



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.

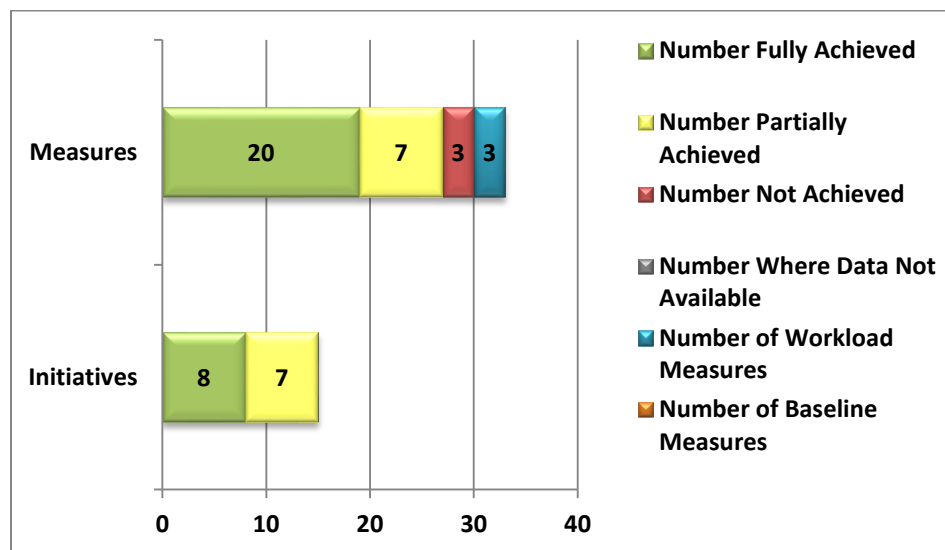
ACCOMPLISHMENTS

- ✓ **Proposed Dixon Settlement Agreement-** On February 16, 2012, U.S. District Court Judge Thomas Hogan gave final approval to a settlement agreement ending the court oversight that was instituted when Saint Elizabeths Hospital was managed by the federal government. Of the 19 court-ordered settlement requirements negotiated in 2001, the District met 15. The settlement agreement covers additional improvements in four areas: expansion of supported housing, supported employment and evidence-based services for children and youth, as well as improved linkage to community-based care post-hospital discharge. The District will have until September 30, 2013 to achieve all the performance measures included in the proposed settlement agreement. **Mayoral priorities for this accomplishment relate to: Self Determination**
- ✓ **Peer Specialist Certification Training** - The first class of 10 peer specialists completed training during the summer of 2011 and received certification in September 2011. A certified peer specialist is someone with mental illness, in recovery, who is qualified to provide peer support services and to bill Medicaid for such services when provided in accordance with an approved treatment plan. The DMH curriculum includes 70 hours of class room training and an 80-hour field practicum, as well as a written examination. The training is intended to develop ten (10) core competencies and provide an opportunity to apply classroom learning in a field setting before final certification is granted. DMH plans to offer an annual peer specialist training program and continuing education will be ongoing. **Mayoral priorities for this accomplishment relate to: Job Creation**
- ✓ **Successful Implementation of Early Childhood Programs** - DMH successfully implemented the Early Childhood Mental Health Consultation Project (Healthy Futures) project and the Parent Infant Early Childhood Enhancement Program (PIECE). The Health Futures Project involves placing one (1) early childhood mental health specialist in each participating child development center one (1) day per week to help identify children who need mental health interventions and providing consultation to teachers, families and children regarding interventions. The PIECE



program provides culturally competent community-based mental health services to infants, toddlers, preschool, and school age children (ages 6 and under), that are responsive to individual family needs. **Mayoral priorities for this accomplishment relate to: Education Quality**




OVERVIEW OF AGENCY PERFORMANCE





Performance Initiatives – Assessment Details

Performance Assessment Key:

 Fully achieved  Partially achieved  Not achieved  Data not reported

Mental Health Authority

OBJECTIVE 1: Expand the range of mental health services.

