passed legislation that required the District to complete implementation of an integrated coordinated mental health system by October 1, 1991.[a] Congress transferred sole responsibility of establishing the required local mental health services to residents of the District.[b] The transfer was not effective until October 1, 1987.
1992	The court determined that no progress had been made to comply with the final implementation plan. The involved parties therefore developed a second plan. This plan is known as the service development plan.
1993	The court appointed a special master to oversee implementation of the service development plan.[c]
1995	The court determined that the District was still unable to comply with the terms of the service development plan. As a result, the involved parties negotiated a third plan, whose goals the District met. This plan is referred to as the Phase I agreement.
1996	The parties negotiated and began to implement a fourth plan, which was significantly broader in scope and required activities such as hiring personnel and developing a homeless service plan. This plan is referred to as the Phase II plan.
1996	The District admitted noncompliance with the fourth plan, and the plaintiffs requested the appointment of a receiver.
1997	On September 10, the court appointed a receiver on the basis that only a receiver provides the court with enough day-to-day authority to force compliance without causing confusion and ambiguity in the administration of the commission.
2000	On March 6, with agreement of all parties, a new receiver, referred to by the court as a transitional receiver, was appointed and officially assumed this role on April 1. The transitional receiver was scheduled to return control of the mental health system to the District between January 1 and April 1, 2001.
2001	On April 2, the court approved the transitional receiver's final plan and required the District to implement it. The plan provided a policy framework for meeting the Dixon mandate, including developmental milestones but not specific service targets.
2002	On May 22, the court found that the District was capable of implementing and was in fact implementing the final plan and thus terminated the receivership. The order also appointed the former transitional receiver as court monitor of District compliance with the final plan, and it approved exit criteria agreed upon by all parties. The monitor was directed to report to the court and the parties no less frequently than every 6 months.
2003	On December 11, the court approved a revised set of exit criteria, which replaced the criteria approved in May 2002, with measurement methodologies, definitions, performance targets and qualitative requirements. In addition, the court ordered that the case would be dismissed when (1) the court monitor affirms that the District has complied with all of the performance targets and qualitative requirements and the court accepts that finding; or (2) the District moves for dismissal and demonstrates "substantial" compliance with the performance targets and qualitative requirements and the court determines the case should be dismissed.

Source: GAO summary of documents from the U.S. District Court for the District of Columbia.

[a]24 U.S.C. 225b(a)(2) (2000). The statute was amended in 1991 to require the District to complete implementation by October 1, 1993.

[b]24 U.S.C. 225b(a)(1) (2000).

[c]The special master's powers included the ability to require compliance reports, make formal and informal recommendations to the parties, and mediate disputes.

Appendix II: Comments from the District of Columbia Department of Mental Health and GAO's Response

Note: GAO comments supplementing those in the report text appear at the end of this appendix.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF MENTAL HEALTH

Office of the Director

March 18, 2004

Kathryn G. Allen
Director, Health Care-Medicaid
and Private Health Insurance Issues
U.S. General Accounting Office
Washington, D.C. 20548

Dear Ms. Allen:

Thank you for this opportunity to comment on the Draft Report on the "District of Columbia: Status of Reforms to the District's Mental Health System" (GAO-04-387). Enclosed are our comments on the Report.

We appreciate the diligence and professionalism of Carolyn Yocum and her team.

Sincerely,

Martha B. Knisley
Director

Enclosure

DC DEPARTMENT OF MENTAL HEALTH COMMENTS TO THE DRAFT REPORT ON THE STATUS OF REFORMS TO THE DISTRICT'S MENTAL HEALTH SYSTEM

Summary of Comments

Thank you for this opportunity to comment on the Draft Report on the **"STATUS OF REFORMS TO THE DISTRICT'S MENTAL HEALTH SYSTEM".** Below are a number of general comments and several specific comments.

