Quality Matters, LLC

28 Tierney Drive
Delmar, NY 12054-3729
Phone (518) 527-1918
Fax (240) 352-1434
E-mail: cjsundram@alumni.ksg.harvard.edu

Final Report

Risinger v. Concannon
United States District Court
District of Maine

By

Clarence J. Sundram, Esq.
Independent Consultant

July 2003

Introduction

Pursuant to an Agreed-Upon Order of the United States District Court, District of Maine, I was retained by the Department of Behavior and Developmental Services as an independent expert consultant to advise the Defendants on how to achieve full compliance with the Settlement Agreement in this matter expeditiously and effectively. As described below, the primary role of the consultant is to make recommendation regarding the timely access to the services covered in a Settlement Agreement in this matter, rather than to evaluate or address issues pertaining to the quality of services provided.

Specifically, the Order requires a written report setting forth recommendations, after considering whether adequate resources have been allocated to achieve expeditious and effective compliance, and whether institutions and systems in place charged with achieving compliance are able to do so. The report is to identify barriers or impediments to compliance and, if such exist, to make recommendations for removing those barriers expeditiously and effectively. An interim report was submitted on March 31, 2003 addressing some of the issues with the data collection and tracking system and supplemented by a progress report on May 19, 2003.

The underlying Settlement Agreement of May 3, 2002 establishes timeliness standards for the provision of in-home behavioral health services and case management services, and for the development of Individual Treatment Plans and Individual Support or Service plans. It also requires that the Department "will develop and implement a system that allows DBDS to identify and track each individual child under the age of 21 for whom a request has been made to an approved agency . . . in order to disclose whether, for that child, the timeliness standards . . . have been complied with and in order to be able to generate data disclosing the nature and extent of compliance with the timeliness standards set forth in this Agreement. (Settlement Agreement, May 3, 2002, paragraph 7)

In preparing this report, I have reviewed the following documents:

- Settlement Agreement, May 3, 2002
- Agreed-Upon Order of February 12, 2003
- Affidavits of Lisa Burgess, February 28, April 1, May 1, May 30, 2003 and July 1, 2003
- Affidavits of Lori Jones, February 28, April 1, May 1, May 30, 2003 and July 1, 2003
- Children's Enrollment Form (CEF)
- Entering A CEF
- Instructions for Monthly Status Update Form for In-home Support Services
- Instructions for Monthly Status Update Form for Case Management Services
- In Home Support Data Entry
- Enrollment and Closure Data Entry
- Risinger Settlement Agreement Report (first-quarter), November, 15 2002
- Risinger Settlement Agreement Report (second-quarter), February 14, 2003
- Rosters of persons on the Waiting List for Case management and In-Home Services, dated May 13, 2003
- EIS monthly reports of children on the waiting list February –July, 2003
- Flow Chart for Children's Services Central Enrollment for Habilitation and Behavioral Health Services, dated May 27, 2003, and related descriptions of the process
- Procedures For Centralized Enrollment And Triage
- Documents pertaining to the rate-setting process for case management services
- Technical Specifications document for EIS, dated May 27, 2003
- Maine Care Children's Cabinet, Annual Report 2002 and Annual Report Update 2003.

In addition, I have met with various staff of DBDS who are involved in developing and maintaining the information system utilized for tracking children who have applied for services, and in interacting with providers of in home services and case management services; with representatives of the Governor's Office and the Legislative Children's Oversight Committee; with Family and Parent Organizations; and with representatives of provider agencies. I also visited several provider agencies where I met with their management and direct support staff, and with parents of children served by the agencies. A complete list of the persons with whom I met is attached as Appendix A.

Many of the persons with whom I met traveled significant distances for the meetings and put aside other obligations to make themselves available. Their candid discussion of the issues and their opinions were enormously helpful in assisting me to understand and appreciate the importance of the services at issue, the strengths of the existing service system and the barriers which have prevented the timely delivery of needed services to children and families. I acknowledge their assistance with gratitude.

Background

The services at issue in this matter are supplied by private providers who contract with the Department of Behavioral and Developmental Services for the provision of case management services (29 Provider agencies) and in-home supports to children who are eligible for such services (47 Provider agencies). These services must be provided to Medicaid-eligible children within 180 days of their "start date," as that term is defined in the Settlement Agreement. Figure 1 displays the overall waiting list for in home services (IHS) since February 2003, as well as the children waiting for services for more than 180 days.[1] These data indicate that while 80% of the 1084 persons on the waiting list in February 2003 were waiting for more than 180 days for in home services, by July 2003 that percentage had dropped to 23.5% and the total number of people on the waiting list had also declined to 637.

