FY 2010 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, the Homeless Outreach Program and the School-Based Mental Health Program.

PERFORMANCE PLAN DIVISIONS:

- Mental Health Authority
- Saint Elizabeth's Hospital
- Office of the Director

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. This includes certifying providers of mental health rehabilitation services and licensing mental health community residential facilities. In addition, it acts as an agent of the Department of Health Care Finance (DHCF), formerly the Medicaid Assistance Administration (MAA), in receiving, verifying eligibility, and authorization of claims for services provided. The Mental Health Authority forwards Medicaid claims to DHCF for payment adjudication.

OBJECTIVE 1: Expand the range of mental health services.

INITIATIVE 1.1: Initiate Early Childhood Mental Health Consultation Pilot.
This pilot program will begin in FY 10. DMH is working with the DOH Early Childhood Comprehensive System (ECCS) Grant Coordinator to launch an early childhood mental health consultation pilot program. There are three components/phases of a system of care for early childhood mental health: (1) prevention; (2) early intervention; and (3) treatment. This pilot project focuses on child-centered, 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 child, staff member, and/or family. The pilot program will fund services for children (ages 0 to 5) at 8 centers (to be identified). The pilot program is funded through a combination of funds provided by the Interagency Collaboration and Services Integration Commission/DCPS and the Community Mental Health Services Block Grant for FY 10. Services will be provided to children and families identified through child/family centered consultation at all of the 8 centers.

INITIATIVE 1.2: Continue implementation of the community based wrap-around pilot program for at-risk children and youth.
This pilot project aims to enable youth who are at great risk of institutional placement to remain in their communities. DMH is leading this initiative in collaboration with several District agencies. The goal is to provide better services to children and youth to improve outcomes more cost effectively. In FY 2009, the target was 24 students. The 2009 program was expanded with funding from OSSE to provide intense wrap-around services for up to 100 students in eight DCPS model schools that have been targeted as "full service schools" – intending to combine academics, mental health, Positive Behavior Intervention (PBIS) and an intensive wrap-around component for the highest-need students. In FY 2010, the target for the wrap-around program is 34 students and the target for the OSSE funded portion of the program is 135 students in eleven (11) middle

schools. Each of the targeted schools also has a full-time mental health clinician assigned as part of the overall School-Based Mental Health Program.

INITIATIVE 1.3: Initiate and complete a planning process to redesign the public mental health system.
This initiative is the third phase of the activities described in DMH's Report to the Council with Recommendations Regarding the Governance of the DC CSA. DMH proposed to reinvest the cost savings from the closure of the DC CSA into a redesign of the public mental health system. FY 2010 activities will include completion of the planning process, issuance of a plan for the redesign and initiation of implementation activities with the goal of expanding the range of services under DMH's auspices to include increased in clinical office-based services.

INITIATIVE 1.4.: Complete planning process for implementation of peer specialist program.
The delivery of mental health services and supports by certified peer specialists is a recognized evidence-based practice that has been effective in other jurisdictions; in some jurisdictions it is a Medicaid-reimbursable service. The use of peers has been proven to enhance service delivery options in recovery. DMH has obtained technical assistance provided by the National Association of State Mental Health Program Directors (NASMHPD) to implement an evidence-based model to employ mental health consumers as certified peer specialists. A goal of this initiative is to have the service supported by Medicaid billings. The kick-off planning workshops for this initiative were held July 15-16, 2009. DMH has established a workgroup to develop a workplan that identifies the activities required for implementation. This initiative is part of the first phase of a planned restructuring of the public mental health system, as discussed in the DC CSA transition plans and described in Initiative 1.3. FY 2010 activities will include implementing the initial phases of the program as identified in the workplan.

OBJECTIVE 2: Increase access to mental health services.

INITIATIVE 2.1: Continue implementation of mobile crisis services and crisis stabilization beds for children and youth.
DMH has contracted with Catholic Charities to provide mobile response stabilization services and four (4) crisis beds to children and families living in the District of Columbia – including children and youth in foster care placed in homes in Maryland and Virginia. The goal is to stabilize an immediate crisis and avert unnecessary inpatient psychiatric hospitalizations. This initiative began in FY 09 and plans for FY 2010 include developing an MOU with crisis providers in Maryland to provide services to children living more than one hour away from the District.

