



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, and the School-Based Mental Health Program.

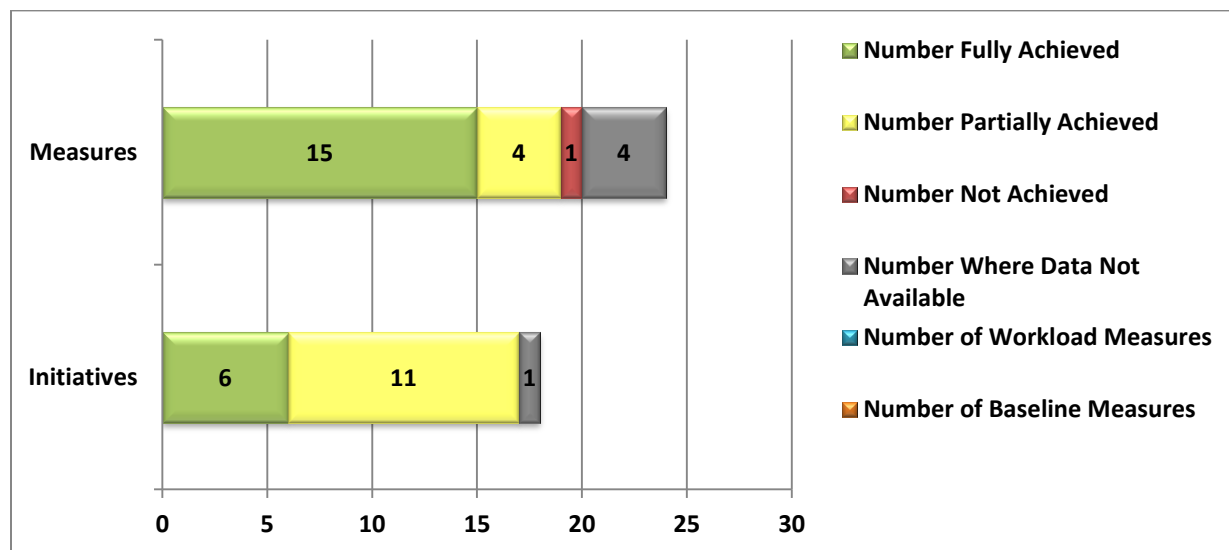
ACCOMPLISHMENTS

- ✓ Developed strategic plan for improving and expanding child community services.
- ✓ Developed 5-year Supportive Housing Strategic Plan.
- ✓ Certified 28 Mental Health First Aid instructors and trained 129 people.

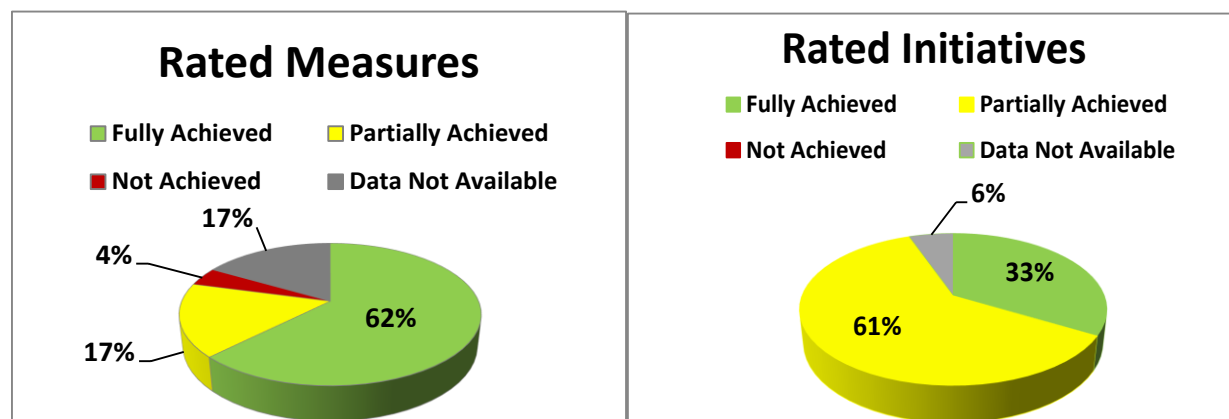


OVERALL OF AGENCY PERFORMANCE

TOTAL MEASURES AND INITIATIVES



RATED MEASURES AND INITIATIVES



Note: Workload and Baseline Measurements are not included

Default KPI Rating:	
$\geq 100\%$	Fully Achieved
75 - 99.99%	Partially Achieved
$< 75\%$	Not Achieved



Performance Initiatives – Assessment Details


Performance Assessment Key:

-  Fully achieved  Partially achieved  Not achieved  Data not reported

Agency Management

OBJECTIVE 1: Ensure system accountability.