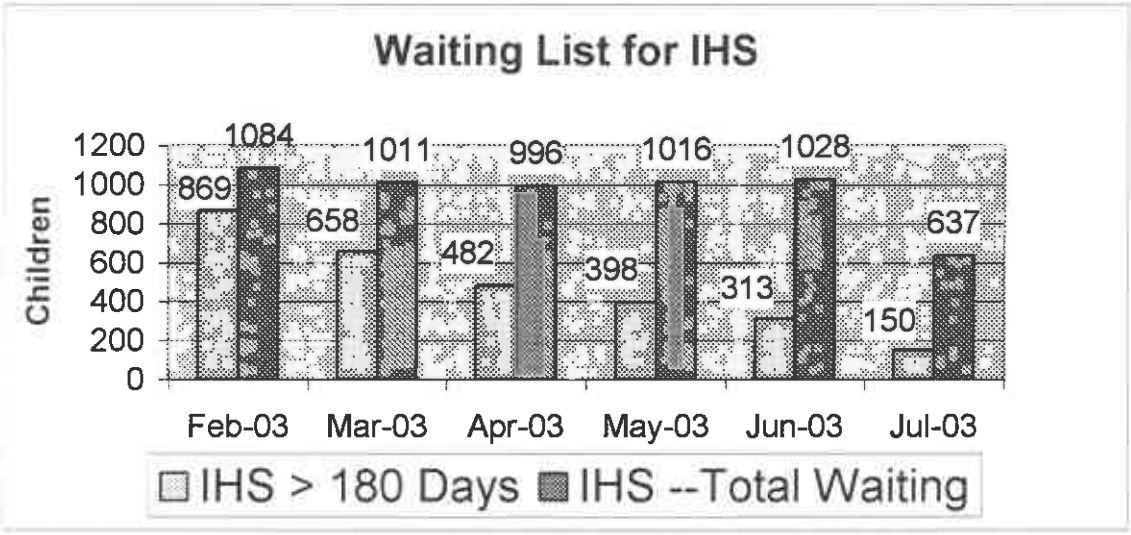

Figure 1

There are two different programs of in-home support services. Children's Habilitation Services are provided pursuant to section 24 of the Maine Medical Assistance Manual to children who have a diagnosis of mental retardation or autism and meet the ICF/MR level of care criteria. Providers are paid according to rates negotiated with DBDS, which are based on their costs. Approximately 1000 children received

[1] Table 1 in Appendix B contains all of the data submitted by DBDS.

services pursuant to this section in FY 2002. There are 152 children on the waiting list for section 24 services and, of these, 27 have been waiting for more than 180 days as of July 1, 2003, according to data supplied by the Department. (See Figure 2) For this service, the overall numbers of persons waiting did not decline significantly between February and July 2003, but the proportion of those waiting more than 180 days declined from 77% in February to 17.8% in July.