The Reform of the District's mental health system is quite sweeping in nature. As correctly stated in the Draft Report, the Court ordered Plan adopted by the Federal Court in *Dixon v. Williams* in May, 2001, contemplated comprehensive reforms in the District's mental health system. In broad terms the reforms contemplated included six broad changes:

1. The Court ordered Plan required the overall system be restructured to include the development of a mental health authority. Such a change when realized would result in the Department making shifts in up to 30% of its budgeted functions.

2. The Plan called for far-reaching changes in mental health practices. In many areas the Plan required the system to meet best practice standards of existing services. In other areas the Plan required the system be expanded to include more contemporary and useful programs particularly in the area of child and youth services that arguably was an area where the District's performance had been dismal. The new Department was required to develop services and supports in accordance with a "systems of care" approach.

3. The Plan required a set of new accountability functions and a complete change in the oversight and monitoring of mental health services.

4. The Plan spoke to consumer protections and the District implemented broad statutory changes within weeks after the new Department of Mental Health was created.

5. The Plan contemplated a complete shift in methods and operations for financing the delivery of inpatient and outpatient services.

6. Finally the Court Ordered Plan required the District create a new Department of Mental Health with new responsibilities for how the Department operates within city government.

The Court Ordered Plan also required many specific changes be made that fell outside of the six broad categories above. The reforms that were required if accomplished would actually result in the most sweeping changes required of a "state" level mental health program in the country in the past fifteen years. If accomplished, the new Department of

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Mental Health would be redirecting *over* 50% of its budget in a five-year period. This is a huge task for a well functioning agency let alone a new agency that is required to carry out both state and local functions.

The Draft Report largely describes two aspects of one of the reforms the agency has undertaken, the implementation of the grievance process and specific aspects of the work of the newly developed Office of Accountability.

The Draft Report goes into great detail on one operations function, claims processing which in and of its itself is not a tenet of the reform of the system but rather an operation to help carry out of the reforms in the system. The Department though has done seminal work to create the "clinical home", access requirements, changes in crisis support and introduction of cultural competency standards, development and implementation of provider qualifications, quality improvement and agency management requirements. Further, massive work is underway to put in force service standards for the first time in this system's history.

From there the report speaks to several issues in depth while overlooking other issues prominent in the *President's New Freedom Commission Final Report*, the Court Ordered Plan and the MH Reform Act of 2001 including Title II of that Act, or new services and practices, including but not limited to Assertive Community Treatment, Supported Employment or Supported Housing.

There is also substantial development underway in the child and youth system of care, including actions to return youth to the city from out of District institutions. Only one reference is made in passing to the creation of Care Coordination and the Access Helpline. The reference was only related to the Unit's enrollment function. The new Department has awarded for the first time a peer advocacy contract; is implementing a Charter agreement with the Department of Health to fundamentally change how persons with co-occurring problems are served and has implemented a major program to introduce medication best practices. The Department was also faced with an enormous to clean up problems associated with past billing practices and poor record keeping. After two years of work by the Department the District wrote down uncollectable receivables dating back to 1992, completed and submitted cost reports dating back to 1988 and completely re-structured its billing practices.

In summary, in spite of the District's failure to meaningfully participate in the last twenty years of mental health reform, the new Department is moving aggressively to become a positive contributor to the health and well being of our community and to persons in our priority service groups.

Specific Comments

Section: What GAO Found

See comment 1.

1. This section, the lead into the report references only a portion of the requirements of

2

the Mental Health Reform Act and the Court Ordered Plan. Notably the Draft Report is silent on development of "systems of care" which are the true cornerstones to the Court Ordered plan and to the legislation creating the Department. These functions are central to the Department's core mission. For example there has been a dramatic increase in enrollment for both children and adults and the gains and challenges in improving consumer access, including but not limited to the outreach efforts made to local community groups, the calls made to the ACCESS Helpline, the location of new staff at Children's Hospital, the expansion of staff into schools, into the Family Court and other locations. DMH began contracting for child and youth services which had been disregarded during the ten years prior to the Department being created, resulting in many children being thrown into the Special Education system, incarcerated in the juvenile justice system or languishing in residential treatment after being placed there from the foster care system.

