Department of Behavioral Health
DBH *(RM0)*

MISSION

The mission of the Department of Behavioral Health (DBH) is to support prevention, resiliency and recovery for District residents in need of public mental health services.

SUMMARY OF SERVICES

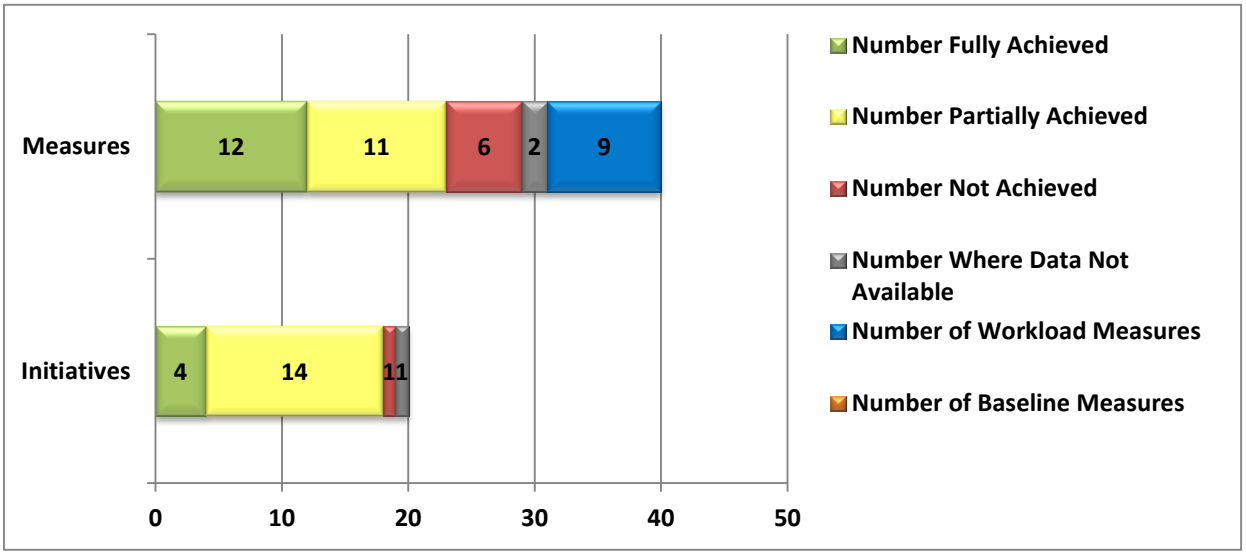
DBH is responsible for developing, supporting and overseeing a comprehensive, community-based, consumer driven, culturally competent, quality mental health system that is responsive and accessible to children, youth, adults, and their families. DBH contracts with a network of community-based, private providers and also provides direct services through Saint Elizabeth's Hospital, the Mental Health Services Division, the Comprehensive Psychiatric Emergency Program, and the School-Based Mental Health Program.

ACCOMPLISHMENTS

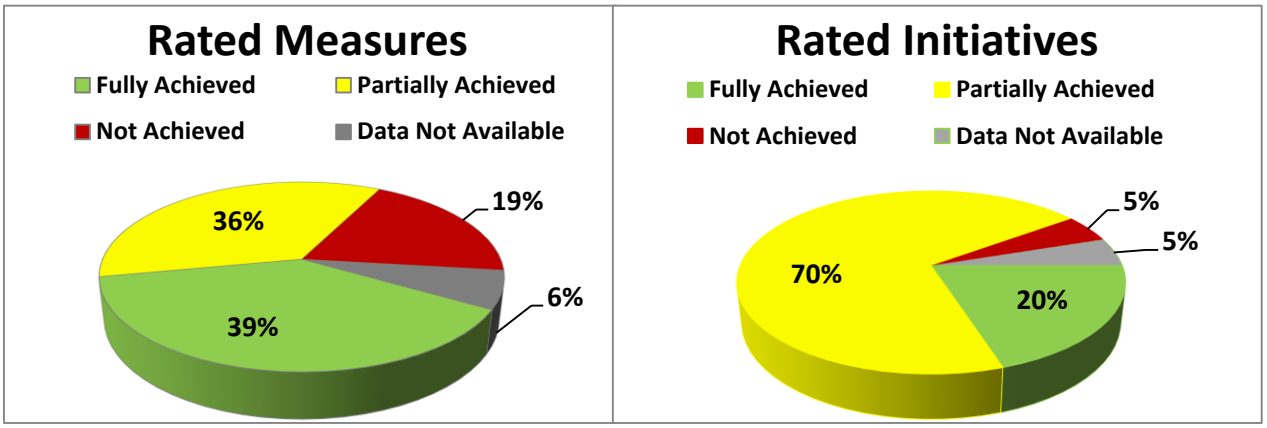
- ✓ DBH had a successful year 1 (see e-Newsletter).
- ✓ DBH contracted for integrated behavioral health and HIV services for TANF recipients and others.
- ✓ Saint Elizabeth's Hospital greatly improved patient care, ending 7-year federal oversight.