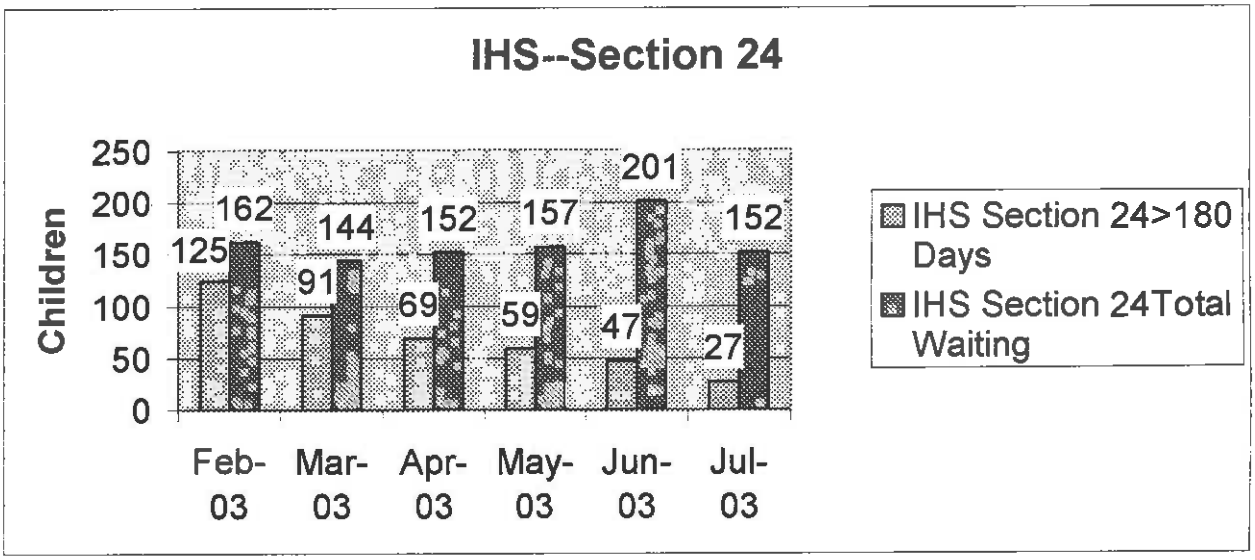

Figure 2

In-home treatment services are provided pursuant to section 65H of the Maine Medical Assistance Manual to children who have a DSM IV Axis I or Axis II diagnosis and have behaviors that cannot be managed by parent/guardians, or which puts them at risk for out of home placement. Providers are paid according to rates fixed by the Department of Human Services, the State Medicaid Agency, which are currently $25/hr. for BS-1 staff (direct support staff) and $75/hr. for BS-2 clinical supervisors. These rates are not cost based. Approximately 1450 children received services under this section in FY 2002. There are 485 children on the waiting list for section 65 services and, of these, 123 have been waiting for more than 180 days as of July 1, 2003, according to data supplied by the Department. (See Figure 3) The data demonstrate that there were significant declines in the numbers of children waiting for service and in the proportion of those waiting for more than 180 days. In February 2003, 80.6% of the 922 children on

the waiting list had been waiting for more than 180 days. By July, that percentage had dropped to 25.4% and the total number of children had fallen to 485.

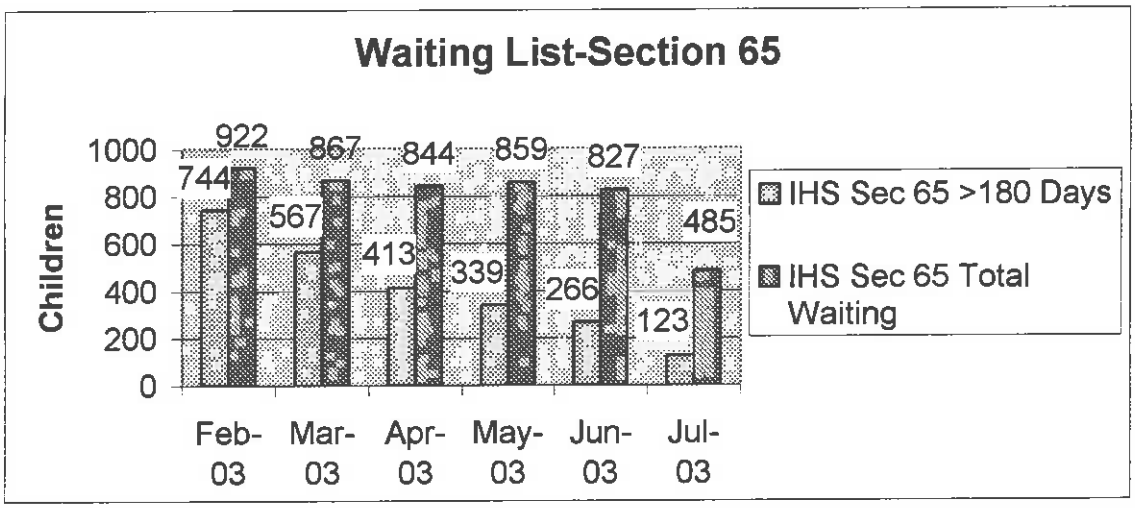

Figure 3

Case management services assist children and families develop Individualized Support Plans (ISPs) and assist in arranging for the services identified in the plans and in assessing the effectiveness of such services. Providers are paid according to rates individually determined based on their costs for each of two levels of case management, subject to maximum caps on reimbursement. Level 1 case management addresses moderate to minimal needs, specifically for those families needing information or help accessing resources or guidance in doing their own case management and advocacy. The Level 1 case management rate is based on a caseload of 25 clients per case manager and is reimbursed at an average monthly rate of $227 per client. Level 2 case management addresses moderate to extensive needs and is for families with complicated clinical situations and resource needs or family difficulties that need more help that Level 1 case management can provide. The Level 2 case management rate is based on a caseload of 15 clients and is reimbursed at an average monthly rate of $420.

Case management services were provided to 5,857 children in fiscal year 2002. There are 463 children on the waiting list for case management services and, of these,

nine have been waiting for more than 180 days as of July 1, 2003, according to data supplied by the Department.

The Settlement Agreement also requires that Individualized Treatment Plans be developed for in-home behavioral services for children who have a medical need for such services covered under section 24 or section 65, within 120 days of the start date. As of July 1, 2003, there were 521 children on the waiting list for the development of a treatment plan, of whom 189 children were waiting for more than 120 days without a treatment plan. (See Figure 4) While the overall waiting list has declined moderately from 625 to 521 between February and July 2003, more than a third of those on the waiting list have been waiting for more than 120 days.