INITIATIVE 1.1: Continue to improve information technology.

-  **Partially Achieved.** The RFP closed on July 20, 2012. The initial meeting of the Review Committee was scheduled prior to July 31, 2012. The next major step is the completion of the proposal review process with final selection expected in November 2012.

Mental Health Authority


OBJECTIVE 1: Expand the range of mental health services.

INITIATIVE 1.1: Implement the D.C. Mental Health First Aid Expansion Project.

-  **Fully Achieved.** The 32-hour Mental Health First Aid (MHFA) Instructors Certification Course for 30 approved applicants was held March 19-23, 2012. Twenty-eight (28) applicants were certified. Some instructors taught the 12-hour Certificate Program courses in May and June that included: 20 community support workers Georgia Avenue Collaborative; 14 staff Washington Center for Aging Services; 30 administrative and shelter staff Catholic Charities. The National Council 12-hour Certificate Program courses taught June-August included: 27 D.C. Public Library staff (branch managers, library technicians, library associates, librarians, special police officers representing 54% of the libraries); and 38 staff from government, community and other organizations. The MHFA Certificate Program trained 129 people, 39 more than planned. DMH purchased course manuals to support the certified instructors' future training efforts.

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

INITIATIVE 2.1: Improve the Community Service Reviews (CSRs) child/youth overall system performance score.

-  **Fully Achieved.** The activities to improve the overall system performance of the child/youth community services review (CSR) included: 1) developing core practice principles that support quality practice, especially as defined by the CSR; 2) providing technical assistance to four (4) child/youth providers with low scores by DMH and Human Systems and Outcomes (HSO) designed for practice improvement with a fifth provider also receiving substantial assistance; and 3) regular meetings of the DMH Committee for Practice Improvement and Integration of the CSR. In May 2012 the Child/Youth CSR was conducted with assistance from HSO. The 89 cases reviewed included joint reviews with CFSA of 24 cases receiving services in both systems. DMH was responsible for conducting 60% of the case reviews with HSO conducting the remaining. The projected target of 65% overall system performance was met. Since May the CSR Unit has hosted a training from HSO on Clinical Case Formulation that was developed as a result of needs identified during the earlier round of technical assistance.



OBJECTIVE 3: Ensure system accountability.

INITIATIVE 3.1: Complete the work of the DMH Service Utilization Task Force.

Partially Achieved. The RAND logic model and diagnostic codes review showed that their definition of service gaps (maximum time between visits) did not consider DMH is bound by a fiscal year. Other emerging factors were persons receiving only one service, a start date in the middle of the year, multiple visits, and the exclusion of some diagnostic groups. Revised reports were run for FY 2010 and FY 2011 adjusting for these variables. The child dashboard was developed in April 2011 with monthly reports through FY 2012. The draft adult dashboard was disseminated in May 2012 and became a quarterly report. Both dashboards provide a variety of service utilization data and the adult dashboard includes gap in service delivery. The development of routine gap analysis reporting for adult and child MHRS service utilization is pending. The Internal Quality Committee (IQC) was expanded in FY 2012 to include the directors of the Adult Services and the Child and Youth Services Divisions. They are the owners of the adult and child dashboards. Moving forward these dashboards will be folded into the IQC standard reporting process.

INITIATIVE 3.2: Publish Provider Scorecard.