OVERALL AGENCY PERFORMANCE

TOTAL MEASURES AND INITIATIVES



RATED MEASURES AND INITIATIVES



Note: Workload and Baseline Measurements are not included

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

Performance Initiatives – Assessment Details

Performance Assessment Key:

Fully achieved | Partially achieved | Not achieved | Data not reported

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.

Fully Achieved. The FY 2014 target for youth reached through planned prevention strategies (7,200) was attained above 100% (17,022). Prevention research suggests that youth do not engage in substance abuse solely because of personal characteristics but rather because of a complex set of factors in their environment. These factors include the rules and regulations to which individuals belong: trust, social ties, relationships and exchanges among people; the norms of the communities in which they live; the messages to which they are exposed; and the availability to minors of alcohol, tobacco, and other drugs.

The DBH funds four (4) DC Prevention Centers (DCPC) that are designed to strengthen the community's capacity to reduce substance use and prevent risk factors through universal approaches. The DCPCs are dynamic, community-based hubs that serve two (2) wards each (Wards 1 and 2; Wards 3 and 4; Wards 5 and 6; Wards 7 and 8). A total of 32,509 District youth and adults were reached through community education, community leadership, and community change strategies in 2014.

The DBH prevention model is distinguished by the creation of a permanent prevention infrastructures that support DCPC and broaden their prevention reach through community prevention networks (CPNs). There are currently 53 CPNs that receive training and technical assistance through the DCPCs and engaged in a 5-step planning process called the Strategic Prevention Framework (SPF). The 5 steps are: 1) assessment; 2) capacity building; 3) strategic action planning; 4) implementation; and 5) evaluation.

INITIATIVE 1.2: Prevent onset and delay progression of substance abuse in youth and young adults from pre-K through age 21 through implementation of culturally sensitive prevention best policies, programs, and practices.

Partially Achieved. During FY 2014 Pre-Kindergarten age children were not included in this initiative. The focus of prevention activities included school age children, youth, and adults that included families. A number of evidenced-based programs were implemented including pilot projects. The narrative that follows describes these programs. Substance abuse 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 sign or symptoms foreshadowing a disorder or biological markers indicating predisposition but do not meet diagnostic criteria at the this time. DBH funded a pilot evidence-based program, *Creating Lasting Connection* implemented by the four (4) youth assessment and treatment programs that reached 93 parents and 108 youth. The pilot targeted selective and

indicated families who had a youth in treatment and other siblings at home (ages 9-17). The premise was the sibling was at greater risk for substance abuse disorders or other interrelated problems (e.g., anxiety and depression, delinquency, poor school performance, and teen pregnancy). The evidence-based program was designed to: 1) improve parent's knowledge and attitudes regarding drug issues and family management skills; 2) increase knowledge and use of community services; 3) improve the communication and refusal skills of participating youth; and 4) delay onset and reduce the frequency of alcohol and drug use among participating youth.

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.

Partially Achieved. The adult treatment goal was met but the adolescent treatment goal was not. The target for adults that successfully complete treatment was 60% and the actual achievement was 61.3%, which is above 100%. The adult treatment system is composed of Withdrawal Management (detoxification), Residential Treatment, Intensive Outpatient Programming (IOP), and Outpatient Programming (OP). Withdrawal Management and Residential Treatment services are substance use disorder services that include a 24-hour structured support and monitoring system. These programs are designed to provide around the clock support and care for individuals who demonstrate the inability to reframe from using their drug of choice. Individuals that participate in treatment at this level are usually successful in completing care due to the intensive structure and support available to endure compliance and abstinence. Individuals receiving treatment in IOP/OP receive a core of treatment services including, Comprehensive Assessments, Case Management, Crisis Intervention, Care Coordination, and a plethora of counseling services (individual, group, and family). The frequency and intensity of services increase with an individual's need for higher levels of care. Each client is provided with an initial behavioral health screening to determine level of care, which matches clients with the appropriate level of care at time of access. After a client's initial placement, clients are re-assessed to determine their continued care plan. Periodic re-assessments and evaluations increase retention in treatment, as well as the completion of treatment outcomes.