● INITIATIVE 1.1: Complete the planning process to redesign the public mental health system.

Response: In FY 2010 DMH initiated a planning process to redesign the public mental health system. In December 2010, the Draft System Redesign Plan was circulated for discussion and review by the stakeholders. The System Redesign Committee proposed 16 recommendations that would (1) reform the Mental Health Rehabilitation Services (MHRS) program to increase flexibility in service delivery and reduce administrative burdens and (2) make structural changes to expand office based treatment and increase access. A number of recommendations addressed children's services including developing a system of care with expanded evidence-based practices and reduced use of psychiatric residential facilities. The plan was not finalized primarily because of the need to coordinate redesign of the public mental health system with the work occurring within the District of Columbia to implement the health care reform requirements of the Affordable Care Act. However, DMH took steps to implement several of the recommendations. The most significant are the following. First, DMH has convened two separate work groups to examine benefits usage and provider administrative requirements. The benefits workgroup expects to issue a report that will include a recommendation for clinical criteria to enable the best design of individualized treatment. The goal of the workgroup is to eliminate duplicative, outdated or unnecessary requirements which will have the effect of strengthening meaningful reporting. As part of streamlining administrative procedures, DMH and APRA are discussing joint certification for providers. Second, to address the recommendations to improve care management, DMH convened an internal workgroup to develop revisions to the Money Follows the Person protocol that expand funding available for care management and support services to persons with mental illness who are transitioning from institutional settings—Saint Elizabeths, nursing homes and psychiatric residential treatment facilities. Work on revisions to the Money Follows the Person protocol will be completed in FY 2012. In addition, DMH along with the Department of Health Care Finance and the Department of Health submitted a request for a health home planning grant to CMS in September 2011. Health homes are one of the demonstration projects authorized by the Affordable Care Act. The implementation of a health home program in the District would also address the System Design workgroups recommendation about integrating physical health and behavioral healthcare. Third, to address the recommendation to develop and implement a web-based, modular data system, DMH has developed specifications for a practice management system. The Request for Proposals is expected to be released in FY 2012. In addition, DMH is participating on the District's Health Reform Committee and is involved in the development of the various IT strategies and the health insurance exchange.

Finally, improvements to children's services include the award of a \$400,000 System of Care Planning grant by SAMHSA which will fund the planning process and address specific recommendations. DMH expanded the array of evidence-based practices that are available for



children and youth. Parent Child Interaction Therapy (PCIT) began in FY 2011. The Trauma-focused cognitive behavioral therapy (TF-CBT) orientation was held in September 2011 and will be fully implemented in FY 2012. Other services have been identified for implementation in FY 2012.

To centralize psychiatric residential facility placement decisions under its authority, DMH established the interagency Residential Placement Committee in April to review level of care requests and make level of care determinations.

Performance Assessment: **Partially achieved.** The Draft System Redesign Plan was circulated and some of the recommendations are being addressed.

INITIATIVE 1.2.: Implement peer specialist program.

Response: The first class of 10 peer specialists completed training during the summer of 2011 and received certification in September 2011. A certified peer specialist is qualified to provide peer support services and to bill Medicaid for such services when provided in accordance with an approved treatment plan. The curriculum includes 70 hours of class room training and an 80-hour field practicum, as well as a written examination. The training is intended to develop ten (10) core competencies: 1) interpersonal skills; 2) practical assessment skills and basic knowledge of mental health and substance abuse disorders; 3) supporting skills to assist the consumer to develop skills identified in the approved treatment plan; 4) documentation of services provided; 5) computer skills; 6) unique role of the peer, using self as a therapeutic presence; 7) ethics and professionalism; 8) Recovery and Wellness Recovery Action Planning (WRAP) or similar planning; 9) advocacy skills; and 10) cultural competency and sensitivity. The field practicum provides the peer specialist candidate with an opportunity to apply classroom learning in a field setting before final certification is granted. DMH plans to offer an annual peer specialist training program and continuing education will be ongoing.