Data not Available. The FY 2012 Provider Scorecard is not scheduled to be completed and published until May 2013. DMH will assess the level of performance achieved for this initiative once the data is available. DMH Office of Accountability staff engaged in a number of preparatory activities related to the development of the FY 2012 Provider Scorecard. This included the development of the FY 2012 Quality Review Tool, which guides the chart review across a number of indicators (overall clinical record, assessment, crisis plan, treatment plan, service provision, and care coordination). The Draft Quality Review Technical Specifications Manual was also developed. The scorecard quality section reports data separately for adults and children. This involves developing a sample for each age group based on consumers receiving at least one service in each quarter during FY 2012. The samples are generated after the fiscal year closes due to the 90-day time lag for claims submission. Once the samples are generated the staff can conduct chart reviews at the CSAs. The scorecard's financial section focuses on extracting a sample of claims paid by Medicaid and local dollars. The FY 2010 claims will be reviewed due to lag-time for submission. The staff conducts audits at the CSAs to determine whether the services are justified.

Mental Health Financing/Fee for Service

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

INITIATIVE 1.1: Improve the total Medicaid claims paid by reducing the exceptions on the front end.

Fully Achieved. During FY 2012, the process to improve the total Medicaid claims paid by reducing exceptions on the front end benefitted from several activities. The first was the continuation of the activity that began in FY 2011 whereby staff was able to force these claims into the system so the providers could see them. The second was working with the DMH Information Technology staff and the vendor to improve the matching on the front end process. The third was the federal requirement related to the implementation of the Health Insurance Portability and Accountability Act (HIPAA) 5010. This is an upgrade on the way HIPPA benchmarks have been defined for processing transactions in the healthcare industry. The HIPPA 5010 essentially has its own front end and basically greatly minimizes and/or eliminates exceptions. As a result, the volume of rejected Medicaid claims on the front end is now negligible, at 3% or less. In FY 2012, the percent of these claims was 2.1%.



INITIATIVE 1.2: Improve the total Medicaid claims paid by reducing the denials by the Department of Health Care Finance (DHCF).

Partially Achieved. In FY 2012, DMH provided technical assistance to providers related to the denial of Medicaid claims by DHCF. This process was two-fold: 1) working with providers on reconciliation based on the nature of the denial, and 2) working with providers' claims appeals denied by Medicaid. A factor that will significantly impact Medicaid claims denial is the DHCF new Timely Filing extension granted in October 2012 that is retroactive to FY 2012. Providers now have 365 days instead of 180 days to file Medicaid claims. This means that DMH providers have until September 30, 2013 to file pending FY 2012 Medicaid claims. Ninety (90) days after the close of FY 2012 the DMH provider Medicaid denial rate was 5.5%. Based on the change in Timely Filing it is anticipated that this rate will decrease to the target 5.0% or less.

INITIATIVE 1.3: Educate providers about the total billing process.

Fully Achieved. During FY 2012, DMH expanded the Billing 101 training by incorporating it into the monthly User Group. Billing 101 also continued to be part of the Provider Connect system training.

Mental Health Services and Support

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).

Fully Achieved. During FY 2012, the DMH Residential Treatment Center Reinvestment Program (RTCPR) performed the following activities: 1) assured that psychiatric residential treatment facilities (PRTFs) met the clinical needs identified in child/youth's treatment plan; 2) assured that the clinical program was adequate to meet the psychiatric and behavioral needs of each child/youth; 3) assured appropriate and adequate lengths of stay by monitoring medical necessity for continued stay; 4) participated in discharge planning and worked collaboratively with the Child and Family Services Agency on their placements and other District agencies (i.e., Department of Youth Rehabilitative Services) as appropriate to assure services were in place upon discharge; and 5) followed discharged youth for at least 6 months after discharge from a PRTF to support the child/youth's successful reintegration into the community. The performance target was to establish a baseline for the period 5/1/11-4/30/12. The target was met with the baseline for total bed days established at 72,687. The performance target for the period 5/1/12-4/30/13 is a 30% decrease (50,880) in the baseline. The performance period is still in progress so data is not available.

