FY 2012 PERFORMANCE PLAN
Department of Mental Health

MISSION
The mission of the Department of Mental Health (DMH) is to support prevention, resiliency and recovery for District residents in need of public mental health services.

SUMMARY OF SERVICES
DMH is responsible for developing, supporting and overseeing a comprehensive, community-based, consumer driven, culturally competent, quality mental health system that is responsive and accessible to children, youth, adults, and their families. DMH contracts with a network of community-based, private providers and also provides direct services through Saint Elizabeths Hospital, the Mental Health Services Division, the Comprehensive Psychiatric Emergency Program, and the School-Based Mental Health Program.

PERFORMANCE PLAN DIVISIONS
- Mental Health Authority (Includes Office of the Director)
- Saint Elizabeths Hospital
- Mental Health Services and Supports
- Mental Health Financing/Fee for Service
- Agency Management

WORKLOAD MEASURES

Workload Measures	FY09 Actual	FY10 Actual	FY11 YTD
Number of adult consumers served[1]	12,956	15,678	17,627[2]
Number of child and youth consumers served[3]	3,569	3,824	4,350[4]
Number of Comprehensive Psychiatric Emergency Program (CPEP) visits	4,271	3,943	3,921
Number of adult mobile crisis team visits	1,089	2,161	1,906
Number of child mobile crisis team visits	396	581	482
Crisis stabilization bed utilization[5]	76.48%	85.63%	88.27%
Number of claims audits conducted	35	16	43
Involuntary acute admissions to Saint Elizabeths Hospital[6]	12%	6.44%	2.80%

[1] Reporting for this indicator is calculated based upon the requirements of *Dixon* Exit Criterion # 7 (penetration rate for services to adults – persons age 18 and above). The data reported for FY 2009 represents the unduplicated adults receiving services through the MHRS program only. The approved reporting methodology changed in FY 2010, so the FY 2010 and FY 2011 data also includes unduplicated adults receiving services through the MHRS, School Mental Health, psychiatric residential treatment program (as monitored by DMH), Assessment Center and Wraparound programs.

[2] Represents preliminary data, based on data run as of, January 11, 2012 representing claims paid to date. Mental health providers have 90 days after rendering an MHRS service to submit a claim, which means that data for FY 2011 will not be finalized until after. March 31, 2012.

[3] See footnote 1.

[4] Represents preliminary data based on data run as of. January 11, 2012. See footnote 2 for explanation of claims lag effect on data reporting.

[5] Bed utilization rate is calculated by dividing the aggregate occupied bed days by the aggregate available bed days.

Mental Health Authority

SUMMARY OF SERVICES:
The Mental Health Authority supports the overall administrative mission of DMH, and encompasses the functions necessary to support the entire system. It is responsible for establishing priorities and strategic initiatives for DMH, as well as coordinating fiscal services, accountability functions, information systems, and service planning and policy development.

The Mental Health Authority monitors and regulates the activities of the public mental health system including certifying providers of mental health rehabilitation services and licensing mental health community residential facilities.

OBJECTIVE 1: Expand the range of mental health services.

INITIATIVE 1.1: Implement the D.C. Mental Health First Aid Expansion Project.
During FY 2011, the D.C. State Mental Health Planning Council (D.C. SMHPC) introduced Mental Health First Aid, an evidence-based public education program about the risk factors and warning signs of mental health problems, their impact, and common treatments as part of the inaugural Judge Aubrey E. Robinson, Jr. Memorial Mental Health Lecture Series. A Kick-Off meeting, four (4) community orientation sessions, and two (2) 12-hour Certificate Courses were conducted during the initial project phase. Mental Health First Aid was extremely well received by and attracted a diverse group of participants. There were 46 individuals trained across the two (2) Certificate Courses.
In FY 2012, DMH received funding through the State Homeland Security Grant program to expand Mental Health First Aid over the next two (2) fiscal years. The expansion project includes training of thirty (30) instructor candidates by the National Council for Community Behavioral Healthcare (National Council), a series of 12-hour Certificate Courses conducted by certified instructors from the National Council and the newly trained instructors from the District, as well as coaching/mentoring for the newly trained District instructors. During FY 2012, it is anticipated that a maximum of 30 persons will be trained as Mental Health First Aid Instructors and a maximum of 90 persons will complete the 12-hour Certificate Courses.

