



Department of Mental Health
(Renamed in FY 14 as Department of Behavioral 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 Elizabeth's Hospital, the Mental Health Services Division, the Comprehensive Psychiatric Emergency Program, and the School-Based Mental Health Program.

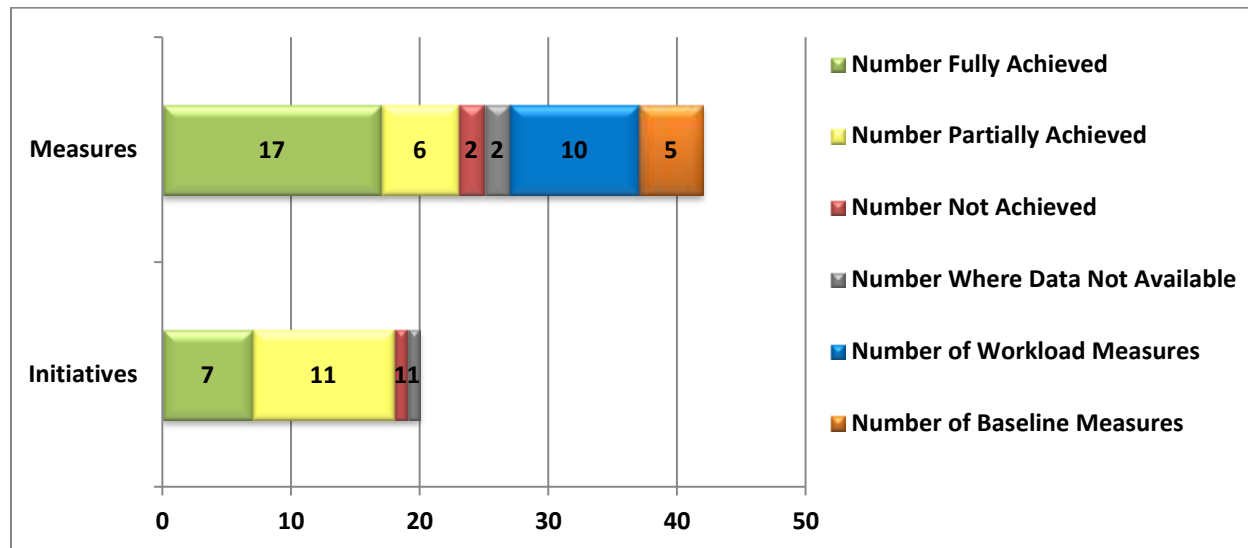
ACCOMPLISHMENTS

- ✓ Initiated planning to launch Department of Behavioral Health on 10/1/13.
- ✓ DC youth in out-of-state Psychiatric Residential Treatment Facilities reduced 23% to 133 for the year.
- ✓ Expanded the number of consumers in permanent supported housing by 136.

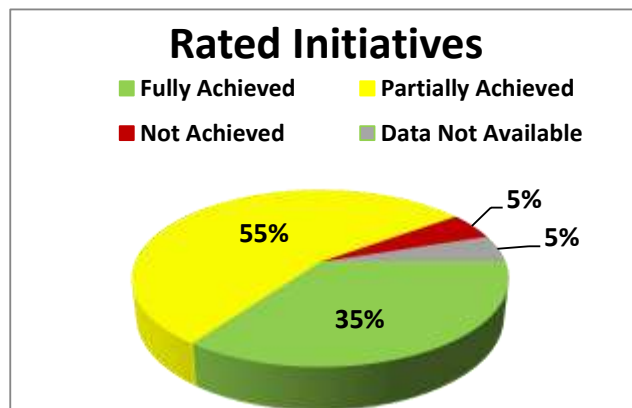
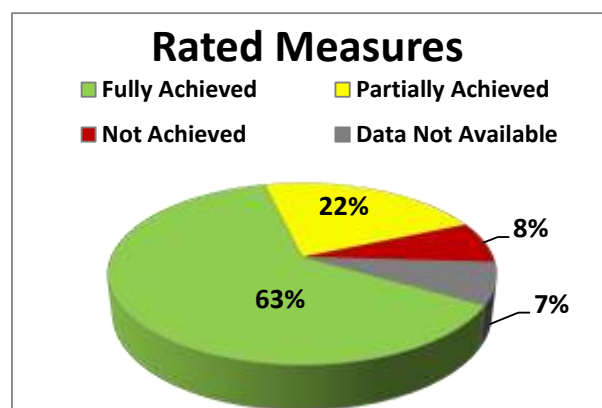


OVERALL AGENCY PERFORMANCE

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

Mental Health Authority

OBJECTIVE 1: Expand the range of mental health services.

