FY 2013 PERFORMANCE PLAN
Department of Mental Health

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

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

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

AGENCY WORKLOAD MEASURES

Measures	FY 2010 Actual	FY 2011 Actual	FY 2012 YTD[1]
Number of adult consumers served	15,678	17,627	18,708
Number of child and youth consumers served	3,824	4,350	4,480
Mental Health Services Division (MHSD) intake/Same Day Service Urgent Care Clinic – adults	2,080	2,825	3,083
MHSD intake/Same Day Service Urgent Care Clinic – child/youth	402	488	489
Number of Comprehensive Psychiatric Emergency Program (CPEP) visits	3,943	3,921	3,925
Number of adult mobile crisis team visits	2,161	1,906	1,094
Number of child mobile crisis team visits	581	482	658
Crisis stabilization bed utilization	85.63%	88.27%	85.0%
Number of claims audits conducted	16	43	41
Involuntary acute admissions to Saint Elizabeths Hospital	6.44%	2.80%	1.8%

[1] The adult and child/youth consumers served data is based on a 1/17/13 data run for FY 12 services. All other data is cumulative for FY12.

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: Work collaboratively with the Department of Health to establish and implement the planning process to create the new Department of Behavioral Health.
On Friday, January 11, 2013 District of Columbia Mayor Vincent C. Gray announced his plan to bring together treatment and services for mental health and substance use disorders to enable better coordination of care to improve outcomes. Services will be delivered through a new Department of Behavioral Health (DBH) made up of DMH and the Addiction, Prevention and Recovery Administration (APRA). This important initiative recognizes that a significant number of mental health consumers have substance use disorders and also builds on joint work already taking place to treat co-occurring disorders.

The planning process during FY 2013 for the new department will be lead by the DMH Director and the Interim Director of the Health Department. The current mental health director will direct the new department. Completion Date: October 2013

INITIATIVE 1.2: Expand the range of services available under mental health rehabilitation services (MHRS) for counseling.
During FY 2012, DMH began training a small cadre of child providers in evidence-based treatment that included Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Child Parent Psychotherapy for Family Violence (CPP-FV). In FY 2013, DMH will expand the MHRS Counseling service to include these evidence-based practices (EBPs). Completion Date: September 2013

OBJECTIVE 2: Increase access to mental health services.

INITIATIVE 2.1: Collaborate with Washington Metropolitan Area Transit Authority (WMATA) on suicide intervention and public awareness program.
In May 2012, WMATA and DMH signed a memorandum of understanding (MOU) for suicide intervention training services and a dedicated crisis intervention Hotline. DMH is

conducting a train-the-trainer suicide prevention training for 20 WMATA staff by providing instruction in Applied Suicide Intervention and Skills Training (ASIST) and Tell Ask Listen Keep Safe (safeTALK). DMH is also participating in the training of the WMATA staff (station managers, vehicle operators, and supervisors). DMH's role also includes providing appropriate immediate crisis intervention and appropriate referrals for ongoing outpatient services for both District and non-District residents. It is anticipated that this project will become fully operational during FY 2013. Completion Date: September 2013

Initiative 2:2 Expand access to early childhood services.
In FY 2012, the Primary Project operated in 30 sites, 16 schools and 14 Child Development Centers. The primary focus is to enhance school related competencies and reduce social, emotional and school adjustment difficulties for children in grades Kindergarten through First. During FY 2013, the Primary Project will increase from 30 to 35 sites. Completion Date: September 2013

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

INITIATIVE 3.1: Develop an assertive community treatment scorecard.
The previously reported initiatives and performance measures associated with the assertive community treatment (ACT) teams focused on: 1) the extent to which they demonstrated fidelity to the evidence-based model; and 2) increasing the number of adult consumers receiving ACT services.

