FY 2015 PERFORMANCE PLAN
Department of Behavioral Health

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.

PERFORMANCE PLAN DIVISIONS
- Behavioral Health Authority
- Addiction Prevention and Recovery Administration
- Saint Elizabeths Hospital
- Behavioral Health Services and Supports
- Behavioral Health Financing/Fee for Service

AGENCY WORKLOAD MEASURES

Measures	FY 2012 Actual	FY 2013 Actual	FY 2014 Actual[1]
Number of adult consumers served[2]	18,744	18,918	22,355
Number of child and youth consumers served[3]	4,187	4,181	5,262
Mental Health Services Division (MHSD) intake/Same Day Service Urgent Care Clinic – adults[4]	3,083	3,628	3,930
MHSD intake/Same Day Service Urgent Care Clinic – child/youth	489	327	272
Number of Comprehensive Psychiatric Emergency Program (CPEP) visits	3,924	3,961	3,765
Number of adult mobile crisis team visits	1,094	1,007	1,794
Number of child mobile crisis team visits	658	505	717
Crisis stabilization bed utilization	85.0%	89.71%	89.06%
Involuntary acute psychiatric adult admissions	1,493	1,366	1,631

[1] Updated data added that was not available at the time this document was printed.
[2] FY12 and FY13 adult data is for mental health only. FY14 data is mental health and substance use for persons 21 and older.
[3] FY12 and FY13 child/youth data is mental health only. FY14 data is mental health and substance use for persons 0-20.
[4] Data for the 4th quarter and YTD is through 9/14, on 9/15 a new electronic chart was instituted and data is not available.

Behavioral Health Authority

SUMMARY OF SERVICES

The Behavioral Health Authority supports the overall administrative mission of DBH, and encompasses the functions necessary to support the entire system. It is responsible for establishing priorities and strategic initiatives for DBH, as well as coordinating fiscal services, accountability functions, information systems, and service planning and policy development.

The Behavioral Health Authority monitors and regulates the activities of the public mental health and substance abuse system including certifying providers of mental health rehabilitation services and substance abuse treatment centers, and licensing mental health community residential facilities.

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 (full system implementation test date planned for December 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

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 second quarter of FY15 and begin the process of developing into a fully functioning Council.
Completion Date: September, 2015.

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.

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. 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.

OBJECTIVE 3: Continually improve the consistency and quality of behavioral 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, will allow a full picture of the quality of services provided by ACT providers. Full implementation of the ACT Scorecard will occur in FY15. **Completion Date: September, 2015.**

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. The target for quality and financial performance on the FY 2014 Scorecard, reported in FY 2015, is 85%. During FY15 DBH 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, 2016**.**

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 expectation are for substance use providers, the CSR Unit will work to educate providers on practice expectations. **Completion Date: September, 2015.**

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 DBH MHRS clinical and billing components beginning September 2014. Completion of Phase I to include global eligibility verification, claims adjudication and benefit structure will occur following a successful system test scheduled for December 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 planned for 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.**

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

KEY PERFORMANCE INDICATORS- *Behavioral Health Authority*

Measures	FY 2013 Actual	FY 2014 Target	FY 2014 Actual[5]	FY 2015 Projection	FY 2016 Projection	FY 2017 Projection
Number of introduction to co-occurring treatment and DBH services classes	Not Applicable	20	17[6]	10	10	10
Number of School Mental Health Programs	52	72	62	72[7]	72	72
Number of early childhood services locations – Primary Project	35	54	44	54[8]	54	54
Provider Scorecard – mental health providers' average quality (adult and child) score[9]	88%	85%	92%	85%	85%	85%
Provider Scorecard- providers' average financial score	70%	85%	76%	85%	85%	85%
Adult Community Services Review (CSR) system score	Not Applicable	80%	74%	Not Applicable[10]	82%	Not Applicable
Child Community Services Review (CSR) system score	70%	Not Applicable[11]	Not Applicable	73%	Not Applicable	76%

[5] Updated data added that was not available at the time this document was printed.
[6] In FY14 there were 17 trainings with 354 people trained. DBH will now conduct 10 trainings per year.
[7] FY15 and FY16 remain the same as FY14 since they are contingent upon additional funding, which is unknown.
[8] FY15 and FY16 remain the same as FY14 since they are contingent upon additional funding, which is unknown.
[9] The adult and child quality score is now combined and represents the mean of all individual mental health provider scores. Also, the Provider Scorecard reports data for the previous fiscal year so the FY13 Scorecard data is reported in FY14 with FY14 data reported in FY15.
[10] Starting in FY14 the Adult and Child Community Services Reviews are conducted every other year on an alternating schedule.
[11] Same as footnote 10 above.

