



FY 2011 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 (Includes Office of the Director)
- Saint Elizabeths Hospital
- Mental Health Services and Supports
- Mental Health Financing/Fee for Service
- Agency Management

AGENCY WORKLOAD MEASURES

| Measures | FY08 Actual | FY09 Actual | FY10 YTD |
|---|----------------|----------------|-------------|
| Number of Comprehensive Psychiatric Emergency Program (CPEP) visits | 3,605 | 4,271 | 2,882 |
| Number of adult mobile crisis team visits | Not Available | 1,089 | 1,278 |
| Number of child mobile crisis team visits | Not Available | 396 | 444 |
| Crisis stabilization bed utilization | 71.2% | 76.48% | 82.75% |



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: Complete the planning process to redesign the public mental health system.

In the October 1, 2008, Report to the Council regarding the closure of the DC Community Services Agency (DC CSA)¹, DMH recommended investing the savings from the DC CSA closure into a redesign of the public mental health system. Desired outcomes of the system redesign include: an increased number of people served; a more robust clinical platform including additional evidence-based services; easy access to appropriate mental health services; reimbursement rates that support the costs of service delivery with reasonable caseloads; flexibility to develop and implement innovative approaches for individuals whose needs are not met with the existing structures; and reduced administrative burden for providers. In FY 2010, DMH convened a group of stakeholders to begin the system redesign planning process. Planning activities will continue into FY 2011. An initial Draft Plan will be developed and issued in January 2011 for comment by stakeholders. A Final Plan will be issued by September 30, 2011, after comments have been received and considered from all stakeholders, and will likely include short-term and long-term goals. Implementation is expected to begin in FY 2011 and may occur over the course of several years, depending on the Final Plan recommendations.

INITIATIVE 1.2.: Implement 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 and has been proven to enhance service delivery options in recovery. In some jurisdictions it is a Medicaid reimbursable service. During FY 2010, DMH convened working groups of stakeholders to develop the Peer Specialist program. This work included the revision of the Mental Health Rehabilitation Services (MHRS) standards to include peer support services, developing the training curriculum and certification standards, and developing supervisory guidelines and standards for qualified practitioners supervising the delivery of peer support services. By September 30, 2011, DMH plans to obtain approval from

¹ The Department of Mental Health, Report to the Council of the District of Columbia Required by the Fiscal Year 2009 Budget Support Act of 2008, Title V, Subtitle 1, Section 5022, Recommendations for the Governance of the District of Columbia Community Services Agency (Council Report) was filed with the Council on October 1, 2008,.



DHCF to include peer support services within its Medicaid-reimbursable services and to train the first class of certified peer specialists.

OBJECTIVE 2: Increase access to mental health services.

INITIATIVE 2.1: Increase the number of adults that receive supported employment services.

DMH contracts with six programs to provide an evidence-based supported employment program for consumers with significant mental health diagnoses. These consumers are those for whom competitive employment has not traditionally been available or for whom competitive employment has been interrupted or intermittent. In FY 2011, DMH will increase the number of persons served to 700, by August 2011. One of the primary barriers to expanding capacity has been the need for additional funding to increase service capacity. In FY 2011, DMH will partner with the Rehabilitation Services Administration (RSA) at the Department on Disability Services. RSA will fund the vocational services provided as part of supported employment. Specifically, an additional 150 supported employment slots will be supported through RSA with American Recovery and Reinvestment Act of 2009 (ARRA) funds. By September 30, 2011, DMH plans to obtain approval from DHCF to bill Medicaid for the mental health support services provided as a component of supported employment.

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 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. Annually, Community Service Reviews (CSRs) are performed on a random sample of children, youth and adults who receive services from DMH. These reviews, conducted by an independent review team, collect data through consumer, family, staff and caregiver interviews, as well as document and record review. Previous CSRs have cited the ability of mental health providers to quickly assemble appropriate and highly functional teams as lacking. Improving performance in this area is expected to have the most significant impact on overall system performance and is required for the District to exit from federal court oversight of the public mental health system (under the "Dixon case"). During FY 2009, DMH developed the internal capacity to conduct the CSRs throughout the year and in FY 2010 began piloting internal reviews and conducting focused, follow-up reviews with providers. During FY 2009 and FY 2010, through its internal CSR unit, DMH implemented interventions in the children's mental health system to improve scores, as well as targeted improvement with one large provider to improve functioning. These strategies resulted in significantly improved scores for the large provider during the FY 2010 reviews. Beginning in the summer of FY 2010 and continuing into FY 2011, the internal CSR unit has expanded its targeted intervention strategy with six providers. The targeted providers include two adult-serving providers and four child-serving providers. This intervention is designed to improve the overall



system performance score and the individual scores for team formation and team functioning. This intervention will be completed by the end of FY 2011.

