



FY 2015 Performance Accountability Report Department of Behavioral Health

INTRODUCTION

The Performance Accountability Report (PAR) measures each agency's performance for the fiscal year against the agency's performance plan and includes major accomplishments, updates on initiatives' progress and key performance indicators (KPIs).

MISSION

The mission of the Department of Behavioral Health (DBH) is to support prevention, treatment, resiliency and recovery for District residents with mental health and substance use disorders through the delivery of high quality, integrated services.

SUMMARY OF SERVICES

DBH will: 1) ensure that every individual seeking services is assessed for both mental health and substance use disorder needs; 2) develop the ability of the provider network to treat co-occurring disorders; 3) establish and measure outcomes for individuals with co-occurring mental health and substance use disorders as well as single illnesses with recovery as the goal; 4) consolidate and enhance provider monitoring to ensure high quality service; and 5) establish a single credentialing process for both mental health and substance use disorder providers. DBH serves as the State Mental Health Authority and the Single State Authority for substance abuse.

OVERVIEW – AGENCY PERFORMANCE

The following section provides a summary of DBH performance in FY 2015 by listing DBH's top three accomplishments, and a summary of its progress achieving its initiatives and progress on key performance indicators.

TOP THREE ACCOMPLISHMENTS

The top three accomplishments of DBH in FY 2015 are as follows:

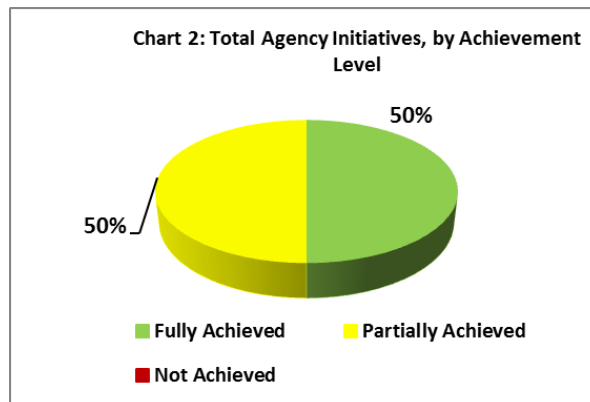
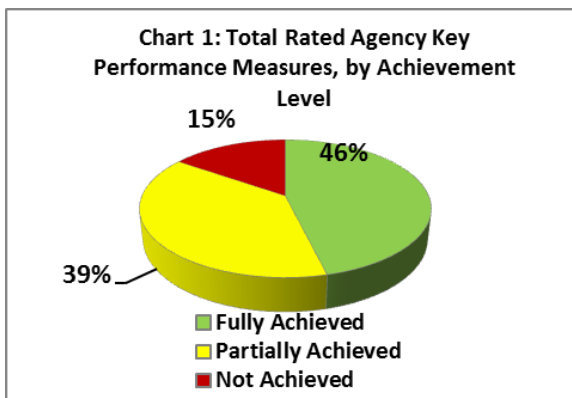
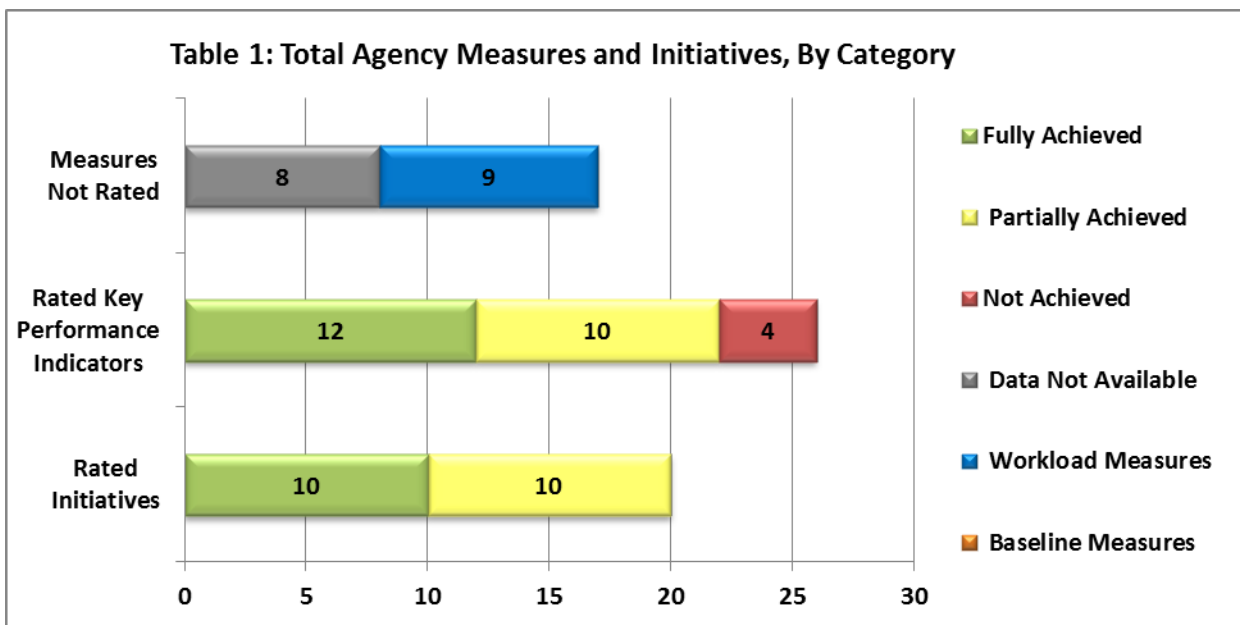
- ✓ In FY 2015, DBH fully implemented its new integrated care applications management system (iCAMS) with the Mental Health Rehabilitation Services (MHRS) providers.
- ✓ In March 2015, Wayne Place transitional housing opened in Ward 8 for young adults ages 18-23 1/2. This DBH and Child and Family Services Agency partnership provides 40 beds where young adults can remain up to 18 months, while receiving mental health and substance use treatment, employment assistance and sustainable housing.



- ✓ In FY 2015, DBH received a \$10 million 5-year federal Strategic Prevention Framework Partnerships for Success award to reduce underage drinking and underage marijuana use in high need communities and to address disparities. DBH has expanded DC Prevention Center grants to add a Partnership for Success coordinator and issued a Request for Applications to fund up to 8 High Need Communities Grants in FY 2016.

