FY 2014 PERFORMANCE PLAN
Department of Behavioral Health[1]

MISSION

The mission of the Department of Behavioral Health (DBH) is to support prevention, treatment, resiliency and recovery for District residents with mental health and substance use disorders through the delivery of high quality, integrated services.

SUMMARY OF SERVICES

DBH will: 1) ensure that every individual seeking services is assessed for both mental health and substance use disorder needs; 2) develop the ability of the provider network to treat co-occurring disorders; 3) establish and measure outcomes for individuals with co-occurring mental health and substance use disorders as well as single illnesses with recovery as the goal; 4) consolidate and enhance provider monitoring to ensure high quality service; and 5) establish a single credentialing process for both mental health and substance use disorder providers. DBH serves as the State Mental Health Authority and the Single State Authority for substance abuse.

PERFORMANCE PLAN DIVISIONS

- Behavioral Health Authority[2]
- Addiction Prevention and Recovery Administration[3]
- Saint Elizabeths Hospital
- Behavioral Health Services and Supports
- Behavioral Health Financing/Fee for Service

AGENCY WORKLOAD MEASURES

Measures	FY 2011 Actual	FY 2012 Actual	FY 2013 YTD
Number of adult consumers served[4]	24,409	25,772	18,969
Number of child and youth consumers served[5]	5,592	5,623	4,586
Mental Health Services Division (MHSD) intake/Same Day Service Urgent Care Clinic – adults	2,825	3,083	2,542
MHSD intake/Same Day Service Urgent Care Clinic – child/youth	488	489	238
Number of Comprehensive Psychiatric Emergency Program (CPEP) visits	3,921	3,925	2,911
Number of adult mobile crisis team visits	1,906	1,094	1,007
Number of child mobile crisis team visits	482	658	505
Crisis stabilization bed utilization	88.27%	85.0%	89.71%
Involuntary acute psychiatric adult admissions	1,025	1493	1,366

[1] Effective October 1, 2013, the Department of Mental Health merged with the Addiction Prevention and Recovery Administration in the Department of Health to integrate treatment and services for residents with mental health and substance use disorders.

[2] For the purposes of the FY14 Performance Plan, the section dedicated to (1800) Behavioral Health Authority includes the Office of the Director and the (1000) Agency Management and (100F) DBH Financial Operations. These divisions were combined to more accurately reflect the functional organization of DBH.

[3] The planning for the DBH began in FY13. APRA is listed as a Divisional Plan consistent with the FY14 budget.

[4] The adult consumers served include DMH and APRA data for persons 21 and older for the reporting periods.

[5] The child consumers served include DMH and APRA data for persons 0-20 for the reporting periods.

Behavioral Health Authority[6]

SUMMARY OF SERVICES

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

The Behavioral Health Authority monitors and regulates the activities of the public mental health and substance abuse system including certifying providers of mental health rehabilitation services and substance abuse treatment centers, and licensing mental health community residential facilities.

OBJECTIVE 1: Expand the range of behavioral health services.

INITIATIVE 1.1: Establish the new Department of Behavioral Health.

Effective October 1, 2013, the Department of Mental Health merged with the Addiction Prevention and Recovery Administration in the Department of Health to integrate treatment and services for residents with mental health and substance use disorders. Mayor Vincent C. Gray formed the new Department of Behavioral Health to improve the health and well-being of residents who receive mental health and substance use disorder treatment and supports. Research shows that integrated treatment produces better outcomes for individuals with co-occurring mental health and substance use disorders. Without integrated treatment, one or both disorders may not be addressed properly. The overall vision of an integrated system is to effectively serve individuals with co-occurring disorders whether they are seeking help for substance use disorders or mental health conditions. The goal is to improve the quality of care for all District residents who need mental health and/or substance use disorders services.

It is estimated that annually about 22,000 adults and children receive mental health treatment while APRA serves about 10,000 residents. Over the next year, the new Department will develop an infrastructure within the mental health and substance use disorder systems to support integrated service delivery. Those residents who need only mental health or substance abuse treatment will continue to be served by the new Department. **Completion Date: September, 2014.**

INITIATIVE 1.2: Establish Health Homes.