OBJECTIVE 4: Ensure system accountability.

INITIATIVE 4.1: Publish Provider Scorecard.

One approach to measuring the quality and cost of mental health services is the use of a scorecard, which summarizes a critical set of indicators that measure the quality of care provided. The DMH Mental Health Services Provider Scorecard includes elements that measure provider performance in three general areas: 1) quality (periodic completion of the Level of Care Utilization System (LOCUS) or Child and Adolescent LOCUS (CALOCUS) and evidence of annual screening for co-occurring substance use disorder); 2) financial (submission of required financial documents and results of annual claim audits); and 3) compliance (evidence of existence of compliance officer and compliance committee). The Provider Scorecard was piloted in FY 2009, and results were shared with each provider as a learning tool. The FY 2010 Scorecard will be published on the DMH website in December 2010. The existence of a published Provider Scorecard will provide a tool for consumers to use in evaluating their choice of providers – through access on the DMH website and upon request

PROPOSED KEY PERFORMANCE INDICATORS— Mental Health Authority

| Measure | FY 2009 Actual | FY 2010 Target | FY 2010 YTD | FY 2011 Projection | FY 2012 Projection | FY 2013 Projection |
|--|----------------|----------------|-------------|-----------------------------------|----------------------|----------------------|
| Number of affordable housing units funded ² | 141 | 100 | 186 | 100 | TBD | TBD |
| Total number of adult consumers served ³ | 13,544 | 13,800 | 14,749 | 3% of adults in D.C. ⁴ | 3% of adults in D.C. | 3% of adults in D.C. |
| Adult consumers receiving supported employment services | 469 | 600 | 456 | 700 | 800 | 1,000 |
| Percent of MHRS eligible children discharged from inpatient psychiatric hospitals who receive a community-based, | 39.25% | 70% | 48.95% | 80% | 80% | 80% |

² This includes units funded through development of affordable housing units by the Department of Housing and Community Development with \$14 million in DMH capital funds (259 units in various stages of development) and 68 Housing Improvement Program Initiatives (HIPi) units, which are small projects for preservation and rehabilitation of existing units where DMH consumers reside. In FY 2011, an additional 100 housing units will be funded. Housing units in FY 2012-2013 depends on funding availability.

³ 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 FY 2010 YTD data reported is for the period from April 1, 2009 – March 31, 2010 as reported to the *Dixon* Court Monitor for his July 2010 report. The FY 2010 YTD 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.

⁴ Target will be set using the most recent U.S. Census Bureau estimate for adults living in the District. This is consistent with the requirements for reporting *Dixon* Exit Criterion #7.



| Measure | FY 2009 Actual | FY 2010 Target | FY 2010 YTD | FY 2011 Projection | FY 2012 Projection | FY 2013 Projection |
|--|----------------|----------------|-------------|--------------------|--------------------|--------------------|
| non-emergency service within 7 days of discharge ⁵ | | | | | | |
| Percent of MHRS eligible adults discharged from inpatient psychiatric hospitals who receive a community-based, non-emergency service within 7 days of discharge ⁶ | 53.51% | 70% | 55.56% | 80% | 80% | 80% |
| Adult overall system scores for team formation ⁷ | 57% | Not Available | 67% | 80% | 85% | 90% |
| Adult overall system scores for team functioning ⁸ | 49% | Not Available | 60% | 80% | 85% | 90% |
| Child overall system scores for team formation ⁹ | 40% | Not Available | 45% | 65% | 80% | 90% |
| Child overall system scores for team functioning ¹⁰ | 30% | Not Available | 33% | 48% | 65% | 80% |
| Number of Dixon exit criteria targets met and approved for inactive monitoring by the Court Monitor ¹¹ | 6 | Not Available | 11 | 19 | 19 | Not Available |
| Scorecard providers' aggregate quality (adult) score ¹² | Not Available | Not Available | Baseline | TBD | TBD | TBD |
| Scorecard providers' aggregate quality (child) score ¹³ | Not Available | Not Available | Baseline | TBD | TBD | TBD |

⁵ This indicator is tracked as *Dixon* Exit Criterion #17. The target for exiting the *Dixon* case is 80%. FY 2010 YTD data is reported for the period from April 1, 2009 – March 31, 2010 as reported to the *Dixon* Court Monitor for his July 2010 report.