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

Partially achieved: The Multi-Systemic Therapy (MST) initiative was Not Met and the Functional Family Therapy (FFT) initiative was Fully Achieved. DMH began an annual evidence-based practices (EBPs) conference by hosting two (2) conferences in FY 2012 (October 2011, September 2012) that attracted 450 participants. These conferences introduced the EBPs being implemented by DMH and presented EBPs models by nationally renowned experts. In January 2012 DMH cross trained 10 Multi-Systemic Therapy (MST) therapists in MST for youth with problem sexual behavior (MST-PSB). Three (3) of the 10 therapists trained are dedicated to blended MST-PSB/MST cases. This clinical adaptation of MST is targeted to adolescents ages 10-17 who have committed sexual offenses and demonstrated other problem sexual behaviors. While 77% of the MST target for FY 2012 was met, it should be noted that MST serves



children/youth up to age 17 who display the most severe and chronic externalizing behaviors, and requires them to be in a stable home setting with a long-term caregiver. FFT serves children/youth up to age 18 who display behaviors ranging from at-risk to severe and requires them to be in a stable setting with a caregiver willing to participate in the treatment. During the fiscal year, far more children met the criteria for FFT, which explains the difference in growth in the number of children served by FFT and MST.

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

Fully Achieved. High Fidelity Wraparound (HFW) is provided by DC Choices and the Collaborative Council, which expanded the capacity to support the 10% increase of children and their families. In addition to broadening the pool of providers, DMH provided outreach to Children's National Medical Center and Psychiatric Institute of Washington for referrals to assist children returning to the community after receiving acute care. DMH also partnered with District child-serving agencies (Child and Family Services Agency, Department of Youth Rehabilitative Services, Office of the State Superintendent of Education, and D.C. Public Schools) to provide wraparound services to children returning to the community from psychiatric residential treatment facilities (PRTFs); and divert children with complex needs from PRTFs as a result of teaming and coordinating services to support the family in addressing behaviors that impact the functioning of the family unit. The HFW target of 232 children/youth served over the FY 2011 baseline was exceeded by 50.

OBJECTIVE 2: Increase access to mental health services.

INITIATIVE 2.1: Develop 300 net new supported housing vouchers, subsidies and/or capital housing units by September 30, 2013.

Fully Achieved. DMH contracted with The Technical Assistance Collaborative, Inc. to develop a housing strategic plan that was finalized in September 2012. This process involved evaluating DMH's current system of supported housing to identify strategies to ensure a continuum of community-based housing and support services that meet consumer needs, are built on best practices, consistent with DMH priority population needs, and cost-effective. The planning process included stakeholders, DMH staff, and other partners. The result of this work is the 5-year Supportive Housing Strategic Plan FY 2012- FY2017, a document that establishes the guiding strategies for DMH's future activity in permanent supportive housing and contains specific actions to be implemented by DMH. The FY 2012 target for DMH housing subsidies was 100 subsidies/vouchers over the FY 2011 baseline of 1,396. DMH awarded 186 housing subsidies, which supported reaching the goal of 1,496 housing subsidies by the end of FY 2012.

INITIATIVE 2.2: Expand access to supported employment services.

Partially Achieved. DMH developed and implemented a Performance Event Screen that Core Service Agencies (CSAs) completed when creating consumer treatment plans in 2012. The CSAs continue to complete the event screen for each individual when completing the 180-day treatment plan, or more often when necessary, to confirm that consumers have been assessed, offered and referred for supported employment authorization. DMH monitors the completion of the event screen by CSAs for accuracy of information. DMH also established and monitors a centralized wait list for consumers who are waiting for available openings at supported employment programs. The method for obtaining information about consumer referral during FY 2012 relied upon the self-report by the DMH CSAs. Due to some inconsistencies in data



reporting the data development process was reviewed. As a result, referral data provided by CSAs is reviewed and monitored weekly by DMH staff to ensure accuracy. The FY 2012 target was 60% of consumers assessed and interested in supported employment would be referred to this service. During the fourth quarter of FY 2012, 1,557 persons were assessed as eligible and interested in the service and 262 were referred.

In September 2012, DMH discovered the supported employment number of new consumers served was not an unduplicated count and made the necessary changes. In FY 2012, DMH was supposed to achieve a 10% increase over the baseline of 761 making the target 837. The actual persons served was 757, which is 90% of the target.

INITIATIVE 2.3: Expand access to early childhood services (Health Futures Program).