INITIATIVE 1.1: Work collaboratively with the Department of Health to establish and implement the planning process to create the new Department of Behavioral Health.

Partially Achieved. FY 2013 was the initial planning phase for establishing the Department of Behavioral Health (DBH). The activities included: 1) creating a Planning Committee, developing a work plan, adopting Guiding Principles and the Charter, establishing work groups and reporting requirements, and identifying data requirements; 2) conducting work group meetings including developing work plans and schedule of deliverables, and monthly report to the Planning Committee; 3) developing a strategy for communication and engagement of partners and the general public; 4) addressing infrastructure issues such as contracts and procurement, billing and claims, certification and accountability; and rules and policy; 5) launching the new Department on October 1, 2013 with consumer/client services continuing and uninterrupted with same mental health or substance use disorder provided; 6) on an ongoing basis continue evaluation of services and identification of gaps, provide training on assessment and treatment of co-occurring disorders, and address a host of other issues; and 7) competitively acquire consultant services to facilitate the development of the DBH. During the FY 2013 fourth quarter a consultant, The Technical Assistance Collaborative, was brought onboard to provide technical assistance for the development and implementation of the DBH.

INITIATIVE 1.2: Expand the range of services available under mental health rehabilitation services (MHRS) for counseling.

Partially Achieved. During FY 2013, DMH continued to work with the Department of Health Care Finance (DHCF) on the development of Evidenced Based Practice (EBP) rules, in an effort to expand MHRS services. The final draft was submitted to DHCF and to the Center for Medicare and Medicaid Services (CMS) for review and feedback. Since the process was taking longer than anticipated, DMH decided to proceed with publishing local EBP rules to expand MHRS Counseling and initially reimburse using local dollars; while simultaneously working with DHCF to have these services Medicaid reimbursable. The proposed local rules included TF-CBT and CPP and were published in July with the final rules published in September 2013. DHCF prepared a State Plan Amendment (SPA) for submission to CMS, for approval of these services as Medicaid reimbursable. The document was finalized and is now ready for CMS submission.

Also, TF-CBT training and consultation activities continued. In June 2013, a contract was awarded to Evidence Based Associates (EBA) to continue the Families First project activities including implementation and sustainability of TF-CBT, CPP-FV, Parent Child Interactive Therapy (PCIT) and Multi-Systemic Therapy for Youth with Problem Sexual Behaviors (MST-PSB). During FY 2013 training began for two (2) additional models: 1) Transition to Independence Process (TIP) System, a community-based model for improving the outcomes of youth and young adults with



emotional/behavioral difficulties; and 2) Trauma Systems Therapy (TST), a treatment model for children and adolescents who have been exposed to trauma. With regard to TIP, the DMH in partnership with EBA announced a pre-application webinar for interested core service agency (CSA) training applicants. It is a pre-requisite for a 2-year TIP Learning Collaborative process beginning July 1, 2013 through June 30, 2015.

A new agency submitted a certification application to become a MST provider. This agency specializes in standard MST, as well as an adaptation of MST called MST for emerging adults (MST-EA). While MST serves youth 10-17, MST-EA serves youth and young adults ages 18-21. The completion of the certification process was pending at the end of FY 2013.

The Child and Youth Services Division in partnership with EBA hosted the third annual D.C. Evidence Based Practice Summit, *Celebrating True System of Care Collaboration Through Evidence-Based Practice Implementation*, on September 27, 2013. It highlights evidence-based programs making a difference for children, youth and their families. Over 300 participants were informed about the EBPs now available for children, youth and their families.

OBJECTIVE 2: Increase access to mental health services.

INITIATIVE 2.1: Collaborate with Washington Metropolitan Area Transit Authority (WMATA) on suicide intervention and public awareness program.

Fully Achieved. The suicide prevention training continued during FY 2013. DMH staff in the Care Coordination Division and Comprehensive Psychiatric Emergency Program provided minimal co-training with WMATA staff. The WMATA staff now conducts the training. DMH will provide assistance as required, for example, helping WMATA staff become trained as trainers, and remain available for future training needs. DMH staff continued to track calls to the WMATA Lifeline. At the end of FY 2013, there were 1,062 calls to this line. Going forward, any calls that are tracked through this line will be reported as a workload measure.

Initiative 2:2 Expand access to early childhood services.

Fully Achieved. During FY 2013, the Primary Project expanded from 30 sites to 35 sites as planned. This evidence-based project, which is an early intervention and prevention program for children ages pre-kindergarten through third grade who are demonstrating mild adjustment problems in the classroom, operates in the Child Development Centers and Community Schools. One-to-one, non-directive play sessions are provided to children at school by trained paraprofessionals under the supervision of the Primary Project Program Manager. Additionally, all sites provide a continuum of service for children who screen positive for mental health services. Children in community schools are referred to the School Mental Health Program (SMHP) clinicians and those in child development centers to the Early Childhood Consultants (Healthy Futures Program).