Behavioral Health Authority

OBJECTIVE 1: Expand the range of behavioral health services.

INITIATIVE 1.1: Establish the new Department of Behavioral Health.

Partially Achieved. While the Department of Behavioral Health (DBH) was created on October 1, 2013 by merging the District's mental health and addiction systems, it is anticipated that the implementation process will be ongoing for the next several years. During FY 2014 the primary focus was on building the framework for an integrated service delivery that included forming a single organizational infrastructure, realigning and training staff, establishing uniform rates for mental health and substance use treatment, bringing together all providers, and rewriting regulations to support Medicaid billing for substance use treatment and recovery. Some of the DBH accomplishments during the first year include: 1) technology, facilities, contracts and procurement, and provider relations were merged into a single organizational infrastructure under Administrative Operations); 2) established one certification unit and a single certification process (mental health and substance use certification employees are now together in the Office of Accountability); 3) trained employees and providers in co-occurring treatment (nearly 100 DBH employees and providers were trained on service delivery for co-occurring mental and substance use disorders and over 300 were given a basic understanding of substance use and mental health

disorders and the relationship between them; 4) added an evidence-based practice for youth with mental and substance use disorders; 5) established multiple points of enrollment for substance use treatment (in addition to the ARC, staff have been trained at Saint Elizabeths Hospital, the Comprehensive Psychiatric Emergency Program (CPEP), and other direct care locations); 6) conducted consumer, provider and staff surveys to hear concerns and priorities and inform the merger process; 7) moved toward Medicaid billing for substance abuse services; and 8) recognized employee contributions.

INITIATIVE 1.2: Establish Health Homes.

Partially Achieved. DBH continues to work with the Department of Health Care Finance (DHCF) to implement the Medicaid Health Home Initiative, which is designed to improve the health outcomes of individuals with serious mental illness (SMI) by employing the following techniques: 1) comprehensive care management; 2) care coordination and health promotion; 3) comprehensive transitional care from inpatient to other settings including appropriate follow-up; 4) individual and family support that includes authorized representatives; 5) referral to community and social support services, if relevant; and 6) health information technology to link services, as feasible and appropriate. The Health Homes are Core Service Agencies (CSAs) and Assertive Community Treatment (ACT) providers, who are certified by DBH to provide care coordination between behavioral health services and primary health care services for those consumers with SMI who have or may develop chronic conditions.

OBJECTIVE 2: Increase access to behavioral health services.

INITIATIVE 2.1: Provide cross-training to all DBH-certified providers.

Partially Achieved. This introductory course provided information about co-occurring mental health and substance use disorders and the implications for treatment. It was designed to help build capacity for DBH certified providers to serve individuals with co-occurring disorders. The content includes an overview of integrated treatment and practices across service systems. The training provided an opportunity to cross-train DBH certified providers, service providers from other sectors of the community, DBH staff, and other interested persons. The FY 2014 target was that 20 introductory behavioral health courses would be offered. A total of 17 courses were conducted achieving 85% of the target. Also, there was a total of 354 attendees that included participation by DBH, the community, and providers.

INITIATIVE 2.2: Expand access to mental health services in schools and early childhood

Partially Achieved. The projected expansion to 71 schools was based on adding 19 new schools to the existing 52 SMHP locations. During FY 2014 nine (9) new schools were added to the program, making the total number of SMHP locations 62. The overall achievement rate for the SMHP expansion in FY 2014 was 87% of the target. The SMHP served 53 schools in School Year 2013-14 and added 9 schools from June - September 30, 2014 bringing the total number of schools to 62. The 9 new schools included 6 D.C. Public Schools (Kimball Elementary, Malcolm X Elementary, Patterson Elementary, McKinley Tech Middle School, Washington Metropolitan High School, and HD Cooke Elementary) and 3 Public Charter Schools (Democracy Prep, Thurgood Marshall, Washington Yu-Ying). Also, 5 additional pending school placements were scheduled to occur within 2 weeks after 9/30/14. The Primary Project served 40 locations in School Year 2013-14 (23 public and public chartered schools and 17 child development centers). Four (4) new sites were added from June- September 30, 2014, bringing the total number to 44.

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

INITIATIVE 3.1: Develop an assertive community treatment scorecard.