Health Homes are a new service delivery framework that provides care coordination for consumers with serious mental illness, or serious mental illness with a chronic physical illness or at risk of developing a chronic physical illness. DBH in partnership with the Department of Health Care Finance (DHCF) is in the process of creating Health Homes, a system by which mental health providers will offer case management and care

[6] For the purposes of the FY14 Performance Plan, the section dedicated to (1800) Behavioral Health Authority includes the Office of the Director and the (1000) Agency Management and (100F) DBH Financial Operations. These divisions were combined to more accurately reflect the functional organization of DBH.

coordination to consumers with mental illness and a chronic physical health conditions or those likely to develop chronic conditions. Completion Date: September, 2014

OBJECTIVE 2: Increase access to behavioral health services.

INITIATIVE 2.1: Provide cross-training to all DBH-certified providers.
In order to enhance the integrated treatment capabilities of DBH-certified providers, DBH will offer twice-monthly classes on "Introduction to Co-Occurring Disorders: Treatment Implications and DBH Services". This will ensure all DBH providers receive information on the concepts of integrated treatment consistent with the philosophy of the DBH. **Completion Date: September, 2014.**

INITIATIVE 2:2 Expand access to mental health services in schools and early childhood.
In FY13, the Department of Mental Health (DMH) provided school-based mental health services in 52 schools, and established Primary Project programs for pre-Kindergarten through second-graders in 35 sites. During FY14, the School Mental Health Program (SMHP) will increase to 71 schools, and the Primary Project program will expand to a total of 54 sites. **Completion Date: September, 2014.**

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

INITIATIVE 3.1: Develop an assertive community treatment scorecard.
In FY13, DMH engaged in data gathering activities related to the development of the assertive community treatment (ACT) scorecard. The various sources of data included: Team/Fidelity scores, focused Community Services Review scores, Mental Health Statistics Improvement Program Surveys, and e-Cura claims based data regarding timeliness of service. The ACT Scorecard will be developed and piloted in FY14 with full implementation completed in FY15. **Completion Date: September, 2014.**

INITIATIVE 3.2: Develop DBH Provider Scorecard.
The Department of Mental Health (DMH) has published a Provider Scorecard for its mental health providers for the last two (2) years. Provider scorecards will be continued during the transition to the Department of Behavioral Health (DBH). FY13 activities of Mental Health Rehabilitation Services (MHRS) providers will continue to be rated using the DMH Provider Scorecard. Our target for quality and financial performance on the FY 2013 Scorecard, reported in FY 2014, is 85%. During FY14, the DBH will develop a new Provider Scorecard for both mental health and substance use disorder treatment providers. The DBH will implement the use of the new provider scorecard in FY15. **Completion Date: September, 2014.**

INITIATIVE 3.4: Expand DBH disaster mental health response capacity.
Disaster Behavioral Health Services provides rapid and effective crisis counseling and stress management through "Disaster Behavioral Health Emergency Response Teams" (DBHERT). In some high surge or regional disasters mental health services may need to

be provided by non-mental health professionals in response to need. The purpose of expanding DBH capacity for disaster mental health response is to compliment the present response teams with additional trained responders.

Training will be provided to interested community members to effectively participate with DBH Disaster Behavioral Health Services in responses. The training curriculum will: 1) be based upon best-practice models; 2) provided in 12 separate modules; and 3) include post-test to detail participants' knowledge gain and/or skills retention. Participating members will be eligible to apply to DBH disaster behavioral health emergency response teams following successful completion of the 7 core training courses and 3 auxiliary training modules of their choice. The anticipated outcome is that by June 2013 there will be an expanded capacity for Disaster Mental Health Response with increased trained members on DMH response teams. The training will occur annually until 125 persons are trained. **Completion Date: September, 2014.**

OBJECTIVE 4: Ensure system accountability to support behavioral health services.