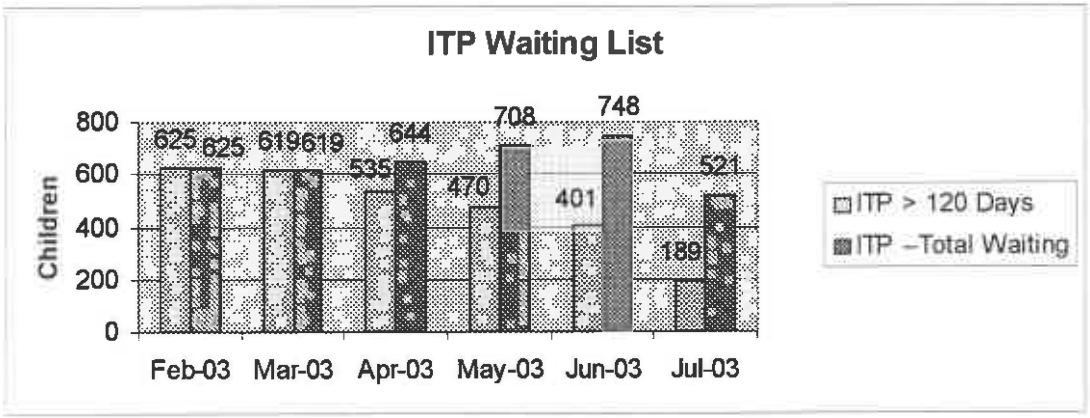

Figure 4

Observations

The services covered by the Settlement Agreement are of vital importance to families and children who are eligible for the services. In the many meetings with parents and representatives of parent groups, it was evident that these services are essential not only for family preservation, but also to provide some semblance of normal family life despite the significant demands on the families' physical, financial and emotional resources created by the mental health needs of their children. In the absence of these services, there are limited options available to families. They can either seek out of home placements for their children, or neglect their needs, with the probable eventual outcome of requiring crisis services or an emergency psychiatric hospitalization. These options are inevitably substantially more expensive for the State and usually undesirable for the child and family as well.

Families offered many opinions about the ways in which the service system could be improved, but there was a broad and general approval of the services provided. As one parent put it, "it's a good system once you've got it, but getting it is the problem."

The data submitted by the Department of Behavioral and Developmental Services show a reduction in the number of children who have not received the covered services within the timelines established by the Settlement Agreement, but there are still a substantial number of children who are unserved within the required timelines. The largest waiting lists are for in home services under section 65H (most of which is in Regions 2 & 3) and for the development of individualized treatment plans. (See Figures 4, 5 and 6, and Appendix B, Table 1)