Partially Achieved. During FY 2014 the planning phase for the DBH ACT Scorecard was completed. It included discussions with the ACT providers about the Scorecard, review and discussion about the ACT data captured in the Adult Services Dashboard, review of ACT usage and outcomes at the Comprehensive Psychiatric Emergency Program, and the review of tools used by the Office of Accountability (OA) for the DBH Quality Review and Provider Scorecard. The DBH ACT Scorecard will utilize data from two (2) instruments, the Dartmouth Assertive Community Treatment Scale **(**DACTS**)** and the Draft ACT Quality Review Tool developed in collaboration with OA. The DACTS fidelity measures include staffing pattern, turnover and continuity, intake rate, participation in hospital admission and discharge, and outcomes such as benefits, housing, crisis services, and chart quality. The Draft ACT Quality Review Tool (ACT QR) was developed over time between July and September 2014. The domains include: 1) Essential Administrative Requirements; 2) Assessment; 3) Crisis and Relapse Planning, and Responsiveness; 4) Treatment Planning; 5) Service Provision; and 6) Care Coordination and Management. During FY 2015 the following activities related to the Draft ACT QR will be implemented: 1) develop a sample to pilot test the Draft ACT QR tool; 2) conduct the pilot test for the Draft ACT QR tool; 3) revise the Draft ACT QR tool as necessary; 4) develop protocols to provide performance ratings and penalties; 5) develop the Quality Review Team for the ACT program; 6) Quality Review Team will develop a work plan; and 7) initiate the ACT Scorecard.

INITIATIVE 3.2: Develop DBH Provider Scorecard.

Partially Achieved. The DBH Provider Scorecard provides valuable information to residents **s**eeking or receiving mental health services to help them choose a provider they believe can best meet their needs. Also, the Provider Scorecard illuminates the strengths of an individual provider and the public behavioral health system and helps to identify areas that require provider and system improvement. The Provider Scorecard rates a community-based mental health provider certified by DBH as a Core Services Agency (CSA) to deliver mental health treatment and supports. Twenty-two (22) of 24 CSAs or 92% met the sampling criteria for the FY 2013 Provider Scorecard. There were several presentations on the FY 2013 Provider Scorecard findings. It was published on the DBH website in June 2014. The FY 2013 Provider Scorecard aggregated adult and child average quality score was 92%, which exceeded the projected 85% by 7%. The providers' average financial score was 76%, which is 89% of the projected 85% and therefore this initiative was partially achieved.

INITIATIVE 3.3: Expand DBH disaster mental health response capacity.

Not Achieved. During FY 2014 61 interested community members were certified as responders through the Disaster Behavioral Health Emergency Response Team Certification Training that included over 20 hours of in-person instruction. The projected number of persons certified was 90, only 68% of the target was achieved. As of September 2014, there were 101 DBH trained individuals. All 101 participants passed their post-tests demonstrating their knowledge and skills and are now eligible to apply to DBH Disaster Behavioral Health Emergency Response Teams. DBH has found that the implementation of this measure leads to discrepancies in training versus certification. While many people have met the full educational (training) they have not actually qualified for certification. Many have completed the training, but fail to follow through with the appropriate application (background checks, references, emergency contacts, ethics agreements, etc.) to actually join the team and become certified. Because DBH has established an ongoing training program as well as the mechanisms and processes for certification, however, DBH

recommends and has requested the removal of this initiative and KPI from the FY 2014 Performance Plan and subsequent fiscal year reporting.

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

INITIATIVE 4.1: Refine Community Service Reviews.

Partially Achieved. During FY 2014 the DBH Community Services Review (CSR) Unit conducted three (3) rounds of the Adult CSR with completed reviews for 42 consumers across 15 Core Services Agencies (CSAs). Thirty-one (31) of the 42 cases reviewed received an acceptable score on the Overall System Performance for practice. The adult system performance is 74%. This represents 92% of the 80% target. Throughout the year, the CSR Unit was involved in the One Plan initiative which merges efforts from the Child and Youth Services Division, CSR Unit, Provider Relations and the Office of Accountability to develop benchmarks for CSAs and provide technical assistance. The CSR Unit continues to provide quarterly trainings to providers to support practice development, within the past year trainings conducted include the "Five Core Elements of Quality Practice" and "New Adult CSR Training."

INITIATIVE 4.2: Implement the care management application.

Partially Achieved. In the FY 2014 fourth quarter, iCAMS went live and operational. On September 15, 2014, all DBH service delivery programs (the clinics at 35 K Street, N.E. and Howard Road, S.E., the School Mental Health Program, Comprehensive Psychiatric Emergency Program, and the Access Helpline at DBH) began using the system. During the mid-fourth quarter a Health Insurance Portability and Accountability Act (HIPPA) and security issue was identified by the DBH team that required further development by the vendor before going live with non-DBH providers. As a result, full system-wide implementation was projected for mid-November 2014 to ensure that those issues are resolved, and functionality is compliant with the expectations of DBH.

