Department of Mental Health
DMH *(RM)*

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.

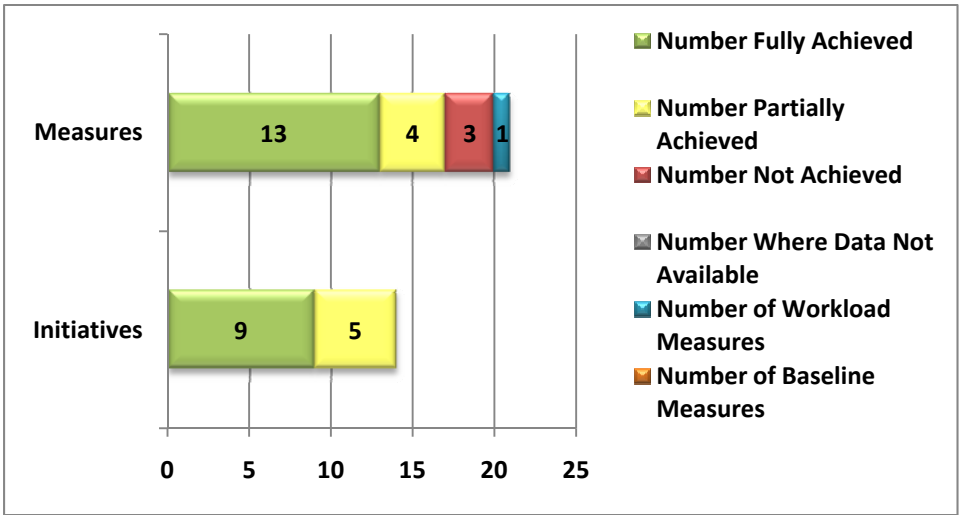
SUMMARY OF SERVICES

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.

ACCOMPLISHMENTS

- ✓ Opened the new Saint Elizabeths Hospital
- ✓ Completed the transition of the closing of the DC Community Services Agency, which moved over 3,000 outpatients from government-operated services to private community mental health providers
- ✓ Received a $1.5 million three-year SAMHSA (the federal Substance Abuse and Mental Health Services Administration) grant for suicide prevention activities, resulting in 8 mini-grants of $50,000 each to 8 community based agencies that will implement suicide prevention activities in partnership with schools, faith-based communities and community centers.

OVERVIEW OF AGENCY PERFORMANCE



Performance Initiatives – Assessment Details

Performance Assessment Key:

Fully achieved | Partially achieved | Not achieved | Data not reported

MENTAL HEALTH AUTHORITY DIVISION

OBJECTIVE 1: EXPAND THE RANGE OF MENTAL HEALTH SERVICES.

INITIATIVE 1.1: Initiate Early Childhood Mental Health Consultation Pilot.
During FY 2010, DMH's Early Childhood Mental Health Consultation Pilot obtained funding from three sources: Project Launch (a DOH Substance Abuse and Mental Health Services Administration grant), the Statewide Commission on Children, Youth and Families; and the FY 2010 Community Mental Health Services Block Grant. In May 2010, services were implemented for children (ages 0 to 5) at 27 centers, a significant expansion from the originally planned eight centers. 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. For the programs FY 2010 operations, there were 488 Early Childhood Teacher/Staff Consultations, 92 Early Childhood Parent Consultations, and 48 Early Childhood Presentations/Trainings.

INITIATIVE 1.2: Continue implementation of the community based wrap-around pilot program for at-risk children and youth.
DC Choices is the lead administrator of the Wraparound Initiative serving youth via two projects: Community Wrap (through DC Choices) and School Wrap (through Full Service Schools). In FY 2010, there was an expansion to 144 slots (110 for Full Service Schools and 34 for Community Wraparound). During FY 2010, a total of 171 children/youth were served, 120 in the Full Service Schools and 51 in the Community Wraparound. Since the program began 2009, a total of 110 youth have been discharged. Positive results achieved at discharge compared to intake include improvements in : 1) functioning in school (fewer behavioral needs and achievement needs); 2) functioning in the community (significantly less taking part in delinquent behaviors); 3) individual functioning (increased behavioral and emotional needs being met); 4) caregiver functioning (less parental skill needs); and 5) functioning at home (for the Community Wrap Pilot 69% of children/youth were diverted from psychiatric residential treatment facilities).