OBJECTIVE 2: Continually improve the consistency and quality of mental health services.

INITIATIVE 2.1: Improve the Community Service Reviews (CSRs) child/youth overall system performance score
The *Dixon* Settlement Agreement requires DMH to conduct child/youth CSRs using the agreed upon sampling methodology and assessment instrument in FY 2012 and FY 2013. DMH is required to contract with Human Systems and Outcomes, Inc. (HSO) to provide support for the annual CSRs, as well as consultation regarding targeted interventions for providers and system capacity building. DMH will also implement targeted interventions with low-performing child/youth providers with the goal of improving their scores. By

[6] The percent is based on the total number of quarterly Saint Elizabeths Hospital acute admissions excluding 15-day transfers and sub-acute divided by the total number of quarterly involuntary acute admissions in other District reporting facilities.

September 30, 2013, DMH will achieve an overall system performance level of 70% on the child/youth CSRs.

OBJECTIVE 3: Ensure system accountability.

INITIATIVE 3.1: Complete the work of the DMH Service Utilization Task Force.
The RAND Corporation Report on *Behavioral Health in the District of Columbia: Assessing Need and Evaluating the Public System of Care* was issued in October 2010. The RAND Report found large gaps in services for high percentages of DMH child and adult consumers in the mental health rehabilitation services (MHRS) program. DMH established a Service Utilization Task Force to centralize the collection and reporting of program and system-level measures for availability and regular dissemination to key stakeholders, and to inform quality improvement activities. The primary strategy is to:
1) develop a process for reporting and tracking data through the Internal Quality Committee (IQC) by January 2012; and 2) develop both adult and child services data dashboards, containing metrics on service utilization, key program measures, and consumer outcomes for MHRS and other services within the public mental health system by April 2012. Specifically, an MHRS services utilization data report will be designed and disseminated at regular intervals to program leadership, including the Deputy Directors of the Office of Programs and Office of Accountability, and the Directors of Child and Adult services. The report will be used to: 1) monitor consumer gaps in service with the objective to identify and intervene with subsets of consumers placed at particular risk of experiencing gaps or underutilizing services; 2) intervene at the system and provider-level to address barriers to access and continuity of care; and 3) evaluate the effectiveness of existing activities within these quality domains that are addressed within the agency performance plan. The development of data dashboards will serve a similar function, but will also integrate and create system-wide access to additional non-MHRS program-area performance data from diverse data sources that was previously unavailable.

INITIATIVE 3.2: **Publish Provider Scorecard.**
In FY 2010, the Office of Accountability (OA) implemented the Provider Scorecard that was piloted in FY 2009. This process included revision of the tools used to collect data for the Scorecard, as well as site visits and other data collection activities. The OA staff conducted chart reviews at 21 Core Service Agencies (CSAs) in order to collect data for the Quality Review section of the Scorecard. The Provider Scorecard assesses three (3) domains for each provider: Quality, Financial, and Compliance with regulations. Only providers who could be assessed across all domains were issued a Scorecard in FY 2010. Sixteen (16) providers were assessed across all three (3) domains, and were issued an overall Scorecard score for FY 2010. These results were shared among the 16 providers on February 28, 2011.

The FY 2011 Scorecard incorporated revisions based on feedback from DMH Senior Staff and community providers and was published on the DMH website on March 7, 2012.