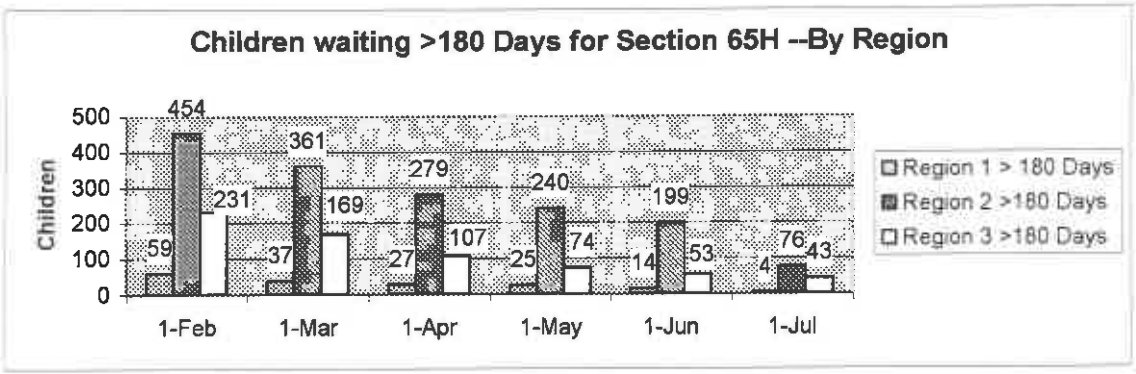

Figure 5

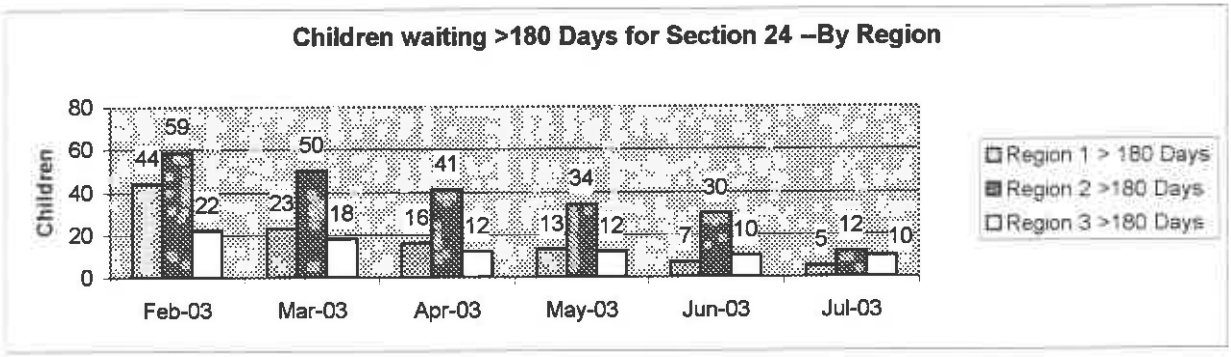

Figure 6

Systemic Barriers to Timely Services

There are three principle barriers to services provided in accordance with the timelines contained in the Settlement Agreement.

a. For in-home behavioral services, the primary problem is insufficient availability due to the difficulty in recruiting, training and retaining staff for these positions. These problems are especially acute in remote areas, which are far from sites where providers are located.

b. For the development of an Individualized Treatment Plan (ITP) within 120 days, the problem is that there is often no one to develop the plan, as provider agencies will not start this process unless they will be delivering the service. There is no method of reimbursing their costs otherwise. Thus, the delays in linking the child with an in home service provider, for which the maximum timeliness standard is 180 days, can also affect the development of an ITP within 120 days.

c. Access to timely services of case managers is affected by the manner in which funding is provided to case management agencies, which requires that, if they do not have current vacancies, they must have enough children waiting to make up a caseload in order to cover the cost.

There are also reports that access to professional evaluations required to establish eligibility, which is part of the intake process, and to re-certify eligibility, is difficult in some parts of the state and for some types of disabilities (e.g., autism, Asperger's syndrome, neuropsychiatic evaluations). It is not clear to what extent this problem affects the timeliness standards at issue, as the reports received are anecdotal.

Each of these issues is addressed in the recommendations in this report.

With respect to the tracking system, it remains a work in progress although improvements have been made in the reliability and accuracy of the data provided. The Department's decision to rely upon the EIS to track children's timely access to the covered services placed this program into a large and complex computer system that is intended to manage virtually all of the data needs of the Department. That system itself is under development and has been undergoing testing, revision and debugging. The system is intended to meet not only the managerial needs of the Department, but also to permit it to respond to information demands arising out of other litigation involving constituent groups of the Department (e.g., class action lawsuits involving adult mental retardation services, the AMHI Consent Decree and other Medicaid waiting list litigation, etc).

This tracking system is one of the priorities in implementing the EIS system. From what I have observed, as resources have been needed to address the particular needs of this part of the data system, the Department has been able to allocate the manpower and secure additional consultation as needed. But the complexity of the EIS has caused some design changes and improvements, that were intended to address initial problems, not to work as intended (e.g., process wizards), requiring more time and effort to implement. In this process, the specific needs of this part of the data system have to be prioritized with other pressing needs, which the EIS must also fulfill. The necessary resources appear to be available but the policy decision to utilize the EIS for this purpose has brought a level of complexity to the task that has caused inherent delays in making the revisions to procedures as the need has arisen. Some of the benefits of the EIS, such as its capacity to produce an almost infinite variety of reports from the data, to provide a scheduling and tickler function, have not been realized as yet, as they have been assigned a lower priority. (See recommendations)

As I previously reported, the system design issues are not the only problem in producing timely and accurate reports of the status of the waiting list for services. Since the entire system is highly dependent upon the quality and timeliness of inputs from provider agencies, and the extent to which they comply with expectations placed upon

them for producing accurate and updated information, the Department has been continually addressing this need with provider agencies. I have been informed that there are 5-6 provider agencies that are responsible for most of the late reports. The Department has addressed this issue by shortening the time frames for providing reports and updates to the Department from monthly to within 5 working days, and has increased the responsibility placed upon the provider for submitting complete and accurate reports. It is now sending back incomplete Children's Enrollment Forms to providers and has determined to withhold payment from providers that do not submit timely reports. Regional team leaders have been instructed to make auditing of data a priority. The new procedure for Centralized Enrollment and management of the waiting list should reduce the likelihood of inaccurate information in the EIS, especially duplicate counts of the same child who is on the waiting list for multiple providers.