Behavioral Health Financing/Fee for Services

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

NITIATIVE 1.1: Begin Medicaid claiming for ASARS services.

No Data Available. There is no data to report at this time. During FY 2014 DBH engaged in the planning and process development phase for this initiative. The Draft Adult Substance Abuse Rehabilitative Services (ASARS) Certification Regulation was developed, incorporating the ASARS State Plan Amendment (SPA) requirements as well as the new American Society of Addiction Medicine (ASAM) practice guidelines. This draft rule was shared with the providers in early October 2014 prior to publication of the rule in the *D.C. Register*. Also, the Department of Health Care Finance (DHCF) completed revisions to the ASARS SPA and was awaiting the fiscal impact statement prior to submission to the D.C. Council. After the planning and process development phase is completed, DBH will begin Medicaid claiming for ASARS services.

Behavioral Health Services and Support

OBJECTIVE 1: Expand the range of behavioral health services.

INITIATIVE 1.1: Increase the number of certified Peer Specialists.

Fully Achieved. The FY 2014 target was to increase the number or certified Peer Specialists to 20. DBH increased the number of certified Peer Specialists to 34 exceeding the target by 14. This was achieved through 3 types of groups. A new Child/Youth/Family Specialty Track (Family Track) was developed for Peer Specialists Certification training. Persons accepted into the Family Track still had to meet the requirements for acceptance into the Core Peer Specialist Certification Training, as well as be identified as parents/guardians/caregivers of children who are in/have been through a mental health system of care. DBH accepted 8 individuals in the Family Track.

- DBH also accepted 10 individuals into the Peer Specialist Certification Training Waiver Program. They were people who had worked at least 5 years as peer advocates and who met the other requirements for the Peer Specialist Certification Training. However, they did not take the entire Peer Specialist Certification Training. These 10 individuals sat for the examination only, and had to pass the examination by 85%.

There were 16 other individuals who completed the requirements of the Core Peer Specialist Certification Training and were subsequently certified by DBH as Peer Specialists. These individuals completed the 70 hours of class work 80 hours field practicum, and passed the final examination.

INITIATIVE 1.2: Increase Coordination with the Department of Corrections.

Fully Achieved. This initiative involved placing a DBH Re-entry Coordinator at the D.C. Jail – Women's Facility to link women with behavioral health issues to appropriate services. The FY 2014 target was that at least 60 women would be served. Two (2) Forensic Mental Health

- Specialists were hired and located at the Department of Corrections. During FY 2014 there were 100 women seen at the Central Treatment Facility exceeding the target by 40. The outcomes for the 100 women who were served include: 1) 91 women were screened as having co-occurring mental health and substance use disorder; 2) 46 women were re-linked to mental health services; and 3) 4 women were newly linked to mental health services.

OBJECTIVE 2: Increase access to behavioral health services.

INITIATIVE 2.1: Increase the number of individuals trained in Mental Health First Aid and in Youth Mental Health First Aid.

Fully Achieved. The FY 2014 target was that 800 people would participate in Adult and Youth Mental Health First Aid (MHFA) trainings. A total of 1,866 persons received training in Adult and Youth MHFA, which exceeds the target by 1,066 trainees. MHFA is a groundbreaking public education program that introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact, and overviews common treatments. Youth MHFA

- is primarily is designed for adults (family members, caregivers, school staff, health and human services workers, etc.) who work with young people 12-25, and is also appropriate as a peer support program for older adolescents. During FY 2014 DBH and other certified instructors taught both the Adult and Youth MHFA courses. One of the DBH adult instructors taught the Police Version of MHFA to D.C. Metropolitan Police recruits. Another DBH instructor was selected as part of the Elite Team of MHFA Quality Evaluators. The Quality Evaluators observe classes and provide coaching. Also, one of the certified instructors became a National Trainer. This individual was one of the trainers for the MHFA forum for active military, veterans, and their families that was part of

the White House national initiative led by First Lady Michelle Obama and Dr. Jill Biden to engage the nation to give service members and their families meaningful opportunities and support. A very diverse group of individuals was trained during FY 2014. They included: consumers; family members; advocacy organizations; community-based agencies; health professionals and organizations; university staff and students; workforce development staff; faith-based organizations; behavioral health and other providers; federal government staff; District agencies (behavioral health, juvenile justice, child welfare, human services,education, police, parks and recreation); court probation; professional and lay persons; first responders; active military; and others.