The Primary Project data show that at the end of School Year 2012-2013: 1) the program operated in 17 school sites and 18 child development centers; 2) there were 2,664 teacher-child rating scale screenings; 3) 1,364 mental health interventions/positive for services; 4) 328 Primary Project service participations; and 5) 785 mental health referrals processed.



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

INITIATIVE 3.1: Develop an assertive community treatment scorecard.

Partially Achieved. Assertive Community Treatment (ACT) is an evidence-based practice that provides intensive, integrated, rehabilitative, community based services for adults with serious mental illness (SMI). ACT consumers typically have experienced multiple psychiatric crises, housing and employment instability, and have been unable to maintain linkages to traditional clinic-based mental health services. During FY 2013, there were 7 ACT providers, 16 ACT teams, and 1,397 consumers were served as of September 30, 2013.

In February and March FY 2013 a random targeted community services review (CSR) was conducted for new consumers assigned to the ACT level of care. Each ACT team participated in the CSR to assess the degree of collaboration, coordination and integration of services for the consumer and how the consumer rated his/her support with the new provider. While the final sample was relatively small (18 consumers), the findings show: 1) strengths (team efforts to engage and support consumers, and engaging family and collateral providers in team meetings); 2) challenges (several teams lacked a vocational specialist or a means of addressing consumers' interest in pursuing employment or career development; and 3) system performance (ratings across the practice measures were well within the acceptable range).

Also, during FY 2013 the ACT program initiated other activities related to the development of an ACT Scorecard by engaging in data gathering and review. The various sources of data included: Team/Fidelity scores, focused Community Services Review scores, Mental Health Statistics Improvement Program Surveys, and e-Cura claims based data regarding timeliness of service. The ACT Scorecard will be developed and piloted during FY 2014 with full implementation completed in FY 2015.

INITIATIVE 3.2: Establish benchmarks for supported employment.

Eliminated. During January and February 2013, meetings were conducted with the 6 qualified Supported Employment providers to discuss the development of quality benchmarks. Three (3) potential benchmarks were reviewed: 1) number of new consumers served each month by each Supported Employment Program; 2) number of employed consumers graduated from the supported employment program after maintaining employment for 1 year; and 3) a 60% Job Placement goal for each Supported Employment provider. The first two (2) benchmarks were agreed upon. While these benchmarks began to be piloted, there was no modification of Supported Employment policies, rules and contractual guidelines. After further consideration, it was determined that additional benchmarks were not necessary since Supported Employment is an evidence-based practice with a body of research that supports its fidelity scale, which already contains benchmarks for performance. There is no need to establish additional benchmarks as they would be duplicative and would not impact the quality of care. DMH made the Office of the Deputy Mayor Health and Human Services and the Office of the City Administrator aware that this initiative will not be continued in FY 2014.

INITIATIVE 3.3: Improve Provider Scorecard.

Partially Achieved. The Provider Scorecard is a tool designed to help users of public mental health services in the District select a provider that best meets their needs. It rates the quality of service delivery in assessment, treatment planning, and coordination of care. It also examines financial compliance with federal and local regulations and laws. The Provider Scorecard KPIs traditionally



reported the average quality score separate for adults and children. During FY 2013, a decision was made not to separate these scores but to report them together for all providers beginning with the FY 2012 Scorecard. The scores are no longer disaggregated because there was a substantial change in the scoring and presentation of the Provider Scorecard to make it easier to use and to understand. The Office of Accountability received extensive feedback from the providers that the previous versions were difficult to analyze.

The FY 2012 Provider Scorecard was published during FY 2013. The providers' FY 2012 Scorecard aggregated adult and child average quality score was 86.41. The FY 2012 Scorecard providers' average financial score was 69.11. Going forward under the behavioral health system, a new Provider Scorecard for both mental health and substance use disorder treatment providers will be developed.

INITIATIVE 3.4: Expand DMH disaster mental health response capacity.

Partially Achieved. The DMH Office of Disaster Mental Health Services formally began in 2007 to lead the emergency preparedness efforts. DMH operates a certification training program for emergency mental health responders. The Disaster Mental Health Responder Certification program includes 9 core training sessions that teach skills/competencies in the attitudes, knowledge, and skills necessary to provide evidence-based, culturally appropriate, and timely services to survivors. Participants who successfully complete post-session testing within a calendar year are eligible to apply. Emergency Mental Health Response Teams are deployed during wide spread community incidents from severe weather to hazardous material spills to terrorist attacks or during high surge or regional disasters.

