Department of Behavioral Health (DBH)
FY2016 Performance Accountability Report (PAR)

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 2016 by listing DBH's top accomplishments, and a summary of its progress achieving its initiatives and progress on key performance indicators.

Top Agency Accomplishments

Accomplishment	Impact on Agency	Impact on Residents
Integration of Certified Peer Specialists in Behavioral Health System: The Certified Peer Specialists in the public and private behavioral health system are trained to provide an array of supportive services to assist mental health and substance use disorder clients in their recovery process. In FY16, there were 92 peers trained in winter, summer, and continuing education sessions.	It provides DBH and our provider network with a larger pool of Peers that can be integrated into delivery of behavioral health services (mental health and substance use disorders) and supports.	Peer Specialists' lived experience helps them to provide a better quality of care to people with mental health and substance use issues and their families. Research indicates that using peers in engagement, continuity of care and outcomes, helps those who they assist. Since they are employed it also helps the local economy.
CABHI Grant: With the CABHI Grant, DBH committed to ensuring a minimum of 300 homeless veterans and chronically homeless individuals with mental illnesses, substance use disorders, or both, are housed each year for 3 years.	CABHI is being used to develop a better infrastructure to support homeless consumers and DBH is engaging SAMHSA to provide technical assistance to explore sustaining this model at the conclusion of the grant in 2 years.	The CABHI grant has added 10 Homeless Outreach Teams to the District's resources to engage homeless veterans and chronically homeless individuals with mental health or substance use disorder issues.
SUD Providers Certification Under Chapter 63: All substance use disorder providers are now certified under Chapter 63.	The ability to claim Medicaid will allow a diversion of local funds to increase non-Medicaid-eligible services such as the Recovery Support Services, previously funded by a now-expired grant.	Chapter 63 was developed to allow a better quality of care in accordance with the new ASAM standards; enable Medicaid claiming for treatment services; and align the certification process with the other DBH certification systems. The impact of the new standards cannot be measured yet but Medicaid claiming has begun.

In FY 2016, DBH had 31 Key Performance Indicators. Of those, 1 were neutral. Of the remaining measures, 39% (12 KPIs) were met, 13% (4 KPIs) were nearly met, and 45% (14 KPIs) were unmet. In FY 2016, DBH had 14 Initiatives. Of those, 21% (3) were completed and 21% (3) were nearly completed, and 57% (8) were not completed. The next sections provide greater detail on the specific metrics and initiatives for DBH in FY 2016.

FY16 Objectives

Division	Objective
Addiction Prevention and Recovery Administration	Reduce priority risk factors that place District children, youth, families, and communities at risk of substance use and interrelated problems
Addiction Prevention and Recovery Administration	Promote long-term recovery from substance use disorder through maintenance of a comprehensive continuum of accessible substance use treatment and recovery support services
Behavioral Health Authority	Expand the range of behavioral health services
Behavioral Health Authority	Increase access to behavioral health services
Behavioral Health Authority	Continually improve the consistency and quality of behavioral health services
Behavioral Health Authority	Ensure system accountability to support behavioral health services
Behavioral Health Authority	Oversee the implementation of agency-wide priorities
Behavioral Health Financing/Fee for Services	Ensure system accountability to support behavioral health services
Behavioral Health Financing/Fee for Services	Oversee the implementation of agency-wide priorities
Behavioral Health Services and Supports	Expand the range of behavioral health services
Behavioral Health Services and Supports	Continually improve the consistency and quality of behavioral health services
Saint Elizabeths Hospital	Continually improve the consistency and quality of behavioral health services

FY16 KPIs

Objective: Continually improve the consistency and quality of behavioral health services

Measure	Target	Freq	Q1	Q2	Q3	Q4	Total	KPI Status	KPI Barriers
Elopement rate: elopements per 1,000 patient days	0.1	A					0.1	Met	
Restraint hours rate: restraints per 1,000 patient hours	0.1	A					0.1	Met	
Percent of patients re-admitted to Saint Elizabeths Hospital within 30 days of discharge	6.5	A					2.4	Met	
Percent of discharges justifying 2 or more anti-psychotic medications	50	Q	73.33	88	93.1	90	87.6	Met	
Patient injury rate: major patient injuries per 1,000 patient days	0.3	Q	0.2	0.1	0.1	0.3	0.2	Met	
Percent of individuals carry formal diagnosis of obesity	70	A					68.9	Nearly Met	At an individual level, BMI can be used as a screening tool but is not diagnostic of the body fatness or the health of an individual. Some of the diagnosis may remain as overweight instead of obese depending on the provider's assessment of the patient. The CDC states that the healthcare provider should perform appropriate health assessments in order to evaluate an individual's health status and risks. If this is the case the provider will place a note in the progress notes in the Avatar data system to explain their rationale.