Proposed Key Performance Indicators- *Mental Health Authority*

Measure	FY10 Actual	FY11 Target	FY11 Actual	FY12 Projection	FY13 Projection	FY14 Projection
Child/Youth CSRs overall system performance	49%	80%	59%[7]	65%	70%	Maintain 70%
Reporting process and tracking through Internal Quality Committee (IQC)	Not Applicable	Not Applicable	Not Applicable	June 2012[8]	Continued tracking and reporting through IQC	Continued tracking and reporting through IQC
Adult dashboard with service, program and consumer outcomes data	Not Applicable	Not Applicable	Not Applicable	June 2012[9]	Continued data generation and reporting	Continued data generation and reporting
Scorecard providers' average quality (adult) score[10]	77.36	Not Applicable	71.42	80.00	TBD	TBD
Scorecard providers' average quality (child) score	73.00	Not Applicable	63.27	80.00	TBD	TBD
Scorecard providers' average financial score[11]	82.86	Not Applicable	80.22	85.00	TBD	TBD

Saint Elizabeths Hospital

SUMMARY OF SERVICES

Adults requiring mental health treatment in a 24-hour inpatient setting may receive services at Saint Elizabeths Hospital. A treatment model has been implemented that parallels life in the community for the vast majority of individuals in the hospital's care. Currently, the Hospital provides both acute and long-term care to adults with either a forensic or civil legal status. It is gradually moving toward the sole provision of tertiary care (3-12 months) for individuals who need the structure and security of a public psychiatric hospital.

[7] As reported by the Dixon Court Monitor in his July 2011 report which is available on the DMH website (wwww.dmh.dc.gov)

[8] As part of the initiative to integrate key performance and outcome measures into standard reporting processes, some reporting and tracking will go through the Internal Quality Committee. This process in not developed and is expected to begin by June 2012.

[9] The Child dashboard has been up and running since April 2011. The Adult dashboard is expected to be developed by June 2012.

[10] Provider Scorecard data derived from provider quality of care in domains like treatment planning, functional assessments, transition planning and atypical medication monitoring. The FY 2010 provider overall Scorecard was published in February 2011 among providers only. The average compliance score was 99.24 but this domain was eliminated from the Scorecard in FY 2011. The baseline from the FY 2010 Provider Scorecard will be used to develop targets for subsequent fiscal years.

[11] Derived from items like provider claims audit results, financial documents, and internal auditing and claims review system.

The baseline from the FY 2010 Provider Scorecard will be used to develop targets for subsequent fiscal years.

OBJECTIVE 1: Continually improve the consistency and quality of mental health services.

INITIATIVE 1.1: **Improve and individualize active treatment options**.
This initiative includes several programs/activities. The competency restoration program provides individuals with 4-5 competency groups per week and the implementation of a weekly "mock trial" to provide experiential learning/practice for pre-trial individuals. The competency group leaders will utilize a new rating scale for assessment of competency to stand trial and communication with the treatment teams. The Readiness Ruler will be used to periodically assess/reassess individuals' stage of change regarding their substance abuse, which guides placement in the most appropriate treatment groups for the individuals' stage of recovery. The women's programming will include parenting/community living skills groups, women's health, women's hygiene and self care, and trauma groups. Discharge programming has been enhanced in the therapeutic learning center (TLC) with more in-depth lessons on distinct discharge planning issues (e.g., understanding benefits).

INITIATIVE 1.2: Improve staff training and development associated with clinical care.
The Hospital has just developed a comprehensive Safety Care Training Plan. In August 2011, seven (7) staff received train-the-trainer safety care training and they began training clinical staff on September 12, 2011. The goal of the training is to ensure all clinical staff are trained by August 2012 with 75% of nursing staff receiving the training by March 31, 2012.

Proposed Key Performance Indicators – *Saint Elizabeths Hospital*[15]

Measure	FY10 Actual	FY11 Target	FY11 Actual	FY12 Projection	FY13 Projection	FY14 Projection
Total Patients Served Per Day	327	300	288	291	288	288
Elopements per 1,000 patient days	.45	.68	.4 1	.45	.41	.41
Patient injuries per 1,000 patient days[12]			.27	.28	.27	.27
Medication variances that occurred for every 1,000 patient days	1.95	2.51	1. 58	2.38	2.27	2.27
Unique patients who were restrained at least once during month[13]	.4	.9	.4	.4	.4	.4
Unique patients who were secluded at least once during month	1.2	.5	.6	.6	.6	.6
Percentage of Patients re-admitted to Saint Elizabeths Hospital within 30 days of discharge[14]	7.0%	8.1%	5.2%	5.0%	4.8%	4.8%