INITIATIVE 1.3: Initiate and complete a planning process to redesign the public mental health system.
In October 2009, DMH convened a workgroup including representatives from other District agencies, stakeholders, advocates, providers and consumers to begin the system redesign planning. The workgroup met eight times over the year. Four sub-committees were formed to examine specific areas and develop recommendations for the redesign, specifically: child services; free-standing mental health clinics; health information technology; and provider restructuring. Each sub-committee issued a preliminary report describing the issues and process for producing a final report with feedback from the workgroup. The goal of issuing a plan for service redesign in FY 2010 did not occur, and planning activities will continue in FY 2011 to allow the development of a Draft Report with review and comment from a broad range of stakeholders.

- **INITIATIVE 1.4: Complete planning process for implementation of peer specialist program.** During FY 2010, DMH convened a planning work group including stakeholders, advocates and consumers to help develop the Peer Specialist program. This past year the Mental Health Rehabilitation Services (MHRS) standards were revised to include peer support services. DMH continues to work on the program through the Peer Specialist Certification Work Group. Outstanding activities include: developing the training curriculum (classroom work, field practicum); developing certification standards; and developing supervisory guidelines and standards for qualified practitioners supervising the delivery of peer support services. DMH is also making changes to its MHRS rules and working with the Department of Health Care Finance to pursue Medicaid reimbursement for this service.

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**.
  During FY 2010, Catholic Charities continued to operate mobile crisis services for children and youth ages 6 to 21 through its Children and Adolescent Mobile Psychiatric Service (ChAMPS). The four crisis beds were operated through July 27, 2010, the end of the contract period. The new contract that has been executed does not include these four beds due to low utilization. As planned, DMH completed an MOU between Catholic Charities and the Prince Georges County crisis provider in August 2009. As a result, ChAMPS staff respond to crisis calls for children and youth who are in the foster care system and reside in Maryland and Virginia, through collaborating with the with the local crisis entity in MD using ChAMPS staff who are dually licensed in both states to accommodate serving children. The total number of crisis calls ChAMPS responded to increased almost 70% from 687 in FY 2009 to 1,015 in FY 2010, a result of substantial outreach about the service in the past year.

- **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 Community Care Project is implemented by the New Directions program at Washington Hospital Center. In October 2009, the target to enroll 23 consumers was achieved. As of August 2010, the contract was amended to allow three additional enrollments. In September 2010, 30 of the available 30 slots for enrollment were filled. There are 17 New Directions consumers in the community.

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**.
  The first DMH Community Services Review (CSR) Unit internal review was conducted in October 2009. Two agency-specific reviews and a full follow-up review of the former DC CSA consumers whose cases were examined in 2009 occurred in FY 2010. The DC CSA review was a focused evaluation of 26 consumers. During the second and third quarters of FY 2010, the CSR Unit facilitated the trainings for both Child-Youth and Adult New and Returning Reviewers in preparation for the 2010 Dixon reviews. The overall system performance rating required by

the Dixon exit criteria for both the adult and child CSRs is 80%. The 2010 overall system performance adult score was 76% and the overall system performance child score was 49% (contributing to these scores were the team formation and team functioning scores, which have improved over FY 2009). During the FY 2010 fourth quarter, the CSR Unit worked to raise community awareness and understanding of the CSR process through a series of community presentations of the 2010 CSR results and began providing intensive targeted technical assistance to six chosen providers (four child serving and two adult serving) to support their practice improvement efforts. DMH anticipates that this will result in an improvement in practice quality at each agency, which will be reflected in improved system performance scores on the 2011 CSR. This work will continue throughout the first quarter of FY 2011.