⁶ This indicator is also tracked as *Dixon* Exit Criterion #17. The target for exiting the *Dixon* case is 80%. FY 2010 YTD data is reported for the period from April 1, 2009 – March 31, 2010 as reported to the *Dixon* Court Monitor for his July 2010 report.

⁷ Data from annual Community Service Review (CSR) report.

⁸ Data from annual Community Service Review (CSR) report.

⁹ Data from annual Community Service Review (CSR) report.

¹⁰ Data from annual Community Service Review (CSR) report.

¹¹ As of September 13, 2010, eleven of the Exit Criteria are inactive and eight remain active. The terms of the consent decree authorize the Court to find the District in substantial compliance with the requirements of the consent decree, without meeting the performance targets for each of the 19 Exit Criteria; should this occur this KPI will be eliminated. Based upon its progress over the past year, DMH expects to have exited court oversight by FY 2013, therefore no FY 2013 target is provided.

¹² 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 Scorecard will be published during the first quarter of FY 2011. The baseline from the FY 2010 Provider Scorecard will be used to develop targets for subsequent fiscal years.

¹³ The baseline from the FY 2010 Provider Scorecard will be used to develop targets for subsequent fiscal years.



| Measure | FY 2009 Actual | FY 2010 Target | FY 2010 YTD | FY 2011 Projection | FY 2012 Projection | FY 2013 Projection |
|---|----------------|----------------|-------------|--------------------|--------------------|--------------------|
| Scorecard providers' aggregate financial score ¹⁴ | Not Available | Not Available | Baseline | TBD | TBD | TBD |
| Scorecard providers' aggregate compliance score ¹⁵ | Not Available | Not Available | Baseline | TBD | 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. At the time of its move to the new building (opened in May 2010), the Hospital reorganized its services and programs and implemented a one hospital model. Program assignment no longer is determined by an individual's legal status but rather is based upon the level of care required consistent with the individual's clinical presentation. The two new primary hospital programs are Intensive Treatment and Transitional Treatment.

OBJECTIVE 1: Increase access to mental health services.

INITIATIVE 1.1: Reduce and maintain daily census of individuals in the care of Saint Elizabeths Hospital to 300 or less.

The construction of the new Saint Elizabeths Hospital building was completed in FY 2010, and staff and individuals in care moved to the new building in May 2010. The new Hospital building has a maximum capacity of 293 beds. With the goal of having all individuals in care receiving service in the new building (and to eliminate the need to operate units outside of the new building), through FY 2011 the Hospital will focus on initiatives to reduce the total inpatients served per day to 300 or less. DMH will continue census reduction activities used in FY 2010 (such as linking high utilizers to assertive community treatment teams and establishing a discharge planning process). DMH will also implement new strategies in FY 2011 to further reduce the Hospital census. New strategies include: improving community-based providers' adherence to policies that assure every individual is seen within 48 hours of hospital admission to participate in treatment and discharge planning; partnering with the Department on Disability Services to ensure appropriate discharge planning and placement for individuals with intellectual disabilities to receive Hospital services; and ensuring all individuals discharged from the Hospital receive a community-based service within seven days of discharge to reduce re-admissions.

¹⁴ 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.

¹⁵ Derived from performance in domains like Medicaid Integrity, completion of mandatory training, and participation in mandatory DMH meetings. The baseline from the FY 2010 Provider Scorecard will be used to develop targets for subsequent fiscal years.



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

INITIATIVE 2.1: Enhance quality of care provided at Saint Elizabeths Hospital by increasing active treatment.