SUMMARY OF PROGRESS TOWARD COMPLETING FY 2015 INITIATIVES AND PROGRESS ON KEY PERFORMANCE INDICATORS

Table 1 (see below) shows the overall progress the DBH made on completing its initiatives, and how overall progress is being made on achieving the agency’s objectives, as measured by their key performance indicators.





| Default KPI Rating: | |
|---------------------|--------------------|
| >= 100% | Fully Achieved |
| 75 - 99.99% | Partially Achieved |
| < 75% | Not Achieved |

In FY 2015 DBH fully achieved half of its initiatives (while cumulatively partially and fully achieving 100% of their total initiatives) and 46% of its rated key performance measures were fully achieved (85% cumulatively partially/fully achieved). **Table 1** provides a breakdown of the total number of performance metrics DBH uses, including key performance indicators and workload measures, initiatives, and whether or not some of those items were achieved, partially achieved or not achieved. **Chart 1** displays that overall progress is being made on achieving DBH’s objectives, as measured by their rated key performance indicators. Please note that **Chart 2** contains only rated performance measures. Rated performance measures do not include measures where data is not available, workload measures or baseline measures. **Chart 2** displays the overall progress DBH made on completing its initiatives, by level of achievement.

The next sections provide greater detail on the specific metrics and initiatives for DBH in FY 2015.

PERFORMANCE INITIATIVES – ASSESSMENT DETAILS

Behavioral Health Authority

OBJECTIVE 1: Expand the range of behavioral health services.

INITIATIVE 1.1: Establish Health Homes.

Health Homes are a new service delivery framework that provides care coordination for consumers with serious mental illness, or serious mental illness with a chronic physical illness or at risk of developing a chronic physical illness. DBH in partnership with the Department of Health Care Finance (DHCF) is in the process of creating Health Homes, a system by which mental health providers will offer case management and care coordination to consumers with mental illness and a chronic physical health conditions or those likely to develop chronic conditions. Use of the new data management system, iCAMS, implemented in September 2014, will allow better coordination of care with primary health care providers. Provider input into the proposed system has necessitated some further refinement of the proposed State Plan Amendment (SPA) which delayed the original implementation date for Health Homes. **Completion Date: September, 2015.**

- **Performance Assessment Key: Partially Achieved.** DBH continues its partnership with DHCF to create Health Homes. The primary goals include: 1) improve care coordination; 2) prevent avoidable hospital and emergency room visits; 3) improve the overall health status of persons



with serious mental illnesses; and 4) reduce health care costs. At the end of July 2015, DBH announced a Request for Applications to provide infrastructure development assistance to DBH certified core services agencies (CSAs) to hire and train Health Home staff (Director, Nurse Care Manager and Primary Care Liaison) by November 15, 2015. All 14 applicants were recommended for funding. The State Plan Amendment (SPA) was approved by the Centers for Medicare and Medicaid Services (CMS) on September 2, 2015. Following a start-up phase that includes staffing and training, implementation of Health Homes is scheduled to begin in January 2016 with full implementation by September 2016.

INITIATIVE 1.2: Implement a Behavioral Health Council.

During FY14, DBH continued the process of developing a Behavioral Health Council (BHC). This involves: 1) combining the two (2) existing mental health councils (D. C. State Mental Health Planning Council (DC SMHPC), a mayoral board and commission and the DBH Partnership Council reporting to the DBH Director); and 2) adding other stakeholder representation to represent the substance use disorder system and clients. The DBH and DC SMHPC application was approved for participation in the National Learning Community Technical assistance (TA) to States. The activities included: 1) monthly participation on the national calls and monthly calls with the consultant; 2) a daylong on-site TA meeting that included mental health and substance abuse consumers/clients, child and adult family members, providers, and others that focused on mental health and substance use disorder services (e.g., prevention, treatment, advocacy organizations); and 3) follow-up planning meetings with the BHC Advisory Committee to develop a work plan and member recruitment strategy. It is anticipated that the inaugural meeting of the BHC will occur during the first quarter of FY15 and begin the process of developing into a fully functioning Council. **Completion Date: September, 2015.**

● **Performance Assessment Key: Fully Achieved.** The process to transition from the DBH mental health councils (DC State Mental Health Planning Council and the DBH Partnership Council) to a behavioral health council was ongoing from FY 2013-FY 2015. It involved technical assistance through the Substance Abuse and Mental Health Services Administration planning councils contractor on the new roles and functions, bylaws, work plan development, participation in state and District conference calls, and on-site technical assistance meetings.

In FY 2015, the DBH Behavioral Health Council (BHC) members were appointed by the DBH Interim Director. The DBH BHC orientation meeting was held in August and included District agencies, consumers/clients, family members, advocates, community organizations, the new DBH Acting Director, Dr. Tanya A. Royster, M.D., DBH grant program staff, and the co-facilitators. The meeting was followed by a conference call to review the next steps including the BHC input to the District FY 2016-2017 Mental Health Block Grant (MHBG) Application, and the election of officers. The DBH BHC input to the MHBG focused on adult and child service system strengths, unmet service needs or critical gaps, and other performance



indicators the BHC would like DBH to consider in the future. The BHC elected officers on September 2, 2015 that included a Chair, Vice- Chair and Secretary.

OBJECTIVE 2: Increase access to behavioral health services.

INITIATIVE 2.1: Increase number of intake points for substance use disorder services.

There are currently four (4) intake points to the substance use disorder services: the Assessment and Referral Center (ARC) co-located at APRA; the Court Urgent Care Clinic (CUCC); and the two (2) hospitals contracted for detoxification services: the Psychiatric Institute of Washington (PIW) and Providence Hospital – Seton House. In order to increase access to substance use disorder services and facilitate continuity of care, DBH has initiated a program to expand access points to its Comprehensive Psychiatric Emergency Program; Saint Elizabeths Hospital; and the four (4) contracted acute-care psychiatric hospitals. Training and orientation to the required electronic system DATA has already begun, and a pilot program is underway. **Completion Date: January, 2015.**

- **Performance Assessment Key: Fully Achieved.** During FY 2015, DBH increased the number of primary behavioral health services intake points from 4 to 9. They include: 1) DBH operated programs (3) - the Assessment and Referral Center (The ARC), Comprehensive Psychiatric Emergency Program (CPEP), and Saint Elizabeths Hospital (SEH); 2) DBH contracted program (1)- Court Urgent Care Clinic; 3) Acute psychiatric hospitals (3) - Providence Hospital-Seton House, Psychiatric Institute of Washington, and Washington Hospital Center; and 4) substance use disorder contractors (2)- Community Connections and Family and Medical Counseling Services, Inc.