In FY 2013, an initiative began to expand the Disaster Services capacity by providing training to interested community members. Participating members are eligible to apply to response teams following successful completion of the 7 core training courses and 3 auxiliary training modules of their choice. Also, during FY 2013, 341 persons participated in the training program and a total of 48 training hours were provided. Forty (40) individuals successfully completed the training program. The total number of responders increased from 55 to 65. The training will occur annually until 150 persons are trained.

OBJECTIVE 4: Ensure system accountability.

INITIATIVE 4.1: Expand DMH grievance process training.

Partially Achieved. During FY 2013, the Office of Consumer and Family Affairs (OCFA) planned to increase the number of grievance training sessions for multiple provider agency staff conducted at the DMH location from 2 to 3. This goal was exceeded as 4 trainings were conducted.

Also, during FY 2013 OCFA planned to conduct grievance training sessions at provider sites for the first time. The goal was to conduct 2 trainings at provider locations. While 2 grievance training sessions were scheduled only one (1) session was completed. Several attempts were made to re-schedule the second training but scheduling conflicts and several staff turnovers prevented the process from going forward. Fifty percent (50%) of the goal was achieved in FY 2013. It is hoped that the scheduling issues will be resolved in FY 2014.



Saint Elizabeth's Hospital

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

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

Partially Achieved. During FY 2013, 57 individuals in the care of Saint Elizabeths Hospital were identified as resistant to leaving and were engaged in programming to facilitate readiness for discharge. Twenty-six (26) or 46% of these individuals were discharged in FY 2013, 8 (14%) began attending day programs in the community, 10 (18%) were enrolled in various community re-entry groups that consistently travel into the community, and 3 (6%) were engaged by the Peer Specialists for transition to community living. In total, 47 (82%) out of 57 were successfully transitioned to community living or showed progress in preparing for discharge. The remaining 10 (18%) have either experienced psychiatric decompensation or refused to engage in the discharge readiness process. Efforts to engage these 10 individuals continue.

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

Fully Achieved. In FY 2013, during Recovery I training, staff were trained on the concept that recovery is an ongoing dynamic process that incorporates a person's strengths, vulnerabilities, and resources. Recovery II training built upon previously learned principles and focused attention on application of recovery principles to promote engagement in treatment. Ninety-nine percent (99%) of the nursing staff completed the Recovery training (178 out of 179). These results exceeded the projected 95% completion by nursing staff.

Development of appropriate recovery-based nursing objectives and interventions is also critical to full implementation of the recovery model. RNs also received two (2) trainings in the development of objectives and nursing interventions (also known as Nursing Assessment I and II). Ninety-eight percent (98%) of RN staff (355 out of 362) completed Nursing Assessment I and II training. These results exceeded the projected 95% completion by RN staff. Nursing Assessment I and II training has now been incorporated into the orientation for all newly hired nurses. In addition, all clinical administrators and nurse managers have completed training in the incorporation of nursing interventions into the individualized recovery plans.

Mental Health Services and Supports

Dixon Settlement Agreement Initiatives

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

OBJECTIVE 1: Expand the range of mental health services.

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

Fully Achieved. The FY 2013 target was to decrease the number of days that District children/youth spend in PRTFs by 30%, or 50,881 bed days. The actual decrease was higher than expected, 35% or 46,378 bed days. The primary factors that led to the decrease include: 1) District child-serving agencies embraced and applied the philosophy of bringing children/youth home to receive community-based treatment; 2) the commitment and collaboration of District agencies working together; 3) the continued appropriate use of the PRTF Review Committee; and 4) the continued critical and thoughtful monthly treatment reviews aimed at ensuring youth receive treatment within the most appropriate level of care.



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

Partially Achieved. The FY 2013 target was to increase the number of children/youth receiving MST by 20%, or 186. As of 9/30/13, 130 children/youth had received MST services. This represents 70% of the target. Although the final number will not be available until after the 90-day claims billing period (12/31/13), it is not anticipated that the target will be met. The two (2) issues that seemed to affect this service include: 1) provider staff turnover resulting in the inability to accept new cases (drop in capacity); and 2) referrals with a 50% rejection rate. While this rate is considered standard among MST providers given inappropriate referrals, DMH wanted to rule out engagement issues. DMH held weekly supervision meetings as well as monthly meetings with MST experts to address all presenting issues. Additionally, a new MST provider applied for certification and will launch MST service delivery during FY 2014. Also, during FY 2014 there will be an emphasis on increasing referrals to Court Social Services and the Department of Youth Rehabilitation Services.