High-quality integrated inpatient mental health treatment that is individualized, recovery-based and facilitates successful return to the community is a critical component of DMH's commitment to creating a community-based system of care. During FY 2010, the Hospital adopted a one hospital model that includes two new primary programs, Intensive Treatment and Transitional Treatment. Both programs operate a Therapeutic Learning Center and associated support program. Individuals in care participate in approximately 20 hours of active treatment each week, either in the Therapeutic Learning Centers or in their house (unit). Active treatment activities include work on recovery, developing life skills necessary to live successfully in the community, and participating in enrichment activities to enhance the quality of life both at the Hospital and after returning home. In FY 2011, the Hospital will enhance its original model to improve quality of treatment provided individuals in its care by: (1) ensuring that the therapy groups occur with sufficient weekly frequency to produce positive change in the focus area and are appropriate to the individual's current level of functioning; and (2) improving collaboration and ongoing communication between treatment team members and clinicians providing services. Based upon both internal and external observation and review, the Hospital will continue to examine and refine its model for providing inpatient treatment throughout FY 2011.

INITIATIVE 2.2: Enhance quality of care provided at Saint Elizabeths Hospital through staff training and development associated with clinical care.

In FY 2011, Saint Elizabeths Hospital will continue activities aimed at improving patient care to meet the requirements set forth in the Settlement Agreement with the Department of Justice, as well standards of the Centers for Medicare and Medicaid Services and other regulatory bodies. Clinical practice requirements under the Settlement Agreement include treatment planning, performance improvement, risk management, and training. Enhancing training is critical to ensuring that staff members fully understand clinical practice requirements, have the knowledge and skills to provide high quality services and appropriately document the services provided. During FY 2011, staff trainings will be expanded and the Hospital will offer a wider range of staff development experiences, including mentoring, consultation and formal educational programs. All clinical staff will be trained in the Positive Behavioral Support model and the Recovery model. As a result of this training expansion, the Hospital will improve patient care. The didactic portion of these trainings will be completed by December 2010 with full implementation and coaching continuing throughout FY 2011.



Saint Elizabeth's Hospital

PROPOSED KEY PERFORMANCE INDICATORS— Saint Elizabeths Hospital¹⁶

| Measure | FY 2009 Actual | FY 2010 Target | FY 2010 Year to Date | FY 2011 Target | FY 2012 Target | FY 2013 Target |
|---|-----------------------|-----------------------|-----------------------------|-----------------------|-----------------------|-----------------------|
| Percent of involuntary acute admissions to Saint Elizabeths Hospital ¹⁷ | 12% | 11% | 12% | 10% | 9% | 9% |
| Total inpatients served per day ¹⁸ | 343 | 316 | 308 | 300 | 291 | 291 |
| Number of elopements per 1,000 patient days ¹⁹ | .89 | .75 | .50 | .68 | .61 | .55 |
| Number of patient injuries per 1,000 patient days | 1.01 | 1.00 | 1.57 | .95 | .90 | .86 |
| Number of medication variances that occurred for every 1,000 patient days | 2.78 | 2.64 | 2.07 | 2.51 | 2.39 | 2.27 |
| Percent of unique patients who were restrained at least once during month | 1.2% | 1.1% | 0.5% | 0.9% | 0.7% | 0.6% |
| Percent of unique patients who were secluded at least once during month | 0.5% | 0.5% | 1.2% | 0.5% | 0.5% | 0.5% |
| Percent of patients readmitted to Saint Elizabeths Hospital within 30 days of discharge | 9.5% | 8.6% | 8.9% | 8.1% | 7.7% | 7.3% |

¹⁶ Several measures below (Number of elopements per 1,000 patient days; Number of patient injuries per 1,000 patient day; Percent of unique patients who were restrained at least once during month; Percent of unique patients who were secluded at least once during month; and Percent of patients readmitted to Saint Elizabeths Hospital within 30 days of discharge) are based on the National Association of State Mental Health Program Directors (NASMHPD) Research Institute, Inc. (NRI) aggregate reports based on measurement data collected from state psychiatric hospitals nationwide, publishing 'National Public Rates (NPR)'. The most recent (May 2010) includes data measured for December 2009. See http://www.nri-inc.org/reports_pubs/2010/National_Public_Rates.pdf. The NPR have been incorporated into the hospital targets.

¹⁷ This measure represents the percentage of total involuntary acute admissions authorized by DMH that are sent directly to Saint Elizabeths Hospital.