Performance Assessment: **Fully achieved.** The first peer specialist training class was initiated and completed in FY 2011.

OBJECTIVE 2: Increase access to mental health services.

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

Response: During FY 2011, DMH continued to contract with the six (6) supported employment programs. One of the primary activities in FY 2011 was the development and submission of supported employment certification rules that will allow DMH providers to bill Medicaid for specific support services related to helping consumers obtain employment. The rules became final on December 9, 2011. It is anticipated that the rules will receive Centers for Medicare and Medicaid Services (CMS) approval in early 2012. This will assist DMH in expanding the supported employment service capacity and increase the number of consumers who receive a service based on the proposed *Dixon* Settlement Agreement.

The second major activity was refining the tracking system for supported employment referrals and those actually receiving services to ensure that an unduplicated count is reported. The refined method was implemented in FY 2011. By the end of FY 2011, 761 consumers had received supported employment services exceeding the targeted 700 consumers.

Performance Assessment: **Fully achieved.** The target of 700 was exceeded as 761 consumers



received supported employment services.

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.**

Response: During FY 2011, the Community Service Review (CSR) unit assumed the management and leadership role for the Community Services review processes from initiation to completion. This included: 1) providing general feedback to stakeholders and specific feedback to agencies by analyzing case information and identifying practice trends for providers; 2) providing technical assistance to select core service agencies (CSAs) to support practice improvement; 3) taking the lead role in managing the logistics of reviews including active participation in case judging and case debriefing sessions for the child-youth CSRs; and 4) collaborating with Human Systems and Outcomes, Inc. (HSO) to lead the child-youth new-reviewer training, and the completion of training for all returning reviewers. A new level of training (CSR-102) was implemented in FY 2011. This training provided CSAs and community stakeholders exposure, awareness and integration of the CSR protocol and concepts into case practice. The CSR team facilitated CSR 102 trainings at various provider and community stakeholder sites with over 250 people participating in the training.

The CSR unit used a qualitative analysis to provide technical assistance to six (6) chosen provider agencies while they worked on the implementation, tracking, and adjusting of agency specific practice development plans, designed to target areas of practice identified during the 2010 Dixon reviews. The areas of focus included engagement and teaming strategies, assessment of needs and strengths, and supervision models.

Performance Assessment: **Partially achieved.** The adult team formation score increased from 67% in FY 2010 to 71% in FY 2011 and team functioning increased from 60% to 63%. This is a significant improvement, although both were less than the projected 80%. The child team formation score increased from 45% in FY 2010 to 57% in FY 2011 but was less than the projected 65%. The child team functioning score increased from 39% to 49% and was higher than the projected 48%.

OBJECTIVE 4: Ensure system accountability.

● **INITIATIVE 4.1: Publish Provider Scorecard.**

Response: In FY 2010, the Office of Accountability (OA) implemented the Provider Scorecard that was piloted in FY 2009. The OA staff conducted chart reviews at 22 core service agencies (CSAs) in order to collect data for the Quality Review section of the Scorecard. The Provider Scorecard assessed three (3) domains for each provider: Quality, Financial, and Compliance with regulations. The results of assessments allow DMH to give each CSA a rating on a Five Star scale. Only the 16 providers who could be assessed across all three (3) domains were issued an overall Scorecard score for FY 2010. The overall Scorecard score for each CSA was published among all providers on February 28, 2011.

As a result of provider feedback, the Compliance domain has been eliminated from the FY 2011 Provider Scorecard. Since Compliance is mandatory and the DMH system has matured, it is not necessary to measure this domain on the Scorecard. The OA staff is in the process of tallying the FY 2011 scores and expects to complete this process by the end of February 2012. The FY 2011



Provider Scorecard will be published to the general public during 2012. Also during 2012, OA will perform trend analysis that will inform the data projections for fiscal years 2012 through 2014. Performance Assessment: **Partially achieved.** The tallying of the scores for the FY 2011 Provider Scorecard is in progress and the publication of this document is pending.