Mental Health Services and Supports

SUMMARY OF SERVICES

Mental Health Services and Supports provides for the design, delivery, and evaluation of mental health services and support for children, youth, families, adults, and special populations to maximize their ability to lead productive lives. The activities include: organizational development (training institute, applied research and evaluation, community services reviews); child and youth services (early childhood and school mental health services, community alternatives for out-of-home, residential care, and diversion from juvenile justice system, youth forensic services and oversight of youth placed in residential treatment centers); adult services (supported housing, supported employment, assertive community treatment, forensic); care coordination (service access and suicide prevention and intervention services); integrated care

[12] Injury in the unusual incident report policy of the Saint Elizabeths Hospital is broadly defined to include any types of injuries regardless of the cause or severity level and the total number of patients injured represents all of the reported injuries including minor injuries treated with first aid alone. However, according to the National Research Institute (NRI) definition, the patient injury rate considers only those injuries that required beyond first-aid level treatment. Saint Elizabeths Hospital used to calculate the patient injury rate to include all of the reported injuries until December 2010. However, we recently modified the logic of our patient injury rate to make it consistent with the NRI's definition, and the patient injury rate provided herein is based on the modified definition: the number of 'major' patient injuries per every 1000 inpatient days. This data became available only since January 2011.

[13] The numbers are not whole numbers because they are monthly averages for the fiscal year and for many months no one was in restraints or seclusion.

[14] Data for June 2011 on 30-day readmission is not yet available as this indicator requires 30-day observation period following discharge.

[15] Patient days serves as the denominator for indicators 2, 3, and 4; Total number of unique patients serves as the denominator for indicators 5 and 6; Target data for FY12-FY13 was set in September 2011 when complete data for FY11 is not available; and FY14 projections repeat the FY13 projections.

(transition consumers from inpatient care to community); mental health services (government operated including same day clinic, multicultural program, deaf/hard of hearing and intellectual disability program, physicians practice group, outpatient competency restoration, pharmacy); and. comprehensive psychiatric emergency services (extended observation beds, mobile crisis, homeless outreach).

OBJECTIVE 1: Expand the range of mental health services.

INITIATIVE 1.1: Reduce the number of days that District children/youth spend in psychiatric residential treatment facilities (PRTFs).
DMH will establish a baseline for the total number of days that District children/youth spend in PRTFs during 1 year by using placement data for the period from May 1, 2011 through April 30, 2012. By September 30, 2013, DMH will reduce the number of bed-days that children/youth with serious emotional disturbances spent in PRTFs by 30%. The PRTF Review Committee, an interagency group convened by DMH that includes representatives from District child-serving agencies (Child and Family Services Agency, Department of Youth Rehabilitation Services, the Office of the State of Superintendent of Education, the District of Columbia Public Schools, and Court Social Services) shall continue to review and issue level of care determinations for proposed PRTF admissions and continued stay requests to ensure that all admissions and continued stays are medically necessary. DMH will track and report on length of stay, reasons for discharge, community services, and outcomes for children/youth discharged from PRTFs in FY 2012 and FY 2013.

INITIATIVE 1.2: Increase evidence-based practices that are appropriate for children/youth.
DMH will increase the provision of two (2) evidence-based practices (EBPs) that are appropriate for children/youth. The EBPs are Multi-Systemic Therapy (MST) and Functional Family Therapy (FFT). The provision of MST and FFT will be increased by 20% in FY 2012. The percentage increase in the provision of MST and FFT will be calculated by comparing the unduplicated number of children/youth served during the baseline period of FY 2011.

INITIATIVE 1.3: Continue the High Fidelity Wraparound Initiative (HFW) and increase the availability of HFW.

This initiative is a collaboration between DMH and District child-serving agencies (Child and Family Services Agency, Department of Youth Rehabilitation Services, and the Office of the State of Superintendent of Education) that began with the care management contract to DC Choices in June 2008. HFW is a family-driven, team-based process for planning and implementing services and supports. Child and Family Teams create plans that are geared toward meeting the unique and holistic needs of children and youth with complex needs and their families. It is an effort to address the overreliance on the use of psychiatric residential treatment facilities (PRTFs) and non-public school placements for treatment and/or education of youth with intense mental, emotional, or behavioral health needs.