Physical assault rate: physical assault rate per 1,000 patient days	6	A		6.3	Nearly Met	The new forensic admissions are involved in more physical assaults which oftentimes require more seclusions.
Provider Scorecard -mental health providers' average quality (adult and child) score	85	A		80.3	Nearly Met	The KPI was partially met achieving 94% of the target for the providers' Quality Score (adult and child) with 80 versus 85%. The ability to meet the target is contingent upon the size of the sample (28 out of 31) and the community provider scores that can range from a high of 94-100 to a low of less than 66.
Provider Scorecard- mental health providers' average financial score	85	A		77.5	Nearly Met	The KPI was partially met achieving 92% of the target for the providers' Financial Score with 78 versus 85%. The ability to meet the target is contingent upon the size of the sample (28 out of 31) and the community provider scores that can range from a high of 94-100 to a low of less than 66.

Percent of missing documentation of medication administration results	0.4	A		0.5	Unmet	The Avatar data system has several areas were medication documentation can occur, i.e., e-MAR administration record, general progress note, and RN Nursing note. The e-MAR Missing Documentation reports extract data from one site. In the third quarter, over the shoulder medication competency assessments occurred. Since that time there has been a steady decline in the percent of missing documentation. Also, the report is now generated weekly and distributed to all Nurse Managers for review and staff-specific corrective actions, as necessary.
Seclusion hours rate: seclusions per 1,000 patient hours	0.07	A		0.1	Unmet	The new forensic admissions are involved in more physical assaults which oftentimes require more seclusions.
Percent of adults who receive at least 1 non-crisis service in a non-emergency setting within 30 days of discharge from a psychiatric hospitalization	80	A		61.5	Unmet	The data is incomplete pending information from DHCF and will be updated upon receipt.
Adult Community Services Review (CSR) system score	82	A		58	Unmet	During the FY16 fourth quarter the Adult CSRs were conducted and the data validated. The results are pending and expected to be available in November.

Percent of admissions with timely completed risk assessments by psychiatrists	90	A		79.8	Unmet	Data is pending currently not available.
Percent of adults who receive at least 1 non-crisis service in a non-emergency setting within 7 days of discharge from a psychiatric hospitalization	70	A		49.9	Unmet	DBH has reported adult continuity of care measures quarterly, bi-annually and annually. The data sources have included DBH claims data, DHCF data including managed care organizations, and hospitals. In FY15 no data was available. In FY16 data was reported but did not meet the proposed targets. Moving forward DBH will try to determine factors related to data collection and reporting. This may include discussions with DBH program and data staff, providers, and contracted hospitals to identify the issues that need to be addressed.

Percent of individuals with obesity (BMI >=30) at end of fiscal year	33	A					38.1	Unmet	The KPI was not met. The FY16 target was 33% and the result is 38%.The Hospital like other treatment settings have people at higher risk of weight gain and obesity due to some medications and a more sedentary lifestyle. The Hospital also has an aging population, total median age 54. The obesity rate at 38% is actually lower than the national average of 40.1% for middle-age adults. Two units have a median age over 65, a total of 52 patients. This population has mobility limitations and fall risks are considerable safety concerns. Some medical options may not always be appropriate.
Percent of discharges with 2 or more anti-psychotic medications	12	Q	20.27	27.78	34.12	23.26	26.6	Unmet	The KPI was not met exceeding the target by 15%. While compiling the data to report to CMS in the summer, a discrepancy in the report from the Avatar data system was noticed. The clinical staff manually reviewed the report and re-calculated the numbers. The data was adjusted accordingly.