In FY 2013, DMH will begin the process of developing an ACT Scorecard to ensure the provision of quality of services across the overall program. This will include: 1) the FY 2013 phase one ACT Scorecard planning process (benchmarking, developing and pilot testing the quality measures and scoring system); and 2) the FY 2014 phase two ACT Scorecard implementation process (assessing and reporting the ACT teams' performance on identified quality measures). Completion Date: September 2014

INITIATIVE 3.2: Establish benchmarks for supported employment.
The previously reported initiatives and performance measures associated with supported employment included: 1) increasing the number of adult consumers receiving supported employment services; and 2) developing a method to assess need for supported employment and referral of consumers to this service.

In FY 2013, DMH will begin the process of establishing benchmarks for supported employment to ensure that quality services are provided across this provider network. It is envisioned that the planning and development process will include: 1) determining the benchmarks in use by other states/jurisdictions; 2) including providers for buy-in and input; 3) developing and pilot testing the benchmarks; and 4) developing a reporting protocol to assess performance related to the benchmarks. In FY 2014, DMH will begin

full implementation of the supported employment benchmarks. Completion Date: September 2014

INITIATIVE 3.3: Improve Provider Scorecard.
In FY 2010, the Office of Accountability (OA) implemented the Provider Scorecard that was piloted in FY 2009. The original Scorecard assessed three (3) domains for each provider: Quality, Financial, and Compliance with regulations. On February 28, 2011, the results of the FY 2010 Scorecard were only shared among the 16 providers that were assessed across all 3 domains.

The FY 2011 Provider Scorecard was published on the DMH website on March 7, 2012. The FY 2012 Provider Scorecard will be published in Spring 2013. The Office of Accountability will make projections for FY 2013 and FY 2014 key performance indicators after the results for FY 2012 Scorecard are completed and tabulated. Completion Date: June 2013

INITIATIVE 3.4: Expand DMH disaster mental health response capacity.
Disaster Mental Health services provide rapid and effective crisis counseling and stress management through "Mental Health Response Teams." 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 DMH 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 DMH Disaster Mental Health Services in responses. The training curriculum will:
1) be based upon best-practice models; 2) provided in 12 separate modules; and
3) include a pre- and post-test to detail participants' knowledge gain and/or skills retention. Participating members will be eligible to apply to DMH response teams following successful completion of the seven (7) core training courses and three (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 150 persons are trained. Completion Date: December 2014

OBJECTIVE 4: Ensure system accountability.

INITIATIVE 4.1: Expand DMH grievance process training.
The DMH grievance process ensures that consumer rights are protected and that they receive the appropriate treatment and services. In FY 2013 DMH will expand the grievance process training by: 1) increasing the number of annual trainings from two (2) to three (3); and 2) providing on-site training to the mental health rehabilitation services (MHRS) providers. The primary focus will be on new providers and those with large staff turnover. It is envisioned that up to three (3) provider trainings will be held during FY 2013. Completion Date: September 2013

KEY PERFORMANCE INDICATORS- *Mental Health Authority*

Measures	FY 2011 Actual	FY 2012 Target	FY 2012 YTD	FY 2013 Projection	FY 2014 Projection	FY 2015 Projection
DMH train-the-trainer suicide prevention for WMATA staff	Not Applicable	Not Applicable	20 WMATA staff	DMH WMATA Lifeline begins receiving calls and data analysis	DMH continues to accept calls to WMATA Lifeline	DMH continues to accept calls to WMATA Lifeline
Expand access to early childhood services – Primary Project	Not Applicable	Not Applicable	30	Increase to 35 sites	TBD	TBD
Develop Assertive Community Treatment (ACT) Scorecard	Not Applicable	Not Applicable	Not Applicable	ACT Scorecard developed	ACT Scorecard implemented	Continue to implement ACT Scorecard
Establish benchmarks for supported employment	Not Applicable	Not Applicable	Not Applicable	Supported employment benchmarks developed	Supported employment benchmarks implemented	Continue to implement supported employment benchmarks
Provider Scorecard - providers' average quality (adult) score	71.42	80.00	TBD after analysis of data	TBD After FY 2012 Scorecard developed	TBD After FY 2012 Scorecard developed	TBD After FY 2012 Scorecard developed
Provider Scorecard - providers' average quality (child) score	63.27	80.00	TBD after analysis of data	TBD After FY 2012 Scorecard developed	TBD After FY 2012 Scorecard developed	TBD After FY 2012 Scorecard developed
Provider Scorecard- providers' average financial score	80.22	85.00	TBD after analysis of data	TBD After FY 2012 Scorecard developed	TBD After FY 2012 Scorecard developed	TBD After FY 2012 Scorecard developed
Expand DMH disaster mental health response capacity	Not Applicable	Not Applicable	Not Applicable	Increase trained members on DMH response teams	Increase trained members on DMH response teams	Continue annual training and up to 150 trained
Increase grievance process training	2	2	1	2	3	3
Provider site grievance process training	Not Applicable	Not Applicable	Not Applicable	2	Up to 3	Up to 3