The FY 2013 target was also to increase the number of families participating in FFT by 20%, or 269. As of 9/30/13, 323 families were actively engaged in FFT exceeding the target by 54. Functional Family Therapy is a “therapeutic model” of intervention that is family relational focused, strength based, and risk and protective factor driven. It utilizes a three (3) phase process that organizes family change in a coherent manner. The first phase is to engage and motivate the youth and family by decreasing negativity, blaming and hopelessness, redirecting their emotions through respect, sensitivity and positive reattribution techniques. The second phase is change behavior by reducing and eliminating problem behaviors by targeting risk factor reduction in accompanying family relational patterns through individualized change interventions and systematic skill training. The third phase is to generalize change across problem situations by increasing the family’s capacity to utilize multi-systemic community resources and to engage in relapse prevention. FFT clinicians work to help families maintain and enhance changes through use of community systems and resources.

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

Partially Achieved. The FY 2013 target was to increase the availability of HFW for children/youth by 20%, or 338. As of 9/30/13, 337 (99.7%) children/youth were served through wraparound, which substantially albeit not completely achieved the target. During FY 2013, DMH continued the bi-monthly meetings with the Child and Family Services Agency, Department of Youth Rehabilitation Services, DC Choices, and Healthy Family Thriving Community Council to discuss children/youth involved in wraparound. Topics included referrals, barriers to service, agency needs, and program strengths. Towards the end of fiscal year, the agencies discussed data sets to tell the stories of children/youth engaged in wraparound. The data sets will be finalized during the FY 2014 first quarter with data capture and reporting projected to begin in the second quarter.

OBJECTIVE 2: Increase access to mental health services.

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

Not Achieved. The FY 2013 target was to increase new supported housing vouchers/subsidies and/or capital housing units to 200. As of 9/30/13, 128 (64%) of the target had been achieved. However, in the FY 2014 first quarter the Department of Housing and Community Development (DHCD) approved development of 195 units with capital funds. The acquisition of these units will exceed the target of 200 by 123 units.

The primary activities during FY 2013 included: 1) the issuance of 136 housing subsidies; and 2)



working with DHCD to identify developers and allocation of DMH capital funds for the development of new or renovated units.

INITIATIVE 2.2: Expand access to supported employment services.

Partially Achieved. The FY 2013 target was to increase the interested consumers referred to supported employment to 60%. As of 9/30/13, 1,207 of 2,035 consumers were offered and referred to supported employment services, or 59.31%. This represents 98.85% of the target.

- During FY 2013, DMH initiated a vigorous review of the supported employment referral process in order to increase the consumers referred to this service. Also, DMH established a wait list for referrals that were managed centrally.

The FY 2013 target was also to increase the number of consumers receiving supported employment by 15%, or 963. As of 9/30/13, 794 of consumers received supported employment services. This represents 82.45% of the target. DMH efforts to increase capacity included providing funding to the four (4) highest performing supported employment providers, which allowed each of them to hire one (1) additional Employment Specialist to increase capacity by a total of 80 new consumers.

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

INITIATIVE 3.1: Improve the Community Service Reviews (CSRs) child/youth overall system performance score.

Fully Achieved. In the third quarter, DMH achieved its FY 2013 goal of an overall system performance score of 70% for the FY 2013 CSRs. Sixty (60) of the 86 cases were deemed acceptable. The results also show a 74% score for consumer status, and a 70% score for consumer progress.

- Human Systems and Outcomes (HSO) conducted two (2) Clinical Case Formulation trainings for providers in January 2013 in an effort to enhance assessment and treatment planning skills. The training participants included clinicians from targeted Core Services Agencies (CSAs) and staff from stakeholders such as Child and Family Services Agency (CFSA) and Health Services for Children with Special Needs (HSCSN). HSO facilitated the CSR New Reviewer training for 2013 and the Returning Reviewer training for staff already trained on the DMH protocol. HSO supported the CSR 2013 process by providing contracted reviewers and logistical support; supplying case consultation services; and running the group debriefing sessions. HSO delivered the 2013 database that was used to inform providers of the results for 2013. In addition, HSO compiled the final report for the FY 2013 CSR.

In an effort to support the training efforts made by HSO the CSR Unit identified specific agencies to provide focused technical assistance. Following the Clinical Case Formation Trainings, all identified targeted providers received individual technical assistance from the CSR Unit. It was individualized and included individual Clinical Case Formation Training that emphasized a case identified by the provider agency. The CSR Unit integrated components of the Practice Principles Training that include Engagement of Service Partners, Assessing and Understanding the Situation, Planning Positive Life Changing Interventions, Implementing Services and Getting and Using Results to review each selected case. The agencies were also provided coaching and support to develop a treatment plan, with goals and potential objectives for the identified consumer. Phase 2 of the technical assistance included conducting “mini” CSRs. The CSR Unit will provide qualitative and quantitative outcome reports on the Child/Youth System to stakeholders and individual providers in



which technical assistance was made available during 2013. To ensure sustainability and continued growth in practice, the Community Services Review Unit has crafted a plan to provide ongoing reviews for adult and children services for FY 2014 and beyond. This plan will be vetted through Senior Management and fully operational in FY 2014 to support practice development.