Percent of children/youth who receive at least 1 non-crisis service in a non-emergency setting within 7 days of discharge from a psychiatric hospitalization	70	Q	30	33.33	50	100	44	Unmet	DBH has reported child/youth continuity of care measures quarterly, bi-annually and annually. The data sources have included DBH claims data, DHCF data including managed care organizations, and hospitals. In FY15 and FY16 no data was reported. Moving forward DBH will try to determine factors related to data collection and reporting including whether the numbers are too small to be significant. This may include discussions with DBH program and data staff, providers, and contracted hospitals to identify the issues that need to be addressed.

Percent of children/youth who receive at least 1 non-crisis service in a non-emergency setting within 30 days of discharge from a psychiatric hospitalization	80	Q	50	66.67	50	100	56	Unmet	DBH has reported child/youth continuity of care measures quarterly, bi-annually and annually. The data sources have included DBH claims data, DHCF data including managed care organizations, and hospitals. In FY15 and FY16 no data was reported. Moving forward DBH will try to determine factors related to data collection and reporting including whether the numbers are too small to be significant. This may include discussions with DBH program and data staff, providers, and contracted hospitals to identify the issues that need to be addressed.
Patient fall rate: patient falls per 1,000 patient days	2.4	Q	2.81	2.99	3.84	2.97	3.1	Unmet	The target of 2.4 was exceeded by .7.

Objective: Expand the range of behavioral health services

Measure	Target	Freq	Q1	Q2	Q3	Q4	Total	KPI Status	KPI Barriers
Number of certified Peer Specialists	80	A					92	Met	
Number of women served by Re-Entry Coordinator in Women's jail	75	Q	52	70	81	115	318	Met	

Objective: Increase access to behavioral health services

Measure	Target	Freq	Q1	Q2	Q3	Q4	Total	KPI Status	KPI Barriers
Number of School Mental Health Programs	70	Q	67	68	68	68	271	Met	

Measure	Target	Freq	Q1	Q2	Q3	Q4	Total	KPI Status	KPI Barriers
Number of early childhood services locations - Primary Project	54	Q	41	45	46	46	178	Met	
Number of introduction to co-occurring disorders and drugs of abuse classes	6	Q	0	3	2	1	6	Neutral Measure	The KPI target was to conduct 6 classes and 6 classes were conducted with the target being met.

Objective: Oversee the implementation of agency-wide priorities

Measure	Target	Freq	Q1	Q2	Q3	Q4	Total	KPI Status	KPI Barriers
Percent of District residents accessing services through ASARS screened for Medicaid eligibility within 90 days of the first date of service	85	A					45.4	Unmet	The FY 16 projection (85%) was not met due to 11 of the 32 SUD providers were required to exit iCAMS and enter DATA WITS in May 2016 which created a gap in their ability to bill Medicaid during the 6 month period. Also, under Medicaid rule providers can bill for services up to 365 days from the date that the client was billed that allows them to back bill. This may be reflected in FY 17 numbers.

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

Measure	Target	Freq	Q1	Q2	Q3	Q4	Total	KPI Status	KPI Barriers
Number of clients who receive DBH Recovery Support Services	2,500	Q	1,047	1,453	2,200	415	5,115	Met	
Percent of youth that successfully complete DBH substance use disorder treatment	20	Q	17.98	36.26	27.66	19.48	25.6	Met	

Measure	Target	Freq	Q1	Q2	Q3	Q4	Total	KPI Status	KPI Barriers
Percent of adults that successfully complete DBH substance use disorder treatment	60	Q	43.79	77.22	21.11	18.79	35.7	Unmet	Discharge and completion rates are adversely affected by three programs: 1) Medication Assisted Treatment (can be over the course of lifetime, average of 1300 clients per year), 2) Residential Services (30-90 days), and 3) Environmental Stability (up to 2 years). These factors can skew outcomes and completion rates. DBH may need to re-think the programs associated with this KPI.

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

Measure	Target	Freq	Q1	Q2	Q3	Q4	Total	KPI Status	KPI Barriers
Number of adults reached through planned prevention strategies	10,047	Q	986	3,846	3,012	5,133	12,977	Met	

Number of youth reached through planned prevention strategies	11,350	Q	315	1,396	2,580	2,512	6,803	Unmet	The projected number of youth reached through planned prevention strategies during a performance period is based on numbers reached during the previous cycle through outreach events by DBH Prevention staff, sub-grantees, and through requests for social marketing materials and presentations. Since engagement relies heavily upon the attendance at events and /or the number and types of requests received for social marketing materials, the projected target number can occasionally be missed. The Substance Use Disorder Prevention Division has been working with its evaluation entity to better capture demographic data in order to make more accurate projections in the future.