Saint Elizabeths Hospital

SUMMARY OF SERVICES

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

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

INITIATIVE 1.1: **Improve treatment approaches for discharge/transition to community living.**

This initiative includes several programs and activities. It targets those individuals in care identified as resistant to leaving the hospital and focuses on increasing their ability to engage in treatment and subsequently transition to the community. Groups emphasize experiential learning (i.e., budgeting, food preparation, travel training) and the functional level of individuals in care is factored into group assignment. In addition to skill-building groups, individuals practice learned skills by going into the community on weekly trips or more frequently if indicated. Peer transition specialists will be used to support individuals in care by pairing them with an individual in care and accompanying them on community outings. It is anticipated that these focused efforts will result in more of these resistant individuals engaging in treatment and transitioning into the community. Completion Date: September 2013

INITIATIVE 1.2: Promote full implementation of recovery model in delivery of nursing care.

This initiative focuses on improving the quality of nursing care provided to individuals in care. With the recent addition of significant numbers of nursing staff to comply with the Department of Justice (DOJ) Settlement Agreement, it is imperative that staffers receive training in the recovery model and are able to fully participate in individualized recovery planning. Completion of competency-based training in the recovery model will be completed by 95% of the nursing staff (both RNs and recovery assistants). In addition, training in development of objectives and nursing interventions will be developed and completed by 95% of RNs by September 2013. Completion Date: September 2013

KEY PERFORMANCE INDICATORS – *Saint Elizabeths Hospital*

Measures	FY 2011 Actual	FY 2012 Target	FY 2012 YTD[2]	FY 2013 Projection	FY 2014 Projection	FY 2015 Projection
Competency-based recovery model training	Not Applicable	Not Applicable	Not Applicable	95% nursing staff	As needed	As needed
Objectives and nursing interventions training	Not Applicable	Not Applicable	Not Applicable	95% nursing staff	As needed	As needed
Total Patients Served Per Day	288	291	276	275	275	275
Elopements per 1,000 patient days	0.41	0.45	0.27	0.28	0.28	0.28
Patient injuries per 1,000 patient days[3]	0.27	0.28	0.35	0.27	0.32	0.30
Missing documentation of medication administration results **(%)**[4]	N/A	N/A	0.34%	0.30%	0.25%	0.20%
Unique patients who were restrained at least once during month (%)[5]	0.4%	0.4%	0.1%	0.1%	0.1%	0.1%
Unique patients who were secluded at least once during month (%)	0.6%	0.6%	0.6%	0.7%	0.6%	0.5%
Percentage of Patients re-admitted to Saint Elizabeths Hospital within 30 days of discharge (%)	5.2%	5.0%	5.3%	6.0%	5.8%	5.5%

[2] FY12 YTD data is the complete FY12 data.
[3] 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.
[4] Measured by dividing the total number of medication administration records with missing documentation by the total number of scheduled medication administration records.
[5] The numbers are not whole numbers because they are monthly averages for the fiscal year and for many months no one was in restraints or seclusion.

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).

***Dixon* Settlement Agreement Initiatives**

All of the *Dixon* Settlement Agreement initiatives are under Mental Health Services and Supports.

OBJECTIVE 1: Expand the range of mental health services.

INITIATIVE 1.1: Reduce the number of days that District children/youth spend in psychiatric residential treatment facilities (PRTFs).