INITIATIVE 4.1: Refine Community Service Reviews.
Community Service Reviews (CSRs) were required by the Department of Mental Health (DMH) pursuant to the Dixon class action lawsuit and resulting Settlement Agreement. After satisfying the Settlement Agreement requirements of 70% system performance in 2013, CSRs are now run and graded entirely by the agency CSR unit. The CSR protocols for child/youth and adults has been refined to include mental health, substance use disorder, physical health, and family resourcefulness system evaluations; to reflect the current language in practice and transition to the DBH. Additionally, CSRs will now be conducted throughout the year, rather than once a year, with the data integrated to provide a complete system picture. In FY14, DBH will: 1) implement the new Adult and Child Protocols; 2) assess the Adult system throughout the year; 3) conduct focused reviews for child providers; and 4) conduct initial CSRs on a small sample of substance abuse treatment providers. In FY15, DBH will then: 1) assess the Child/Youth system throughout the year; 2) conduct focused reviews for the adult system; and 3) continue to include substance abuse treatment providers in the system wide assessment. **Completion Date: September, 2014.**

INITIATIVE 4.1: Implement the care management application.
Planning for the new Integrated Care Applications Management System (iCAMS) is continuing with initial implementation expected to occur in FY14. The care 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. iCAMS will also be able to interface with the DATA WITS systems used by the substance abuse providers. **Completion date: September 2014.**

KEY PERFORMANCE INDICATORS- *Behavioral Health Authority*

Measures	FY 2011 Actual	FY 2012 Actual	FY 2013 Target	FY 2013 YTD	FY 2014 Projection	FY 2015 Projection	FY 2016 Projection
Introduction to co-occurring treatment and DBH services	NA	NA	2	NA	20	20	20
Number of School Mental Health Programs	59	53	52	52	72	72[7]	72
Number of early childhood services locations – Primary Project	16	30	35	35	54	54[8]	54
Provider Scorecard – mental health providers' average quality (adult) score	71.42	78.2[9]	85	85	85	85	85
Provider Scorecard[10] –mental health providers' average quality (child) score	63.27	NA[11]	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Provider Scorecard-providers' average financial score	80.22	76.6	85	85	85	85	85
Number of persons trained with disaster mental health response capacity	50	75	80	70	90	100	110
Adult Community Services Review (CSR) system score	79%	NA	NA	NA	80%	NA[12]	80%
Child Community Services Review (CSR) system score	59%	65%	70%	70%	NA[13]	75%	75%

[7] FY15 and FY16 remain the same as FY14 since they are contingent upon additional funding, which is unknown.
[8] FY15 and FY16 remain the same as FY14 since they are contingent upon additional funding, which is unknown.
[9] In FY12 going forward the Adult and Child quality scores are combined, eliminating the separate Adult score.
[10] Starting with the FY12 Scorecard going forward, the adult and child quality scores are combined. The subsequent reporting will be the average quality score.
[11] In FY12 going forward the Adult and Child quality scores are combined, eliminating the separate Child score.
[12] Starting FY14 the Adult and Child Community Services Reviews will be conducted every other year on an alternating schedule
[13] Same as footnote 11 above

Addiction Prevention and Recovery Administration

SUMMARY OF SERVICES

The Addiction Prevention and Recovery Administration (APRA) integrated within the new DBH promotes access to substance abuse prevention, treatment and recovery support services. Prevention services include: raising public awareness about the consequences of substance abuse, and providing evidence-based program resources to community and faith-based organizations to promote safe and healthy families and communities. APRA promotes long-term recovery by developing and maintaining a recovery-oriented system via a continuum of substance abuse and recovery support services. Treatment services include assessment and referral; outpatient; intensive outpatient; residential; detoxification and stabilization; and medication-assisted therapy. Wrap-around services are also provided such as mentoring, education skill building, and job readiness training.

OBJECTIVE 1: Reduce priority risk factors that place District children, youth, families, and communities at risk of substance use and interrelated problems.

INITIATIVE 1.1: Promote safe and healthy children, youths, families, and communities through implementation of prevention strategies.

APRA funds DC Prevention Centers (DCPC) designed to strengthen the community's capacity to reduce substance abuse and prevent risk factors. The centers work with the community to implement best practices and connect community resources. All four centers provide a consistent prevention strategy across the District but also have the flexibility to address the unique characteristics and priorities of the geographic area and populations served in their designated wards. The DCPCs also collect data to determine annual progress toward identified prevention outcomes and implement quality improvement activities. By September 30, 2014, the prevention centers are expected to increase the number of adults reached through their planned prevention strategies by 10 percent. **Completion Date: September, 2014.**

INITIATIVE 1.2: Prevent the onset of and delay the progression of substance abuse in youth and young adults from pre-K through age 21 through implementation of culturally sensitive prevention best policies, programs, and practices.