INITIATIVE 2:2 Expand access to mental health services in schools and early childhood.

During School Year 13-14, the DBH School Mental Health Program (SMHP) continued to provide services to 52 schools (40 D.C. Public Schools and 12 Public Charter Schools). The focus was on: 1) identifying and prioritizing placement at both the District Public and Charter expansion schools; and 2) hiring staff to backfill current vacancies and staff that will be placed in the expansion schools. Also, the Primary Project, pre-Kindergarten through second-grade, expanded from 35 to 40 sites (23 schools and 17 child development centers). During FY15, the SMHP will continue to hire staff to increase to 71 schools and a total of 54 Primary Project sites. **Completion Date: September, 2015.**

- **Performance Assessment Key: Partially Achieved.** During School Year 2014-2015, the DBH School Mental Health Program (SMHP) expanded to 65 schools. This included 45 D.C. Public Schools and 20 Public Charter Schools. This represents 93% of the projected target to operate in 70 schools. The primary focus was on: 1) identifying and prioritizing placement at both the District Public and Public Charter expansion schools; and 2) hiring staff to backfill current vacancies and staff that would be placed in the expansion schools.



- **Performance Assessment Key: Partially Achieved.** The Primary Project, pre-Kindergarten through second-grade, expanded to 45 sites (28 schools and 17 child development centers). This represents 83% of the projected target to operate in 54 sites. The Primary Project statistics include: 1) 4,775 children were screened by teachers using the Teacher-Child Rating Scale; 2) 2,456 children screened positive for needing more intensive mental health intervention; 3) 1,067 children screened positive for early intervention/prevention services (Primary Project); 4) 441 children received Primary Project services; and 5) 292 End-of-Year Conferences were held with parents/guardians of participating children.

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

INITIATIVE 3.1: Develop an assertive community treatment scorecard.

Assertive Community Treatment (ACT) is an evidence-based practice for the mental health consumers with the highest need for services to enable them to continue to live in the community. In FY14, DBH developed an ACT-specific Quality Review tool that will be used in conjunction with the fidelity assessments to produce the ACT Scorecard. The ACT Quality Review tool has been disseminated to the providers and after provider input will be finalized. In FY15, this tool will be used to assess each ACT provider and combined with the fidelity assessment, used to allow a full picture of ACT providers. Full implementation of the ACT Scorecard will occur in FY15. **Completion Date: September, 2015.**

- **Performance Assessment Key: Partially Achieved.** The process to develop an assertive community treatment (ACT) scorecard began in FY 2013 and continued during FY 2014. The activities during this period included data gathering by reviewing qualitative and quantitative information and data sources, and the development of the Draft ACT Quality Review Tool. In FY 2015, beginning in the second quarter the integration of the ACT data into the DBH Provider Scorecard was explored as a pilot study. Since the Provider Scorecard data reports information from the previous fiscal year, the results of the ACT pilot study will be published in the FY 2015 Provider Scorecard during FY 2016.

INITIATIVE 3.2: Develop DBH Provider Scorecard.

The Department of Behavioral Health (DBH) has published a Provider Scorecard for its mental health providers for the last three (3) years. FY14 activities of Mental Health Rehabilitation Services (MHRS) providers will continue to be rated using the DBH Provider Scorecard. Our target for quality and financial performance on the FY 2014 Scorecard, reported in FY 2015, is 85%. During FY15 we will work to expand the Scorecard to capture the quality of specialty services. DBH will also develop a new Provider Scorecard for both mental health and substance use disorder treatment providers, using newly published certification standards for substance use disorder providers. The new provider scorecard will be implemented in FY16. **Completion Date: September, 2015.**



- **Performance Assessment Key: Partially Achieved.** The FY 2014 Mental Health Rehabilitation Services Provider Scorecard results were developed in FY 2015. The quality score (adult and child) achievement level is 84.39%, which represents 99.28% of the 85% target. The quality scores for each of the 23 mental health services providers are posted on the DBH website.
- **Performance Assessment Key: Partially Achieved.** The financial score achievement level is 74.35%, which represents 87.47% of the 85% target. The financial scores for each of the 23 mental health services providers are also posted on the DBH website.

OBJECTIVE 4: Ensure system accountability to support behavioral health services.

INITIATIVE 4.1: Institutionalize Community Services Reviews.

Community Service Reviews (CSRs) were required by the Dixon class action lawsuit and resulting Settlement Agreement. As of 2013, DBH is solely responsible for coordinating and conducting CSRs. In FY14, DBH was able to conduct system wide CSRs on a sample of adult consumers in addition to conducting a targeted review for child/youth. The CSR protocols for child/youth and adults has been refined to include mental health, substance use disorder, physical health, and family resourcefulness system evaluations; to reflect the current language in practice and transition to the DBH. In FY15, DBH will: 1) assess the child/youth system throughout the year; 2) conduct a focused review for the adult system; 3) continue to include a select number of child/ youth agencies who provide substance abuse treatment in the system wide assessment, and 4) conduct a focus group or survey to assess the practice expectations for substance use providers. Once the CSR Unit is able to access what practice expectations are for substance use providers, the CSR Unit will work to educate providers on practice expectations. **Completion Date: September, 2015.**

- **Performance Assessment Key: Partially Achieved.** In FY 2015, DBH completed most of the activities related to this initiative. The child system CSR was conducted. A total of 85 cases were reviewed with 80 completed by DBH staff, two (2) jointly completed by DBH and Child and Family Services Agency (CFSA) staff, and three (3) completed by CFSA. A new protocol was introduced jointly developed with CFSA. It is based on current best-practice models and defines quality in a more stringent manner. The CSR unit also completed a focused review of older adults (65 years and older) receiving day rehabilitative treatment between July 20-30, 2015 that consisted of 12 cases.