The provision of HFW will be increased by 10% in FY 2012. The percentage increase in the provision of HFW will be calculated by comparing the unduplicated number of children/youth served during the baseline period of FY 2011.

OBJECTIVE 2: Increase access to mental health services.

INITIATIVE 2.1: Develop 300 net new supported housing vouchers, subsidies and/or capital housing units by September 30, 2013.
The *Dixon* Settlement Agreement requires DMH to develop a strategic plan that includes resource development to address the identified need for supported housing by September 30, 2012. The strategic plan will be developed in consultation with consumers and consumer advocates, including advocates for persons who are homeless. In addition, DMH will develop three hundred (300) net new supported housing vouchers, subsidies or capital housing units.

At a minimum, 200 of the 300 will be net new supported housing vouchers/subsidies. The remaining 100 may be satisfied through either net new supported housing vouchers or subsidies or net new capital units in development by September 30, 2013. A baseline number was established in conjunction with the completion of the *Dixon* Settlement Agreement. DMH will work collaboratively with the D.C. Housing Authority and the Department of Housing and Community Development to develop the net new housing vouchers, subsidies and/or capital housing units.

INITIATIVE 2.2: Expand access to supported employment services.
The *Dixon* Settlement Agreement requires DMH to establish a methodology for Core Service Agencies (CSAs) to use to assess the need for supported employment. After the methodology is established, beginning April 1, 2012 through September 30, 2013, DMH shall ensure that 60% of the total number of adults with serious mental illness (SMI) who are assessed for the need for supported employment and who express an interest during the treatment planning process are referred to supported employment services. DMH will also increase the number of consumers who receive at least one (1) supported employment service in FY 2012 by 10% over the total served in FY 2011. The percentage increase in the provision of supported employment will be calculated by comparing the unduplicated number of adults served during the baseline period of FY 2011.

INITIATIVE 2.3: Expand access to early childhood services (Health Futures Program). During FY 2010, in partnership with the DOH Early Childhood Comprehensive System (ECCS) Grant Coordinator, DMH launched the start-up phase of this pilot program that focuses on child and family-centered, and program consultation. The primary goal of child-centered or family-centered consultation is to address an individual child's (and/or family's) difficulties in functioning well in the early childhood setting. The programmatic consultation focuses on improving the overall quality of the program or agency and/or assisting the program to solve a specific issue that affects more than one (1) child, staff member, and/or family. The program is offered in Child Development Centers (CDCs). During FY 2011, a project evaluation was completed,

which recommended: (1) adding universal screening for social-emotional development for young children in the Healthy Futures CDCs to help identify children who need additional child-specific consultation services and referrals for developmental assessments; (2) building on the coordination with the Primary Project, an evidence-based early intervention implemented by DMH in five of the Healthy Futures CDCs in year one; and (3) adding an external, objective assessment of the changes in the classroom quality to increase the rigor of the evaluation measures. In FY 2012, the Health Futures Program will be offered in 24 CDCs and will coordinate with the Primary Project for referrals. In addition, universal screening will be offered in all CDCs.

OBJECTIVE 3: Continually improve the consistency and quality of mental health services.

INITIATIVE 3.1: Ensure provider compliance with the Continuity of Care guidelines regarding discharge planning and services provided post discharge from a psychiatric hospitalization. By September 30, 2013, DMH will ensure that: 1) 70% of adults and 70% of children/youth receive at least one (1) non-crisis service in a non-emergency setting within 7 days of discharge from a psychiatric hospitalization; and 2) 80% of adults and 80% of children/youth receive at least one (1) non-crisis service in a non-emergency setting within 30 days of discharge from a psychiatric hospitalization. DMH will also develop, monitor, and enforce Continuity of Care performance standards for the CSAs. These performance standards will be required in DMH policy and DMH Human Care Agreements.