Addiction Prevention and Recovery Administration

SUMMARY OF SERVICES

The Addiction Prevention and Recovery Administration, newly merged with the former Department of Mental Health, is now the substance use arm of the Department of Behavioral Health (DBH). DBH funds, regulates, and monitors substance use prevention, treatment, and recovery support services in the District of Columbia. Prevention services are driven by data and three (3) levels of best practice strategies: 1) universal strategies are targeted to the general public or a whole population; 2) selective strategies are targeted to individuals or a population sub-group whose risk is significantly higher than average; and 3) indicated services are targeted to individuals who are identified as having a minimal but detectable signs or symptoms foreshadowing a disorder or biological markers indicting predisposition but do not meet diagnostic criteria at this time. A continuum of treatment services is offered to meet the needs of the diversity of clients accessing the system. These services include outpatient, intensive outpatient, residential, withdrawal management, and medication-assisted therapy. Wrap-around services are also provided such as education skill building, and job readiness training. Finally, DBH promotes a recovery-oriented system of care through recovery support services. These services include mentoring and coaching, as well as assistance with transportation and housing. These services pave the way for District residents affected by substance use disorders to turn their short-term gains into long-term success in their recovery.

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, youth, 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%). However, during FY 2014 there was a sizeable increase over the projected targets due to several 1-year national substance use campaigns and initiatives. For the FY 2015 target, DBH will use the FY 2013 actual data as the baseline year to adjust for the fact that the FY 2014 level of performance will not likely be sustainable at the District level. **Completion Date: September, 2015.**

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 less likely 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.**

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

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

In APRA's adult system, 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 adult 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.**

KEY PERFORMANCE INDICATORS - Addiction Prevention and Recovery Administration

Measures	FY 2013 Actual	FY2014 Target	FY2014 Actual	FY2015 Projection	FY2016 Projection	FY 2017 Projection
Number of adults reached through planned prevention strategies	7,548	8,303	15,487	9,133	10,047	11,052
Number of youth reached through planned prevention strategies	8,527	9,380	17,022	10,318	11,350	12,485
Number of technical assistance encounters provided to prevention stakeholders	Not Applicable	Not Applicable	Not Applicable	100	120	150
Number of clients who receive Recovery Support Services	Not Applicable	Not Applicable	Not Applicable	2,000	2,500	3,000
Percent of adults that successfully complete treatment	59.4%	60%	61.3%	60%	60%	60%
Percent of youth that successfully complete treatment	19.6%	20%	10.6%	20%	20%	20%

Saint Elizabeths Hospital

SUMMARY OF SERVICES

Adults requiring mental health treatment in a 24-hour inpatient setting may receive services at Saint Elizabeths Hospital. A treatment model has been implemented that parallels life in the community for the vast majority of individuals in the hospital's care. Currently, the Hospital provides both acute and long-term care to adults with either a forensic or civil legal status. Emphasis continues to be on implementation of the recovery model and ensuring that the provision of treatment helps individuals in care stabilize as quickly as possible and return to the community with the skills and supports necessary for a successful transition.

OBJECTIVE 1: Continually improve the consistency and quality of behavioral 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>=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>=30) to below 40%. **Completion date: 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 FY15, 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 50%. **Completion date: September, 2015.**

KEY PERFORMANCE INDICATORS – *Saint Elizabeths Hospital*

Measures	FY 2013 Actual	FY 2014 Target	FY 2014 Actual[12]	FY 2015 Projection	FY 2016 Projection	FY 2017 Projection
Percent of discharges with ≥ 2 anti-psychotic medications[13]	Not Applicable	25%	15%	20%	15%	15%
Percent of discharges with appropriate justification documented when discharged with ≥2 anti-psychotic medications[14]	Not Applicable	20%	14%	40%	60%	60%
Percent of nursing staff with competency-based recovery model training[15]	95%	95%	90%	95%	95%	95%
Percent of clinical staff with competency-based recovery model training	Not Applicable	85%	100%	85%	85%	85%
Total patients served per day	267	275	283	275	275	275
Elopements per 1,000 patient days	0.31	0.28	0.09	0.28	0.28	0.28
Patient injuries per 1,000 patient days[16]	0.15	0.25	0.34	0.25	0.25	0.25
Percent of missing documentation of medication administration results[17]	0.41%	0.25%	0.61%	0.20%	0.20%	0.20%
Percent of unique patients who were restrained at least once during month	0.04%	0.1%	0.44%	0.1%	0.1%	0.1%
Percent of unique patients who were secluded at least once during month	1.0%	0.1%	2.12%	0.1%	0.1%	0.1%
Percent of patients re-admitted to Saint Elizabeths Hospital within 30 days of discharge	6.3%	5.9%	2.03%	5.8%	5.8%	5.8%

