



## Department of Mental Health DMH (RM)

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### 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 District of Columbia Community Services Agency (DCCSA), the Comprehensive Psychiatric Emergency Program, the Homeless Outreach Program and the School-Based Mental Health Program.

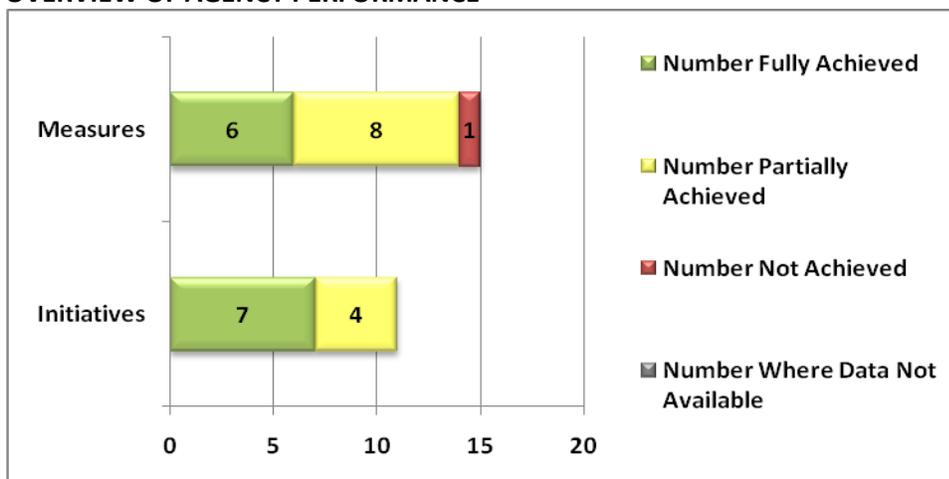
### AGENCY OBJECTIVES

1. Expand the range of mental health services.
2. Increase access to mental health services.
3. Continually improve the consistency and quality of mental health services
4. Ensure system accountability.

### ACCOMPLISHMENTS

- ✓ Met the deadlines in the FY 2009 Budget Support Act by transitioning 2,500 consumers from the District of Columbia Community Services Agency (DC CSA) to the private provider network
- ✓ Served over 1,400 consumers with the new adult Mobile Crisis Services from November 1, 2008.
- ✓ Partnered with MPD to develop and implement Crisis Intervention Officer Training. Over 60 officers were trained during three (3) separate training classes.

### OVERVIEW OF AGENCY PERFORMANCE





## Performance Initiatives – Assessment Details

### Performance Assessment Key:

 Fully achieved     Partially achieved     Not achieved     Data not reported

### OBJECTIVE 1: Expand the range of mental health services.

#### **INITIATIVE 1.1: Work with DCPS to expand the school-based mental health program.**

The DMH School Mental Health Program (SMHP) met its goal of expanding to ten schools; from 48 to 58 schools during School Year 2008-2009. Further, DMH implemented an early childhood education program called the Primary Project in 12 schools. This evidence-based program provides early intervention services to children identified with emotional and behavioral difficulties in grades K and 1. A total of 991 students were screened with 164 students participating in the program.

#### **INITIATIVE 1.2: Implement the community based wrap-around pilot program for at-risk children and youth.**

This initiative is funded by CFSA, DYRS, OSSE, and DMH. The Blackman Jones settlement agreement with the District, resulted in the transfer of \$1M from OSSE to DMH to provide intensive wraparound services for up to 100 students in eight (8) DCPS model schools targeted as “full service schools”- combining academics and mental health. Also, CFSA, DYRS and DMH provided funding for 24 slots for children across the community. This service was augmented with additional funding from the State Mental Health Block that supported an additional 10 slots bringing the total Wraparound capacity to 134 by June 2009. By the end of FY 2009, 123 of the 134 Wraparound slots (over 90% of the total slots available and 99% of the slots available at the beginning of the fiscal year) were filled. The wraparound identification, referral, admissions and service delivery components are all fully operational. Seventy-one percent of the youth served in the community-based wraparound effort were able to be served in the community rather than in a residential placement. One hundred percent of the youth in the school-based wraparound process remain in their community and within their school placements.

#### **INITIATIVE 1.3: Continue partnership with the Department of Housing and Community Development to develop 150 new affordable housing units for persons with mental illness.**

As of September 30, 2009, 248 housing units had been approved for financing since November 2008. In FY 2009, 141 new housing units were approved for financing (94% of the target). 48 consumers have moved into their own apartments.