See comment 2.

2. There are a myriad of consumer protections called for in Title II of the MH Act beyond the grievance policy. These protections include improved policies and rules for seclusion and restraint, information privacy, retention of civil rights, consent for youth, medication administration, consent to treatment, service planning, durable power of attorney, declarations of advance instructions, conditions of mental health treatment and separate legislation for the modernization of the Ervin Act.

See comment 3.

3. In FY 2002 when the MHRS system was first implemented payments were made to providers within 60 days on average; however, this time frame has been reduced significantly. This section therefore does not accurately portray payments to providers in FY 2003. Fiscal Year 2003 MHRS billings net of $ 4 million in initial denials that were returned for further adjudication was $30,429,329 by early January, 2004[1].

Further 77% of those claims were paid in 30 days and an additional 12% were paid in 60 days. If two providers who experienced significant edit problems in their initial claims are subtracted from the equation, DMH payments within 30 days were 82% of claims and another 13% were paid within 60 days. Clearly payments were as prompt as most 3rd party payor sources across the country, private or public. Thus slow payment cannot be substantiated although the perception of this slow payment persists. Clearly the changes providers had to make to a fee-for-service system have effected their cash flow but the conventional wisdom that this is associated with slow payment by DMH is not fully warranted.

Results in Brief (page 3)

See comment 1.

1. This section does not reference new services, the creation of the "clinical home", new service planning, provider requirements and access/outreach requirements---all centerpieces of the Court Ordered Plan.

See comment 2.

2. The Draft Report refers to affordable housing as absent, yet the Department has done a

[1] By 2-05 this amount had grown to $ 37 million with approximately 5 million in denials still outstanding. We assume the final billings for FY 2003 net of final denials will reach between $35 and $40 million.

3

massive re-write of the Housing Plan written during the Receivership period to increase the number of affordable housing units that can be made available. The Department has sought and secured additional funding and continues to expand affordable housing at a pace equal to or greater than any other jurisdiction in the country. Every month new subsidies and new housing units are made available and DMH has successfully stayed ahead of demand. DMH has developed over 120 units of new housing this past year and have somewhere between 300-500 units in the pipeline based on financing arrangements being completed now.

See comment 2.

3. DMH is not attempting to develop additional acute care beds, rather we are attempting to re-locate them.

Now on pp. 5-10.

Background/ System Prior to the Plan (pages 5-8)

See comment 2.

1. On page 6 there is a reference to a delay in hiring senior managers as reported by the Transitional Receiver as one of two reasons for his extending the date for ending Receivership. This statement is out of context. The Transitional Receiver points to the need for new senior staff to get underway with their tasks but is more explicit about needing more time to get major initiatives underway. Indeed the Director hired senior staff at a remarkable speed. The Senior Deputy Director, one of the three Deputy Directors and two CEOs relocated to the District within four months. Two other Deputy Directors came on board as did the General Counsel, Acting Chief Clinical Officer, who was later made permanent and the Chief Regulatory Counsel. The Director hired 9 senior staff within four months of being appointed Director of the agency. Although we cannot speak for the Transitional Receiver (Court Monitor), we believe he would say today that assuming the probationary requirements could be met within six to seven months was unrealistic and in no way indicative of the Department's capacity to manage its own affairs at that time.

Now on pp. 10-12.

Final Plan and Exit Criteria (pgs. 9-11)

Now on p. 12.
See comment 4.

The Chart on page 11 is excellent depiction of the phases and expected results for the time period. However it appears the assumption has been made that DMH has not begun work on meeting the 15 system performance targets, or begun using consumer functioning and consumer satisfaction data. In fact the Office of Consumer and Family Affairs has just submitted a report on consumer satisfaction reviews conducted in November, 2003. DMH has not reported on these but has initiatives underway in each of these areas to meet each of the performance targets. Given that the Chart is labeled expected results---not reported results--- there should be a distinction that the "step has been started". It is correct to state that DMH has not begun submitting performance target data although work is underway to begin that process.