National prevention policy and research indicates there is a period of increased risk for development of substance abuse disorders. People who do not develop a substance use problem by age 21 are unlikely to do so. The average age of onset of substance use in the District is before age 13. District youth who use alcohol, tobacco and other drugs (ATOD) before age 13 are more likely to become involved in other risk behaviors such as increased drug use, physical fights, sexual activity, and carrying a weapon Therefore, the introduction of prevention interventions must begin at early ages and be integrated into partnerships within DOH and other District agency partners. By September 30, 2014, the prevention centers are expected to increase the number of youth reached through their planned prevention strategies by 15 percent. **Completion Date: September, 2014.**

OBJECTIVE 2: Promote long-term recovery from substance use disorder through maintenance of a comprehensive continuum of accessible substance abuse treatment and recovery support services.

INITIATIVE 2.1: Promote sobriety by linking residents to clinically appropriate substance abuse treatment and recovery support services.

Plans of care are developed for each client entering into treatment. The levels of care within APRA's clinical continuum include medically monitored non-hospital detoxification, residential treatment, intensive outpatient treatment, and outpatient treatment. Clients are expected to advance through the levels of care until they successfully complete treatment. By September 30, 2014, APRA will maintain the percentage of clients that successfully complete treatment, which is above the national standard.

Completion Date: September, 2014.

KEY PERFORMANCE INDICATORS - Addiction Prevention and Recovery Administration

Measures	FY2012 Actual	FY2013 Target	FY2013 YTD	FY2014 Projection	FY2015 Projection	FY 2016 Projection
Number of adults reached through planned prevention strategies	13,176	7,400	7,548	8,400	7,400	7,400
Number of youth reached through planned prevention strategies	10,933	6,000	8,527	7,200	6,000	6,000
Percent of adults that successfully complete treatment	67.90%	60%	59.4%	60%	60%	60%
Percent of youth that successfully complete treatment	31.71%	25%	19.6%	25%	25%	25%

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. Emphasis continues to be on implementation of the recovery model and ensuring that the provision of treatment helps individuals in care stabilize as quickly as possible and return to the community with the skills and supports necessary for a successful transition.

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

INITIATIVE 1.1: **Improve the quality of pharmaceutical care by reducing poly-pharmacy and accomplishing effective medication reconciliations across the continuum of care.**

Poly-pharmacy, the prescription of more than two (2) psychotropic medications, is a common practice in the treatment of psychiatric illness. While poly-pharmacy may sometimes be appropriate and justifiable, in general, physicians are encouraged to consider and try alternative medication regimens whenever possible. In fact, many regulatory bodies, including Joint Commission, provide guidelines and measures on poly-pharmacy management. The Saint Elizabeths Hospital is committed to curtail the use of poly-pharmacy and improve documentation related to poly-pharmacy practice. The Hospital will measure its performance using evidence-based guidelines, review and update the relevant policies and guidelines, modify psychiatric assessment forms and discharge plan of care, and provide trainings to physicians consistent with revised policies, guidelines, and forms.

Additionally, the Hospital is planning to establish and implement an effective medication reconciliation system. Medication reconciliation is the process of identifying the most accurate list of all medications prescribed to an individual and using this list to provide correct medications for patients anywhere within the health care system. Individuals in our care are often seen by a multitude of providers before, during, and after discharge and it is imperative to have an effective communication system in regards to medication history and current medications. In FY14, the Hospital will ensure that its medication reconciliation policy and procedures are aligned with the national standard and enhance communication of medication information and reconciliation, internally and externally, at every transition point, including 1) admission from the community to the Hospital, 2) transfer from the Hospital to another medical facility and return; and 3) discharge and transition from the Hospital to the community. The Hospital will further monitor its progress by analyzing medication variance incidents and adverse drug reactions related to or caused by lack of communication and inadequate medication reconciliations. **Completion Date: September, 2014.**

INITIATIVE 1.2: Promote full implementation of recovery model.
Building upon the basic recovery training provided to all nursing staff in FY13, additional training will commence for all team leaders and charge nurses in October 2013. These trainings will help the participants develop the skills necessary to meet the challenges of their roles, to more effectively and efficiently achieve their performance standards, and ultimately enhance the communication between individuals in care and staff. In addition, training will be provided to all treatment teams that focus on team building and effective interdisciplinary communication. Completion of the competency-based training for team leaders and charge nurses will be completed by 95% of these staff by November 2013. Treatment team training will be completed by all treatment teams by December 2013. **Completion Date: December, 2013.**