### OBJECTIVE 2: Increase access to mental health services.

#### **INITIATIVE 2.1: Continue implementation of enhanced community-based psychiatric crisis emergency services for adults in accordance with stakeholder developed plan.**

DMH fully achieved this initiative. The Mobile Crisis Services (MCS) was fully staffed and began



providing services on November 1, 2008. The MCS is staffed by a multidisciplinary team of mental health workers including: peer counselors, mental health counselors, mental health specialists, addiction treatment specialists, social workers, and psychiatrists.

In FY 2009, the MCS made 1089 crisis visits; served a total of 1,489 consumers and made a total of 2,977 contacts inclusive of non-face to face as well as in-person contacts.

The Phase 2 renovation of CPEP to add eight extended observation beds (72-hour) (EOB) was completed December 22, 2008. The EOB began operating in February 2009. In FY 2009, there were a total of 270 admissions to these beds.

**INITIATIVE 2.2: Implement mobile crisis services and crisis stabilization beds for children and youth.**

DMH fully achieved this initiative. In October 2008, Catholic Charities began operating the Child and Adolescent Mobile Psychiatric Service (ChAMPS) under contract with DMH. The goal of this service is to provide on-site crisis stabilization within one hour of a call.

- ChAMPS provides follow-up visits as needed to stabilize the family situation and/or connect the family to needed support services. ChAMPS also makes referrals to crisis/respite beds as needed for children/youth via Sasha Bruce, St. Ann's Children's Home or a group of specialized foster homes. During FY 2009, ChAMPS received a total of 687 crisis calls. The mobile team was dispatched for 396 face-to-face contacts in response to these calls.

**INITIATIVE 2.3: Implement an Integrated Care Management Program to provide community-based care for 30 consumers who have been receiving inpatient services at Saint Elizabeths Hospital for more than six months.**

- DMH fully achieved this initiative. In March 2009, DMH contracted with the Washington Hospital Center to implement an Integrated Community Care Project to serve 23 individuals in the first year. The program enrolled 23 and moved four (4) consumers from Saint Elizabeths into the community by September 30, 2009.

The Integrated Care Model is financed through a Case Rate financing mechanism that promotes and supports individualized, flexible, effective and efficient services designed to assist long-term inpatient consumers to function effectively in the community. The Case Rate includes the continued use of the Mental Health Rehabilitation Service (MHRS) fee for service structure.

**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.**

- DMH began developing the internal capacity to conduct the CSRs during FY 2009. The CSR Unit is responsible for assessing overall performance of the mental health system using the CSR instrument and applying the results of the assessment to provide technical supports and resources to improve the quality of practice. This unit is now fully functional. The CSR Unit will use the historical data gathered through the Dixon CSRs and conduct CSRs on an ongoing basis. The implementation of focused reviews began in November 2009, with a review of the experience of a sample of 26 consumers who transitioned from the DC CSA to community



providers.

The results of the 2009 Adult Dixon CSR were as follows:

57% of cases were found to have acceptable team formation (a 4% increase from the 2008 finding of 53%)

49% of cases were found to have acceptable team functioning (a 2% decrease from the 2008 finding of 51%).

The results of the 2009 Child Dixon CSR were:

40% of the cases were found to have acceptable team formation (a 7% decrease from the 2008 finding of 47%)

30% of the cases were found to have acceptable team functioning (a 4% increase from the 2008 finding of 26%)

Copies of the Dixon CSR Reports are available on the DMH website ([www.dmh.dc.gov](http://www.dmh.dc.gov)). Click on the link to Dixon Case Information. There are links to Exit Criterion #3 (adults) and Exit Criterion #4 (children) at the bottom of the page.

### **INITIATIVE 3.2: Complete and implement transition plan for the D.C. Community Services Agency (DCCSA).**

DMH fully achieved this initiative and DMH met the deadlines in the FY 2009 Budget Support Act by completing and implementing a transition plan for the DC CSA consumers. In accordance with the requirements of in the Implementation Plan to the Council, DMH transitioned more than 2,500 consumers from the DC CSA to the private provider network during FY 2009. With the majority of consumers enrolled with new providers and resulting staff reductions, the DC CSA effectively ceased operations in August 2009. Unique services for specialty services performed by the DC CSA have been transferred within DMH, i.e., consumers with limited or no English proficiency (LEP/NEP), consumers with co-occurring developmental disabilities and consumers who are deaf or hearing impaired), a restoration to competency program, and a psycho-educational program. As of December 15, 2009, 3003 consumers have been transferred to new providers. DMH estimates that there are an additional 167 former DC CSA consumers who remain to be transferred to a new provider by March 31, 2010. These consumers are receiving services from DMH continuity of care transition teams. DMH has set up a Physicians Practice Group so former DC CSA consumers can remain with the same psychiatrist by choice and to support the private provider network. Also, DMH will continue to operate the community pharmacy.