In FY 2015, DBH continued to include child/ youth substance use disorder (SUD) treatment agencies in the system-wide assessment. Fourteen (14) of the 85 cases reviewed in the Child CSR were youth with co-occurring SUDs. Also, a work group to plan qualitative evaluations of SUD treatment services met multiple times. The meetings focused on educating the leadership and quality assurance staff in the SUD Treatment Division (formerly APRA) about



the CSR process and protocols, and discussions about best practice models and defining the practice model for DBH SUD treatment services. DBH will continue to work on delivering common practice expectations for the behavioral health system providers.

INITIATIVE 4.2: Expand the integrated care management application.

Implementation of the new Integrated Care Applications Management System (iCAMS) is continuing with initial phase of MHRS clinical and billing components beginning September 7, 2014. Completion of Phase I to include global eligibility verification, claims adjudication and benefit structure will occur on October 26, 2014. The care management system will replace e-Cura and Anasazi, as well as the Office of Consumer and Family Affairs grievance database and some of the Office of Accountability databases. iCAMS will also be able to interface with the DATA WITS systems used by the substance abuse providers. Phase II beginning April 1, 2015 will allow full implementation of the new Health Homes initiative. Integration of the ASARS program is to be determined. **Completion date: September, 2015.**

- **Performance Assessment Key: Fully Achieved.** In October 2014, DBH began a pilot program with DBH providers as a beta site. In January 2015, iCAMS was introduced as a pilot program to one external provider (Green Door). After a successful testing period in which minor problems were corrected, iCAMS was implemented in February 2015 by the remaining MHRS providers. iCAMS is now being expanded to substance use providers certified under the new 22 DCMR A63 regulations. DBH will implement the Health Home program on iCAMS in January 2016.

OBJECTIVE 5: Oversee the implementation of agency-wide priorities.

INITIATIVE 5.1: Conduct agency sustainability assessment using OCA approved criteria developed by DDOE and OP in accordance with Mayor’s Order 2013-209 (Sustainable DC Governance Goal 1, Action 1.2; Built Environment Goal 3)

Within one hundred twenty (120) days after the City Administrator approves sustainability assessment criteria developed jointly by the District Department of the Environment and the Office of Planning, each agency head subject to the authority of the mayor shall use the criteria to evaluate the sustainability of their respective operations in accordance with the requirements of Mayor’s Order 2013-209, the Sustainable DC Transformation Order, and submit to his or her responsible Deputy Mayor and the Office of the City Administrator the results of the agency’s internal assessment. **Completion Date: April 2015**

- **Performance Assessment Key: Fully Achieved.** During FY 2015, the DBH Chief of Administrative Operations submitted the required information via the data collection format provided as instructed.



KEY PERFORMANCE INDICATORS- Behavioral Health Authority

| | KPI | Measure | FY 2014 YE Actual | FY 2015 YE Target | FY 2015 YE Revised Target | FY 2015 YE Actual | FY 2015 YE Rating | Budget Program |
|---|-----|--|-------------------------|-------------------------|------------------------------------|-------------------------|-------------------------|-----------------------------|
| ● | 1.1 | Number of introduction to co-occurring treatment and DBH services classes | 17 | 10 | 10 | 9 | 90% | Behavioral Health Authority |
| ● | 2.1 | Increase the number of School Mental Health Programs | 62 | 72 | 72 | 65 | 90.28% | Behavioral Health Authority |
| ● | 2.2 | Increase the number of early childhood services locations – Primary Project | 44 | 54 | 54 | 45 | 83.33% | Behavioral Health Authority |
| ● | 3.1 | Provider Scorecard –mental health providers’ average quality (adult and child) score | 92% | 85% | 85% | 84.39% | 99.28% | Behavioral Health Authority |
| ● | 3.2 | Provider Scorecard-providers’ average financial score | 76% | 85% | 85% | 74.35% | 87.47% | Behavioral Health Authority |
| ● | 4.1 | Adult Community Services Review (CSR) system score | 84% | Not Applicable | Not Applicable | Not Applicable | Not Applicable | Behavioral Health Authority |
| ● | 4.2 | Child Community Services Review (CSR) system score | Not Applicable | 73% | Not Applicable | 49.41% | 67.69% | Behavioral Health Authority |

Addiction Prevention and Recovery Administration

OBJECTIVE 1: Reduce priority risk factors that place District children, youth, families, and communities at risk of substance use and interrelated problems.

INITIATIVE 1.1: Promote safe and healthy children, youths, families, and communities through implementation of prevention strategies.



DBH funds DC Prevention Centers (DCPCs) designed to strengthen the community's capacity to reduce substance use and prevent risk factors. The centers work with the community to implement best practices and connect community resources. All four (4) centers provide a consistent prevention strategy across the District but also have the flexibility to address the unique characteristics and priorities of the geographic area and populations served in their designated wards. The DCPCs also collect data to determine annual progress toward identified prevention outcomes and implement quality improvement activities. By September 30, 2015, the prevention centers are expected to increase the number of youth and adults reached through their planned prevention strategies by 10 percent (10%). **Completion Date: September, 2015.**

- **Performance Assessment Key: Fully Achieved.** Substance use disorder prevention services are primarily funded through the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) that focuses on primary prevention or whole populations. The SAPTBG supports a sustainable community prevention infrastructure and DBH grants to four (4) DC Prevention Centers (DCPCs). The DCPCs continued to expand their ability to develop and implement planned preventive interventions through 53 Community Prevention Networks (CPNs). In FY 2015, an independent federal technical assistance project highlighted the value of this approach for an urban area with culturally diverse populations. The CPNs receive training in a 5-step Strategic Prevention Framework planning process and produce outcome-based action plans. The Prevention Centers exceeded the 10% projected increase in the number of youth and adults through planned prevention strategies with 18,896 for adults and 19,299 for youth.

As part of the federal SAPTBG requirements, DBH supports initiatives to enforce underage tobacco laws and to reduce underage tobacco use. DBH prevention staff conducts a random sample of unannounced tobacco compliance checks annually in cooperation with the Metropolitan Police Department and a youth serving organization. In 2015, DBH conducted 433 unannounced inspections to tobacco licensees. A total of 4.3% of the vendors sold tobacco products to underage youth, an all-time low rate in the District. States and the District have severe financial penalties if more than 20% of licensees in the random sample sell to youth. New Merchant Education materials were also developed in FY 2015 and are being disseminated through DBH staff and DCPCs.