INITIATIVE 2.2: Continue implementation of an Integrated Care Management Program to provide community-based care for consumers who have been receiving inpatient services at Saint Elizabeths Hospital for more than six months.

The Integrated Care Management Program is a pilot program designed to provide intensive community-based care to patients with complex needs and a history of long-term stays (more than 6 months) at Saint Elizabeths Hospital. Without appropriate individualized supports in the community, these consumers are at risk for continued long term inpatient care or returning to Saint Elizabeths Hospital for an extended stay upon discharge. DMH initiated this pilot program during the third quarter of FY 09 and will continue it through FY 10. As of June 30, 2009, there were seven (7) enrollees and one person discharged from Saint Elizabeths. The target for FY 2010 is twenty-three (23) enrollees.

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

INITIATIVE 3.1: Improve the Community Service Reviews (CSRs) scores for team formation and functioning for both children and adults.
Effective mental health services require intensive and team-based case management, where everyone involved in the individual's care participates in treatment planning. Previous Community Service Reviews have cited the ability of mental health providers to quickly assemble appropriate and highly functional teams as lacking. Improving performance in this core function is expected to have the most significant impact on overall system performance. During FY 2009, DMH developed the internal capacity to conduct the CSRs throughout the year to facilitate use of the practice model throughout the mental health system. Starting in FY 2010, DMH's internal CSR unit will begin piloting internal reviews. The first internal review is scheduled to be conducted in October 2009. The internal CSR unit will also conduct a focused, follow-up review of all DC CSA consumers whose cases were reviewed during the 2009 Dixon Adult CSR.

INITIATIVE 3.2: Complete implementation of a transition plan for the D.C. Community Services Agency (DCCSA).
DMH's enabling legislation and the Dixon Final Court-Ordered Plan anticipated that DMH would operate the DCCSA for a limited period of time (three years or as long as needed). In response to the requirements of the enabling legislation and the Dixon Final Court Ordered Plan, as well as the recommendation by the Dixon Court Monitor, DMH instituted a review and planning process with the DCCSA's senior management in 2007 and retained KPMG to provide support for developing governance options for the DCCSA. In accordance with the requirements of the FY 2009 Budget Support Act, DMH submitted its recommendations and an implementation plan for completing the recommendations to the Council of the District of Columbia. Over 2,500 consumers selected a new provider during FY 2009. The plan requires closure of most DC CSA services by March 31, 2010. Plans for FY 2010 include transfer of remaining consumers and establishing a unit to operate the remaining government operated services (pharmacy and specialty services, including a physicians practice group, multicultural services, psycho-educational services and services for people with hearing impairments or developmental disabilities.)

OBJECTIVE 4: Ensure system accountability.

INITIATIVE 4.1: **Improve system accountability by implementing the next phase of the audit and Medicaid integrity plans.**
In FY 10, DMH will roll-out its provider scorecard program, after piloting the program in FY 09. The provider scorecard program is designed to report on the results of the audits that DMH regularly conducts in accordance with the audit and Medicaid integrity plans that were implemented in FY 08 and FY 09. In FY 09, DMH continued to conduct regular audits and work with DHCF on recoupment of funds paid for services that did not meet District or federal requirements. During FY 2010, DMH will implement a major change in recoupment policy. Beginning with dates of service on October 1, 2009 and beyond, all audited claims that fail will be extrapolated to the entirety of billed claims for the audited period.

PROPOSED KEY PERFORMANCE INDICATORS– Mental Health Authority

	Metric	FY 2008 Actual	FY 2009 Actual	FY 10 Target	FY 11 Target	FY 12 Target
OBJECTIVE 1: EXPAND THE RANGE OF MENTAL HEALTH SERVICES						
1.	Early Childhood Program Outcome Measures	N/A	N/A	500	500	TBD
2.	Number of affordable housing units funded[1]	0	0	100	150	N/A
OBJECTIVE 2: INCREASE ACCESS TO MENTAL HEALTH SERVICES						
3.	Total number of adult consumers served[2]	11,819	11,944[3]	13,800	14,000	15,000
4.	Total number of children/youth consumers served[4]	3,228	3,373[5]	5,775	6,000	7,000
5.	Number of CPEP Visits[6]	3,605	3,913[7]	4,400	4,550	4,600