- **INITIATIVE 3.2: Complete and implement transition plan for the D.C. Community Services Agency (DCCSA).**
The DC CSA transition plan was fully implemented as of March 11, 2010. A total of 3,133 consumers transferred from the DC CSA to the private provider network. The Office of Accountability monitored the transition of consumers to their new MHRS provider throughout FY 2010 and will continue to conduct these monitoring activities for a full year after the transition (through Spring 2011). Results of the FY 2010 monitoring showed that: the majority of consumers rate their overall experience as positive or very positive and most consumers had an initial visit within 30 days of the transfer. In addition, the Mental Health Services Division (MHSD) was established to provide the remaining government-operated functions formerly provided by the DC CSA. The MHSD includes: a multicultural program; deaf/hard of hearing and intellectual disability program; physicians practice group; outpatient competency restoration; pharmacy; and same-day services program that provides urgent care services to adults and children. During FY 2010, MHSD served approximately 4,134 adult and child consumers (1,262 were served off-site by the Physicians Practice Group). The MHSD served as the clinical home for 1,051 (25.4%) of the consumers served during FY 2010. MHSD provides specialized mental health services that are not otherwise readily available.

OBJECTIVE 4: **ENSURE SYSTEM ACCOUNTABILITY.**

- **INITIATIVE 4.1: Improve system accountability by implementing the next phase of the audit and Medicaid integrity plans.**
During FY 2010, DMH rolled out its Mental Health Services Provider Scorecard program, to provide a tool for consumers in choosing their provider. The Scorecard includes elements that measure performance in three general areas: quality of care, financial operations; and compliance. The FY 2010 Scorecard will be published on the DMH website in December 2010, after all the scoring for FY 2010 is completed. Another FY 2010 goal to improve accountability was implementation of a recoupment policy that uses extrapolation. Implementation of this change has been delayed, to correspond with finalizing a rule through the Department of Health Care Finance (DHCF) that allows extrapolation for all Medicaid claims. In FY 2010, DMH also continued to conduct mental health rehabilitation services (MHRS) audits, including five MHRS Claims Audits. In addition, the FY 2008 Claims Audits (initial) was finalized and the notification of FY 2008 Final Audit Results was sent to 20 agencies.

SAINT ELIZABETHS HOSPITAL

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.**

  During FY 2010, Saint Elizabeths Hospital (SEH), the DMH Office of Consumer and Family Affairs (OCFA), and the Integrated Care Division continued to collaborate on implementing a peer support partner program to support the discharge process. The Transitional Specialists have been instrumental in working with the SEH staff to move long-term consumers into the community. Ten Transitional Specialists were employed, with seven at SEH, two based in the community, and one at OCFA. The DC CSA transition was one of the first DMH initiatives to deploy large numbers of peer specialists in a single project. Due to the great success achieved, two (2) of the Transitional Specialists were transferred from SEH to the newly formed DMH Mental Health Services Division to continue the peer to peer engagements. In September 2010, one of the Transitional Specialists was placed in a position with a grant funded project to begin providing peer support to other peers around physical health issues. During FY 2010, the Transitional Specialists supported the transition of seven (7) consumers from Saint Elizabeths Hospital to the community. One (1) of those consumers has been re-hospitalized since discharge.

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 was completed in December 2009 and individuals in the hospital's care began moving into the new building on May 3, 2010. By May 10, 2010 individuals had resumed participating in a full day of therapeutic programs in the centers. The Saint Elizabeths Hospital average daily census consistently dropped throughout FY 2010 from an average of 343 per day in September 2009 to 313 individuals per day. In addition, during FY 2010, SEH had a total of 442 admissions and a total of 484 discharges, a net reduction of 42.

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.**

  In March 2010, DMH contracted with the American Health and Wellness Institute, to train hospital clinicians and other direct-line staff on person-centered planning. This approach to treatment planning will improve the quality of services provided at Saint Elizabeths Hospital by requiring an integrated, interdisciplinary treatment plan for each individual in care. During FY 2010, all Saint Elizabeths clinicians, including social workers, psychiatrists, psychologists, rehabilitation specialists, and nursing staff completed four training modules: developing focus statements, objectives, and interventions; developing clinical formulation; engaging individuals in care; and discharge planning. In addition, clinical chart audits recently began and these results will provide further information about the benefits of the training for individuals in care. In addition, an internal coach/mentor has been assigned to each unit and has observed at least two recovery planning meetings per month and completed two clinical

chart audits per month. The Individual Recovery Plan manual was revised to incorporate this approach and will be distributed in October 2010. Data from Q4 2010 showed continued improvement in the quality of the individual recovery plan (IRP) conferences with better presentation of symptoms, engagement of the individual, and in individualizing objectives and interventions. Further technical assistance, provided through a contract, is expected to further improve performance.