FY16 Workload Measures

Measure	Freq	Q1	Q2	Q3	Q4	Total
Number of adult consumers served	A	12,882	12,842	12,715	13,547	13,547
Number of child and youth consumers served	A	2,299	2,552	2,848	2,750	2,750
Crisis stabilization bed utilization	Q	77.25	79.84	67.03	62.75	71.6
Mental Health Services Division (MHSD) intake/Same Day Service Urgent Care Clinic - adults	Q	1,411	1,435	1,355	1,367	5,568
MHSD intake/Same Day Service Urgent Care Clinic - child/youth	Q	123	58	22	6	209
Number of Comprehensive Psychiatric Emergency Program (CPEP) visits	Q	940	863	951	941	3,695
Number of adult mobile crisis team visits	Q	241	230	293	282	1,046
Number of child mobile crisis team visits	Q	282	223	189	236	930
Involuntary acute psychiatric adult admissions	Q	470	401	428	460	1,759
Number of persons trained with disaster mental health response capacity	Q	0	0	20	60	80

FY16 Initiatives

Title: Implement the Cooperative Agreement to Benefit Homeless Individuals (CABHI) grant

Description: DBH successfully applied for and received a CABHI grant from SAMHSA, which begins October 2, 2015. Working in partnership with the District's Interagency Council on Homelessness (ICH), the Department of Human Services (DHS), the Department of Health Care Finance (DHCF), and homeless service providers, DBH has committed to ensuring a minimum of 300 homeless veterans and chronically homeless individuals with mental illnesses, substance use disorders, or both, are housed each year for the next three years. The grant will allow DBH and its partners to provide non-Medicaid services such as outreach, engagement and referral to these vulnerable individuals and access the District's housing resources through the Coordinated Entry program. Through this grant opportunity, DBH and the District will be able to develop its protocols and policies for building the support system to this extremely vulnerable position. Completion Date: September 2016.

Complete to Date: 50-74%

Status Update: Matched close to 200 clients to CABHI Providers. Continued provider technical support to ensure full compliance for Year 2 CABHI outreach. Worked on Year 2 strategic plan for CABHI-States DC. Developed Provider assessment questions for yearend evaluations. Participated in CABHI match meetings. Met with the Federal VA to collaborate and connect as many DC Veterans as possible

If Incomplete, Explanation: DBH committed to ensuring a minimum of 300 homeless veterans and chronically homeless individuals with mental illnesses, substance use disorders, or both, are housed each year for 3 years.

Title: Transition all currently-certified Substance Use Disorder Treatment and Recovery Providers to the new certification standards

Description: DBH finalized new certification standards for all substance use disorder (SUD) treatment and recovery providers in September 2015. These new standards are designed to 1) increase the standard of care and enhance person-centered treatment given by providers; 2) allow most treatment services to be reimbursed by Medicaid for Medicaid-eligible individuals; and 3) align the certification standards with other DBH programs. As providers are certified under the new standards they will incorporate the use of iCAMS, the new data management system used by DBH. This will enhance documentation and also support the integration of care. Completion Date: June 1, 2016.

Complete to Date: Complete

Status Update: All active SUD providers are now certified pursuant to the new certification guidelines contained in 22 DCMR A63. SUD providers with a Human Care Agreement with DBH are now billing Medicaid for eligible consumers.

If Incomplete, Explanation: The initiative was completed.

Title: Establish Health Homes

Description: Health Homes are a new service delivery framework that provides care coordination for consumers with serious mental illnesses, or a 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 a mental illness and a chronic physical health condition or those likely to develop chronic conditions. Use of the new data management system, iCAMS (full system implementation by September 2015), will allow better coordination of care with primary health care providers. The State Plan Amendment (SPA) was approved by the Center for Medicare and Medicaid Services (CMS) on September 2, 2015. Completion Date: September 2016.

Complete to Date: 25-49%

Status Update: The Health Home capacity is 3,900. During the fourth quarter 288 individuals voluntarily agreed to be enrolled in the Initiative. To date, 1,516 individuals are enrolled. As such 39% of the enrollment goal has been achieved.