The Office of Accountability is responsible for monitoring the DC CSA Transition Plan implementation process. This monitoring includes:

- Consumer Satisfaction Surveys,
- Continuity of Care Monitoring, and
- Consumer Transition Voucher (CTV) Claims Auditing.

### **INITIATIVE 3.3: Enhance quality of care provided at Saint Elizabeths by implementing person-centered treatment planning that is integrated across disciplines.**

As of September 30, 2009, 540 staff had been trained out of 560 who could be trained (96.4%). Staff receives didactic presentations on pertinent topics (e.g., overview of person-centered planning, stage of change, clinical formulation). The initial units trained were instrumental in



developing the individual recovery plan (IRP) forms and the recovery planning manual. The activities during FY 2009 include hands on training on 14 units (8 civil and 6 forensic) with person- centered recovery planning consultants. These consultants attended recovery team meetings and provided education and feedback about stage of change, engagement of individuals in recovery planning, and the process of recovery planning. In addition, recovery plan forms were revised to incorporate person-centered concepts and feedback from DOJ. The IRP manual is in the process of being revised with these new and modified forms which include examples and operational instructions for use of the forms, as well as tip sheets, auditing tools and guides.

**OBJECTIVE 4: Ensure system accountability.**

**INITIATIVE 4.1: Improve fiscal accountability by implementing Phase 2 of the audit plan.**

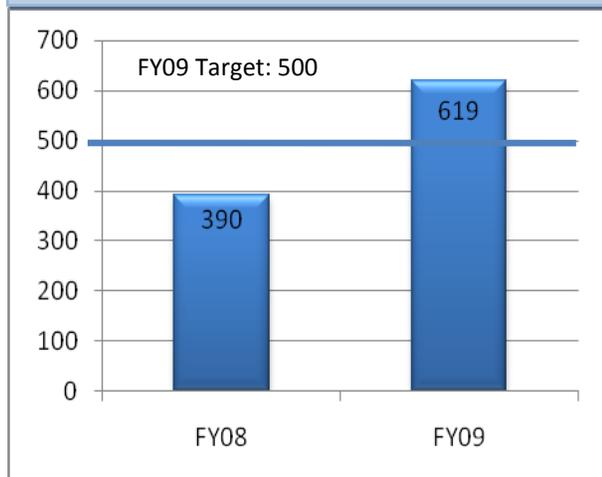
DMH met the goals of the Phase 2 audit plan. During FY 2009, the following activities were conducted by the Office of Accountability (OA): 44 Claims Audits, 21 Quality Reviews; and 34 Continuity of Care Monitoring visits. In addition, OA conducted 7 Focused Reviews in response to complaints. Four of the Focused Reviews were completed during FY 2010, 3 are pending completion. The FY 2006 Same Day Services Claims Audit resulted in \$18,625.66 in repayments; and the FY 2007 Initial Claims Audit resulted in a repayment due of \$1,689.07.

**INITIATIVE 4.2: Saint Elizabeths Hospital will institute new billing and coding to ensure Medicaid and Medicare claims are accurately submitted.**

This initiative was partially achieved during FY 09. A number of activities were initiated in order to meet the Medicaid and Medicare new billing and coding initiative. A Chief Administrative Officer (CAO) to oversee administrative, billing, and compliance operations was hired in December 2008. The Hospital engaged the Public Consulting Group (PCG) to provide daily technical assistance for Billing Operations. A Draft Billing Operations Policies and Procedures Manual was also developed. Working in concert with the CAO and his staff, PCG designed processes to review, correct and submit backlogged Fiscal Year 2007 Medicare and Medicaid claims. The activities during FY 2009 have included: completion of 2007 revenue cycle activities and initiation of 2008 claims submittal; timely filing of 2007 and 2008 cost reports for both Medicare and Medicaid; implementation of standard process for reviewing chart compliance in advance of claiming activities; establishment of project in order to use Avatar for claims processing; additional billing staff training; a member of the revenue cycle staff team has become a certified coder; and the review of existing policies and procedures including developing new ones. A final billing manual based on real process flows and revenue cycle best practices is anticipated by December 2009.