[12] Saint Elizabeths Hospital measures are now annualized to allow data auditing. FY14 data added after end of fiscal year.
[13] This is a nation-wide behavioral healthcare measure defined by Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Hospital is required to report to the Center for the Medicare and Medicaid Services (CMS).
[14] It is also a behavioral healthcare measure defined by JCAHO and the Hospital is required to report to CMS.
[15] It was modified in FY14 to measure the percentage of completed training for nursing staff.
[16] The National Research Institute (NRI) definition considers only those injuries that require beyond first-aid level treatment. Saint Elizabeths Hospital modified its logic to make it consistent with NRI's definition.
[17]Measured by dividing the total number of medication administration records with missing documentation by the total number of scheduled medication administration records.

Behavioral Health Services and Supports

SUMMARY OF SERVICES

Behavioral Health Services and Supports include the design, delivery, and evaluation of a variety of services and supports for children, youth, families, adults, and special populations to maximize their ability to lead productive lives. The activities include: organizational development (training institute, applied research and evaluation, community services reviews); child and youth services (early childhood and school mental health services, community alternatives for out-of-home, residential care, and diversion from juvenile justice system, youth forensic services and oversight of youth placed in residential treatment centers, ASTEP treatment centers); adult services (supported housing, supported employment, assertive community treatment, forensic); care coordination (service access and suicide prevention and intervention services); integrated care (transition consumers from inpatient care to community, transitioning consumers from community residential facilities to less restrictive environments and Health Homes); mental health services (government operated including same day clinic, multicultural program, deaf/hard of hearing and intellectual disability program, physicians practice group, forensic assessments, outpatient competency restoration, pharmacy); substance abuse treatment services (government operated intake and assessment center); comprehensive psychiatric emergency services (extended observation beds, mobile crisis, homeless outreach) and onsite forensic services (an urgent care clinic at the D.C. Superior Court for immediate assessments for mental health and substance abuse issues).

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.**

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**.

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.**

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.**

KEY PERFORMANCE INDICATORS – *Behavioral Health Services and Supports*

Measures	FY 2013 Actual	FY 2014 Target	FY 2014 Actual[18]	FY 2015 Projection	FY 2016 Projection	FY 2017 Projection
Number of certified Peer Specialists	14	20	34	60	60	60
Number of women served by Re-Entry Coordinator in Women's jail	Not Applicable	60	100	75	75	75
Number of People in Mental Health First Aid Trainings	645	800	1,866	500	500	500
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	67.09	70%	61.52%	70%	70%	70%
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	71.28	70%	61.79%	70%	70%	70%
Percent of adults that receive at least one (1) non-crisis service in a non-emergency setting within 30 days of discharge from a psychiatric hospitalization	75.81	80%	74.10%	80%	80%	80%
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	86.13	80%	76.65%	80%	80%	80%

[18] Behavioral Health Services and Supports FY14 data added that was not available at the time this document was printed.

Behavioral Health Financing/Fee for Service

SUMMARY OF SERVICES

The Behavioral Health Financing/Fee-for-Service Division is responsible for managing the financing of mental health services and supports. The DBH Claims Administration/Billing unit is responsible for: 1) claims processing and adjudication/processing of local fund warrants to the OCFO for D.C. Treasury payment to mental health rehabilitation services (MHRS) and adult substance abuse rehabilitative services (ASARS) providers (pre-process Medicaid claims to verify eligibility and authorization), and 2) Medicaid claims billing and reconciliation (collection and reporting of Medicaid federal funds portion (FFP) reimbursement).

OBJECTIVE 3: Continually improve the consistency and quality of behavioral 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 being in March 2015DBH is working closely with the Department of Health Care Finance in the implementation of this initiative. **Completion Date: September, 2015.**

KEY PERFORMANCE INDICATORS - *Behavioral Health Financing/Fee for Service*

Measures	FY 2013 Actual	FY 2014 Target	FY 2014 Actual	FY 2015 Projection	FY 2016 Projection	FY 2017 Projection
Percent of clean claims adjudicated within 30 days of receipt	97%	98%	99%	97%	99%	100%
Percent of District residents, accessing services through ASARS, screened for Medicaid eligibility within 90 days of the first date of service[19]	Not Applicable	Not Applicable	No Data Available	50%	90%	95%

[19] No data is available for ASARS since its implementation is pending.