KEY PERFORMANCE INDICATORS – *Saint Elizabeths Hospital*

Measures	FY 2012 Actual	FY 2013 Target	FY 2013 YTD[14]	FY 2014 Projection	FY 2015 Projection	FY 2016 Projection
Percent of discharges with ≥ 2 anti-psychotic medications[15]	NA	NA	NA	25%	20%	15%
Percent of discharges with appropriate justification documented when discharged with ≥2 anti-psychotic medications[16]	NA	NA	NA	20%	40%	60%
Percent of nursing staff with competency-based recovery model training[17]	NA	95%	95%	95%	95%	95%
Percent of clinical staff with competency-based recovery model training	NA	NA	NA	85%	85%	85%
Total patients served per day	276	275	267	275	275	275
Elopements per 1,000 patient days	0.27	0.28	0.31	0.28	0.28	0.28
Patient injuries per 1,000 patient days[18]	0.35	0.27	0.15	0.25	0.25	0.25
Percent of missing documentation of medication administration results[19]	0.34%	0.30%	0.41%	0.25%	0.20%	0.20%
Percent of unique patients who were restrained at least once during month	0.1%	0.1%	0.04%	0.1%	0.1%	0.1%
Percent of unique patients who were secluded at least once during month	0.6%	0.7%	1.0%	0.1%	0.1%	0.1%
Percent of patients re-admitted to Saint Elizabeths Hospital within 30 days of discharge	5.3%	6.0%	6.3%	5.9%	5.8%	5.8%

[14] This is monthly average data for the first 9 months of FY13, between October 2012 and June 2013. Data for the last measure on 30 day readmission rate includes data only for 8 months until May 2013.
[15] This is a newly proposed measure for FY14 to evaluate the 1st initiative. It is a nation-wide behavioral healthcare measure defined by Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Hospital is required to report to the Center for the Medicare and Medicaid Services (CMS) on a quarterly basis.
[16] This is another newly proposed measure for FY14 to evaluate the 1st initiative. It is also a behavioral healthcare measure defined by JCAHO and the Hospital is required to report to CMS, along with the 1st measure above.
[17] This is a modified measure for FY14 to evaluate the 2nd initiative. In the current fiscal year, we are measuring the percentage of completed training for nursing staff only. The goal for FY14 is to implement training for all clinical staff and measure the percentage of completed training.
[18] Patient injury rate according to the National Research Institute (NRI) definition, considers only those injuries that require beyond first-aid level treatment. Saint Elizabeths Hospital modified its logic to make it consistent with NRI's definition. This data became available only since January 2011.
[19] It is measured by dividing the total number of medication administration records with missing documentation by the total number of scheduled medication administration records.

Behavioral Health Services and Supports

SUMMARY OF SERVICES

Behavioral Health Services and Supports provides for the design, delivery, and evaluation of behavioral 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, ASTEP treatment centers); adult services (supported housing, supported employment, assertive community treatment, forensic); care coordination (service access and suicide prevention and intervention services); integrated care (transition consumers from inpatient care to community, transitioning consumers from community residential facilities to less restrictive environments and Health Homes); mental health services (government operated including same day clinic, multicultural program, deaf/hard of hearing and intellectual disability program, physicians practice group, forensic assessments, outpatient competency restoration, pharmacy); substance abuse treatment services (government operated intake and assessment center); comprehensive psychiatric emergency services (extended observation beds, mobile crisis, homeless outreach) and onsite forensic services (an urgent care clinic at the D.C. Superior Court for immediate assessments for mental health and substance abuse issues).

OBJECTIVE 1: Expand the range of behavioral health services.

INITIATIVE 1.1: Increase the number of certified Peer Specialists.

By September 30, 2014, DBH will increase the number of certified Peer Specialists by 20 and develop a certified Family Peer Specialist program for families of child and youth consumers. **Completion Date: September, 2014.**

INITIATIVE 1.2: Increase Coordination with the Department of Corrections

DBH will place a DBH Re-entry Coordinator in the D.C. Jail – Women's Facility, to facilitate the linkage of women with mental health or substance abuse issues being linked prior to discharge with the appropriate services provider. In FY14, at least 60 women will be served. **Completion Date: September, 2014.**

OBJECTIVE 2: Increase access to behavioral health services.