The FY 2013 Child/Youth CSR was completed in May 2013. Reviews were conducted during May 6 - May 22, 2013 with one joint review conducted the week prior to accommodate the schedule with CFSA. There were 87 children/youth reviews conducted during the review period. DMH continued to work closely with CFSA and the Court Monitor for the *LaShawn v. Gray* case, the Center for the Study of Social Policy, to jointly review the cases of children served by both systems. The joint reviews provided comprehensive information about children and will serve as a model for ongoing cooperation between the two (2) agencies.

INITIATIVE 3.2: Ensure provider compliance with the Continuity of Care guidelines regarding discharge planning and services provided post discharge from a psychiatric hospitalization.

Partially Achieved. During FY 2013, DMH made substantial progress toward meeting its goal to provide timely community-based services to children and adults following discharge from a psychiatric facility. The goal was that 70% of both adults and children would be seen in 7 days of discharge and 80% would be seen in 30 days of discharge. For adults, 67.86% (represents 96.94% of the target) received a service within 7 days and 78.24% (represents 97.80% of the target) received a service within 30 days. For children, 67.33% (represents 96.19% of the target) received a service within 7 days and 83.30% (exceeds target representing 104.13%) received a service within 30 days.

- Given that Medicaid providers have 1 year to submit claims for services, these FY 2013 numbers may increase.

To further assure timely continuity of care post-discharge services, consumer information including service utilization will be integrated into the new DBH health management information system known as the Integrated Care Applications Management System (iCAMS), scheduled to go live June 2014. Each consumer's community-based service plan including appointments and service outcomes will be automatically tracked. Alerts will notify service providers and DBH of any missed appointments. Care coordination will thus be immediately activated to continue the consumer's engagement in his/her treatment and recovery plan and prevent any interruption in continuity of care.

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 denials by the Department of Health Care Finance (DHCF).

Fully Achieved. The updated mental health rehabilitation services (MHRS) claims status report shows that the Medicaid claims denial rate for the FY 2013 close-out to date is at 4.62%, which is within the projected 5% or less. By the end of FY 2012 DHCF made its online claims system compliant with the Health Insurance Portability and Accountability Act 5010. This allowed providers to submit adjustments and voids for denied claims online and bypass paper claims processing. In addition, DMH introduced and trained its MHRS providers on this new process throughout FY 2013 at its monthly User Group meeting. Providers have greatly expanded their use of the DHCF web portal to re-work denied Medicaid claims.



Agency Management

OBJECTIVE 1: Ensure system accountability.

INITIATIVE 1.1: Implement the care management application.

Partially Achieved. In FY 2013, DMH began implementing iCAMS to manage the District's public mental health system. The electronic health record/data system is expected to replace several primary data systems (e-CURA, Anasazi and Panacea Rx), as well as secondary data systems (the grievance, housing and emergency services data trackers). The goal of iCAMS is to centralize the documentation and reporting of information related to consumers and providers in order to support the decrease of manual processes and the support for multiple systems. Additionally, the product is expected to result in an increase of information sharing, monitoring, reporting and evaluation, as well as support the provision of appropriate and timely services to consumers.



The iCAMS project kick off was May 7, 2013. Implementation of iCAMS involves collaboration between the DMH implementation team and the identified vendor for the iCAMS product. The project champion (Chief of Administrative Operations), as well as the project contracting officer technical representative (Chief Information Officer) have assembled an implementation team to oversee the day to day operations. This team includes three (3) staff whose areas of concentration are technical, clinical and business process/claims. The implementation team met with the Department programs to gather requirements and ensure that that the product will meet the needs of the multi-faceted public mental health system. The initial release of iCAMS is expected to take place within the third quarter of FY 2014, and the system is expected to be fully operational by the end of FY 2014.