OBJECTIVE 4: Ensure system accountability.

INITIATIVE 4.1: Continue to promote revenue enhancement.
In FY 2009, the District of Columbia Community Services Agency (DC CSA) transitioned into the smaller Mental Health Services Division (MHSD). One of the major goals is to generate revenue in support of operations. As the MHSD raised the productivity hours required for its staff to targets consistent with industry standards for privately operated mental health clinics, its productivity hours per month per staff FTE increased. The measure of productivity is based on the number of units of service provided to consumers. Increased productivity results in more medically necessary services being provided to consumers in the community, increasing community tenure and eliminating or reducing hospital stays. As its productivity increases, MHSD is able to increase its revenue and decrease the use of local dollars, along with its advantage of lower costs than the DC CSA because of its smaller size.

Proposed Key Performance Indicators – *Mental Health Services and Supports*

Measure	FY10 Actual	FY11 Target	FY11 YTD	FY12 Projection	FY13 Projection	FY14 Projection
Baseline and reduced number of bed days C/Y spend in PRTFs	Not Applicable	Pending	Pending	Baseline Established	30% reduction in number of bed days	Maintain 30% reduction
Increase C/Y receiving Multi-Systemic Therapy (MST)	Not Applicable	Baseline for MST	129	20% increase in FY11 MST baseline	20% increase in FY12 MST baseline	Maintain 20% increase
Increase C/Y receiving Functional Family Therapy (FFT)	Not Applicable	Baseline for FFT	82	20% increase in FY11 FFT baseline	20% increase in FY12 FFT baseline	Maintain 20% increase
Increase C/Y receiving High Fidelity Wraparound (HFW)	Not Applicable	Baseline for HFW	211	10% increase in FY11 HFW baseline	20% increase in FY12 HFW baseline	Maintain 20% increase
300 net new supported housing vouchers/subsidies and/or capital housing units	Not Applicable	Baseline and methodology for vouchers/subsidies and capital units in development	1,396	Strategic plan and resource development for supported housing need	200 supported housing vouchers/subsidies and/or 100 capital housing units	Maintain 200 supported housing vouchers/subsidies and/or 100 capital housing units
Method to assess need for supported employment and referral of consumers to service	Not Applicable	Baseline for total number of consumers served in supported employment	761	60% of interested consumers referred to supported employment	60% of interested consumers referred to supported employment	Maintain 60% referral of interested consumers
Increase number of consumers receiving supported employment service	Not Applicable	Not Applicable	Not Applicable	10% increase in number receiving service in FY11	15% increase in number receiving service in FY12	Maintain 15% increase
Adults receive at least one (1) non-crisis in a non-emergency setting within 7 days of discharge from a psychiatric hospitalization	**52.78%**	**80%**	**69.63%**	Not Applicable	70%	Maintain 70%
C/Y receive at least one (1) non-crisis in a non-emergency setting within 7 days of discharge from a psychiatric hospitalization	**45.6%**	**80%**	**55.96%**	Not Applicable	70%	Maintain 70%

Measure	FY10 Actual	FY11 Target	FY11 YTD	FY12 Projection	FY13 Projection	FY14 Projection
Adults receive at least one (1) non-crisis service in a non-emergency setting within 30 days of discharge from a psychiatric hospitalization	Pending	Pending	Pending	Not Applicable	80%	Maintain 80%
C/Y receive at least one (1) non-crisis service in a non-emergency setting within 30 days of discharge from a psychiatric hospitalization	Pending	Pending	Pending	Not Applicable	80%	Maintain 80%
MHSD productivity hours per month per FTE	65 hours per month per FTE	77 hours per month per FTE	79 hours per month per FTE	83 hours per month per FTE	87 hours per month per FTE	87 hours per month per FTE

Mental Health Financing/Fee for Service

SUMMARY OF SERVICES

The Mental Health Financing/Fee-for-Service Division is responsible for managing the financing of mental health services and supports. The DMH Claims Administration/Billing unit is responsible for: 1) claims processing and adjudication/processing of local fund warrants to the OCFO for D.C. Treasury payment to mental health rehabilitation services (MHRS) providers (pre-process Medicaid claims to verify eligibility and authorization), and 2) Medicaid claims billing and reconciliation (collection and reporting of Medicaid federal funds portion (FFP) reimbursement).