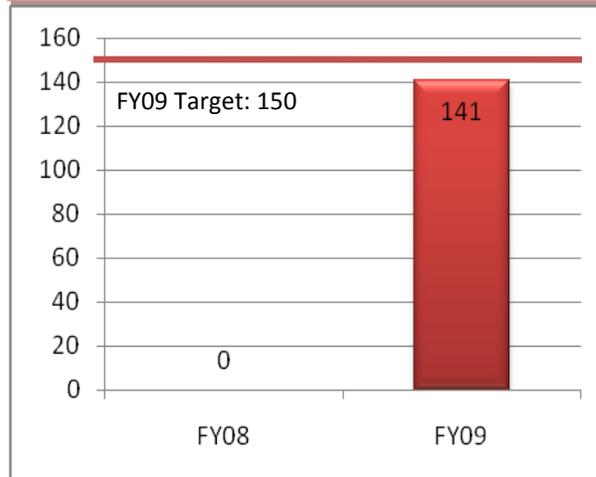
## Key Performance Indicators – Highlights

From Objective 1: Number of adult consumers enrolled in Assertive Community Treatment



**FULLY ACHIEVED**

From Objective 1: Number of new affordable housing units under development



**PARTIALLY ACHIEVED**

### More About These Indicators:

#### *How did the agency's actions affect this indicator?*

- DMH and DHCF implemented a rate increase for ACT services, which ensures that reimbursement for this intensive service is comparable to other jurisdictions. Five new ACT providers obtained certification and three began providing ACT services during FY 2009.
- DMH actively sought ACT referrals from the provider and advocacy community
- DMH established a Care Management function to link individuals with complex needs to the appropriate range of services. Care managers connected many individuals to ACT services.

#### *What external factors influenced this indicator?*

- National prevalence data indicated that the District needed to increase its capacity of ACT services. Local stakeholders and advocates, staff made requests for more ACT services.

#### *How did the agency's actions affect this indicator?*

- In FY 2008, DMH entered into an MOU with the Department of Housing and Community Development (DHCD) to use \$14 million in capital funds from DMH to develop 150 housing units in FY08, with another 150 housing units slated for development in FY09 for DMH consumers. DHCD has issued several Notices of Funding Availability (NOFAs) since 2008 to seek developers.
- As of September 2009, DHCD has 248 units in the pipeline; 48 consumers have moved into completed units.

#### *What external factors influenced this indicator?*

- Consumers, providers and mental health advocates have articulated the need for affordable housing for mentally ill individuals.
- The time required to identify and develop sites can slow the progress of development.



## Key Performance Indicators – Details

### Performance Assessment Key:

● Fully achieved    
 ● Partially achieved    
 ● Not achieved    
 ● Data not reported

	Measure Name	FY2008 YE Actual	FY2009 YE Target	FY2009 YE Revised Target <sup>1</sup>	FY2009 YE Actual	FY2009 YE Rating	Budget Program
●	1.1 Percent of schools with a school-based mental health program.	23.3	23.7	23.3	23.68%	101.65%	COMMUNITY CONTRACT PROVIDERS
●	1.2 Number of new affordable housing units funded	0	150		141	94%	COMMUNITY CONTRACT PROVIDERS
●	2.1 Total number of adult consumers served	11431	13500		13382 <sup>2</sup>	99.13%	MENTAL HEALTH AUTHORITY
●	2.2 The number of child consumers served over the entire fiscal year.	2777	5525	4250 <sup>3</sup>	3511 <sup>4</sup>	82.61%	MENTAL HEALTH AUTHORITY
●	2.3 The number of CPEP visits	3605	3780		4271	112.99%	MENTAL HEALTH AUTHORITY
●	2.4 Number of Adult Mobile Crisis Team visits	0	700		1089	155.57%	MENTAL HEALTH AUTHORITY

<sup>1</sup> Agencies have been permitted to change their targets as long as 1) the original targets are published in the PAR, as they are here, and 2) a strong justification was presented for the change.

<sup>2</sup> Data reported for this measure was extracted from DMH's claims processing system on December 19, 2009. DMH providers are authorized to submit claims for services rendered during FY09 until December 31, 2009. Accordingly, there is a lag in reporting complete data for the fiscal year until all claims processing is complete. Claims processing is usually completed by March 31<sup>st</sup> of the subsequent fiscal year. This claims lag also affects reporting for several other claims-based Key Performance Indicators, the indicators measuring the number of children who receive a service (KPI 2.2), the number of children who receive a community-based service within seven (7) days of discharge from an inpatient psychiatric setting (KPI 3.3), the number of adults who receive a community-based service within seven (7) days of discharge from an inpatient psychiatric setting (KPI 3.4), the percent of Medicaid claims submitted to DHCf (KPI 4.1) and the percentage of clean claims adjudicated (KPI 4.2).