If Incomplete, Explanation: The Year 1 implementation included a start-up period, identifying providers, training, and recruiting voluntary participants.

The capacity is 3,900 with 39% filled in FY16. The efforts to reach the enrollment goal include disseminating 5,000 letters in July FY16 to individuals in and outside the DHB system that have a serious mental illness and eligible for Medicaid to make them aware of the Health Home program. An additional 10,000 letters will be disseminated in November FY17.

Title: Expand public awareness of behavioral health resources

Description: DBH has an extensive array of behavioral health services available to the residents of the District including preventive services, behavioral health treatment, and behavioral health supports. However, the general public's and other service agency's lack of awareness of available resources often precludes an individual getting the services they need. Therefore, the agency will develop a marketing plan that will include the development of educational materials and activities to reach a greater portion of the population and increase public awareness of behavioral health issues including 1) the dangers of synthetic drugs (e.g. K2); 2) decreasing stigma around mental illnesses; and 3) available services and supports and how to access them. Completion Date: September 2016.

Complete to Date: 75-99%

Status Update: The Blunt Truth (marijuana laws), There is a Reason (underage drinking), Beat the Street materials (MPD led events) and materials for partners. Synthetic Narcotics campaign focused on overdoses stemming from opioids targeting adults. The Recovery Month behavioral health celebration at Howard University with over 300 people participants

If Incomplete, Explanation: The three marketing campaigns (prevention of marijuana use by underage youth, use of synthetic drugs; and the K2 Synthetic Narcotics Awareness Project targeting persons 18-26) are ongoing. DBH will include a date only because the system requires it.

Title: Increase awareness of behavioral health needs of older adults

Description: Older adults may have behavioral health needs that did not manifest, were not identified at a younger age, or have only recently developed. The Department is committed to ensuring that it enables people in the behavioral health system who may assess or treat these older adults to have the tools they need to assist these individuals in the best manner possible. Therefore during FY 16 the Department will work with primary care providers to identify a tool that can be used to screen older adults for behavioral health issues. The Department will also develop identify a curriculum and training resources and supports that can be used to train hospital and home health care workers to best address the needs of older adults with behavioral health issues. Completion Date: September 2016.

Complete to Date: 25-49%

Status Update: The American Psychiatric Association President will query colleagues on behalf of DBH and Age Friendly DC Initiative representatives about the screening tool. Community-based hospitals were reluctant about behavioral health screenings on all admittees. A survey conducted of nursing homes and hospitals about training needs and capacities revealed a wide range of training needs and capabilities.

If Incomplete, Explanation: DBH is working with Age Friendly DC Initiative representatives on identifying a screening tool. A major issue is the community-based hospitals are reluctant to conduct behavioral health screenings on all admittees.

Title: Develop DBH Provider Scorecard

Description: The Department of Behavioral Health (DBH) has published a Provider Scorecard for its mental health providers for the last four (4) years. FY15 activities of Mental Health Rehabilitation Services (MHRS) providers will continue to be rated using the DBH Provider Scorecard. The target for the mental health providers' quality and financial performance on the FY 2015 Scorecard, reported in FY 2016, is 85%. During FY16 DBH will develop a new Provider Scorecard for both mental health and substance use disorder treatment providers, using the newly published certification standards for substance use disorder providers that were finalized in September 2015. The new provider scorecard will be finalized and piloted in FY16. Completion Date: September 2016.

Complete to Date: 50-74%

Status Update: The DBH FY15 Provider Scorecard was completed by the end of the FY16 third quarter with review during the fourth quarter. It is posted

on the DBH website. DBH will begin data gathering and pilot testing of the new Provider Scorecard in November of FY17, for completion before the end of FY17

If Incomplete, Explanation: The initiative references two Scorecards. The FY15 Provider Scorecard was completed. The new Provider Scorecard to include mental health and substance use disorders was not completed.

Title: Develop an agency-wide dashboard for agency management

Description: In FY 16, a dashboard, a daily data report which summarizes key critical agency data points, will be provided to the Director on a daily basis. This dashboard will allow the Director to best assess agency performance and make recommendations for improvement. Completion Date: January 2016.

Complete to Date: 25-49%

Status Update: The dashboard that had previously been developed which included hospital, substance use, and mental health data is still being used. Additional dashboards were created in iCAMS for various managers. Staff was identified who need to have the dashboarding software loaded onto their computers. However, data validation and utility needs to be refined.