INITIATIVE 1.2: Prevent the onset of and delay the progression of substance use in youth ages 8-18 through implementation of culturally sensitive prevention best policies, programs, and practices.

National prevention policy and research indicates there is a period of increased risk for development of substance use disorders. People who do not develop a substance use problem by age 21 are unlikely to do so. The average age of onset of substance use in the District is before age 13. District youth who use alcohol, tobacco and other drugs (ATOD) before age 13 are more likely to become involved in other risk behaviors such as increased



drug use, physical fights, sexual activity, and carrying a weapon. Therefore, the introduction of prevention interventions must begin at early ages and be integrated into partnerships within DBH and other District agency partners. By September 30, 2015, DBH will provide 100 hours of technical assistance to relevant community stakeholders on using established prevention strategies to reduce and delay the first use of ATOD. **Completion Date: September, 2015.**

● **Performance Assessment Key: Fully Achieved.** To reverse the escalating trends of District youth using alcohol, tobacco and other drugs (ATOD) at earlier ages (before age 13), DBH is collaborating with the Department of Health to develop a public education campaign, a requirement in Initiative 71. The target audiences are District youth 10-17 and young adults 18-25. The goals are to: 1) educate youth and young adults about the harms of marijuana use; 2) increase awareness of the District's marijuana laws related to public health and safety including what is legal and illegal; and 3) connect residents to DBH prevention, treatment and recovery services. The FY 2015 total number of encounters was 1,865.5.

Also, in FY 2015 DBH received a \$10 million, 5-year federal grant, Strategic Prevention Framework Partnerships for Success to reduce underage drinking and underage marijuana use in high need communities and to address disparities. DBH determined that all 8 Wards are at risk and a comprehensive strategy is required to achieve outcomes. The award is based on the premise that changes at the community level will, over time, lead to measurable changes at the District level. By working together to foster change, states and targeted communities of high need can more effectively begin to overcome the challenges underlying their substance use prevention priorities.

DBH has expanded DC Prevention Center grants to add a Partnership for Success coordinator and issued a Request for Applications to fund up to 8 High Need Communities Grants in FY 2016. The coordinators will support a strategic planning process and funds from the High Need Grants will be used to implement the action plans. Continuation of an Epidemiological Outcomes Workgroup, an Evidence-Based Workgroup and a Prevention Partnership Council are also required. An external evaluator is tracking and documenting results at the District and high need community levels.

OBJECTIVE 2: Promote long-term recovery from substance use disorder through maintenance of a comprehensive continuum of accessible substance abuse treatment and recovery support services.

INITIATIVE 2.1: Promote sobriety by linking residents to clinically appropriate substance abuse treatment and recovery support services.

Clients will be treated within a more integrated system of care reflecting the newly implemented Adult Substance Abuse Rehabilitation Services (ASARS) benefit under Medicaid, improved collaboration with the Medicaid Managed Care Organizations (MCOs) and improved capacity to recognize and address co-occurring mental illness vis-à-vis the merger with the former



Department of Mental Health. APRA has built the infrastructure through its electronic health record by which clients may advance through the levels of care until they successfully complete treatment. Clients initially receiving services at an intensive level of care (e.g. inpatient detoxification or residential treatment) will be referred to lower levels of care upon completion to cement, and build upon, the clinical gains made at the intensive levels. By September 30, 2015, APRA will continue to maintain its percentage of clients that successfully complete treatment, which is above the national standard.

In APRA's adolescent system, the completion rate for individuals receiving treatment falls below the national average of 36 percent. Thus in an effort to raise the completion rate for individuals in care, APRA is working in collaboration with CFSA and created a seamless referral process using the Districts Automated Treatment Accounting System (DATA). APRA and CFSA implemented a Memorandum of Understanding (MOU) which utilizes a mobile assessor to meet and engage clients at home, work, or school. APRA is also working with DYRS to create and implement a similar MOU arrangement. In addition, APRA recently implemented a new Evidenced Based Practice (EBP) called the Adolescent- Community Reinforcement Approach (A-CRA). APRA has engaged the Adolescent Substance Abuse Treatment Expansion Programs (ASTEP) to implement this EBP throughout the District. To date, there are over 45 adolescents and their families which are receiving services under this EBP. In addition, APRA provided SBIRT, motivational interviewing, and other trainings to select CFSA staff with the intent to maintain the appropriate resources to keep adolescents engaged throughout their treatment episode. APRA anticipates an increase in the completion rate during FY 2015. **Completion Date: September, 2015.**

- **Performance Assessment Key: Fully Achieved.** All DBH certified treatment providers are required to link clients to continuing care and recovery services. The engagement process includes ongoing assessment at specific intervals. The District's continuum of care includes Withdrawal Management Care, Residential Treatment, Intensive Outpatient Programs, Outpatient Programs, and Recovery Support Services. Following the initial assessment providers reassess client addiction impact severity and continued risk factors. Based on assessment, they are linked with continuing care and recovery services. During the FY 2015 fourth quarter, there was a 17% increase in successful completions for adults and 4% increase for adolescents and young adults. This increase in part is due to linkages to continued care and recovery supports. Continued Care Services may include case management, care coordination, request for reauthorizations, and reassessments at specific intervals. Recovery Support Services may include peer mentoring, recovery coaching, and other supportive services that contribute to keeping clients engaged in treatment and sobriety after completing treatment services. During FY 2015, 2,000 clients received these services. Essentially, keeping clients involved in treatment and recovery services is the key to successful treatment completions. Thus, the supportive services offered to clients in treatment and recovery services increase the likelihood that they will complete treatment by minimizing associated risk factors and barriers to sobriety.