Saint Elizabeth's Hospital

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.**

Response: During the FY 2011 second quarter the Hospital successfully closed two (2) transitional units located in the Annex building and since then all individuals in the Hospital's care have been served in the new facility. In March 2011, the Hospital was serving a total of 276 individuals per day whereas it served 300 per day in December 2010. Despite the Hospital's continued efforts to return more individuals to their family or community, there was an increase of census in April (283) and May (286) due to a notable increase of forensic admissions. However, by June 2011, the number dropped again to 276 per day. During FY 2011, the quarterly average of patients served per day was 288.

Performance Assessment: **Fully achieved.** The FY 2011 quarterly average was 288 patients served per day.

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.**

Response: During FY 2011, the Saint Elizabeths Hospital programming was revised in both Therapeutic Learning Centers and now includes more groups delineated by cognitive functional level, more competency-based groups for pretrial individuals in care, and more curriculum-based groups. Data indicated that 67% of individuals in care are scheduled for 20 hours per week of treatment. However, the majority of individuals in care were not attending 20 hours of treatment per week. In order to increase the number of individuals in treatment, unit-based treatment is being developed on the admissions units for individuals not yet stable enough to participate in the therapeutic learning centers.

Performance Assessment: **Partially achieved.** Unit-based treatment is being developed to help reconcile the discrepancy between individuals scheduled for treatment and those in care who actually receive 20 hours of treatment per week.

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

Response: All interdisciplinary recovery plan (IRP) teams received coaching and mentoring during FY 2011 from both internal mentors and external consultants. Based on IRP observation and clinical chart audits, the majority of the IRPs include individualized goals, objectives, and interventions, and are modified to address progress or lack thereof toward discharge. In addition, over 90% of the staff have received training in the recovery model and positive behavior support model. Lastly, all clinical staff will receive training in Safety Care, a positive behavior support training curriculum designed to provide staff with preventive de-escalation techniques and should they be necessary, physical intervention techniques. As of September 30, 2011, 157 staff had completed this 2-day training, approximately 65% more staff need to



complete this training. It is expected that this will be completed by March 2012.

Performance Assessment: **Partially achieved.** Approximately 65% more staff need to be trained.

Mental Health Services and Supports

OBJECTIVE 1: Expand the range of mental health services.

● **INITIATIVE 1.1: Implement early childhood mental health consultation project.**

Response: The Early Childhood Mental Health Consultation (Healthy Futures) Project began in FY 2010 and involves child and family-centered, and program consultation for children age 0-5. One (1) early childhood mental health specialist is placed in each participating child development center (CDC) one (1) day per week to help identify children who need mental health interventions. A one-year evaluation of the Healthy Futures project for the period June 2010 through June 2011 was conducted by the Georgetown University Center for Child and Human Development. Key findings include: (1) More than 1,200 young children had access to high-quality mental health consultation services in community CDCs in all areas of the District. Only 3 children were expelled from their CDC, a rate that is half the national average of 6.7 per 1,000; (2) Significant changes in teachers' behavior and classroom practices was seen in several areas including: staff awareness, children's peer interactions, more teaching about feelings and emotional problem solving skills, and a reduction in negative staff behaviors (e.g., shouting); (3) CDC directors reported significant improvements in their staff's ability to manage challenging behavior, their knowledge of how to refer children and families for mental health services, and their comfort with mental health services; (4) Teachers reported small but significant reductions in several areas of job stress; and (5) All of the CDC directors were completely satisfied with the Healthy Futures Project, would recommend the program to their colleagues, and wanted to continue receiving the services.

Performance Assessment: **Fully achieved.** The project evaluation findings show this project has been successfully implemented. Also, all of the key performance measures were exceeded (1,556 teacher staff consultations versus 900 projected; 230 parent consultations versus 144 projected; 141 presentations/trainings versus 50 projected).