- **INITIATIVE 3.2: Ensure that staff is trained and utilizes the Clinical Work Station (CWS) phase of the Avatar System.**
  The Avatar Clinical Work Station (CWS) has been implemented and during FY 2010 all staff were trained and utilized the Avatar system to perform key clinical processes. Training is ongoing as new forms go live in the system. In addition, all clinical employees are utilizing CWS as an interdisciplinary approach to patient care, with all initial assessments, progress notes, discharge care plans, and medication, lab, pharmacy and nutrition orders being completed in Avatar. During the fourth quarter of FY 2010 additional enhancements were added, including: psychiatry, non-medication orders, billing, discharge plan of care, forensic review board, and the individual recovery plan. Data clean-up efforts will continue through FY 2011 to ensure and maintain the integrity of the system. The CWS allows the assurance of compliance with emerging electronic health record requirements.

OBJECTIVE 4: ENSURE SYSTEM ACCOUNTABILITY

- **INITIATIVE 4.1: Saint Elizabeth's Hospital will institute new billing and coding process to ensure Medicaid and Medicare claims are accurately submitted.**
  During FY 2010, Saint Elizabeths Hospital instituted several changes to its Billing Operations for improving billing and coding processes to ensure that Medicaid and Medicare claims were accurately submitted. Changes included; implementing new policies and procedures (which outlines procedures and helps in benefits screening for patients);implementing an internal review function; training almost 90% of Hospital employees on the Corporate Integrity Agreement (that settle prior allegations of improper billing); and implementing new forms in the Avatar system to better capture accurate patient financial data that was previously captured manually. DMH also continues to use Public Consulting Group (PCG) to assist in revenue projection, cost reporting and claims submission. All of these changes were instituted to ensure that all Medicare and Medicaid claims were accurate and to ensure timely submission of claims for reimbursement. Finally, during FY 2010 the Hospital was able to submit virtually all of its FY 2009 Medicare and six months of FY 2010 Medicare claims for reimbursement, the first time in over four years the Hospital has successfully submitted Medicare claims in the same year services were rendered.

Key Performance Indicators – Details

Performance Assessment Key:

Fully achieved | Partially achieved | Not achieved | Data not reported

	Measure Name	FY2009 YE Actual	FY2010 YE Target	FY2010 YE Actual	FY2010 YE Rating	Budget Program
AGENCY MANAGEMENT						
1.1	Early Childhood Program Outcome Measures	0	500	580	116%	OFF OF PROGRAMS & POLICY
1.2	Number of new affordable housing units funded.	0	100	186	186%	OFF OF PROGRAMS & POLICY
2.1	Total number of adult consumers served	11944	13800	15549[1]	112.67%	MENTAL HEALTH AUTHORITY
2.2	Total number of children/youth consumers served.	3373	5775	4281[2]	74.13%	MENTAL HEALTH AUTHORITY
2.3	Number of mobile crisis team visits (adults)	1768[3]	1300	2161	166.23%	COMPREHENSIVE PSYCH EMER PROG
2.4	Number of mobile crisis team visits (children)	396	300	581	193.67%	OFF OF PROGRAMS & POLICY
2.5	Number of CPEP visits	3913		3943		COMPREHENSIVE PSYCH EMER PROG
2.6	Crisis stabilization bed utilization	76.48%	85	85.63%	100.74%	MENTAL HEALTH AUTHORITY
2.7	Total number of adult consumers receiving an ACT service.	553	650	979	150.62%	MENTAL HEALTH AUTHORITY
3.1	Percent of MHRS eligible children discharged from inpatient psychiatric	39	70	45.6%[4]	65.14%	OFF OF PROGRAMS AND POLICY

[1] Represents preliminary data, based on data run as of 10/20/2010, representing claims paid to date. Mental health providers have 90 days after rendering an MHRS service to submit a claim, which means that data for FY 2010 will not be finalized until after December 31, 2010.