KEY PERFORMANCE INDICATORS- Addiction Prevention and Recovery Administration

| | KPI | Measure | FY 2014 YE Actual | FY 2015 YE Target | FY 2015 YE Revised Target | FY 2015 YE Actual | FY 2015 YE Rating | Budget Program |
|--|-----|---|-------------------------|-------------------------|------------------------------------|-------------------------|-------------------------|--|
| | 2.1 | Number of adults reached through planned prevention strategies | 15,487 | 9,250 | 9,133 | 12,519 | 137.07 | Addiction Prevention and Recovery Administration |
| | 2.2 | Number of youth reached through planned prevention strategies | 17,022 | 7,920 | 10,318 | 11,770 | 114.07 | Addiction Prevention and Recovery Administration |
| | 2.3 | Number of technical assistance encounters provided to prevention stakeholders | Not Applicable | 100 | 100 | 1,896.5 | 1896.5 | Addiction Prevention and Recovery Administration |
| | 2.4 | Percent of adults that successfully complete treatment | 61.3% | 60% | 60% | 46.97% | 78.28 | Addiction Prevention and Recovery Administration |
| | 2.5 | Percent of youth that successfully complete treatment | 10.6% | 25% | 20% | 13.35% | 66.76% | Addiction Prevention and Recovery Administration |
| | 2.6 | Number of clients who receive Recovery Support Services | Not Applicable | Not Applicable | 2,000 | 6,192 | 309.6 | Addiction Prevention and Recovery Administration |



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

INITIATIVE 1: Reduce weight gain and obesity levels of individuals in care.

Individuals in a psychiatric treatment setting are at higher risk of weight gain and becoming obese due to side effects of many psychiatric medications. According to the SEH's recent Trend Analysis report, the average percentage of weight gain reached 9% by 120 days of admission and the percentage of individuals in care with obesity (BMI \geq 30) was 42% as of September 30, 2013. For FY 15, Saint Elizabeths will reduce the average weight gain during the 1st 120 days of hospitalization to below 7% and the percentage of individuals with obesity (BMI \geq 30) to below 40%. **Completion date: September, 2015.**

- **Performance Assessment Key: Fully Achieved.** The target was to reduce the percentage of individuals with obesity to below 40% and it was reduced to 33% by the end of FY 2015. This is the lowest level since the Hospital measured the obesity rate. In recent years the reduction of obesity amongst individuals in care at the Hospital has been a major interest and there has been gradual and consistent progress in FY 2015. At the beginning of FY 2015, it was chosen as one of the Certified Public Manager (CPM) six (6) sigma training projects supported by *the Center for Excellence in Public Leadership from the George Washington University* as well as inclusion in the DBH performance plan. The project team formed a work group composed of staff from multiple disciplines and treatment teams, facilitating focus groups, conducting a variety of data analyses, and implementing a pilot project to encourage healthy food consumption and physical activities among individuals in care. The team also routinely monitored documentation of weight and height measures, missing or outdated nutrition screenings, and any discrepancies between (Body Mass Index – BMI calculated based on weight and height) and obesity diagnosis in the electronic medical record system (documented by physician). Findings were shared among both leadership and line staff, increasing the awareness of the obesity issue across the Hospital. As a result, progress was demonstrated in every area: the percentage of missing/outdated documentation of weight and height measures decreased from 32% and 21%, respectively, in March to 21% and 11%; in August 2015 the percentage of individuals with missing/outdated nutrition screenings declined from 22% in March to 1% in August. The percentage of individuals in care with obesity (defined based on BMI \geq 30) who have accurate obesity diagnosis updated in medical record system increased to 60% as of September 2015.

INITIATIVE 2: Increase documented justification for individuals on more than one anti-psychotic medication.

According to the CMS Quality Data Report, 23% of individuals discharged during the 1st half of FY13 were prescribed with more than one anti-psychotic medication, and only 5% of those had appropriate justification for when more than one antipsychotic medication was



prescribed documented in their records. For FY 15, Saint Elizabeths will increase the percentage of records containing appropriate documentation on justification (rationale) for individuals prescribed with more than one anti-psychotic medication to 40%. **Completion date: September, 2015.**



Performance Assessment Key: Fully Achieved. The target was to increase documentation justifying discharging individuals with more than one anti-psychotic medication to 40% by September 2015. This goal was exceeded as the appropriate documentation justification achievement level was 44%. The FY 2015 level is an increase of 30% over the FY 2014 level of 14%.

Beginning in FY 2015, the Office of Quality and Data Management worked with the Department of Psychiatry and the Avatar (medical records billing system) development team to revise the discharge plan of care to better document anti-psychotic medications as well as initiated dialogue with physicians regarding poly-pharmacy. The revised discharge plan of care mandates documentation of justification when two or more anti-psychotic medications are prescribed was implemented in June 2015. As a result, the rate of appropriate documentation justification increased significantly in FY 2015. During the fiscal year, there were 384 individuals with at least one anti-psychotic medication prescribed at discharge and of those 78 or 20% had two or more anti-psychotic medications prescribed. Of those 78, 34 or 44% had appropriate justification for multiple anti-psychotic medications. It is expected the Hospital will make further progress in FY 2016.



KEY PERFORMANCE INDICATORS-Saint Elizabeths Hospital

| | KPI | Measure | FY 2014 YE Actual | FY 2015 YE Target | FY 2015 YE Revised Target | FY 2015 YE Actual | FY 2015 YE Rating | Budget Program |
|--|-----|--|-------------------------|-------------------------|------------------------------------|-----------------------------|-------------------------|---------------------------|
| | 1.1 | Percent of discharges with ≥ 2 anti-psychotic medications | 15% | 20% | 20% | 20.31% | 98.46% | Saint Elizabeths Hospital |
| | 1.2 | Percent of discharges with appropriate justification documented when discharged with ≥2 anti-psychotic medications | 14% | 40% | 40% | 43.59% | 108.97% | Saint Elizabeths Hospital |
| | 1.3 | Percent of nursing staff with competency-based recovery model training | 90% | 95% | 95% | Not Applicable ¹ | Not Applicable | Saint Elizabeths Hospital |
| | 1.4 | Percent of clinical staff with competency-based recovery model training | 100% | 85% | 85% | Not Applicable ² | Not Applicable | Saint Elizabeths Hospital |
| | 1.5 | Total patients served per day | 283 | 275 | 275 | 275 | 100% | Saint Elizabeths Hospital |
| | 1.6 | Eloperments per 1,000 patient days | 0.09 | 0.28 | 0.10 | 0.03 | 329.43% | Saint Elizabeths Hospital |
| | 1.7 | Major Patient injuries per 1,000 patient days | 0.34 | 0.25 | 0.30 | 0.16 | 185.31% | Saint Elizabeths Hospital |
| | 1.8 | Percent of missing documentation of | 0.61% | 0.25% | 0.50% | 0.65% | 76.79% | Saint Elizabeths |

¹ Part of FY14 initiatives and was accomplished. The Hospital no longer tracks this data.