Now on pp. 13-19.

DMH Has Assumed Oversight Authority and Responsibility for Providing Care (pgs. 11-18)

See comment 1.

1. DMH has taken on a whole new responsibility for creating a "system of care". The

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MH Reform Act defines "system of care" and makes explicit the responsibility for the Department to develop systems of care for both adults and children. Inherent in developing systems of care are development of collaboration, financing, resource allocation, training and delivery of services across all appropriate public systems.

To be effective, a system of care is built on the individualization of mental health services and supports for each person (and their family and supporters) articulated in an individualized recovery or resiliency plan. Each plan should be designed to promote recovery and resiliency and develop social, personal and community living skills including helping a person meet their basic and essential human needs. This means that it is DMH's responsibility to develop an integrated, community-based mental health service system, with outreach, emergency services, crisis intervention and stabilization, age-appropriate educational support and job readiness along with housing support, family and caregiver support and education. For children it means adding prevention and early intervention

The section does a thorough job of describing the infrastructure supports for a large part of the mental health reform -- creating the MHRS. However, in doing so, it creates the impression that developing MHRS infrastructure has been the single major activity of the Department over the past two years. On balance it is one of six major activities for the Department during this time.

See comment 2.

2. The Draft Report references leadership positions that have experienced turnover or long periods of vacancy, without providing important explanatory details, especially for the two examples discussed. The *first* Chief Financial Officer left after one year because of her mother's illness. The appointment of a replacement was delayed approximately nine months in favor of retaining a senior health care executive to finish the 12-year-old Cost Reports and complete the overhaul of the reimbursement functions for St. Elizabeths Hospital.

Further DMH and the CFO determined that making a change during the budget period would not be in the best interest of the Department. It appears the authors of this report may have included the Transitional Receiver's CFO. This individual declined to be considered for the position before the Department was formed for personal and health reasons. His decision was well known before the Department was created and he stayed to help with the transition. On the other hand Win Dearing, Deputy Director for Administration and Finance has been in his job since the inception of the Department.

Frances Priester was appointed to the position of Director of Consumer and Family Affairs only three months after the incumbent left the Department to take a post in the mayor's office.

DMH assumed the role of Licensing Community Residential Facilities (CRFs) within five months of the passage of the 2001 Reform Act. DMH had no budget for this function, yet hired and trained staff on the standards, upgraded the standards and established a competency based training program. DMH cleaned up the licensing

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program that was woefully behind, for the first time issued sanctions where needed and met the never previously achieved goal of licensing all facilities within a one year time frame.

See comment 5.

On provider audits, the report does not reference that there were no standards for provider audits; that provider audits had never been conducted before; that prior to the Reform Act of 2001 and the subsequent passage of rules, the providers had never been required to update treatment plans; and that treatment plan requirements had never been backed up by reviews and sanctions. It was fully expected that providers would not be in compliance and that this first round of audits conducted within 6-9 months of each provider's initial certification would be a good test of where improvements needed to be made.

See comment 6.

With respect to investigations of unusual incidents, the system had never experienced a review of unusual incidents. Also, unusual incidents range from consumers returning late for dinner to injury and abuse. Therefore DMH is faced with thousands of unusual incidents that in the normal course of family life would be routine behavior for teenagers. The DMH sorts through incidents to very quickly conduct reviews on serious incidents while routinely reviewing less serious problems. More importantly, DMH is trending incidents now. This is an excellent risk management and quality improvement tool.

Now on pp. 18-19.

DMH Continues the District's Historical Role as a Direct Provider (pgs. 16-18)

See comment 2.