OBJECTIVE 2: Increase access to mental health services.

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

Response: The wait time initiative was developed based on the volume of consumers seen in FY 2010. The number of consumers served increased significantly during FY 2011 with a range of 14 to 30 additional consumers being served per day. The highest number of consumers served in one week was 103. As a result of the increase in volume, the wait time increased based on the volume of consumers to be served. The number of consumers sent from other agencies for medication evaluation also increased.

Other factors affecting wait time include: 1) no increase in staff to accommodate the increased volume of consumers presenting for service; 2) consumers tend to present in the mornings between 8:30 a.m.-9:00 a.m. rather than periodically throughout the day; and 3) consumers who need to be linked to a core service agency (CSA) require additional time during the intake process.

The Mental Health Services Division (MHSD) staff implemented several strategies to improve



wait times: 1) separated consumers requiring abbreviated assessments (medication only) from consumers requiring full assessments; 2) met with referral sources to request later staggered appointments for consumers who would normally present at 8:30 a.m.; 3) located nurses on the first floor to expedite the nursing component of the intake process; and 4) initiated a revision of the intake form to make it shorter that is in progress.

In addition, during FY 2011 MHSD converted from a manual count to an electronic count that provided more specific data type for adults seen in intake at the Same Day Urgent Care Clinic. The FY 2010 unduplicated count is 2,080 with 8,093 clinical contacts for these consumers, averaging 3.9 contacts per consumer. The FY 2011 unduplicated count is 2,825 with 12,641 clinical contacts for these consumers, averaging 4.5 contacts per consumer. Manual and electronic data confirms that the trend from FY 2010 to FY 2011 shows that more consumers present for intake and consumers need more clinical contacts after intake, until they are fully connected to their CSA psychiatrist.

Performance Assessment: **Partially achieved.** A number of strategies to improve wait times were implemented that take into consideration the increase in volume of consumers and the variety of needs of the presenting consumers. Program data shows increases over FY 2010 in the number of consumers served, clinical contacts, and contacts per consumer.

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.**

Response: In FY 2011, there were 13 ACT teams that served 1,125 consumers. The ACT Coordinator and Adult Systems of Care Manager continued to provide a hands on, systematic approach to consultation and training that included: monitoring the status of improvement areas of ACT teams whose FY 2010 fidelity scores were 3 or below; conducting the FY 2011 fidelity assessments and providing feedback; providing onsite visits to each team; shadowing clinicians experienced in the model; frequent (daily) telephone and email consultation; basic model training; focused training and support for program leaders and supervisors; developing outcome monitoring and feedback; and conducting a monthly ACT providers meeting.

The FY 2011 ACT fidelity reviews were conducted during the fourth quarter. The results indicate that seven (7) of 13 teams or 53.84% received a score of 4 or higher; meeting the goal that at least 50% of ACT teams improve their total scores to this range. In FY 2010, only one (1) team received a score of 4 or higher.

Performance Assessment: **Fully achieved.** The key performance measures for ACT teams were exceeded in that: 1) 1,125 adult consumers received ACT services versus the projected 1,000, and 2) 53.84% of the ACT teams received a score of 4 or higher versus the projected 50%.

OBJECTIVE 4: Ensure system accountability.

● **INITIATIVE 4.1: Promote revenue enhancement.**

Response: Forty-two percent (42%) of the physicians met the 60% minimum productivity standard, and for other clinical staff, 29% met the 60% minimum productivity standard. However, in FY 2011 there was a 4% increase in overall average productivity per staff.

The number of clinical staff included in this key performance indicator calculation decreased



from 40 in FY 2010 to 27 in FY 2011. Through program reorganization and staff attrition, 10 staff were not included in the FY 2011 staff productivity calculation. Also, the productivity reports for three (3) physicians who work off-site at private CSAs was not included due to system issues, which have been identified and will be corrected in FY 2012.