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.

Partially Achieved. In FY 2014 the goal of training all DBH providers including sub and specialty providers on the use and administration of the Child and Adolescent Functional Assessment Scale (CAFAS) and the Preschool and Early Childhood Functional Assessment Scale (PECFAS) was achieved. In June 2014 implementation of the CAFAS/PECFAS began at several DBH programs. They included: 1) Parent Infant Early Childhood Enhancement Program, 2) School Mental Health Program (for children receiving summer services), and 3) the Residential Treatment Center Reinvestment Program that monitors youth while they are in a psychiatric residential treatment facility and post discharge. The original plan was to implement the CAFAS/PECFAS across all DBH providers in conjunction with the roll out of the new DBH care management system (iCAMS) on September 7, 2014. Due to security concerns the decision was made at the end of August to delay the full roll out of iCAMS. When the iCAMS system is ready, the CAFAS and PECFAS will be integrated into this data system for both completion of the instrument and storage of the data and reports. However, given the delay in the full roll out of iCAMS, a revised plan for implementation of the CAFAS/PECFAS was developed. All DBH providers will begin using the CAFAS/PECFAS on November 1, 2014. The CAFAS/PECFAS will be completed through the FAS Outcomes system, the web based system available through Multi Health Systems (MHS), the owner of the CAFAS/PECFAS. Once initiated, the CAFAS/PECFAS will then be completed every 90 days as long as services continue.

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

Partially Achieved. The data shows increased compliance for adults and children/youth across all four (4) continuity of care measures. The results for the percent of the target achieved include: adults seen within 7 days of discharge (87.89%), children/youth seen within 7 days of discharge (88.27), adults seen within 30 days of discharge (92.63%), and children/youth seen within 30 days of discharge (95.81%).

Saint Elizabeth's Hospital

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

INITIATIVE 1.1: Improve the quality of pharmaceutical care by reducing poly-pharmacy and accomplishing effective medication reconciliations across the continuum of care. Partially Achieved. The measures for this initiative do not have an absolute percentage scale. Also, the goal for the percent of discharges with ≥2 antipsychotic medications is to reduce the percentage. This was achieved as the target was 25% and the actual performance was 15%. The goal for the percent of discharges with appropriate justification documented when discharged with ≥2 antipsychotic medications is to increase the percentage. This was not achieved as the target was 20% and the actual performance was 14%, which is 70% of the target. Poly-pharmacy, the prescription of more than two (2) psychotropic medications, is a common practice in the treatment of psychiatric illness. While poly-pharmacy may sometimes be appropriate and justifiable, in general, physicians are encouraged to consider and try alternative medication regimens whenever possible. In fact, many regulatory bodies, including the Joint Commission on Accreditation of Hospitals**,** provide guidelines and measures on poly-pharmacy management. The Saint Elizabeths Hospital has been committed to curtail the use of poly-pharmacy and improve documentation related to poly-pharmacy practice. During FY 2014, the Hospital took a number of steps to implement this initiative. For example, the Pharmacy department and the Director of Psychiatry routinely track any complex pharmacology regiments. The pharmacy reviews when a second antipsychotic is started or a third neuroleptic is started and they communicate with the psychiatrist to see if the order is appropriate and make recommendations when appropriate. The Director of Psychiatric Services follows up with the attending psychiatrist when an individual is recommended for a trial of Clozapine. The Forensic Review Board also tracks any individuals on poly-pharmacy. Sometimes, more than one anti- psychotic medication may be appropriate following failures of multiple mono-therapy treatment attempts. In these cases, a brief documentation of a summary related to the medication review and decision making is requested to the ordering doctor.

INITIATIVE 1.2: Promote full implementation of recovery model.

Partially Achieved. There were two (2) measures for this initiative. The percent of new clinical staff with competency-based recovery model training was projected at 85% and the achievement was 100%, which exceeded the target by 15%. The percent of nursing staff with competency-based recovery model training was projected at 95% and the achievement was 90%, which fell slightly short of the target. Building upon the basic recovery training provided to all nursing staff in FY 2013, additional training started for all team leaders and a majority of charge nurses in FY 2014. These trainings were designed to help the participants develop the skills necessary to meet the challenges of their roles, to more effectively and efficiently achieve their performance standards, and ultimately enhance the communication between individuals in care and staff as well as interdisciplinary communication As of September 30, 2014, the Hospital had a total of 33 team leaders who completed the recovery model training. Additionally, there were 58 charge nurses and of those, 49 or 84% completed the training by the end of FY 2014. This makes 90% (82) of the total nursing staff in leadership positions (91) in compliance with the FY 2014 recovery model training requirements. The remaining charge nurses will complete the training by December 31, 2014. In addition, an overview of the recovery model was provided to all new clinical staff hired in FY 2014. The overview highlights the principles of the recovery model as well as the history of the implementation of the recovery model at the Hospital. In FY 2014, there were a total of 65 new clinical employees who were required to attend this training and all of them (100%) completed this training during their new employee orientation/training weeks.