The reference to the Core Service Agency as the largest provider is accurate but the portrayal of the public core service agency as having an increase over the next largest provider of three times obscures the fact that DMH added over ten new providers in FY 2003. The addition of new providers and additional consumers to other existing providers accounted for more growth in the system than did increased enrollment at the Public Core Service Agency.

See comment 2.

With respect to St. Elizabeths, the Transitional Receiver did not put a time frame on reductions at the hospital. We believe the Court Monitor would agree that stabilizing the new system to meet the Balanced Budget Act changes to Medicaid reimbursement, creating MHRS and changes in the DMH Housing Plan and ACT would be necessary to sustain decreases without creating more turmoil in the community. After 30 thirty years experience of de-institutionalization, the field has learned that decreasing state hospital census should be done planfully to not add to homelessness, increase in incarceration rates and general turmoil and risk in individual consumer's lives. Also we believe the Court Monitor would agree the closure of DC General and failures at Greater Southeast Hospital make gaining support for adding new psychiatric services within local hospitals more difficult. In fairness, the report should reference such external events that are beyond the control of DMH yet have a substantial impact on our ability to achieve our mandates.

The St. Elizabeths budget has already been reduced an additional $2 million in FY 2004 and will be reduced again in FY 2005. The Hospital's census is not hostage to housing

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concerns, contrary to some of the reported observations. Supported housing subsidies and units are available and the DMH has speeded up this schedule for availability this year. DMH is ahead of schedule for developing housing capacity and already has one of the largest local housing programs in the country.

The St. Elizabeths Hospital has also undertaken massive reform in the past two years: 1. All of the hospital's operations were moved from the West to East Campus in order to reduce costs. St. Elizabeths received a CMS certification without conditions for the first time in five years. St. Elizabeths developed a treatment mall, which was praised by the CMS Certification Team that recently surveyed the hospital. Likewise the PCSA had *no* information system when it was formed in late FY 2001 and is now implementing a new modern system, The PCSA has also modernized its clinical programs and has reformed its medical services, pharmacy and the payeeship program. It has added a new homeless program, the Sobering Center and ahs reformed the Child/Youth Crisis Services.

See comment 7.
Now on pp. 20-26.

Enrollment and Billing System is Designed to Coordinate Clinical, Administrative, and Financial Processes (pgs. 18-25)

The title of this section reflects a significant misapprehension. The enrollment and billing systems are not the major functions in the design of the clinical, administrative and financial processes. The billing system is an administrative function, but it only helps with the major administrative design function that is the shift from a non-performing contract system operated entirely as if it were a grants system to a performance-focused fee-for-service-system that will serve as the system's segui to a fully developed performance driven system. As a result of this reform, DMH is only paying for services provided directly to consumers rather than paying for an agency's capacity to serve consumers. One major difference, DMH implemented this system in eighteen months rather than over a period of years that has generally been the case in most states and local jurisdictions. DMH was placed at a serious disadvantage of having to make this shift more quickly than desirable mostly as a result of past performance and changes in Medicaid regulations. DMH successfully made that shift but not without needing considerable technical support and an infusion of local resources.

Now on pp. 27-31.

See comment 2.

Consumer Centered Approach Blending Choice and Protection is Evolving (pgs. 25-29)

As stated above, the Report focuses on one area, consumer grievances, to the exclusion of a large body of protections that are new and updated in the District. For example, DMH has updated seclusion and restraint rules and policies and the District has passed a bill modernizing the Ervin Act. To many consumers, these areas are of equal or greater importance than the grievance rule implementation.

Consumer-centered services and consumer rights are evolving concepts all around the country. No assessment of the District's progress in these areas would be complete without a comparison of our progress in each area compared to national trends.

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See comment 2.