² Ibid



| | | | | | | | | |
|---|------|--|-------|-------|-------|-------|--------|---------------------------|
| | | medication administration results | | | | | | Hospital |
| ● | 1.9 | Percent of unique patients who were restrained at least once during month | 0.44% | 0.10% | 0.10% | 0.99% | 10.06% | Saint Elizabeths Hospital |
| ● | 1.10 | Percent of unique patients who were secluded at least once during month | 2.12% | 0.10% | 0.10% | 3.3% | 3.03% | Saint Elizabeths Hospital |
| ● | 1.11 | Percent of patients re-admitted to Saint Elizabeths Hospital within 30 days of discharge | 2.03% | 5.80% | 7.00% | 6.03% | 116% | Saint Elizabeths Hospital |

Behavioral Health Services and Supports

OBJECTIVE 1: Expand the range of behavioral health services.

INITIATIVE 1.1: Increase the number of certified Peer Specialists.

In June 2014, DBH admitted 28 individuals into the Peer Specialist Certification Training (PSCT). Eight (8) of these individuals were also the first participants of the Family Peer Specialist program for families of child and youth consumers (the Child/Youth/Family Specialty Track). DBH also accepted eight (8) individuals into the Peer Specialist Certification Waiver Program. In FY 2015, due to the high demand for Peer Specialists, DBH will hold two (2) PSCT classes, one (1) in January and one (1) in June. DBH anticipates increasing the number of Certified Peer Specialist by at least 60 for FY 2015. DBH will also begin development of the curriculum for Recovery and Youth Peer Specialists, with the first classes planned to occur in FY 2016. **Completion Date: September, 2015.**

- **Performance Assessment Key: Fully Achieved.** The DBH's target to increase the Certified Peer Specialists to at least 60 was met. This was achieved across three (3) certification trainings held in January, June and September 2015. These trainings included the Core Curriculum Peer Certification Training and the Family Member Certification training. During FY 2015, a total of 45 Peer Certification training participants completed the course and graduated. Also, 15 Family Member Certification training participants completed the course and graduated, bringing the total to 60.



INITIATIVE 1.2: Introduce a new Evidence-Based Practice for youth with substance use disorders.

In FY 2013, APRA (then under the Department of Health) received a federal grant to introduce the Adolescent Community Reinforcement Approach (ACRA) to youth with substance use disorders. ACRA, an evidence-based practice, is a therapy for adolescents and transitional aged youth between the ages of 12-21 with co-occurring mental health and substance use. The ACRA model also includes the caregivers and community participation in sessions. DBH has awarded sub-grants to three (3) of the four (4) certified ASTEP providers and conducted training so that these providers can start ACRA treatment for appropriate youth. In FY 15, DBH will ensure that all four (4) ASTEP providers are able to provide ACRA to youth ages 12-18 and trained to start providing ACRA to transition age youth ages 18-24 in FY 16.

Completion Date: September, 2015.

- **Performance Assessment Key: Partially Achieved.** DBH ensured that all four (4) ASTEP providers were able to provide the specialty service ACRA. However, due to staff turnover and challenges at one of the ASTEP sites, there are only three (3) providers that are currently providing this service. DBH is working with the provider as well as our workforce development team to offer technical assistance to overcome the presented challenges. With regard to the age of the participating adolescents and transitional aged youth, DBH currently provides services to youth ages 12-20. The Department has initiated a planning process to increase the services to individuals up to the age of 24.

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

INITIATIVE 3.1: Implement the Child and Adolescent Functional Assessment Scale (CAFAS) at all child providers within the DBH network and most child-serving agencies in the District.

By September 30, 2015, DBH will ensure all child and youth providers within the DBH network have been trained on and are using the CAFAS/PECFAS. Required use of the CAFAS/PECFAS begins on September 7, 2014 with the simultaneous advent of iCAMS, the new data management system for DBH. A single functional assessment tool used by child and youth provider agencies will allow DBH and the providers to develop more individualized treatment plans focused on identified areas of need, and allow them to assess whether the child or youth demonstrates improved daily functioning associated with the implementation of services. Use of CAFAS/PECFAS will also allow DBH to assess the efficacy of specific interventions and different providers so that if a child or youth is not making progress, the providers will be able to identify how the treatment plan should be modified to better serve the person. In June 2014, the Department of Youth Rehabilitation Services and the Department of Human Services (Parent and Adolescent Support Services (PASS) began implementation of the CAFAS. In January 2015, the Child and Family Services Agency will begin using the CAFAS/PECFAS. A data sharing system is being developed between these agencies allowing the different agencies serving one child to utilize each other's assessments,



which will in turn enhance integration and continuity of care. **Completion Date: September, 2015.**

- **Performance Assessment Key: Fully Achieved.** All DBH providers began using the CAFAS on November 1, 2014. iCAMS was initiated in February 2015 and the CAFAS score is imported into iCAMS. CFSA implemented the CAFAS for both the out-of-home (foster care) and in-home youth served by CFSA and their private agencies on July 1, 2015. Thus, the CAFAS has been implemented at most child serving agencies including DBH, DYRS, CFSA, and DHS (PASS and ACE). The data sharing system is still under development. At present, all agencies collaborate in the completion of the CAFAS and the sharing of the CAFAS report on a case by case basis when a child is served by more than one agency. This is supported through the DBH Teaming policy. Development of a more automated data sharing process is under development.

INITIATIVE 3.2: Implement a tiered licensure and reimbursement system for Mental Health Community Residence Facilities (MHCRFs).

MHCRFs are homes for those mental health consumers who are unable to live independently due to their mental health needs. A tiered licensure and reimbursement system will ensure that residents in the MHCRFs receive the mental health supports needed for successful community living, and will also ensure the MHCRF providers have the resources needed to sustain the homes. In FY 14 DBH conducted a rate review to determine appropriate reimbursement rates; these rates and the tiered licensure will be fully implemented in FY 15. **Completion Date: September, 2015.**

- **Performance Assessment Key: Partially Achieved.** On October 1, 2014, DBH implemented a tiered licensure and rate structure for Mental Health Community Residence Facilities (MHCRFs). MHCRF operators were provided the opportunity to submit a proposal for contract award for Supportive Residence (SR) and Supportive Rehabilitative Residence (SRR) services. The rate structure included: 1) Supportive Residence (SR) - \$54.13 per day, 2) Supportive Rehabilitative Residence (SRR) - \$90.92 per day, and 3) Intensive Residence (IR) - \$130.89 per day. The results of the award process include 28 vendors awarded SR contracts and four (4) awarded SRR contracts. The Intensive Residence (IR) providers will be identified in FY 2016.