Partially Achieved. More than 1,300 young children had access to high-quality mental health consultation services in 25 child development centers (CDCs) in all but one ward of the city. Only 3 children were expelled from their CDC, a rate that is less than half the national average of 6.7 per 1,000. Healthy Futures consultants worked with nearly 60 children who were identified with problem behaviors. Of these, parents consented to 24 children receiving child-specific consultation; and Devereux Early Childhood Assessments (DECAs) were completed by 24 teachers and 22 parents. Also, DMH implemented the Primary Project in 14 CDCs. This evidence-based practice identifies young children (pre-kindergarten through third grade) with early school adjustment difficulties through the use of carefully developed screening and detection methods. All areas were achieved except full implementation of universal screening. Social-Emotional Screening was piloted in four (4) CDCs with full implementation scheduled in FY 2013. Full implementation in all the CDCs was not possible as Centers had difficulties with the internal processes to implement screening, obtaining necessary consents and coordinating existing efforts with Early Stages that was also involved with a screening pilot in several CDCs throughout the city.

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

INITIATIVE 3.1: Ensure provider compliance with the Continuity of Care guidelines regarding discharge planning and services provided post discharge from a psychiatric hospitalization.

Partially Achieved. Continuity of Care outcome reporting continues. The Integrated Care Division (ICD) is working with the Office of Accountability to assist in monitoring and reinforcing the Continuity of Care requirements for the CSAs. ICD has also sent each Clinical Director the CSA-specific data on performance with requests for review and plans for improvement. This communication has highlighted the issue of consumers receiving non-crisis services from Medicaid providers who are not necessarily MHRS providers. The results for the four (4) continuity of care measures for FY 2012 are as follows: 1) the target for both adults and children/youth receiving a community-based service within 7 days of discharge is 70%; the adult finding was 71.3% and the children/youth finding was 61%; and 2) the target for both adults and children/youth receiving a community service within 30 days of discharge is 80%; the adult finding was 80.8% and the children/youth finding was 79.4%.

OBJECTIVE 4: Ensure system accountability.

INITIATIVE 4.1: Continue to promote revenue enhancement.

Partially Achieved. The Mental Health Services Division (MHSD) efforts to improve staff productivity at all levels is an ongoing initiative. These efforts include but are not limited to staff training and development activities, group and individual consultation. An additional strategy



was to increase the amount that productivity measures count as part of the performance improvement plan. The FY 2012 productivity measure is currently 68.5% representing 82.53% of the target. Given the lag-time in off-site billing, by mid-November there should be some increase. MHSD will integrate the data that was reported quarterly in the KPI into its internal reporting process on an annual basis.

Saint Elizabeth Hospital

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

INITIATIVE 1.1: Improve and individualize active treatment options.

Partially Achieved. The competency restoration program implementation was fully achieved. Competency groups, including Mock Trial, are scheduled for individuals 4-5 times per week, and the groups are differentiated by cognitive level to ensure those with significant cognitive impairments are provided treatment at an appropriate learning pace. A modified progress note for the competency groups was implemented and is completed weekly for each individual and provided to the respective treatment teams. The Readiness Ruler implementation was fully achieved. The Readiness Ruler assessment is conducted twice per year, with the most recent being September/October 2011 and March 2012 (the September/October 2012 implementation is nearing completion). For the September/October 2011 implementation, 34% of those assessed had modifications made to their treatment schedules, and the March 2012 implementation resulted in a change in schedule for 46% of those assessed. The Women's programming was partially achieved with the addition of trauma, self-care, hygiene, substance abuse recovery, and health groups. Discharge Planning group enhancement was fully achieved, with groups (Finances and Benefits, Housing, Services in the Community, Day Programs, and Travel Training) focusing on distinct areas of discharge, with special groups for the significantly cognitively impaired.

- **INITIATIVE 1.2: Improve staff training and development associated with clinical care.**
Partially Achieved. All clinical staff is required to participate in Safety Care training. As of September 30, 2012, ninety (90%) of staff completed the training including nursing staff.