[1] This KPI was edited to read "funded" rather than "developed" to make the measure more consistent with the agency's FY 2009 Performance Accountability Report.
[2] Reporting for this indicator is calculated based upon the requirements of Dixon Exit Criterion # 7 (penetration rate for services to adults).
[3] Data is reported for the period from April 1, 2008 through March 31, 2009. It includes only adults receiving at least one MHRS during the reporting period.
[4] Reporting for this indicator is calculated based upon the requirements of Dixon Exit Criterion # 5 (penetration rate for services to children & youth).
[5] Data is reported for the period from April 1, 2008 through March 31, 2009. It includes only children and youth receiving at least one MHRS during the reporting period.
[6] The Comprehensive Psychiatric Emergency Program is a twenty-four hour/seven day a week operation that provides emergency psychiatric services, mobile crisis services and extended observation beds for individuals 18 years of age and older.
[7] Data is reported for the period from October 1, 2008 through August 31, 2009.

	Metric	FY 2008 Actual	FY 2009 Actual	FY 10 Target	FY 11 Target	FY 12 Target
6.	Number of Adult Mobile Crisis Team Visits	N/A	990[8]	1,300	1,500	1,600
7.	Number of Child Mobile Crisis Team Visits	N/A	278[9]	300	350	400
8.	Crisis stabilization bed utilization[10]	71.2%	TBD	85%	90%	90%
9.	Total number of adult consumers receiving an ACT service	440	553[11]	650	850	1,000
OBJECTIVE 3: CONTINUALLY IMPROVE THE CONSISTENCY AND QUALITY OF MENTAL HEALTH SERVICES						
10.	Percent of MHRS[12] eligible children discharged from inpatient psychiatric hospitals who receive a community-based, non-emergency service within 7 days of discharge[13]	48.03%	39%[14]	70%	80%	80%

[8] Data is reported for the period from November 1, 2008 through August 31, 2009, and includes only contacts involving the deployment of the mobile crisis team.
[9] Data is reported for the period from October 28, 2008 through June 30, 2009 and includes only contacts involving the deployment of the mobile crisis team.
[10] This indicator was revised during FY 2008, since DMH does not collect data about the number of consumers referred to a crisis stabilization bed diverted from an inpatient psychiatric bed. DMH has been reporting utilization of crisis beds throughout FY 2009 and will continue to report on this measure throughout FY 2010.
[11] Data is reported for the period from October 1, 2008 through August 15, 2009.
[12] Mental Health Rehabilitation Services
[13] This indicator is also tracked as Dixon Exit Criterion #17. The target for exiting the Dixon case is 80%. Targets for FY 2009 and FY 2010 have been adjusted to reflect expected performance based upon performance throughout FY 2008.
[14] Data is reported for the period from April 1, 2008 through March 31, 2009.

	Metric	FY 2008 Actual	FY 2009 Actual	FY 10 Target	FY 11 Target	FY 12 Target
11.	Percent of MHRS eligible adults discharged from inpatient psychiatric hospitals who receive a community-based, non-emergency service within 7 days of discharge[15]	53.5%	51.4%[16]	70%	80%	80%
OBJECTIVE 4: ENSURE SYSTEM ACCOUNTABILITY						
12.	Percent of Total Federal Revenue Collected[17]		N/A	N/A	N/A	N/A
13.	Percent of Medicaid claims submitted to DHCF that are paid		Pending	85%	88%	88%
14.	Percentage of clean claims adjudicated by DHCF or MCO within 5 business days of submission		Pending	95%	98%	98%
15.	Number of Dixon exit criteria targets met and approved for inactive monitoring by the Court Monitor	3	6[18]	15	19	19

[15] This indicator is also tracked as Dixon Exit Criterion #17. The target for exiting the Dixon case is 80%. Targets for FY 2009 and FY 2010 have been adjusted to reflect expected performance based upon performance throughout FY 2008.

[16] Data is reported for the period from April 1, 2008 through March 31, 2009.