KEY PERFORMANCE INDICATORS- Behavioral Health Services and Supports

| | KPI | Measure | FY 2014 YE Actual | FY 2015 YE Target | FY 2015 YE Revised Target | FY 2015 YE Actual | FY 2015 YE Rating | Budget Program |
|--|-----|---------|-------------------------|-------------------------|------------------------------------|-------------------------|-------------------------|-------------------|
| | | | | | | | | |



| | | | | | | | | |
|---|-----|---|--------------------|-----|-----|---------------------------------|--------------------|---------------------------------------|
| ● | 1.1 | Number of certified Peer Specialists | Data Not Available | 30 | 60 | 60 | 100% | Behavioral Health Services & Supports |
| ● | 1.2 | Number of women served by Re-Entry Coordinator in Women's jail | Data Not Available | 75 | 75 | 284 | 378.67% | Behavioral Health Services & Supports |
| ● | 1.3 | Number of People in Mental Health First Aid Trainings | 1,041 | 500 | 500 | 1,134 | 226.8% | Behavioral Health Services & Supports |
| ○ | 2.1 | Percent of adults that receive at least one (1) non-crisis service in a non-emergency setting within 7 days of discharge from a psychiatric hospitalization | 58.10% | 70% | 70% | Data Not Available ³ | Data Not Available | Behavioral Health Services & Supports |
| ○ | 2.2 | Percent of children/youth that receive at least one (1) non-crisis service in a non-emergency setting within 7 days of discharge from a psychiatric hospitalization | 60.12% | 70% | 70% | Data Not Available ⁴ | Data Not Available | Behavioral Health Services & Supports |
| ○ | 2.3 | Percent of adults that receive at least one (1) non-crisis service in a non-emergency setting within 30 days of | 70.87% | 80% | 80% | Data Not Available ⁵ | Data Not Available | Behavioral Health Services & Supports |

³ Ibid.

⁴ Ibid

⁵ Ibid



| | | | | | | | | |
|---|-----|--|--------|-----|-----|---------------------------------|--------------------|---------------------------------------|
| | | discharge from a psychiatric hospitalization | | | | | | |
| ● | 2.4 | Percent of children/youth that receive at least one (1) non-crisis service in a non-emergency setting within 30 days of discharge from a psychiatric hospitalization | 74.85% | 80% | 80% | Data Not Available ⁶ | Data Not Available | Behavioral Health Services & Supports |

Behavioral Health Financing/Fee for Service

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

INITIATIVE 3.1: Begin Medicaid claiming for ASARS services.

Implementation of Medicaid billing for Adult Substance Abuse Rehabilitative Services (ASARS) was begun in FY13 through a partnership with the Department of Health Care Finance to amend the ASARS SPA and develop regulations that will allow implementation of Medicaid services and billing. The work continued through FY 2014. Submission of the amended SPA to CMS for approval should occur in early 2015 with the regulations finalized in time for Medicaid billing to begin in January 2015 DBH is working closely with the Department of Health Care Finance in the implementation of this initiative. **Completion Date: September, 2015.**

● **Performance Assessment Key: Partially Achieved.** The Centers for Medicare and Medicaid Services (CMS) approved the amended SPA in August 2015. The new certification regulations that implemented the SPA were finalized in September 2015 and Medicaid billing is expected to begin by December 1, 2015. DBH continues to work closely with the Department of Health Care Finance on the implementation of this initiative.

KEY PERFORMANCE INDICATORS- Behavioral Health Financing/Fee for Service

| | | | | | | | | |
|---|-----|---------|---------|---------|---------|---------|---------|----------------|
| ● | KPI | Measure | FY 2014 | FY 2015 | FY 2015 | FY 2015 | FY 2015 | Budget Program |
| ● | | | YE | YE | YE | YE | | |
| ● | | | Actual | Target | Revised | YE | YE | |

⁶ Ibid



| | | | | | Target | Actual | Rating | |
|---|------------|--|----------------|-----|---------------|-----------------------------|----------------|---------------------------------------|
| ● | 1.1 | Percent of clean claims adjudicated within 30 days of receipt | 99% | 97% | 97% | 96.96% | 99.96% | Behavioral Health/ Fee for Service |
| ● | 2.1 | Percent of District residents, accessing services through ASARS, screened for Medicaid eligibility within 90 days of the first date of service | Not Applicable | 50% | 50% | Not Applicable ⁷ | Not Applicable | Behavioral Health/ Fee for Service |

⁷ Ibid



WORKLOAD MEASURES – APPENDIX

WORKLOAD MEASURES ●

| Measure Name | FY 2013 YE Actual | FY 2014 YE Actual | FY 2015 YE Actual | Budget Program |
|--|-------------------|-------------------|-------------------|-------------------|
| Number of adult consumers served | 18,918 | 22,355 | 22,122 | Agency Management |
| Number of child and youth consumers served | 4,181 | 5,262 | 5,289 | Agency Management |
| Mental Health Services Division (MHSD) intake/Same Day Service Urgent Care Clinic – adults | 3,628 | 3,930 | 5,398 | Agency Management |
| MHSD intake/Same Day Service Urgent Care Clinic – child/youth | 327 | 272 | 248 | Agency Management |
| Number of Comprehensive Psychiatric Emergency Program (CPEP) visits | 3,961 | 3,765 | 3,802 | Agency Management |
| Number of adult mobile crisis team visits | 1,007 | 1,794 | 1,276 | Agency Management |
| Number of child mobile crisis team visits | 505 | 717 | 836 | Agency Management |
| Crisis stabilization bed utilization | 89.71% | 89.06% | 85.63% | Agency Management |
| Involuntary acute psychiatric adult admissions | 1,366 | 1,631 | 2,134 | Agency Management |