The effectiveness of these measures in producing timely and accurate reports can only be judged by examining the end product. The Department staff have developed internal procedures to continually examine the quality and accuracy of the data being entered into the EIS and it is my opinion that these procedures are reasonable and are resulting in increasingly reliable reports. As noted in my progress report, due to the time needed to enter and audit the data, the EIS is not able to provide "real time" information. Even as these processes are being implemented to verify the accuracy of the information, the status and numbers of the children on the waiting list might be changing. For these reasons, the reports may not be precisely accurate; however, they provide a reasonable accounting of the status of children on the waiting list.

While I have met with the staff involved in the various phases of data collection, entry, and auditing, and have discussed system design issues with the EIS staff, consultants and BDS managers, I have not personally audited the reports produced.

Recommendations

I. Reducing or eliminating the waiting list for in-home supports services and case management services requires expanding the availability of such services. There are two broad strategies that can be utilized to increase service capacity. The first is to facilitate the expansion of existing provider agencies or the development of new services, especially in areas which are unserved or underserved. The second is to examine the utilization of existing resources to determine whether there are opportunities for more efficient utilization/deployment of resources.

A. Expanding Service Capacity

1. The ability to expand service capacity is highly dependent upon the ability to recruit, train and retain additional workers who are qualified to provide the services needed, especially in areas that are unserved or underserved. There are several barriers at present inhibiting recruitment and retention. Chief among them is the manner in which these positions are structured and compensated. Most families receive a few hours of in-home service before and/or after the normal school day. For a worker to get sufficient hours to equal a full workweek, it is often necessary to work six or seven days. These front-line jobs are typically structured as hourly positions, with no benefits, sick leave, or vacation time. If the child is hospitalized or out of the home, if the family goes on vacation or does not require service on a particular day, the employee's paycheck is affected. Providers report that worker's schedules are changed frequently based on the child's and/or family's changing needs. Employees are required to travel from their homes to work sites that may be at a great distance and involve substantial travel time. Most employers do not reimburse travel time and expenses, further reducing the real wages of these direct support staff. Not surprisingly, turnover in these positions is high and places children and families in the position of continually adjusting to changes in staff in their homes and enduring service interruptions.

One provider agency that has full-time employees, provides benefits, and reimburses travel expenses reports a more stable and committed work force, but also reports running a substantial annual deficit for this service. Other providers have simply ceased providing the service.

The Department needs to reexamine the reimbursement rate structure and adjust it to cover the reasonable and necessary costs of providers to support a stable workforce. While there is a role for part-time, hourly workers, this cannot be the mainstay of the service system. The front-line positions should pay a living wage, and provide a reasonable benefit package.[2] The state should establish a policy on reimbursing, through its rate structure, the cost of travel and transportation for front-line workers who must travel beyond a normal commuting distance (e.g., 15 to 20 miles, 20 to 30 minutes).

In re-examining the rate structure, the Department should also ensure that the rates cover reasonable administrative costs for supervision, training, staff attendance at training, meetings among multiple direct care workers supporting the same family, meetings with case managers, and, for case managers, time spent in discharge planning for children who are in hospitals or residential facilities. One provider agency has estimated that its true costs in providing section 65H services are $33/hr. (the same as is currently reimbursed for adult in-home services) rather than the $25/hr. currently paid.

2. While the Katie Beckett waiver program offers some options for people who do not qualify for traditional Medicaid, this program is not well-known and, reportedly, even some staff in the Medicaid agency do not fully understand how it works. This program has great potential to enhance services to families in need. I recommend that the Department support the creation of a position in each region

[2] The State may want to explore the option of asking for federal approval for employers to buy into Medicaid for low wage workers, and determine if this is a cost-effective strategy for meeting employees' benefit needs.

of a Katie Beckett coordinator to provide education and information to families and service providers, and to provide training and assist families in the application process for the Katie Beckett waiver.

3. For families eligible for in-home services, who have gone unserved beyond the 180 day timeline, and for whom there is no clear prospect of service in the reasonably near future due to the unavailability of providers in the geographic area, the state should develop a mechanism (e.g., vouchers) authorizing the family to secure services by qualified independent contractors for an interim period, and provide oversight of such services through BDS regional office staff or through a contract with a qualified clinician. Once this system is in place, BDS should consider the appropriate use of vouchers in unserved and underserved areas well in advance of the maximum timelines for service.

4. For children who do not have an Individualized Treatment Plan within 90 days from the Start Date, the Department should ensure that they are assigned to Level 1 case management to develop a preliminary treatment plan, recognizing that this plan will undergo revision once the child is assigned to a provider agency.

5. With respect to case management services, providers report that if their caseloads are full, they must wait until they have 15 new children assigned before they hire a case manager as the reimbursement rates are predicated on this caseload (Level 2). If there are fewer than 15 children, the agency will incur the cost but will have no way of recouping its expenses through the reimbursement system. The Department should provide start-up funding to provider agencies to hire case managers to serve children who are nearing the 180-day deadline.