The Draft Report mentions a "gap in documentation of the consumers' participation in – and agreement with---their treatment plans". Prior to FY2002, this documentation was not a requirement, nor was the level of consumer participation now required even expressed as important. It is not surprising that a gap in documentation was found. What is most encouraging was evidence found in 59% of the plans. This would be considered a large success in most jurisdictions after the first audit. Traditional mental health professional and academic views are still mixed on the efficacy or advisability of the consumer's role and direction of treatment. Thus DMH faces an uphill battle on this approach.

Even more difficult is implementing consumer choice. Most states do not even attempt to provide choice at the level DMH requires choice. One reason states flock to using Medicaid waivers is to limit choice. Therefore DMH is introducing a wholly new concept. The statement that DMH is "addressing gaps" in consumer choice does not go far enough. More accurately, DMH is promoting consumer choice and introducing a variety of mechanisms to give consumers more choice.

This section references the Enrollment Specialist role but does not reference the training on choice, the requirements for provider policies, the role of the Access Helpline and Care Coordination overall and the role of Delivery Systems Management in both consumer choice and the development and implementation of the "clinical home" concept.

See comment 8.

The Draft report makes reference to comments of the Court Monitor and the local PAMI agency concerning problems with consumer choice and community follow-up upon discharge from the hospital. However, these observations were not quantified, and the report provides no other basis upon which to assess their reliability. Finally the last portion in this section references the new grievance policy but does not reference that DMH was instrumental in laying the groundwork for it in the MH reform legislation, that DMH held countless sessions with advocates and stakeholders on both the rule drafting and the implementation of the grievance policy, contracted out an external grievance peer support function, and trained all providers and numerous stakeholders on the entire process. DMH is effecting profound systems change, not just drafting policy.

Now on pp.31-39.

DMH Faces Challenges in Developing the Capability to Measure Performance Against Exit Criteria (pgs. 29-38)

See comment 9.

This section also presents an incomplete account of events leading to the development of products, in this case the targets for measuring performance against the exit criteria. DMH proposed the 17 performance targets after DMH did extensive research on performance targeting, including convening a panel of nationally recognized experts in delivery systems management.

The discussion of the reasons for not including baseline data misses a critical factor. Many of the services and supports contemplated in the performance targets did not exist

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prior to the DMH becoming a Department. For example ACT was not offered prior to mid FY 2002 therefore there was no baseline. Most communities across the country cannot measure the success of ACT because the programs being offered do not have fidelity to the ACT model even after years of development. Thus having a baseline here or anywhere would be impossible.

Suitable baselines are not available with respect to most of the measures. When DMH did its research on other jurisdictions for comparison purposes, the DMH found that the services being measured did not exist in a form by which genuine comparison could be made. Thus baseline became less relevant and DMH progress against itself became the choice for measurement. This means that DMH will be creating a baseline agreeable to the Court Monitor and Plaintiffs.

See comment 10.

Finally the last part of this section focused on data collection and data integrity. Both are important issues. However, DMH would submit, given the total disregard for data collection and integrity prior to FY 2001, DMH is making good progress. DMH tied electronic data collection to the development of the eCURA system. It is a struggle for new providers struggling to meet data requirements, while attempting to get off the ground organizationally and administratively. This process has also been slowed by the work necessary for providers and the Department to become HIPAA compliant. This federal regulatory initiative has caused massive re-writes and delays nationwide.

Some of the performance criteria do not lend themselves to electronic data collection. For instance, both the adult and child homeless services targets are largely tied to the development of access and new programs not yet fully organized. The performance targets reflect the developmental nature of these service approaches.

The reference to deficiencies in service utilization data again do not take into account the developmental stage of the process. Five different departments in city government carry out RTC placement. Several departments have their own case management and tracking systems. Thus DMH and its partner agencies are re-structuring the entire service system. This means that assignment of youth in RTCs to a clinical home is quite complicated. A review of the SAMHSA literature and research explicates this. Again this is a national phenomenon. DMH does refer all youth to a Core Service Agency that it places in RTCs and is working with other agencies to make this a reality across the board in FY 2004, but it would not be wise to take on this task without first assuring we are not creating confusion and duplication.