If Incomplete, Explanation: There have been some IT issues that have adversely affected moving forward to create a more universal, interactive and accessible system. Claims were not being processed as they were supposed to, and much time was spent addressing this problem. Without a trustworthy data set for much of the year, it was impossible to create reports.

Title: Issue practice guidelines for co-occurring care

Description: One of the primary goals in merging the District's mental health and substance use disorder authorities into one agency was to provide better integrated care to those residents with both mental health and substance use disorders. With the development of new certification and treatment standards for the substance use disorder providers and the imminent implementation of Health Homes for persons with serious mental illnesses, the Department is now able to use the new services and standards to focus on truly integrated care. The Department will develop and issue practice guidelines for integrated co-occurring care to its providers. These guidelines are critical both to establish the standard of integrated care and to measure the quality of integrated services being provided. Completion Date: September 2016.

Complete to Date: 75-99%

Status Update: Practice Guidelines for Co-Occurring services are in the final stages. Critical components have been developed with the provision of treatment and recovery for individuals with co-occurring disorders. Training with best-practice guidelines for the treatment services for Co-Occurring care provided. An integrated person-centered approach with effective practice implementation is the focus.

If Incomplete, Explanation: The Practice Guidelines for Co-Occurring services are in the final stages.

Title: Implement use of a common assessment tool to identify individuals with behavioral health conditions at greatest risk of homelessness to use as a factor in prioritizing housing resources.

Description: DBH has limited housing resources available to individuals with serious mental illness with very limited incomes (below 30% of the Average Median Income). DBH has both rental vouchers and housing units, developed in cooperation with the Department of Housing and Community Development, which it administers through the DBH Home First Program. DBH will implement the use of a common assessment tool, the Vulnerability Index Service Prioritization and Decision Assistance Tool (VI-SPDAT), for consumers who are homeless. This will enable greater prioritization of the limited housing resources for homeless consumers and also allow these individuals to be part of the District's Coordinated Assessment and Housing Placement (CAHP) program.

Complete to Date: 75-99%

Status Update: In the FY16 fourth quarter, DBH continued to work with Coordinated Entry to identify homeless singles who had been surveyed using the

VI-SPDAT tool and were DBH consumers eligible for a DBH voucher. During this period, DBH issued 8 vouchers of the 40 total DBH vouchers committed to Coordinated Entry

If Incomplete, Explanation: DBH will use the VI-SPDAT survey results to identify vulnerable, homeless consumers to fill the remaining 3 vouchers.

Title: Transition all contracted substance use disorder (SUD) providers to iCAMS

Description: iCAMS, the data management system that has been instituted for the Behavioral Health Authority and MHRS providers, will allow providers and DBH to have better knowledge of consumers' history and treatment. In the near future DBH will be able to get real-time information from community hospitals and Federally Qualified Health Centers (FQHCs) in the District that will allow for the inclusion of physical health and hospitalization data to assist with greater care coordination and treatment. As SUD providers transition to certification under the new standards, they will also transition to iCAMS which will, in turn, allow for truly integrated care and enhanced data management and analysis. This should lead to better outcomes for the consumers and improved agency performance. Completion Date: July 2016.

Complete to Date: 0-24%

Status Update: DBH worked with the SUD provider network on the transition to iCAMS. Over 19 providers transitioned but there were complications with the system that could not be fixed. All providers were transitioned back to an upgraded version of the DATA/WITS system.

Title: Begin Medicaid claiming for Adult Substance Abuse Rehabilitative Services (ASARS)

Description: Implementation of Medicaid billing for 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. CMS approved the amended SPA in August 2015. The new certification regulations which implemented the SPA were finalized in September 2015 and Medicaid billing is expected to begin by December 1, 2015. DBH is working closely with the Department of Health Care Finance in the implementation of this initiative. Completion Date: September 2016.

Complete to Date: Complete

Status Update: All Adult Substance Abuse Rehabilitative Services (ASARS) providers are Chapter 63 certified and enrolled with DHCF to enable Medicaid billing. Some providers do not qualify for Medicaid billing due to the Institutions for Mental Diseases (IMD) exclusion (i.e., residential facilities with more than 16 beds).