[17] The information reported for this indicator is calculated in accordance with the formula required for reporting on Dixon Exit Criterion #19 (collection of federal revenue). The Dixon Court Monitor has found that DMH has satisfied the performance requirement for Dixon and has deemed Exit Criterion #19 inactive. Although DMH is required to continue to report on its performance to the Court Monitor, it will no longer report on this indicator for purposes of the performance management plan beginning in FY 2009

[18] As of July 29, 2009. DMH has also requested inactive status for Exit Criterion #10 (supported employment), which has been denied by the Dixon court monitor. DMH requested modification of the targets for Exit Criterion #9 (supported housing) and Exit Criterion #17 (continuity of care). The request for modification of the target for Exit Criterion #9 is pending. The request for modification of the target for Exit Criterion #17 was denied.

Saint Elizabeths Hospital

SUMMARY OF SERVICES:

Adults requiring mental health treatment in a 24-hour inpatient setting may receive services at Saint Elizabeths Hospital (SEH). The three primary programs are Acute Care, Continuing Care, and Forensic Services, with both acute and long-term care provided to forensic and non-forensic adults. The Hospital will gradually move toward the sole provision of tertiary care (3-12 months). Acute care, as planned, will primarily be provided under agreements with local hospitals. The Hospital will continue to provide tertiary care and long-term forensic inpatient services.

OBJECTIVE 1: Expand the range of mental health services.

INITIATIVE 1.1: Implement a peer support partner program to support discharge of individuals receiving care at Saint Elizabeths Hospital that are considered to be high-utilizers or are resistant to being discharged.

In FY 09, Saint Elizabeths Hospital and the DMH Office of Consumer and Family Affairs began collaborating on the implementation of a peer support partner program to support the discharge process. The Peer Mediation Specialist Training was conducted June 3-5, 2009. A total of nine (9) individuals were awarded the Training Certificate. During the remainder of FY 09 several of the trainees served as peer support partners for the DCCSA transitioning consumers. One introduced the idea of moving into the community to consumers who participate in the Wellness Recovery Action Plan (WRAP) classes. Some of the trainees worked on other projects.

In FY 2010, the trainees will begin working as peer support partners/transition specialists to assist consumers transitioning from Saint Elizabeths into the community and support them in their placement. Peer support partners are fully integrated team members who provide highly individualized services in the community and promote client self-determination and decision-making. Peer support partners also provide essential expertise and consultation to the entire team to promote a culture in which each individual's point of view and preferences are recognized, understood, respected, and integrated into treatment, rehabilitation, and community self-help activities. Peer support partners, having experienced a severe mental illness, may assist the other members of the team in understanding the individual's perspective and experience.

OBJECTIVE 2: Increase access to mental health services.

INITIATIVE 2.1: Reduce census of patients at Saint Elizabeths Hospital to 325.

The construction of the new Saint Elizabeths Hospital building is scheduled for completion in FY 2010. Occupancy is planned for spring 2010. During FY 2009, Saint Elizabeths Hospital engaged in a variety of census reduction activities (i.e., increasing the acute bed capacity for involuntary patients in general hospitals, linking high utilizers to assertive community treatment (ACT) teams, establishing a discharge planning process in coordination with staff from the Mental Health Authority and participating in the Integrated Care pilot project which targets long-term patients for discharge). In FY 2010, the hospital and Authority will continue these activities in an effort to reduce the overall census to an

average of 325, so that the hospital will only need to operate 2 units outside of the new hospital.

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

INITIATIVE 3.1: Enhance quality of care provided at Saint Elizabeths by implementing person-centered treatment planning that is integrated across disciplines.
DMH will contract with experts in person-centered planning to train hospital clinicians and other direct-line staff. The person-centered approach to treatment planning will improve the quality of services provided at Saint Elizabeths by requiring an integrated, interdisciplinary treatment plan for each patient. All clinicians, including social workers, psychiatrists, psychologists, rehabilitation specialists, and nursing staff, will be required to participate in developing integrated, interdisciplinary treatment plans for each patient. FY 2010 activities will include ensuring that all clinicians are appropriately trained and that person-centered treatment plans are completed for all patients.

INITIATIVE 3.2: Ensure that staff is trained and utilizes the Clinical Work Station (CWS) phase of the Avatar System.