The statement that there is a gap between the number of children and youth enrolled in the system and the number actually receiving services lacks quantitative support. Such an assessment is complicated by the fact that DMH cannot produce an accurate count of persons actually receiving services until all claims data has been submitted by provider agencies. In other words, there is a lag time between confirmation of enrollment and confirmation of receipt of services.

The Draft Report cites the collection of discharge data as an accuracy problem, but does

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not acknowledge that the performance targets that lead to the correct processes being put into place were not formalized until November, 2003. DMH has already moved far beyond what is reported in this Draft Report in two months now that we are all clear on what information is to be reported. The Draft Report fails to mention that until a court order is in place, DMH has no legal grounds to request information from an organization it neither regulates nor contracts with, including most of the private hospitals in the Districts. It should be noted that all the hospitals we have met with have been very willing and supportive of this activity and we are already getting good verifiable data from several hospitals.

This section does not seem to acknowledge fully that DMH is moving ahead quickly to overcome deficiencies in performance targeting that date back 20 to 30 years. DMH is encouraged by the support and progress it has made to date in these areas.

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The following is our response to DMH's letter dated March 18, 2004.

GAO's Response to DMH's Comments

Our responses below correspond to the comments numbered in the margin of DMH's letter.

1. DMH commented that the draft report references only a portion of the requirements of the Mental Health Reform Act and the court-ordered plan and does not discuss the development of "systems of care," which it characterizes as cornerstones of the court-ordered plan and the legislation creating DMH. We believe that the report adequately characterized the immensity of the tasks faced by DMH. The scope of this report encompassed the actions taken by DMH since its creation to comply with the Dixon Decree. As such, we reported on the status of the District's effort to establish a community-based system of mental health care, with a focus on four key areas of reform that were confirmed by the court monitor to be central to compliance with the Dixon Decree. Because many of the services and initiatives under way were still evolving and had incomplete data at the time of our work, we did not believe that a comprehensive assessment of DMH's progress on all activities was appropriate. As a result, we focused on the data collection methods for the 17 performance targets relating to the District's compliance with the court's exit criteria.

2. We modified the report where appropriate to address information about the additional consumer protections, the number of supportive housing arrangements, the relocation of acute care beds, the hiring of senior managers, the status of leadership positions at DMH, the increases in service provision at the public CSA, the difficulty of adding new psychiatric services in local hospitals, and the results of provider audits.

3. DMH stated that the draft report did not accurately portray payments made to providers in fiscal year 2003 and that our findings on slow payments to providers could not be substantiated. We modified the report to reflect the updated data on billings for fiscal year 2003. However, we disagree that payment problems could not be substantiated. Provider contracts with DMH were tied to the billing projections, which meant that DMH could not pay claims for providers who exceeded their projections until their contracts were changed. The court monitor's 2003 reports also indicate that claims payment has been an area of concern. Our draft report acknowledged that DMH had made the necessary contract changes to allow providers to be paid for the remainder of fiscal year 2003. Additionally, we cited DMH's plan

for fiscal year 2004, which aimed to prevent similar billing problems from occurring.

4. With regard to our assessment of DMH's status in meeting court expectations, DMH commented that it believes table 2 reflects our assumption that DMH has not begun work on meeting the 15 system performance targets or begun using consumer functioning and consumer satisfaction data. DMH stated that it has not reported on these steps but has initiatives under way to meet each one and therefore the table should reflect that the "step has been started." As of March 2004, the court monitor had not received evidence that these steps were in process, but confirmed that DMH had conducted preliminary work that had not been captured in court documents. Thus, we modified the report to reflect that these steps were "in planning." In addition, the report refers to the work under way to meet the exit criteria, such as the consumer telephone survey conducted in 2003 to help DMH develop its consumer satisfaction review and data collection efforts from providers for some of the exit criteria measures.