INITIATIVE 2.1: Increase the number of individuals trained in Mental Health First Aid and in Youth Mental Health First Aid.

By September 30, 2014, DBH will support the training of at least 500 individuals in Mental Health First Aid and at least 500 individuals in Youth Mental Health First Aid. Mental Health First Aid trains people in the community to recognize signs and symptoms of mental health issues and implement first steps to secure appropriate care for an individual experiencing a mental health problem. **Completion Date: September, 2014.**

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

INITIATIVE 3.1: **Implement the Child and Adolescent Functional Assessment Scale (CAFAS) at all child providers within the DBH network.**
By September 30, 2014, DBH will ensure all child and youth providers within the DBH network have been trained on and are using the CAFAS. A single functional assessment tool used by child and youth provider agencies will allow DBH and the providers to develop more individualized treatment plans focused on identified areas of need, and allow them to assess whether the child or youth demonstrates improved daily functioning associated with the implementation of services. Use of CAFAS will also allow DBH to assess the efficacy of specific interventions and different providers so that if a child or youth is not making progress, the providers will be able to identify how the treatment plan should be modified to better serve the person. Completion Date: September, 2014.

INITIATIVE 3.2: Ensure continued provider compliance with the Continuity of Care guidelines regarding discharge planning and services provided post discharge from a psychiatric hospitalization.
By September 30, 2014, DMH will continue to 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.
Completion Date: September, 2014.

KEY PERFORMANCE INDICATORS – *Behavioral Health Services and Supports*

Measures	FY 2012 Actual	FY 2013 Target	FY 2013 YTD	FY 2014 Projection	FY 2015 Projection	FY 2016 Projection
Number of certified Peer Specialists	12	15	14	20	30	30
Number of women served by Re-Entry Coordinator in Women's jail	NA	NA	NA	60	75	75
Number of People in Mental Health First Aid Trainings	130	248	645	800	500	500
Percent of adults that receive at least one (1) non-crisis service in a non-emergency setting within 7 days of discharge from a psychiatric hospitalization	71.3%[20]	70%	67.09	70%	70%	70%

[20] DMH worked with DHCF to verify additional data sources and revised the data.

Measures	FY 2012 Actual	FY 2013 Target	FY 2013 YTD	FY 2014 Projection	FY 2015 Projection	FY 2016 Projection
Percent of children/youth that receive at least one (1) non-crisis service in a non-emergency setting within 7 days of discharge from a psychiatric hospitalization	61%[21]	70%	71.28	70%	70%	70%
Percent of adults that receive at least one (1) non-crisis service in a non-emergency setting within 30 days of discharge from a psychiatric hospitalization	80.8%[22]	80%	75.81	80%	80%	80%
Percent of children/youth that receive at least one (1) non-crisis service in a non-emergency setting within 30 days of discharge from a psychiatric hospitalization	79.4%[23]	80%	86.13	80%	80%	80%

[21] Same as above.
[22] Same as above.
[23] Same as above.

Behavioral Health Financing/Fee for Service

SUMMARY OF SERVICES

The Behavioral Health Financing/Fee-for-Service Division is responsible for managing the financing of mental health services and supports. The DBH 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) and adult substance abuse rehabilitative services (ASARS) 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 1: Continually improve the consistency and quality of mental health services.

INITIATIVE 1.1: Begin Medicaid claiming for ASARS services.

Implementation of Medicaid billing for Adult Substance Abuse Rehabilitative Services (ASARS) was begun in FY13 and will be fully implemented during FY14. DBH must ensure adult substance abuse providers are able to provide services in accordance with ASARS requirements prior to billing Medicaid. DBH is working closely with the Department of Health Care Finance in the implementation of this initiative.

Completion Date: September, 2014.

Measures	FY 2012 Actual	FY 2013 Target	FY 2013 YTD	FY 2014 Projection	FY 2015 Projection	FY 2016 Projection
Percent of clean claims adjudicated within 30 days of receipt	NA	NA	NA	NA	90%	100%
Percent of District residents, accessing services through ASARS, screened for Medicaid eligibility within 90 days of the first date of service	NA	NA	NA	NA	90%	95%