¹⁸ This measure combines civil and forensic patients. The data reported is the census as of the last day of the last month of each quarter. Beginning in FY 2011, this KPI is being reported as the total inpatients served per day instead of average daily census. Daily census counts the number of inpatients present on the unit but does not include those who are on temporary leave, and thus may not accurately represent the total number of patients served. Starting in FY 2011, the number of all inpatients on the hospital roll will be reported, which will include those who may not be present on the unit as they are placed on leave. The target numbers have been adjusted accordingly.

¹⁹ This measure combines civil and forensic patients and refers to the elopement rate for the entire fiscal year.



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 (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: Implement early childhood mental health consultation project.

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. During the third quarter of FY 2010, services were implemented for children (ages 0 to 5) at 27 centers, which was a significant expansion to the planned project which originally involved services at eight (8) centers. These services are provided to children and families identified through child/family centered consultation at all centers, as well as programmatic consultation to Child Development Center staff. During FY 2011, as the project completes its first year of operation, the focus will be on improving the quality of the consultation services and implementing quantitative measures to facilitate program evaluation, which will be completed by the end of FY 2011.

OBJECTIVE 2: Increase access to mental health services.

INITIATIVE 2.1: Redesign same day urgent care services delivery system.

A need within the District's public mental health system exists for the provision of same-day urgent care services for adults and children. This service was provided by the DC CSA beginning in FY 2008. During the implementation of the recommended closure of the DC CSA, DMH elected to continue to offer the same-day urgent care service through its government-operated services program. The Mental Health Services Division



provides a same day urgent care intervention for adults and children. Services include triage, assessment, supportive counseling, crisis intervention, medication services, and linkage to ongoing services for consumers without other resources. The service is intended to intervene to prevent relapse or full-blown crisis by alleviating presenting problems. The volume of consumers served in the same-day services program is approximately twelve per day but has ranged between nine and twenty-one. DMH began tracking the waiting time for consumers in July 2010. During the second quarter of FY 2011, DMH will analyze the data gathered during the six-month tracking period to identify trends and factors affecting waiting time. After completion of the analysis, DMH will develop strategies to address any issues identified that result in longer waiting time.

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

INITIATIVE 3.1: Improve the assertive community treatment (ACT) team audit fidelity scores.

Assertive Community Treatment (ACT) is an evidence-based intensive community-based service for people with serious mental illness. DMH contracts with several ACT providers to deliver these services. To measure the degree to which the ACT program is consistent with the ACT model, DMH uses the Dartmouth ACT Fidelity Scale (DACTS), which assesses human resources, organizational, and service issues. The results from the FY 2010 fidelity assessment show that the total mean score for the District's ACT teams ranged from 3.4 to 4.0. The DACTS acceptable range across the domains is 4.0 – 5.0. Each provider submitted an individual performance improvement plan to address areas of concern specific to its program, areas in which scores were at 3.0 or below, and is monitored for improvement in that area. These individual performance improvement plans will be monitored and tracked during FY 2011. In addition, DMH has identified five areas for improvement across the entire system in FY 2011, specifically: (1) supported employment; (2) treatment of clients with co-occurring disorders; (3) participation of peer specialists on ACT teams; (4) staff retention; and (5) dual diagnosis groups. Strategies to address each area will be implemented in FY 2011. The next annual fidelity assessment will be completed in the fourth quarter of FY 2011. The goal is for at least 50% of ACT teams to improve their total scores to a 4.0 or higher, which will be achieved through monitoring each team's performance improvement plan and specialized training for all ACT teams on the areas identified for system wide improvement.

OBJECTIVE 4: Ensure system accountability.

INITIATIVE 4.1: Promote revenue enhancement.

One of the major goals for DMH's remaining government-operated services is to generate revenue in support of operations. Low productivity by the DC CSA staff and the limited revenue generated by the program was a significant factor cited in the decision to close the DC CSA. During FY 2010, the historical productivity targets increased from 50% to 65% for physicians and from 50% to 60% for all other staff. These targets are consistent with industry standards for privately operated mental health



clinics.²⁰ The productivity measure is based on the number of units of service provided to consumers. Increased productivity will result in more medically necessary services being provided to consumers in the community, increasing community tenure and eliminating or reducing hospital stays. Increasing productivity to 60% for staff and 65% for physicians will also result in a 40% increase in claims billed. All forty clinical staff will be held to these clinical and productivity standards. Performance improvement plans will be implemented for staff who do not meet the productivity standards. If the problem persists, progressive disciplinary action will be taken to encourage fiscal and clinical compliance. This process will be ongoing during FY 2011.