Performance Assessment: **Partially achieved.** Staff not meeting their minimum requirements will receive the next disciplinary step as spelled out in the progressive discipline procedures.

Mental Health Financing/Fee for Service

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

● INITIATIVE 1.1: Increase the number of clean claims processed.

Response: DMH processes all claims received within 5 business days and submits them to the Department of Health Care Finance (DHCF), which adjudicates every Friday night (regardless of the status). This process is always 100% because it occurs within 5 business days.

Performance Assessment: **Fully achieved.** During FY 2011, this initiative was 100% achieved.

● INITIATIVE 1.2: Improve revenue collections booked by the OCFO.

Response: During FY 2010, DMH changed from weekly to daily claims processing. Provider claims from the previous day are imported daily. DMH confirms eligibility and authorizations daily, and submits claims to DHCF 3 times weekly (Monday, Wednesday, Thursday). This has reduced processing time for DMH and DHCF.

Performance Assessment: **Partially achieved.** During FY 2011, this initiative was achieved at 87%.

Agency Management

OBJECTIVE 1: Maintain efficient and effective agency operations.

● INITIATIVE 1.1: Reduce average contracting cycle time.

Response: During FY 2011 the DMH contracting and procurement activities remained consistent with established standards. In accordance with District Contracting and Procurement laws, rules and 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); Request for Quotes (RFQs) (\$25,001-100,000)=20 BDs; Competitive Sealed Bids (CSBs) and Invitation for Bids (IFBs) (\$100,001-\$1 million)=120 BDs; exceeding \$1 million=150 BDs; Request for Proposals (RFPs) (\$100,001-\$1 million)=150 BDs, and exceeding \$1 million=180 BDs.

Performance Assessment: **Fully achieved.** DMH contracting and procurement activities met and fit within the District defined parameters.



Key Performance Indicators – Details

Performance Assessment Key:

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

		Measure Name	FY2010 YE Actual	FY2011 YE Target	FY2011 YE Revised Target	FY2011 YE Actual	FY2011 YE Rating	Budget Program
Agency Management								
●	1.1	PALT	0	60				AGENCY MANAGEMENT
●	1.2	Percentage of subgrantees budget spent on programmatic cost.	0	65%				AGENCY MANAGEMENT
●	1.3	Percentage of scheduled monitoring reports as defined in agency monitoring plan completed for each grant award	0	100%				AGENCY MANAGEMENT
Mental Health Authority								
●	1.1	Number of affordable housing units funded	186	100		256	256%	MENTAL HEALTH AUTHORITY
●	1.2	Total number of adult consumers served	14,749	14,572		17,642	121%	MENTAL HEALTH AUTHORITY
●	1.3	Adult consumers receiving supported employment services	456	700		761	108.71%	MENTAL HEALTH AUTHORITY
●	1.4	Total number of child and youth consumers served.	0	4,500		5,040	112%	MENTAL HEALTH AUTHORITY



		Measure Name	FY2010 YE Actual	FY2011 YE Target	FY2011 YE Revised	FY2011 YE Actual	FY2011 YE Rating	Budget Program
●	2.1	Percent of MHRS eligible children discharged from inpatient psychiatric hospitals who receive a community-based, non-emergency service within 7 days of discharge	48.95%	80%		55.96%	69.95%	MENTAL HEALTH AUTHORITY
●	2.2	Percent of MHRS eligible adults discharged from inpatient psychiatric hospitals who receive a community-based, non-emergency service within 7 days of discharge	55.56%	80%		69.63%	87.41%	MENTAL HEALTH AUTHORITY
●	3.1	Adult overall acceptable system scores for team formation	67%	80%		70.51%	88.14%	MENTAL HEALTH AUTHORITY
●	3.2	Adult overall system scores for team functioning	60%	80%		62.82%	78.53%	MENTAL HEALTH AUTHORITY
●	3.3	Child overall system scores for team formation	45%	65%		57.47%	88.42%	MENTAL HEALTH AUTHORITY
●	3.4	Child overall system scores for team functioning	33%	48%		49.43%	102.97%	MENTAL HEALTH AUTHORITY
●	4.1	Number of Dixon exit criteria targets met and approved for inactive monitoring by the Court Monitor	11	19		15	78.95%	MENTAL HEALTH AUTHORITY