5. DMH commented that the draft report did not indicate that there were no standards for provider audits, that provider audits had never been conducted, and that DMH expected that providers would not be in compliance. The draft report stated that DMH's new responsibilities for regulating and monitoring providers, including conducting audits, were a shift away from the structure of its predecessor office and that the monitoring framework was in the early stages of implementation. We revised the report to reflect DMH's expectation that providers would not be in compliance with the new standards.

6. With regard to the draft report's discussion of unusual incidents, DMH noted that the District's mental health system had never experienced a review of unusual incidents and stated that unusual incidents ranged in severity from consumers returning late for dinner to injury and abuse. DMH also stated that it is faced with thousands of unusual incidents and said that it sorts through incidents quickly and is beginning to identify trends. We modified the report to reflect the range of severity of unusual incidents.

7. DMH commented that the report's subheading, "Enrollment and Billing System Is Designed to Coordinate Clinical, Administrative, and Financial Processes" represents a significant misapprehension. DMH stated that the enrollment and billing systems are not the major functions in the design of the clinical, administrative, and financial

processes. DMH characterized the billing system as an administrative function that helped with the transition from a grants-based system of delivering services to a performance-focused fee-for-service (FFS) system. We believe that the enrollment and billing system is an important design component. For example, the final court-ordered plan outlines that a comprehensive enrollment and billing system that links payment to treatment is necessary to access federal Medicaid revenue through the mental health rehabilitation services option, which was identified in our October 2000 report and in the final plan as a key component for reforming the District's mental health system. Further, DMH's enrollment and billing information system is used to enroll consumers, reimburse providers, and, according to DMH officials, may eventually be the primary mechanism for collecting the performance data required to meet the Dixon exit criteria.

8. Regarding our findings on consumer choice and community follow-up after a consumer's discharge from the hospital, DMH stated that comments from the court monitor and the local Protection and Advocacy for Individuals with Mental Illness (PAIMI) agency (University Legal Services), were not quantified and that the report provides no other basis upon which to assess their reliability. As of January 2004, DMH was in the process of developing methods to track consumer choice and had not reported data to the court on community follow-up after discharge from the hospital. Absent that data, we relied on the court monitor's judgments regarding DMH's progress in implementing the court-approved plan. Additionally, the District mental health advocates with whom we spoke are part of the federally-mandated protection and advocacy system.

9. DMH commented that our findings on DMH's capability to measure performance against the exit criteria (1) presented an incomplete account of events leading to the development of the performance targets and (2) missed critical factors for why baseline data were not included in the exit criteria requirements, specifically, that having a baseline would be impossible because services did not exist before DMH became a department and there was no basis for comparison with other jurisdictions. In response to DMH's first concern, we revised the report to clarify that the court monitor did not act alone to develop the targets for measuring performance against the exit criteria. Regarding the second concern, the draft report stated that baseline data were omitted because historical data are generally incomplete and many of the performance targets require the collection of new information from DMH and its providers. We modified the

report to reflect that DMH was unable to identify comparable baselines from other jurisdictions.

10. With regard to our findings on data collection and integrity, DMH commented that the draft report did not take into account the developmental stage of the data collection process. DMH noted that some of the performance criteria do not lend themselves to electronic data collection, gaps in service utilization data for children and youth placed in residential treatment centers must be viewed in the context that five city departments carry out placements, and the draft report's statement that there is a gap between the number of children and youth enrolled and the number receiving services lacks quantitative support. We modified the draft to reflect that the two performance measures related to homeless consumers do not lend themselves to electronic data collection, which was confirmed by the court monitor, and that addressing the gap in service utilization data requires coordination with other District agencies that typically have their own tracking systems. The draft report stated that according to the court monitor, the first consumer services review for children and youth revealed a gap between the number of children and youth enrolled and the number receiving services. DMH did not provide us with the number of children and youth enrolled and receiving services. In the absence of that data, we relied on the court monitor's report, which cited the gap identified by the consumer services review.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

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