PROPOSED KEY PERFORMANCE INDICATORS— Mental Health Services and Supports

| Measure | FY 2009 Actual | FY 2010 Target | FY 2010 YTD | FY 2011 Projection | FY 2012 Projection | FY 2013 Projection |
|--|----------------|----------------|-------------------|--------------------|--------------------|--------------------|
| Early Childhood Teacher/Staff Consultations ²¹ | Not Available | Baseline | 246 | 900 | TBD | TBD |
| Early Childhood Parent Consultations | Not Available | Baseline | 37 | 144 | TBD | TBD |
| Early Childhood Presentations/ Trainings | Not Available | Baseline | 15 | 50 | TBD | TBD |
| Number of adult consumers receiving an ACT service | 619 | 650 | 891 | 1,000 | 1,080 | 1,080 |
| Same Day Service, Urgent Care: adult and child consumers seen at intake | Not Available | Not Available | 3,181 | 3,600 | 3,700 | 3,800 |
| Number of Physician's Practice Group psychiatrists working in community CSAs ²² | Not Available | 10 | 10 | 11 | 12 | Not Available |
| Percent of Assertive Community Treatment (ACT) teams score in | Not Available | Not Available | 18% ²⁴ | 50% | 75% | 100% |

²⁰ Productivity is calculated based on the available hours in a year (2,088) with paid annual leave/holidays subtracted. For full time staff, 96 hours billed in a month out of 160 available hours is 60%, and 104 hours billed is 65% productivity.

²¹ KPIs on Early Childhood consultations, presentations and trainings have been updated from the FY 2010 Performance Plan to better measure services provided in the Early Childhood Program. During FY 2010, DMH tracked the total number of consultations provided under this program. Going forward, DMH will document in more detail the types of consultations and other services provided. FY 2012- FY 2013 targets to be determined pending funding availability.

²² Represents number of Physician's Practice Group psychiatrists working in community CSAs at least once a day. DMH committed to operate the PPG until the end of FY 2012. Therefore, no performance target is established for FY 2013.



| Measure | FY 2009 Actual | FY 2010 Target | FY 2010 YTD | FY 2011 Projection | FY 2012 Projection | FY 2013 Projection |
|--|----------------|----------------|-------------|--------------------|--------------------|--------------------|
| acceptable range on fidelity audit ²³ | | | | | | |
| Staff productivity measure (percent of staff reaching 60% minimum productivity standard) ²⁵ | Not Available | 50% | TBD | 60% | 70% | 80% |
| Physician productivity measure (percent of staff reaching 65% minimum productivity standard) | Not Available | 50% | TBD | 60% | 70% | 80% |

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 1: Increase revenue generation through efficient and effective claims processing and billing.

INITIATIVE 1.1: Increase the number of clean claims processed.

The DMH Claims Processing operations will be reorganized by December 31, 2010. Reorganization activities include revision of position descriptions and reporting relationships to ensure segregation of duties, adequate internal controls and improved efficiency. The claims processing and adjudication functions (processing MHRS claims) will be separated from the billing function (billing for government operated services such as CPEP, school-based mental health, the physicians’ practice group and other DMH operated programs) and revenue collection and reconciliation activities. Additional staff (including a Claims Revenue Manager and a Claims Management Specialist) were brought on board in FY 2010 to oversee billing staff, manage claims-related processes

²⁴Two of the 11 ACT team fidelity scores were at the 4.0 range; however, 6 of these teams were new in FY 2010.

²³The Dartmouth ACT Fidelity Scale is the instrument that is used. A total mean score of 4.0 or above is with the acceptable range. For FY 2011 to FY 2013, targets are based on each team’s total mean score on the 28-item fidelity scale.

²⁵Calculation for minimum productivity standards derived from Baseline Readiness for Medicaid Rehab Option Implementation, National Council Consulting Services March 14-15, 2006.



and act as a liaison between DMH, units that support claims processing (Provider Relations, IT and Program staff) and between DMH and Department of Health Care Finance (DHCF). During FY 2011, all staff will be cross-trained on critical functions to ensure that there is sufficient backup for each function. This training will be completed by March 31, 2011.

INITIATIVE 1.2: Improve revenue collections booked by the OCFO.