By September 30, 2013, DMH will reduce the number of bed-days that children/youth with serious emotional disturbances spent in PRTFs by 30%.

INITIATIVE 1.2: Increase evidence-based practices that are appropriate for children/youth.

By September 30, 2013, DMH will increase the provision of Multi-Systemic Therapy (MST) and Functional Family Therapy (FFT) by 20%.

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

By September 30, 2013, DMH will increase the provision of HFW by 20%.

OBJECTIVE 2: Increase access to mental health services.

INITIATIVE 2.1: Increase new supported housing vouchers/subsidies and/or capital housing units.

DMH will develop 200 net new supported housing vouchers, subsidies and/or capital housing units by September 30, 2013.

INITIATIVE 2.2: Expand access to supported employment services.
In FY 2013, DMH will increase the interested consumers referred to supported employment to 60% and increase by 15% the number receiving this service.

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

INITIATIVE 3.1: **Improve the Community Service Reviews (CSRs) child/youth overall system performance score.**
By September 30, 2013, DMH will achieve an overall system performance level of 70% on the child/youth CSRs.

INITIATIVE 3.2: Ensure provider compliance with the Continuity of Care guidelines regarding discharge planning and services provided post discharge from a psychiatric hospitalization.
By September 30, 2013, DMH will ensure that: 1) 70% of adults and 70% of children/youth receive at least one (1) non-crisis service in a non-emergency setting within 7 days of discharge from a psychiatric hospitalization; and 2) 80% of adults and 80% of children/youth receive at least one (1) non-crisis service in a non-emergency setting within 30 days of discharge from a psychiatric hospitalization.

KEY PERFORMANCE INDICATORS – *Mental Health Services and Supports*

Measures	FY 2011 Actual	FY 2012 Target	FY 2012 YTD[6]	FY 2013 Projection	FY 2014 Projection	FY 2015 Projection
Child/Youth CSRs overall system performance	59%	65%	65%	70%	70%	75%
Baseline and reduced number of bed days C/Y spend in psychiatric residential treatment facilities (PRTFs	Not Applicable	Baseline Established 72,687[7]	33,348[8]	50,881 (30% reduction in number of bed days	48,337 (5% reduction in number of bed days)	45,920 (Maintain 5% reduction)
Increase C/Y receiving Multi-Systemic Therapy (MST)	129 (Baseline for MST)	155 (20% increase in FY11 MST baseline)	119	20% increase in final FY12 MST baseline[9]	Established after FY13 MST baseline complete	Established after FY14 MST baseline complete
Increase C/Y receiving Functional Family Therapy (FFT)	82 (Baseline for FFT)	98 (20% increase in FY11 FFT baseline)	224	20% increase in final FY12 FFT baseline[10]	Established after FY13 FFT baseline complete	Established after FY14 FFT baseline complete
Increase C/Y receiving High Fidelity Wraparound (HFW)	211 (Baseline for HFW)	232 (10% increase in FY11 HFW baseline)	282	20% increase in FY12 HFW baseline[11]	Established after FY13 HFW baseline complete	Established after FY14 HFW baseline complete
Increase new supported housing vouchers/subsidies and/or capital housing units and develop a housing plan	1,396 (Baseline and methodology for vouchers/ subsidies and capital units in development)	Strategic plan and resource development for supported housing need and 100 new subsidies	Supportive Housing Strategic Plan 2012-2017 Increased to 1,502 vouchers and capital units	200 (Supported housing vouchers/sub-sidies and/or capital housing units)	100 (Supported housing vouchers/sub-sidies and/or capital housing units)	100 (Maintain supported housing vouchers/sub-sidies and/or capital housing units)

[6] FY12 YTD is the complete FY12 data.
[7] The bed days baseline is May 1, 2011-April 30, 2012.
[8] Actual bed days is from date of admission for children in a PRTF for the period May 1-September 30, 2012. The end of the comparison to baseline reporting period is April 30, 2013.
[9] FY13 projections will not be available until after 12/31/12 due to the 90-day claims lag time. The FY14 and FY15 projections will be established after the previous fiscal year baselines are complete.
[10] FFT same as above.
[11] HFW same as above.