6. To expand the recruitment pool, the Department should institute a procedure to waive the training requirement if there is reliable information about equivalent qualifications (e.g., potential part-time workers with 4-year college degrees may

be able to demonstrate equivalent training against the 50-hour training requirement for BS-1s.)

B. **Utilization of Existing Resources.**

1. The Department needs to develop a Quality Assurance program to regularly evaluate the quality, responsiveness and effectiveness of the in home services and supports provided to families. In this process, it will be important to examine provider discharge planning practices, and whether service planning clearly identifies goals to be achieved by the services, and criteria for discharge. Part of this program should include utilization review to identify capacity that may be available through a review of:

   a. high users of services and the effectiveness of the services provided to them;
   b. families whose needs may have changed or diminished;
   c. families who will require a level of maintenance over the long-term to preserve gains that have been achieved;
   d. families who can be discharged from service. (At present, very few discharges occur due to the achievement of service goals. Families are understandably reluctant to terminate services that are so hard to obtain. This reluctance is even greater if there is no assurance of priority if the family's needs change and services are once again required. Appropriate discharges may be possible if they are accompanied by an individualized crisis plan that assures prompt and priority access to services should they be needed in the future.).

2. The full implementation of the Centralized Enrollment system for in-home services should also help improve the efficient use of existing resources. When multiple provider agencies receive direct referrals, and do not know when the family enters into service with another agency, each agency may be performing their own assessment and own eligibility determination. Eventually only one of

them will become the provider agency, which is eligible to bill for its services. The time spent by the other agencies is essentially wasted and non-reimbursable. (One agency estimated that 20% of their time is spent on inappropriate referrals and people whom they do not serve.)

III. Administrative recommendations

1. Recognizing that the timelines in the Settlement Agreement are outer limits for the provision of services, the Department should develop a tickler system, independent of the EIS until this function is operational, to:

    a. Identify cases that are 30 days from the maximum waiting period, and assign them for special review to determine what steps might be taken to provide timely services (For example, cases described in recommendations I (A)(3) (4) and (5)); and

    b. keep track of dates when re-evaluations are due, or the Katie Beckett renewal is due, to alert providers and families in sufficient time to ensure that deadlines are not missed.

2. The Department should develop a practice of sending providers a monthly report generated by the EIS for all children assigned to the agency, with a request to verify the accuracy and current status of all information with respect to each of the children. These EIS reports may prove useful to provider agencies in their own management of their caseloads, while also reinforcing the importance of timely and accurate information in the EIS system.

3. While the Department has expressed an intention to withhold payment as a tool to ensure the timely completion by provider agencies of the reports required to track children on the waiting list, no written procedures exist either to make all staff

aware of this process or give provider agencies adequate notice of their potential financial jeopardy. This policy should be appropriately adopted and formalized.

Clarence J. Sundram, Esq.
Independent Consultant

Appendix A

List of Persons Attending Meetings with Independent Expert Consultant

The following persons were interviewed or attended meetings to discuss children's mental health services. Peter Rice of the Disability Rights Center, and Patrick Ende, of Maine Equal Justice Partners attended portions of these meetings. Joan Smyrski, Assistant to the Deputy Commissioner, assisted in arranging the meetings and attended most of them.

In-home Support Providers:

Lee Jellison, Care & Comfort
Teresa Barbieri, Woodfords Family Services
MJ Dougherty, Woodfords Family Services
John Carroll, Richardson Hollow MH Services
Chris Davis, Richardson Hollow MH Services
Charity Webster, Support Solutions
Sara Camolli, Support Solutions
Ann Rossignol, Waban
Tammy Smith, Gentiva
Tricia Kail, UCP
Sally Larrabee, Charlotte White Center

Governor's Office:

Kathryn Ainsworth, Senior Policy Advisor
Kurt Adams, Legal Counsel to the Governor
Todd Lowell, Assistant Attorney General

Central Office / Management Staff:

Sabra Burdick, Acting Commissioner, DBDS
Ron Taglienti, Children's Systems Manager
Lisa Burgess, Director of Children's Services, BDS
Lori Jones, Children's Services Information Systems Manager
Richard Hayward, System Team Leader
Michael Biddle, System Analyst
Dennis Tan, Consultant

Other BDS Staff

Jeanne Tondreau, Family Information Specialist- Region II
Lynn Dorso, Family Information Specialist- Region II

Gary Kaszas, Enrollment Specialist, Presque Isle
Bonnie McLaughlin, Enrollment Specialist, Lewiston
Michael DiFillipo, Quality Improvement Specialist, Lewiston
Michael Austin, Quality Improvement Specialist, Lewiston
Cindy Trinward, Quality Improvement Specialist, Portland
Brenda Gagnon, Regional Supervisor, Portland
Teresa Barrows, BDS Region II