Key Performance Indicators – Details

Performance Assessment Key:

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

	KPI	Measure Name	FY 2012 YE Actual	FY 2013 YE Target	FY 2013 YE Revised Target	FY 2013 YE Actual	FY 2013 YE Rating	Budget Program
Agency Management								
●	1.1	Number of adult consumers served	18,708	Target Not Required		18,680	Workload Measure Not rated	AGENCY MANAGEMENT
●	1.2	Number of child/youth consumers served	4,480	Target Not Required		4,126	Workload Measure Not rated	AGENCY MANAGEMENT
●	1.3	Mental Health Services Division (MHSD) intake/Same Day Service Urgent Care Clinic “adults	3,083	Target Not Required		3,628	Workload Measure Not rated	AGENCY MANAGEMENT
●	1.4	MHSD intake/Same Day Service Urgent Care Clinic “child/youth	489	Target Not Required		327	Workload Measure Not rated	AGENCY MANAGEMENT
●	1.5	Number of Comprehensive Psychiatric Emergency Program (CPEP) visits	3,925	Target Not Required		3,961	Workload Measure Not rated	AGENCY MANAGEMENT
●	1.6	Number of adult mobile crisis team visits	1,094	Target Not Required		1,382	Workload Measure Not rated	AGENCY MANAGEMENT
●	1.7	Number of child mobile crisis team visits	658	Target Not Required		608	Workload Measure Not rated	AGENCY MANAGEMENT
●	1.8	Crisis stabilization bed utilization	85%	Target Not Required		87.98%	Workload Measure Not rated	AGENCY MANAGEMENT
●	1.9	Number of claims audits conducted	41	Target Not Required		79	Workload Measure Not rated	AGENCY MANAGEMENT
●	1.10	Involuntary acute admissions to Saint Elizabeth’s Hospital	1.8	Target Not Required		0.97%	Workload Measure Not rated	AGENCY MANAGEMENT



	KPI	Measure Name	FY 2012 YE Actual	FY 2013 YE Target	FY 2013 YE Revised Target	FY 2013 YE Actual	FY 2013 YE Rating	Budget Program
Mental Health Authority								
●	2.1	DMH train-the-trainer suicide prevention for WMATA staff & receive calls to WMATA Lifeline	21	No Target Provided		1062 ⁱ	Baseline Measure (Not Rated)	MENTAL HEALTH AUTHORITY
●	2.2	Expand access to early childhood services - Primary Project	30	35		35	100%	AGENCY MANAGEMENT
●	3.1	Develop Assertive Community Treatment (ACT) Scorecard	N/A	No Target Provided		See Note 1 ⁱⁱ	Baseline Measure (Not Rated)	MENTAL HEALTH AUTHORITY
●	3.2	Establish benchmarks for supported employment	N/A	N/A		No Data See Note 2 ⁱⁱⁱ	Note Rated (Eliminated)	MENTAL HEALTH AUTHORITY
●	3.3	Provider Scorecard - providers average quality adult & child score combined	N/A	No Target Provided		86.41 ^{iv}	Baseline Measure (Not Rated)	MENTAL HEALTH AUTHORITY
●	3.4	Provider Scorecard providers average quality (child) score	N/A	N/A		No Data See Note 3 ^v	Note Rated (Eliminated)	MENTAL HEALTH AUTHORITY
●	3.5	Provider Scorecard-providers average financial score	N/A	No Target Provided		69.11	Baseline Measure (Not Rated)	MENTAL HEALTH AUTHORITY
●	3.6	Expand DMH disaster mental health response capacity	N/A	No Target Provided		65	Baseline Measure (Not Rated)	MENTAL HEALTH AUTHORITY
●	4.1	Increase grievance process training	N/A	2		3	150%	MENTAL HEALTH AUTHORITY
●	4.2	Provider site grievance process training	N/A	2		1	50%	MENTAL HEALTH AUTHORITY



	KPI	Measure Name	FY 2012 YE Actual	FY 2013 YE Target	FY 2013 YE Revised Target	FY 2013 YE Actual	FY 2013 YE Rating	Budget Program
St. Elizabeth's Hospital								
●	1.1	Competency-based recovery model training	N/A	95		99.44%	104.68%	SAINT ELIZABETH'S HOSPITAL
●	1.2	Objectives and nursing interventions training	N/A	95		98.07%	103.23%	SAINT ELIZABETH'S HOSPITAL
●	1.3	Total Patients Served Per Day	276	275		256 ^{vi}	107.42%	SAINT ELIZABETH'S HOSPITAL
●	1.4	Elopements per 1,000 patient days	0.27	0.28		0.02%	1662.34%	SAINT ELIZABETH'S HOSPITAL
●	1.5	Patient injuries per 1,000 patient days	0.35	0.27		0.03%	906.03%	SAINT ELIZABETH'S HOSPITAL
●	1.6	Missing documentation of medication administration results	0.34	0.3		0.10%	306.14%	SAINT ELIZABETH'S HOSPITAL
●	1.7	Unique patients who were restrained at least once during month	0.1	0.1		0.0 ^{vii}	>100%	SAINT ELIZABETH'S HOSPITAL
●	1.8	Unique patients who were secluded at least once during month	0.6	0.7		0.01% ^{viii}	>100%	SAINT ELIZABETH'S HOSPITAL
●	1.9	Percentage of Patients re-admitted to Saint Elizabeth's Hospital within 30 days of discharge	5.3%	6%		5.59%	107.25%	SAINT ELIZABETH'S HOSPITAL