During FY 2011, the collection of Medicaid revenue reimbursement will be improved through increased billing to Medicaid and the re-working of outstanding receivable claims to maximize revenue collections booked by the Office of the Chief Financial Officer (OCFO). DMH’s goal is for FY 2011 is for 88% of Medicaid claims submitted to DHCF to be processed and paid. As discussed in Initiative 1.1 above, the planned reorganization of the Claims Processing operations will facilitate improved revenue collection. During FY 2010, a billing staff member has been embedded at each of the DMH-operated services so that billing is done on-site. In addition, IT enhancements have been made that are expected to result in more efficient turn-around on correction and resubmittal of denied claims by providers.

PROPOSED KEY PERFORMANCE INDICATORS— Mental Health Financing/Fee for Service

| Measure | FY 2009 Actual | FY 2010 Target | FY 2010 YTD | FY 2011 Projection | FY 2012 Projection | FY 2013 Projection |
|---|----------------|----------------|-------------|--------------------|--------------------|--------------------|
| Percentage of clean claims adjudicated by DHCF within 5 business days of submission ²⁶ | Not Available | 100% | 100% | 100% | 100% | 100% |
| Percent of Medicaid claims submitted to DHCF that are processed and paid | 79% | 85% | 82.86% | 88% | 88% | 88% |

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 1: Maintain efficient and effective agency operations.

INITIATIVE 1.1: Reduce average contracting cycle time.

DMH has independent procurement authority. During FY 2011, the DMH Contracts and Procurement Unit will review and analyze FY 2009 and FY 2010 procurement data on contract cycle time (the time to complete a contract) in order to determine a baseline.

²⁶ This metric is based on the Department of Health Care Finance (DHCF) weekly billing cycle. All clean claims DMH receives from providers are submitted to DHCF weekly, by noon on Friday. DHCF processes the claims on Friday and Saturday night, and reports the results on Monday morning.



This baseline will be defined using the Procurement Administrative Lead Times (PALT), the time between the acceptance of a complete Purchase Request and the Contract Award. After a baseline PALT is determined, the Contracts and Procurement Unit will develop strategies to improve performance. The goal is to ensure more efficient work processes. Analysis of the FY 2009 and FY 2010 data and development of strategies to reduce contract cycle time will be completed by September 2011. An internal performance measure will also be developed. The implementation of the strategies and performance monitoring will be ongoing during FY 2011.

PROPOSED KEY PERFORMANCE INDICATORS— Agency Management ²⁷

| Measure | FY 2009 Actual | FY 2010 Target | FY 2010 YTD | FY 2011 Projection | FY 2012 Projection | FY 2013 Projection |
|---|----------------|----------------|---------------|--------------------|--------------------|--------------------|
| Establish PALT baseline | Not Available | Not Available | Not Available | Baseline | TBD | TBD |
| % of subgrantee's budget spent on programmatic costs ²⁸ | Not Available | Not Available | Not Available | 65% | 65% | 65% |
| % of scheduled monitoring reports as defined in agency monitoring plan completed for each grant award ²⁹ | Not Available | Not Available | Not Available | 100% | 100% | 100% |

²⁷ KPIs below are based on District Contracting & Procurement laws, rules & regulations. The Procurement Administrative Lead Times (PALT) is the time between the acceptance of a complete Purchase Request and the Contract Award. The establishment of PALT directly affects the Timeline/Schedule of a Procurement Action by imposing a defined timeframe. Target PALTs are as follows: Small purchases (\$5,001-25,000) =15 business days (BDs); RFQs (\$25,001-100,000)=20 BDs; CSBs & IFBs (\$100,001-\$1 million)=120 BDs; exceeding \$1 million=150 BDs; RFPs (\$100,001-\$1 million)=150 BDs, and exceeding \$1 million=180 BDs. Also, at this time DMH is unable to project the number of HCA, contracts and modifications that will be processed due to pending FY 2010 and FY 2011 contract funding reductions.

²⁸ The Wise Giving Alliance of the Better Business Bureau identifies 65% to be an industry standard for this measure <http://www.bbb.org/us/Charity-Standards/>. This metric measures all subgrantees' programmatic costs as a percentage of their overall costs.

²⁹ Pursuant to 11.4 of the Grants Manual and Source Book all District agencies must complete monitoring reports. All District agencies should be in compliance with this standard. The standard is 100%.