<sup>3</sup> DMH adjusted the target for children and youth to reflect a 35% increase in performance over FY 2008. This is a downward adjustment of the original target, which was set using the criteria for Dixon exit criterion #5. The adjusted target reflects a realistic increase in the number of children served through the MHRS system only. DMH expects to achieve the Dixon target in FY 2010 by including children receiving mental health services from an MCO in the count (which is permissible under the terms of the Dixon consent decree).

<sup>4</sup> See footnote #2 above.



2.5	Crisis Stabilization beds utilization	75	80	76.48%	95.60%	COMMUNITY CONTRACT PROVIDERS
2.6	Total number of adult consumers receiving an ACT service	390	500	619 <sup>5</sup>	123.80%	MENTAL HEALTH AUTHORITY
3.1	Percent of patients readmitted to Saint Elizabeths Hospital within 30 days of discharge	8.5	9	9.27% <sup>6</sup>	97.08%	SAINT ELIZABETH'S HOSPITAL
3.2	Percent of patients readmitted to Saint Elizabeths Hospital within 180 days of discharge	20.8	23	26.6% <sup>7</sup>	86.47%	SAINT ELIZABETH'S HOSPITAL
3.3	Percent of MHRS eligible children discharged from inpatient psychiatric hospitals that receive a community-based, non-emergency service within 7 days of discharge.	46	60	54.04% <sup>8</sup>	90.07%	MENTAL HEALTH AUTHORITY
3.4	Percent of MHRS eligible adults discharged from inpatient psychiatric hospitals that	46	60	53.51% <sup>9</sup>	89.19%	COMMUNITY SERVICES AGENCY

<sup>5</sup> The data reported is the number of consumers enrolled in ACT as of September 30, 2009. The targets for this KPI were established to measure the number of consumers enrolled and receiving ACT services at the end of the fiscal year. There are consumers who received an ACT service during FY 2009, who subsequently discontinued receipt of ACT services and are not included in this count.

<sup>6</sup> The 30-day readmission rate is calculated by dividing the total number of patients readmitted within 30 days of discharge by the total number of discharges during the reporting period. The data reported may include patients who were transferred to a medical facility for treatment of a medical condition and then returned to Saint Elizabeths.

<sup>7</sup> The 180-day readmission rate is calculated by dividing the total number of patients readmitted within 180 days of discharge by the total number of discharges during the reporting period. The data reported may include patients who were transferred to a medical facility for treatment of a medical condition and then returned to Saint Elizabeths. Data reported reflects all readmissions within 180 days, for consumers who were discharged during the period beginning October 1, 2008 and ending on March 31, 2009 (the first six months of FY 2009).

<sup>8</sup> Data reported for this KPI was extracted from DMH's claims processing system on November 6, 2009. Please see footnote 2 for discussion regarding the effect of the claims lag on reported data.

<sup>9</sup> See footnote 7.



	receive a community-based, non-emergency service within 7 days of discharge.						
● 4.1	Percent of Medicaid claims submitted to DHCF that are paid.	79	82		82.86%	101.05%	MENTAL HEALTH AUTHORITY
● 4.2	Percentage of clean claims adjudicated by DHCF or MCO within 5 business days of submission	0	95		98.67% <sup>10</sup>	103.86%	MENTAL HEALTH AUTHORITY
● 4.3	Number of Dixon exit criteria target met and approved for inactive monitoring by the Court Monitor <sup>11</sup>	3	13		6 <sup>12</sup>	46.15%	MENTAL HEALTH AUTHORITY

<sup>10</sup> Data reported reflects clean claims processed by DMH within 5 days of submission.

<sup>11</sup> On September 4, 2009, the District of Columbia filed a Motion to Vacate and Dismiss the Dixon Case (Motion to Dismiss) to the U.S. District Court. This motion remains pending. The Dixon plaintiffs submitted a response opposing the District's motion on November 18, 2009. Two amicus briefs were also filed in support of the plaintiffs' opposition to the Motion to Dismiss.

<sup>12</sup> In August 2007, DMH submitted evidence of compliance with the requirements of Exit Criterion #10, Supported Employment to the Court Monitor. The Court Monitor denied DMH's request to move Exit Criterion #10 to inactive status. On October 26, 2009, DMH submitted a request for modification of the performance indicator and targets for Exit Criterion #9, Supported Housing to the Court Monitor. To date, the Court Monitor has not responded to this request. If approved, DMH believes that it has data which would meet the proposed modified performance targets. On December 9, 2009, DMH submitted evidence of compliance with the requirements of Exit Criterion #11, Assertive Community Treatment (ACT) to the Court Monitor. DMH requested that Exit Criterion #11 be moved to inactive monitoring status.