		Measure Name	FY2010 YE Actual	FY2011 YE Target	FY2011 YE Revised Target	FY2011 YE Actual	FY2011 YE Rating	Budget Program
St. Elizabeth Hospital								
●	1.1	Percent of involuntary acute admissions to Saint Elizabeths Hospital	12%	10%		2.80%	357.59%	SAINT ELIZABETH'S HOSPITAL
●	1.2	Total inpatients served per day.	308	300		288	104.17%	SAINT ELIZABETH'S HOSPITAL
●	1.3	Number of elopements per 1,000 patient days	0.5	0.68		0.41	164.85%	SAINT ELIZABETH'S HOSPITAL
●	1.4	Number of patient injuries per 1,000 patient days	1.57	0.95		0.27	351.85%	SAINT ELIZABETH'S HOSPITAL
●	1.5	Number of medication variances that occurred for every 1,000 patient days	2.07	2.51		1.58	158.86%	SAINT ELIZABETH'S HOSPITAL
●	1.6	Percent of unique patients who were restrained at least once during month	0.5%	0.9%		0.36%	249.23%	SAINT ELIZABETH'S HOSPITAL
●	1.7	Percent of unique patients who were secluded at least once during month	1.2%	0.5%		0.6%	77.88%	SAINT ELIZABETH'S HOSPITAL
●	1.8	Percent of patients readmitted to Saint Elizabeths Hospital within 30 days of discharge	8.9%	8.1%		5.18%	156.37%	SAINT ELIZABETH'S HOSPITAL



		Measure Name	FY2010 YE Actual	FY2011 YE Target	FY2010 YE Revised Target	FY2011 YE Actual	FY2011 YE Rating	Budget Program
Mental health Services and Support								
●	1.1	Early Childhood Teacher/Staff Consultations	246	900		1556	172.89%	MENTAL HEALTH SERVICES AND SUPPORTS
●	1.2	Early Childhood Parent Consultations	37	144		230	159.77%	
●	1.3	Early Childhood Presentations	15	50		144	288%	MENTAL HEALTH SERVICES AND SUPPORTS
●	1.4	Number of adult consumers receiving an ACT service	891	1,000		1,125	112.50	MENTAL HEALTH SERVICES AND SUPPORTS
●	1.5	Same Day Service, Urgent Care: adult and child consumers seen at intake	3,181	3,600		2825	78.47%	MENTAL HEALTH SERVICES AND SUPPORTS
●	2.1	Number of Physician's Practice Group psychiatrists working in community CSAs	10	11		9	81.82%	MENTAL HEALTH SERVICES AND SUPPORTS
●	2.2	Percent of Assertive Community Treatment (ACT) teams score in acceptable range on fidelity audit	18%	50%		53.85%	107.69%	MENTAL HEALTH SERVICES AND SUPPORTS
●	2.3	Staff productivity measure (percent of staff reaching 60% minimum productivity standard)	0	60%		29.41%	49.02%	MENTAL HEALTH SERVICES AND SUPPORTS



		Measure Name	FY2010 YE Actual	FY2011 YE Target	FY2011 YE Revised Target	FY2011 YE Actual	FY2011 YE Rating	Budget Program
●	2.4	Physician productivity measure (percent of staff reaching 65% minimum productivity standard)	0	60%		41.67%	69.44%	MENTAL HEALTH SERVICES AND SUPPORTS
		Mental Health Finance/Free – for Service						
●	1.1	Percentage of clean claims adjudicated by DHCF within 5 business days of submission	100%	100%		100%	100%	
●	1.2	Percent of Medicaid claims submitted to DHCF that are processed and paid	85%	82.86%		89.41%	102%	