Measures	FY 2011 Actual	FY 2012 Target	FY 2012 YTD[6]	FY 2013 Projection	FY 2014 Projection	FY 2015 Projection
Method to assess need for supported employment and referral of consumers to service	Not Applicable	Assess consumer need and referral to supported employment	17%[12] (60% of interested consumers referred to supported employment	60% of interested consumers referred to supported employment	60% of interested consumers referred to supported employment	60% (Maintained)
Increase number of consumers receiving supported employment service	761 (Baseline for total number of consumers served in supported employment)	837 (10% increase in number receiving service in FY11)	757	963 (15% increase in number receiving service in FY12)	5% increase in number receiving service in FY13	5% increase in number receiving service in FY14
Adults receive at least one (1) non-crisis service in a non-emergency setting within 7 days of discharge from a psychiatric hospitalization	69.63%	70%	71.3%[13]	70%	70%	70% (Maintained)
C/Y receive at least one (1) non-crisis service in a non-emergency setting within 7 days of discharge from a psychiatric hospitalization	55.96%	70%	61%[14]	70%	70%	70% (Maintained)
Adults receive at least one (1) non-crisis service in a non-emergency setting within 30 days of discharge from a psychiatric hospitalization	Not Applicable	80%	80.8%[15]	80%	80%	80% (Maintained)
C/Y receive at least one (1) non-crisis service in a non-emergency setting within 30 days of discharge from a psychiatric hospitalization	Not Applicable	80%	79.4%[16]	80%	80%	80% (Maintained)

[12] This data is for the FY12 fourth quarter only. The period to meet the targeted 60% is April 1, 2012- September 30, 2013.
[13] DMH worked with DHCF to verify additional data sources and revised the data.
[14] Same as above.

[15] Same as above.
[16] Same as above.

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

INITIATIVE 1.1: Improve the total Medicaid claims paid by reducing the denials by the Department of Health Care Finance (DHCF).

This initiative was introduced in the FY 2012 Performance Plan and is being continued in FY 2013. The primary purpose is to help the providers in correcting and re-billing Medicaid claims as a way to maximize federal funding. In FY 2013, DMH will continue to review the provider denial rate of Medicaid claims and provide assistance as necessary in an effort to reduce the denials by DHCF. Completion Date: September 2013

KEY PERFORMANCE INDICATORS - *Mental Health Financing/Fee for Service*

Measures	FY 2011 Actual	FY 2012 Target	FY 2012 YTD	FY 2013 Projection	FY 2014 Projection	FY 2015 Projection
Improve total Medicaid claims paid by facilitating providers reducing DHCF denials.	5.1% Medicaid denials	Reduce Medicaid denials to 5% or less	5.5% Medicaid denials	Reduce Medicaid denials to 5% or less	Reduce Medicaid denials to 5% or less	Reduce Medicaid denials to 5% or less

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: Ensure system accountability.

INITIATIVE 1.1: Implement the care management application.
DMH issued the RFP for an Integrated Care Applications Management System (iCAMS) application in FY 2012. 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.

The RFP closed on July 20, 2012. The initial meeting of the Review Committee was scheduled prior to July 31, 2012. The next steps and milestones related to the implementation of the care management system include the following: 1) completion of the proposal review process with final selection by November 2012; 2) initiation of the process to build the new care management system that will occur over a 16-18 month period; and 3) full implementation of the care management system is anticipated by June 2014. Completion Date: June 2014

KEY PERFORMANCE INIDCATORS – *Agency Management*

Measures	FY 2011 Actual	FY 2012 Target	FY 2012 YTD	FY 2013 Projection	FY 2014 Projection	FY 2015 Projection
Implement iCAMS	Not Applicable	Issue RFP for care management system	RFP closed July 20, 2012	Select vendor and begin building the system over 16-18 month period	iCAMS fully operational by June 30, 2014	Continue to implement iCAMS