Family / Parent Organizations:

Patricia Small, Children's Oversight Committee
Carrie Horns, NAMI Maine
Carol Tiernan, Gaining Empowerment Allows Results (GEAR)
Kimberly Megrath, Southern Maine Parent Awareness
Sharon Harbin, Children's Oversight Committee
Janice LaChance, Maine Parent Federation
Donald Brann, Autism Society of Maine
Cathy Cyr, Autism Society of Maine / Parent
Rebecca Weinstein, DD Council

Case Management Providers:

Jeff Janell, Youth & Family Services
Donna Dwyer, Sweetser
Trish Niedorowski, WINGS
Catherine Ryder, Tri-County Mental Health Services
Blanca Gorrola, Community Counseling Center
Katie Campbell, Community Counseling Center
Lynda Flood, Catholic Charities Maine
Ed French, Sweetser
Heather Bingelis, Richardson Hollow Mental Health Services
Tricia Kail, UCP
Richard Brown, Charlotte-White Center
Susan Hancock, Catholic Charities Maine

Site Visits

Lewiston, Maine

Support Solutions – Children's In-home Supports (section 24)

Sandra Hebert, Director of Children's Services
Heather Jacoby, Program Manager
Faryl Orlinsky, Program Manager
Sara Comolli, Program Manager
Charity Webster, Program Manager
Danielle Driski, BS 1

Will Liberty, BS 1
Tanya Labbee, Parent
Terri Allen, Parent

Richardson Hollow – Children's In-home Supports (section 65 – H.)

Linda Hertel, Chief Executive Officer
John Carroll, Assistant Clinical Director of Children's Services
Libia Coutinho, BS 1 and Team Leader
Lee Howitt, BS 1
Theresa Winslow, Parent
Christine Corson, Parent
Denise Esancey. Parent

Bangor, Maine

Wings -- Case Management Services

Trish Niedorowski, Executive Director
Cindy Schroeder, Clinical Director
Wanda Anderson, Program Supervisor
Ann Hartman, Program Supervisor
Jo DeVries, Case Manager
Beth Cotrell, Case Manager
Helen Spencer, parent
Mrs. Hermanowski, parent

Charlotte White Center -- Case management and In Home Services

Pamela Jacobson, Office Manager
Sally Larrabee, Coordinator, In Home Supports
Stephen W. Pratt, Sr., BS 1
Brad Bosse, BS 1
Suzanne Sovin, BS 1
Judy Lenihan, BS II
Glenn Davis, consumer
Janice Tolman, parent

Appendix B -- Table 1

Waiting List Data– Feb 1-July 1, 2003[3]						
	1-Feb	1-Mar	1-Apr	1-May	1-Jun	**1-Jul**
Case Mgmt. >180 Days				4	4	**9**
Case Mgmt. –Total Waiting				259	398	**463**
ITP > 120 Days	625	619	535	470	401	**189**
ITP –Total Waiting	625	619	644	708	748	**521**
IHS > 180 Days	869	658	482	398	313	**150**
IHS --Total Waiting	1084	1011	996	1016	1028	**637**
IHS Sec 65 >180 Days	744	567	413	339	266	**123**
IHS Sec 65 Total Waiting	922	867	844	859	827	**485**
Region 1 > 180 Days	59	37	27	25	14	**4**
Region 1 > Total Waiting	68	55	59	68	69	**31**
Region 2 >180 Days	454	361	279	240	199	**76**
Region 2 Total Waiting	565	568	574	605	579	**275**
Region 3 >180 Days	231	169	107	74	53	**43**
Region 3 Total Waiting	288	244	211	186	179	**179**
IHS Section 24>180 Days	125	91	69	59	47	**27**
IHS Section 24 Total Waiting	162	144	152	157	201	**152**
Region 1 > 180 Days	44	23	16	13	7	**5**
Region 1 Total Waiting	64	47	58	64	96	**60**
Region 2 >180 Days	59	50	41	34	30	**12**
Region 2 Total Waiting	69	68	71	66	64	**41**
Region 3 >180 Days	22	18	12	12	10	**10**
Region 3 Total Waiting	29	29	23	27	41	**51**

[3] Data submitted by DBDS from EIS reports. Note that the report periods do not necessarily coincide with the report periods for data submitted in the monthly affidavits submitted by Lori Jones pursuant to Judge Singal's February 12, 2003 order. DBDS staff also report that the information relative to ITPs and case management was not entered into the EIS until late March or early April. The data from the more recent months is believed to be more accurate than the earlier numbers for many of the reasons described in the report.