Key Performance Indicators – Details

Performance Assessment Key:

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

	KPI	Measure Name	FY 2013 YE Actual	FY 2014 YE Target	FY 2014 YE Revised Target	FY 2014 YE Actual	FY 2014 YE Rating	Budget Program
Addiction Prevention and Recovery Administration								
	1.1	Number of adults reached through planned prevention strategies	7,548	8,400		15,487	184.37%	ADDICTION PREVENTION AND RECOVERY ADMIN
	1.2	Number of youth reached through planned prevention strategies	8,527	7,200		17,022	236.42%	ADDICTION PREVENTION AND RECOVERY ADMIN
	2.1	Percent of adults that successfully complete treatment	59.4%	60%		61.32%	102.20%	ADDICTION PREVENTION AND RECOVERY ADMIN
	2.2	Percent of youth that successfully complete treatment	19.6%	25%		10.64%	42.55%	ADDICTION PREVENTION AND RECOVERY ADMIN
Behavioral Health Authority								
	2.1	Introduction to co-occurring treatment	NA	20		17	85.00%	MENTAL HEALTH AUTHORITY
	2.2	Number of School Mental Health Programs	52	71		62	87.32%	MENTAL HEALTH AUTHORITY
	2.3	Number of early childhood services locations -Primary Project	35	54		44	81.48%	MENTAL HEALTH AUTHORITY
	3.1	Provider Scorecard "mental health providers average quality adult and child score	86.41	85		92	108.24%	MENTAL HEALTH AUTHORITY
	3.2	Provider Scorecard-providers average	69.11	85		76	89.41%	MENTAL HEALTH AUTHORITY

	KPI	Measure Name	FY 2013 YE Actual	FY 2014 YE Target	FY 2014 YE Revised Target	FY 2014 YE Actual	FY 2014 YE Rating	Budget Program
		financial score						
🟡	**4.1**	Adult Community Services Review (CSR) system score	NA	80		73.81%	92.26%	MENTAL HEALTH AUTHORITY
⚪	**4.2**	Child Community Services Review (CSR) system score	70	NA		No data reported[1]	Not Rated	MENTAL HEALTH AUTHORITY
Saint Elizabeth's Hospital								
🟢	**1.1**	Percent discharges with 2 or more anti-psychotic meds	NA	25%		15.17%	164.80%	SAINT ELIZABETH'S HOSPITAL
🔴	**1.2**	Percent discharges justification documented when discharged with 2 or more anti-psychotic meds	NA	20%		14.29%	71.43%	SAINT ELIZABETH'S HOSPITAL
🟡	**1.3**	Percent of nursing staff with competency-based recovery model training	95%	95%		90.11%	94.85%	SAINT ELIZABETH'S HOSPITAL
🟢	**1.4**	Percent of clinical staff with competency-based recovery model training	NA	85%		100%	117.65%	SAINT ELIZABETH'S HOSPITAL
🟡	**1.5**	Total patients served per day	267	275		283	89.41%	SAINT ELIZABETH'S HOSPITAL
🟢	**1.6**	Elopements per 1,000 patient days	0.31	0.28		0.09	299.30%	SAINT ELIZABETH'S HOSPITAL
🔴	**1.7**	Patient injuries per 1,000 patient days	0.15	0.25		0.34	72.88%	SAINT ELIZABETH'S HOSPITAL
🔴	**1.8**	Percent of missing documentation of medication administration results	0.41%	0.25%		0.61%	40.98%	SAINT ELIZABETH'S HOSPITAL
🔴	**1.9**	Percent of unique patients who were	0.03%	0.01%		0.44%	2.27%	SAINT ELIZABETH'S HOSPITAL