	KPI	Measure Name	FY 2012 YE Actual	FY 2013 YE Target	FY 2013 YE Revised Target	FY 2013 YE Actual	FY 2013 YE Rating	Budget Program
Mental Health Serv. & Sup.								
●	1.1	Baseline and reduced C/Y bed days in PRTFs	33,348	50,881 ^{ix}		46,378 ^x	>100%	MENTAL HEALTH SERVICES AND SUPPORTS
●	1.2	Increase C/Y receiving MST	119	20		69.89%	349.46%	MENTAL HEALTH SERVICES AND SUPPORTS
●	1.3	Increase C/Y receiving FFT	224	20		120.07%	600.37%	MENTAL HEALTH SERVICES AND SUPPORTS
●	1.4	Increase C/Y receiving HFW	282	20		99.70%	498.52%	MENTAL HEALTH SERVICES AND SUPPORTS
●	2.1	Increase new supported housing vouchers/subsidies and/or capital housing units and develop a housing plan	1,502	200		128	64%	MENTAL HEALTH SERVICES AND SUPPORTS
●	2.2	Method to assess need for supported employment and referral of consumers to service	17%	60%		59.31%	98.85%	MENTAL HEALTH SERVICES AND SUPPORTS
●	2.3	Increase number of consumers receiving supported employment service	757	963		794	82.45%	MENTAL HEALTH SERVICES AND SUPPORTS
●	3.1	Child/youth CSRs overall system performance	65%	70%		69.77%	99.67%	MENTAL HEALTH SERVICES AND SUPPORTS
●	3.2	Adults receive at least one (1) non-crisis service in a non-emergency setting within 7 days of discharge from a psychiatric hospitalization	71.3	70%		67.86%	96.94%	MENTAL HEALTH SERVICES AND SUPPORTS



	KPI	Measure Name	FY 2012 YE Actual	FY 2013 YE Target	FY 2013 YE Revised Target	FY 2013 YE Actual	FY 2013 YE Rating	Budget Program
●	3.3	Children/youth receive at least one (1) non-crisis service in a non-emergency setting within 7 days of discharge from a psychiatric hospitalization	61%	70%		67.33% (^{xi})	96.19% (^{xii})	MENTAL HEALTH SERVICES AND SUPPORTS
●	3.4	Adults receive at least one (1) non-crisis service in a non-emergency setting within 30 days of discharge from a psychiatric hospitalization	80.8%	80%		78.24% (^{xiii})	97.80% (^{xiv})	MENTAL HEALTH SERVICES AND SUPPORTS
●	3.5	Children/youth receive at least one (1) non-crisis service in a non-emergency setting within 30 days of discharge from a psychiatric hospitalization	79.4%	80%		83.30% (^{xv})	104.13% (^{xvi})	MENTAL HEALTH SERVICES AND SUPPORTS
Mental Health Financing/Fees For Service								
●		Improve total Medicaid claims paid by facilitating providers reducing DHCF denials	4.8%	≤5%		4.62% (^{xvii})	108.23%	MENTAL HEALTH FINANCING/ FEE FOR SERVICE



Key Performance Indicators Endnotes

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- i Number of calls to WMATA Lifeline. The first year of operation for the WMATA Lifeline was 9/1/11-10/31/12 with 75 calls. In FY13 there were 1,062 calls. This will become a workload measure in FY14.
 - ii FY13 was the initial planning phase with the intent that the ACT Scorecard would be developed in FY14. Baseline data would not be available until FY15 once the Scorecard is fully implemented.
 - iii Eliminated duplicative with current Supported Employment evidence-based fidelity scale.
 - iv The providers' average quality score now aggregates adult and child scores that were previously reported separately.
 - v In the FY12 Provider Scorecard going forward the Adult and Child quality scores are combined. There is no longer a separate child score.
 - vi Fewer patients served in an inpatient psychiatric hospital than projected (275); down is better
 - vii No patients restrained is a very good- outcome
 - viii Fewer patients secluded than expected (0.7) is a very good outcome
 - ix Represents 30% bed days reduction
 - x Represents 35% bed days reduction which is higher than expected and is a very good outcome
 - xi $371/551=67.33\%$
 - xii $67.33\%/70.0=96.19\%$ of target
 - xiii $852/1089=78.24\%$
 - xiv $78.24\%/80.0=97.80\%$ of target
 - xv $459/551=83.30\%$
 - xvi $83.30\%/80.0=104.13\%$ of target
 - xvii $3,282,501/71,049,787 =4.62\%$