The CWS will allow automation of key clinical processes and ensure compliance with emerging electronic health record requirements. Implementing CWS will also ensure continued data aggregation. All clinical staff will be required to be trained and to utilize CWS for an interdisciplinary approach to patient care including: Treatment/Care Planning, Individual and Group Progress notes, Assessments, and Nursing Reports.

OBJECTIVE 4:

INITIATIVE 4.1: Saint Elizabeth's Hospital will institute new billing and coding process to ensure Medicaid and Medicare claims are accurately submitted.
In August 2008, the District entered into a corporate integrity agreement with the U.S. Department of Health and Human Services to settle allegations of improper billing in the 1990s. In FY 09, DMH developed written policies and procedures and a code of conduct for all billing staff. Staff have been trained in proper claims submission procedures. A project team was established to develop a data dictionary and test claims processing using Avatar. An independent audit organization was retained and will continue to conduct review of claims activity. These measures will ensure that Saint Elizabeths accurately bills for services and will once again make it possible for Saint Elizabeths to seek reimbursement from federal health care programs. FY 2010 activities include completion of the final version of the billing procedures manual and use of Avatar for claims processing.

PROPOSED KEY PERFORMANCE INDICATORS– Saint Elizabeth's Hospital

	Metric	FY 2008 Actual	FY 2009 Actual	FY 10 Target	FY 11 Target	FY 12 Target
OBJECTIVE 3: CONTINUALLY IMPROVE THE CONSISTENCY AND QUALITY OF MENTAL HEALTH SERVICES						
1.	Percent of involuntary acute admissions to St. Elizabeths Hospital		12%[19]	11%	10%	9%
2.	Average daily census of patients receiving civil and forensic inpatient services.[20]		343	316 (8% reduction)	300 (5% reduction)	291 (3% reduction)
4.	Number of civil and forensic program elopements that occurred per 1,000 patient days.[21]		0.89	0.76 (15% reduction)	0.68 (10% reduction)	0.61 (3% reduction)
6.	Number of patient injuries per 1000 patient days.		3.4[22]	3.0	2.5	2.11
7.	Number of medication variances that occurred for every 1000 patient days.		1.3[23]	1.0	1.0	1.0
8.	Percent of unique patients who were restrained at least		1.3[24]	1.0	1.0	1.0

[19] Data reported through July 31, 2009.
[20] This measure combined 2 KPIs which previously tracked civil and forensic patients separately. In preparation for moving into one hospital in which individual placement on unit is dependent on clinical need, individuals in care will not be assigned to units based on legal status. Our information system, AVATAR, will track data for each unit and each unit is likely to have individuals in care with different legal statuses.
[21] This measure combined 2 KPIs which previously tracked civil and forensic patients separately. In preparation for moving into one hospital in which individual placement on unit is dependent on clinical need, individuals in care will not be assigned to units based on legal status. Our information system, AVATAR, will track data for each unit and each unit is likely to have individuals in care with different legal statuses.
[22] Projected for FY 2009.
[23] Projected for FY 2009.
[24] Projected for FY 2009.

	Metric	FY 2008 Actual	FY 2009 Actual	FY 10 Target	FY 11 Target	FY 12 Target
	once.					
9.	Percent of unique patients who were secluded at least once.		.5[25]	.5	.5.	.5

Office of the Director

[25] Projected for FY 2009.

OBJECTIVE 1: Maintain efficient and effective agency operations

STANDARD CITYWIDE OPERATIONAL MEASURES

Measure	FY09 YTD
Contracts	
% of sole-source contracts	
Average time from requisition to purchase order for small (under $100K) purchases	
# of ratifications	
% of invoices processed in 30 days or less	
Customer Service	
OUC customer service score	
Finance	
Variance between agency budget estimate and actual spending	
Overtime as percent of salary pay	
Travel/Conference spending per employee	
Operating expenditures "per capita" (adjusted: per client, per resident)	
People	
Ratio of non-supervisory staff to supervisory staff	
Vacancy Rate Total for Agency	
Admin leave and sick leave hours as percent of total hours worked	
Employee turnover rate	
% of workforce eligible to retire or will be within 2 years	
Average evaluation score for staff	
Operational support employees are percent of total employees	
Property	
Square feet of office space occupied per employee	
Risk	
# of worker comp and disability claims per 100 employees	