OBJECTIVE 3: Continually improve the consistency and quality of mental health services.

INITIATIVE 3.1: Improve the total Medicaid claims paid by reducing the exceptions on the front end.

DMH recognized that there was a pool of MHRS claims that do not make it into the system. This was because they were Electronic Data Interface (EDI) errors (formatted incorrectly) and kicked out (rejected). During the third quarter of FY 2011, DMH modified the front end process to get greater accountability and was able to force these claims into the system so the providers could see them. Working with the providers DMH saw a reduction in the rejected claims. In FY 2012, DMH will review the reports prior to implementing this process to establish a baseline, assess progress made, and set a performance target for reducing front end errors (rejects).

INITIATIVE3.2: Improve the total Medicaid claims paid by reducing the denials by the Department of Health Care Finance (DHCF).

During FY 2011, DMH partnered with DHCF to provide tools/methods to the providers to increase claims approval. For example, how to roll up claims that represented

legitimate same day service. This back end approach is aimed at helping the providers in correcting and re-billing Medicaid claims. The District is granting fewer local dollars due to budget constraints so it is important to maximize federal funding. In FY 2012, DMH will review the provider denial rate of Medicaid claims (baseline), assess progress made, and set a performance target to facilitate providers reducing the denials by DHCF.

INITIATIVE3.3: Educate providers about the total billing process.
In 2009 DMH implemented *Billing 101- DMH Claims Billing Basics.* This activity did not occur on a routine basis. In May 2011, *Billing 101* became a monthly course to review the steps in the billing process, how to get paid and when, timely filing, denials, and discussion of all billing changes. It was added to the system training curriculum and precedes the Provider e-Cura, Provider Connect training. It has proven to be a useful tool and will be continued in FY 2012.

Proposed Key Performance Indicators - *Mental Health Financing/Fee for Service*

Measure	FY10 Actual	FY11 Target	FY11 YTD	FY12 Projection	FY13 Projection	FY14 Projection
Improve total Medicaid claims paid by reducing exceptions on the front end.	$375,158	**No target identified**	$93,489	Develop baseline, assess progress, set target and monitor.	Continued tracking and monitoring, adjust target as necessary	Continued tracking and monitoring, adjust target as necessary
Improve total Medicaid claims paid by facilitating providers reducing DHCF denials.	8.8% Medicaid denials	**No Target Identified**	**11.4% Medicaid denials**	Reduce Medicaid denials to 5% or less	Continued tracking and monitoring, adjust target as necessary	Continued tracking and monitoring, adjust target as necessary

Agency Management

SUMMARY OF SERVICES
The Agency Management program provides for administrative support and the required tools to achieve an agency's operational and programmatic results. This program is standard for all agencies using performance-based budgeting.

OBJECTIVE 4: Ensure system accountability.

INITIATIVE 4.1: Continue to improve information technology.
There have been ongoing challenges to the development of a viable and accessible Department-wide information system. The community systems include e-Cura (a managed care application for claims processing), Anasazi (a client data system for the Mental Health Services Division) and LOCUS/CALOCUS (a web-based application used to determine consumer functioning levels and identify appropriate level of care). In addition, the program staff use a number of small-specialized databases that can be accessed on the network or across the Internet. AVATAR is the clinical management

information system used to capture patient care services at Saint Elizabeths Hospital (SEH).

DMH plans to issue the RFP for a care management application in FY 2012. This care management system, called ICAMS (Integrated Care Application Management System) is intended to replace e-Cura and Anasazi, as well as the Office of Consumer and Family Affairs grievance database and some of the Office of Accountability databases. A project manager for this effort has already been recruited. The new care management system is anticipated to come online 16-18 months after the procurement process is completed. Legacy applications will operate in parallel as the new system is prototyped, built, tested and implemented. All providers will be required to use the new practice management system, which will include an electronic health record.