Key Performance Indicators – Details

Performance Assessment Key:

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

	KPI	Measure Name	FY 2011 YE Actual	FY 2012 YE Target	FY 2012 YE Revised Target	FY 2012 YE Actual	FY 2012 YE Rating	Budget Program
Mental Health Authority								
	2.1	C/Y CSRs overall system performance	59	65		65.17%	100.26%	MENTAL HEALTH AUTHORITY
	3.1	Average quality score adults	71.42	80		NA		MENTAL HEALTH AUTHORITY
	3.2	Average quality score child	63.27	80		NA		MENTAL HEALTH AUTHORITY
	3.3	Provider average financial score	80.22	85		NA		MENTAL HEALTH AUTHORITY
St. Elizabeths Hospital								
	1.1	Total inpatients served per day	288	291		277	105.05%	SAINT ELIZABETH'S HOSPITAL
	1.2	Eloperments per 1,000 patient days	0.41	0.45		0.03%	1643.45%	SAINT ELIZABETH'S HOSPITAL
	1.3	Patient injuries per 1,000 patient days	0.27	0.28		0.03%	1062.74%	SAINT ELIZABETH'S HOSPITAL
	1.4	Medication variances per 1,000 patient days	1.58	2.38		0.09%	2608.48%	SAINT ELIZABETH'S HOSPITAL
	1.5	Unique patients restrained once during month	0.4	0.4		0.13%	297.83%	SAINT ELIZABETH'S HOSPITAL
	1.6	Unique patients secluded once during month	0.6	0.6		0.59%	101.31%	SAINT ELIZABETH'S HOSPITAL
	1.1	Baseline & reduced C/Y bed days in PRTFs	NA	NA		NA	Baseline year	MENTAL HEALTH SERVICES AND SUPPORTS



	KPI	Measure Name	FY 2011 YE Actual	FY 2012 YE Target	FY 2012 YE Revised Target	FY 2012 YE Actual	FY 2012 YE Rating	Budget Program
Mental Health Services and Support								
●	1.2	Increase C/Y receiving MST	129	20		76.77%	367.7%	MENTAL HEALTH SERVICES AND SUPPORTS
●	1.3	Increase C/Y receiving FFT	82	20		228.57%	1142.86%	MENTAL HEALTH SERVICES AND SUPPORTS
●	1.4	Increase C/Y receiving HFW	211	10		121.55%	1215.52%	MENTAL HEALTH SERVICES AND SUPPORTS
●	1.5	300 net new supported housing vouchers/subsidies and/or capital housing units	1,396	100		186	186%	MENTAL HEALTH SERVICES AND SUPPORTS
●	1.6	Method to assess need for supported employment and referral of consumers to service	NA	60%		16.8%	28.05.8%	MENTAL HEALTH SERVICES AND SUPPORTS
●	1.7	Increase number of consumers receiving supported employment service	761	837		757	90.44%	MENTAL HEALTH SERVICES AND SUPPORTS
●	1.8	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%	90.44%	MENTAL HEALTH SERVICES AND SUPPORTS
●	1.9	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%	101.86%	MENTAL HEALTH SERVICES AND SUPPORTS
●	1.1	Adults receive at least one (1) non-crisis service in a non-emergency setting within 30 days of discharge from a psychiatric hospitalization	N/A	80%		80.78%	100.97%	MENTAL HEALTH SERVICES AND SUPPORTS



	KPI	Measure Name	FY 2011 YE Actual	FY 2012 YE Target	FY 2012 YE Revised Target	FY 2012 YE Actual	FY 2012 YE Rating	Budget Program
●	1.11	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%	99.21%	MENTAL HEALTH SERVICES AND SUPPORTS
●	1.12	MHSD productivity hours per month per FTE	79	83		274	330.12%	MENTAL HEALTH SERVICES AND SUPPORTS
Mental Health Financing/Fee for Service								
●	1.1	Improve total Medicaid claims paid by reducing exceptions on the front end.	NA	<3%		2.06%	145.58%	MENTAL HEALTH FINANCING/FEE FOR SERVICE
●	1.2	Improve total Medicaid claims paid by facilitating providers reducing DHCF denials.	11.4	5%		5.46%	91.54%	MENTAL HEALTH FINANCING/FEE FOR SERVICE