Title: Increase integration of peers in the behavioral health system of care

Description: The Substance Abuse and Mental Health Services Administration (SAMHSA) and best practices urge the use of peers in a recovery oriented model. DBH has a well-developed peer certification program that is being enhanced to include a curriculum for youth peers and peers in substance use disorder treatment, in addition to the adult and family peer programs already established. The Department recognizes that older adults may have specific needs that are best addressed by their peers as well and will ensure that the number of older adults who become Certified Adult Peers is increased. Increasing the use of peers in our System of Care will both enhance the services being provided and allow for greater employment opportunities amongst DBH consumers. Current certified peers are employed throughout the public mental health system. During FY16, the DBH Office of Consumer and Family Affairs (OCFA) will continue to offer certification training that includes two tracks for the core curriculum peer specialists training and two tracks for the family member certification training. OCFA monitors the number of persons who successfully complete these courses and graduate as well as the certification status of current peers. Completion Date: September 2016.

Complete to Date: Complete

Status Update: DBH Office of Consumer and Family Affairs launched the Youth Peer Support Specialist Certification. Two (2) young adults and 21 adults graduated from the Summer Class. Also, 10 continuing education classes were offered to Peer Specialists. The Recovery Month (mental health and substance

use) celebration at Howard University was attended by over 300 people

Title: Establish outcome measures for system and service assessment and improvement

Description: Integral to determining if District residents are getting the best care is establishing a standard by which the best care can be measured. As the agency continues to improve its service delivery system with new certification and treatment standards for the SUD providers and the implementation of the Health Homes for people with serious mental illnesses, those outcome measures that will allow agency and provider performance to be evaluated must be developed. The use of iCAMS, the new data management system for DBH and its providers, will allow the agency to more easily determine when and if providers are meeting specific outcome measures which will in turn allow the agency to work on improving those programs that need improvement and determining best practices from those providers that are consistently successful in improving the wellness of DBH consumers. The success of the Health Home Initiative will be determined by each provider program's ability to achieve outcomes as measured by the Centers for Medicare and Medicaid Services (CMS) and DBH Health Home Core Quality Measures. The purpose of the core set is to assess individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes specific to the provision of health home services. The data related to the CMS and the District Core Health Home quality measures will be collected beginning January 2016. Completion Date: September 2016.

Complete to Date: 0-24%

Status Update: A draft of outcome measures has been created, and the top mental health and substance use measures have been prioritized. A work group will be convened in early FY17 to ensure the data is accurate and the definitions and logic are clear. As the priority reports are finalized, additional outcome reports will be created

If Incomplete, Explanation: The first phase of this process began in FY16 with the drafting of outcome measures and prioritizing behavioral health measures. The FY17 phase will include creating a work group that will provide input for subsequent developing processes.

Title: Reduce weight gain and obesity levels of individuals in care

Description: Individuals in a psychiatric treatment setting are at higher risk of weight gain and becoming obese due to side effects of many psychiatric medications as well as a more sedentary lifestyle. According to the SEH's FY14 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¿=30) was 42% as of September 30, 2013. The obesity rate declined to 37% as of September 30, 2014. However, it is still significantly higher than the obesity rate of District adult population (23%). The Hospital's further study suggests that a significant weight gain is likely to occur in the early stage of hospitalization. In FY15, the SEH launched a six sigma project team that started working with multiple disciplines to develop and implement strategies to mitigate the weight gain and lower the obesity rate among individuals in care. The Hospital's goal is to reduce the obesity rate to below 33% by the end of FY16. During FY16, the Hospital will track two measures related to obesity: 1) the percent of individuals in care with obesity, and 2) the percent of individuals in care with obesity who have accurate obesity diagnosis updated in Axis-III at the end of the fiscal year. Completion Date: September 2016.

Complete to Date: 50-74%

Status Update: 1. Calorie restricted diets for Individuals in care (IICs) based on BMI were instituted. 2. Provided better snack choices in vending machines including low calorie, low fat alternatives. 3. Increased access to courtyards to promote physical activity. 4. Made referrals for major medical and surgical weight-loss interventions.

If Incomplete, Explanation: The Hospital like other inpatient settings treat people who are at higher risk of weight gain and obesity due to some medications and a more sedentary lifestyle. The Hospital also has an aging population. Some may also have mobility limitations and fall risks are considerable safety concerns. Some medical options may not always be appropriate.