	KPI	Measure Name	FY 2013 YE Actual	FY 2014 YE Target	FY 2014 YE Revised Target	FY 2014 YE Actual	FY 2014 YE Rating	Budget Program
		restrained at least once during month						
●	**1.1**	Percent of unique patients who were secluded at least once during month	0.97%	1.00%		2.12%	47.16%	SAINT ELIZABETH'S HOSPITAL
●	**1.1**	Percent of patients re-admitted to Saint Elizabeth's Hospital within 30 days of discharge	5.59%	5.90%		2.03%	285.65%	SAINT ELIZABETH'S HOSPITAL
Behavioral Health Financing/Fee for Service								
●	**1.1**	Percent of clean claims adjudicated within 30 days of receipt	NA	98%		98.20%	100.20%	MENTAL HEALTH FINANCING/ FEE FOR SERVICE
●	**1.2**	Percent of District residents, accessing services through ASARS, screened for Medicaid eligibility within 90 days of the first date of service	NA	NA		No data reported[2]	Not Rated	MENTAL HEALTH FINANCING/ FEE FOR SERVICE
Behavioral Health Services Supports								
●	**1.1**	Number of certified Peer Specialist	14	20		34	170%	MENTAL HEALTH SERVICES AND SUPPORTS
●	**1.2**	Women served by Re-Entry Coordinator in women's jail	NA[3]	60		100	166.67%	MENTAL HEALTH SERVICES AND SUPPORTS
●	**2.1**	Number of people in Mental Health First Aid trainings	1,114	800		1,866	233.25%	MENTAL HEALTH SERVICES AND SUPPORTS
●	**3.1**	Percent adults receive at least 1 non-crisis service within 7 days discharge psychiatric hospitalization	67.86%	70%		61.52%	87.88%	MENTAL HEALTH SERVICES AND SUPPORTS

	KPI	Measure Name	FY 2013 YE Actual	FY 2014 YE Target	FY 2014 YE Revised Target	FY 2014 YE Actual	FY 2014 YE Rating	Budget Program
●	**3.2**	Percent children/youth receive at least 1 non-crisis service within 7 days discharge psychiatric hospitalization	67.33%	70%		61.79%	88.27%	MENTAL HEALTH SERVICES AND SUPPORTS
●	**3.3**	Percent adults receive at least 1 non-crisis service within 30 days discharge psychiatric hospitalization	78.24%	80%		74.10%	92.62%	MENTAL HEALTH SERVICES AND SUPPORTS
●	**3.4**	Percent children/youth receive at least 1 non-crisis service within 30 days discharge psychiatric hospitalization	83.3%	80%		76.65%	95.81%	MENTAL HEALTH SERVICES AND SUPPORTS
Agency Management								
●	**1.1**	Number of adult consumers served	18,680	Not Applicable		21,536	Workload Measure Not Rated	AGENCY MANAGE-MENT
●	**1.2**	Number of child and youth consumers served	4,126	Not Applicable		5,017	Workload Measure Not Rated	AGENCY MANAGE-MENT
●	**1.3**	MHSD Intake/Same Day Service Urgent Care Clinic and adults	3,628	Not Applicable		3,930	Workload Measure Not Rated	AGENCY MANAGE-MENT
●	**1.4**	MHSD Intake/Same Day Service Urgent Care Clinic and children/youth	327	Not Applicable		272	Workload Measure Not Rated	AGENCY MANAGE-MENT
●	**1.5**	Number of Comprehensive Psychiatric Emergency Program (CPEP) visits	3,961	Not Applicable		3,784	Workload Measure Not Rated	AGENCY MANAGE-MENT

	KPI	Measure Name	FY 2013 YE Actual	FY 2014 YE Target	FY 2014 YE Revised Target	FY 2014 YE Actual	FY 2014 YE Rating	Budget Program
●	**1.6**	Number of adult mobile crisis team visits	1,382	Not Applicable		1,794	Workload Measure Not Rated	AGENCY MANAGE-MENT
●	**1.7**	Number of child mobile crisis team visits	608	Not Applicable		717	Workload Measure Not Rated	AGENCY MANAGE-MENT
●	**1.8**	Crisis stabilization bed utilization	87.98%	Not Applicable		89.06%	Workload Measure Not Rated	AGENCY MANAGE-MENT
●	**1.9**	Involuntary acute psychiatric adult admissions	0.97	Not Applicable		0.13%	Workload Measure Not Rated	AGENCY MANAGE-MENT

[1]Starting in FY14 the Adult and Child CSRs will be conducted every other year on an alternating schedule. The Child CSR will be conducted in FY15, no data to report.
[2]The ASARS implementation is pending approval of the state plan amendment (SPA) that will occur in FY15; no data to report.
[3]This KPI was Introduced in FY14.