[2] Represents preliminary data, based on data run as of 10/9/2010, representing claims paid to date. Mental health providers have 90 days after rendering an MHRS service to submit a claim, which means that data for FY 2010 will not be finalized until after December 31, 2010. .

[3] This number also reflects visits to consumers that were not initial crisis visits (such as follow-up visits, etc.).

[4] Represents preliminary data, based on data run as of 10/20/2010, representing claims paid to date. Mental health providers have 90 days after rendering a service to submit a claim, which means that data for FY 2010 will not be finalized until after December 31, 2010.

		hospitals who receive a community-based, non-emergency service within 7 days of discharge.					
	3.2	Percent of MHRS eligible adults discharged from inpatient psychiatric hospitals who receive a community-based, non-emergency service within 7 days of discharge.	51.4	70	52.78%[5]	75.40%	OFF OF PROGRAMS AND POLICY
	4.1	Percent of Medicaid claims submitted to DHCF that are paid.	0	85	91.95%	108.18%	DMH FINANCIAL OPERATIONS
	4.2	Percentage of clean claims adjudicated by DHCF or MCO within 5 business days of submission.	0	95	100%	105.26%	DMH FINANCIAL OPERATIONS
	4.3	Number of Dixon exit criteria targets met and approved for inactive monitoring by the Court Monitor	6	15	12[6]	80.00%	MENTAL HEALTH AUTHORITY
	ST. ELIZABETHS HOSPITAL						
	3.1	Percent of involuntary acute admissions to St. Elizabeth Hospital	12	11	6.44%	170.88%	MENTAL HEALTH AUTHORITY
	3.2	Average daily census of patients receiving inpatient services.	343	316	316.9	99.72%	SAINT ELIZABETH'S HOSPITAL
	3.3	Number of elopements that occurred per 1000 patient days	0.89	0.75	0.41	184.59%	SAINT ELIZABETH'S HOSPITAL
	3.4	Number of patient injuries per 1000 patient days[7]	1.01	1	1.79	55.88%	SAINT ELIZABETH'S HOSPITAL

[5]Represents preliminary data, based on data run as of 10/20/2010, representing claims paid to date. Mental health providers have 90 days after rendering a service to submit a claim, which means that data for FY 2010 will not be finalized until after December 31, 2010.

[6] A request to move Exit Criterion # 11 – Assertive Community Treatment Services for Adults with Serious Mental Illness was submitted to the Court Monitor on September 2, 2010. The Court Monitor approved inactive monitoring status on November 2, 2010. A request for inactive monitoring status for Exit Criterion #5 – Services to Children and Youth was submitted to the Court Monitor on November 4, 2010.

[7] The review of patient injuries requires a manual data verification process that is time consuming and delays the confirmation of accurate data. Other factors contributing to the increased reporting may be training or performance related. At this point the Hospital is not certain whether the reporting practice has increased and/or the incidence of injury or violence has increased, in other words, there can be an overall increase in unusual incidence reporting but not necessarily an increase in the

3.5	Number of medication variance that occurred for every 1000 patient days.	2.78	2.64	1.98	133.36%	SAINT ELIZABETH'S HOSPITAL
3.6	Percent of patients who were restrained at least once.	1.2	1.1	0.46%	238.81%	SAINT ELIZABETH'S HOSPITAL
3.7	Percent of unique patients who were secluded at least once[8]	0.5	0.5	1.20%	41.75%	SAINT ELIZABETH'S HOSPITAL

incidence of injury. The Hospital has a Violence Reduction Committee that is working on identifying the factors that contribute to injuries and the incidence of violence, and strategies to address these issues.

[8] On average during FY 2010, the number of persons secluded each month ranged from 0 to 4, except for one month, which was significantly higher. This outlier caused a significant increase in the FY 2010 average. However, the FY 2010 monthly average of 1.2% is still lower than the national average of 2.6%.