Q71. Please provide the results of the midyear and last year's end of the year surveys that were distributed to school administrators to measure the satisfaction of services provided by SMHP clinicians. In your response, please indicate any actions taken to address concerns raised in the FY14 surveys regarding the need to have additional or full-time SMHP clinicians in schools.

DBH Response:

Administrators were asked to complete a midyear and end of the year satisfaction survey asking for feedback regarding the services provided by the SMHP clinicians. During SY 14-15, thirty (53 per cent) of the administrators returned the midyear survey (N=57) and 44 (75 per cent) administrators returned the end of the year survey (N=59). Overall, the results from both of the surveys were extremely positive and the administrators were satisfied with the SMHP services.

The majority of administrators reported that SMHP clinicians were knowledgeable about mental health issues of the students at their schools, were professional and had a caring attitude, and adhered to and complied with the school policies in conjunction with the implementation of the program. In addition, they reported that clinicians were available and provided services and support to children and families, as well as, the teachers and staff. For example, almost all of the administrators at midyear (93 per cent) and at the end of the year (91 per cent) indicated that clinicians worked collaboratively with school staff, parents/guardians and students to meet the mental health needs of the school. Approximately 86 per cent of the administrators also reported that the clinicians were flexible and available to see students and families as needed. In addition, nearly all of the administrators (97 per cent at midyear and 93 per cent at the end of the year) reported that they felt comfortable consulting with the SMHP clinician regarding a student with a social or emotional concern and 86 per cent of the administrators at midyear and at the end of the year were satisfied with the outcome of the consultation.

While the majority of administrators (83 per cent) were satisfied with the quality of services, 30 per cent of the administrators at the end of the year indicated the range of services was not adequate. Of these individuals approximately half indicated the need for a full-time clinician or requested an additional SMHP clinician to be placed at their school. This is consistent with the FY 14 surveys. At this time, the SMHP does not have any additional clinicians to place in the schools who have requested increases in either clinician time or an additional clinician.

Overall the results of the survey were extremely positive, and all but two of the administrators indicated that they would like for the SMHP to continue providing services at their schools.

Q72. Please provide an update on the implementation of iCAMS for SMHP and how this has improved the integration of care.

DBH Response:

All aspects of SMHP treatment services are fully integrated in iCAMS. Full integration in iCAMS moved the program from paper-based client records to a centralized electronic health record system that establishes one record for each consumer regardless of the program or service assignment across all DBH mental health provider network. As a result, SMHP clinicians are better able to coordinate care and collaborate with other mental health providers/agencies ensuring an integrated approach to care. This shared access to consumer's record supports communication and information sharing across agencies and programs and serves as a significant strength in the system of care in the District. Integration in iCAMS has supported improvement in continuity of care for consumers, communication and data sharing in real time.

The SMHP is also working with the iCAMS team to customize the system to track the prevention services and supports delivered to children and youth.

Q73. Please provide an update on the High Fidelity Wraparound Program. How many individuals were served in FY15 and to date in FY16?

- *a. How many individual were served in FY15?*
- *b. How many children were diverted from PRFT placements? Please provide a breakdown for the school and community-based programs.*
- *c. What community-based organizations provide the case management for the wrap program? How many children did each serve?*
- *d. Please provide any outcome evaluations or reports of the program from the past two years.*

DBH Response

a. How many individual were served in FY15?

In FY 15, a total of 319 children and their families were served in the High Fidelity Wraparound process. In the first quarter FY16, a total of 188 children and families are receiving Wraparound.

b. How many children were diverted from PRFT placements? Please provide a breakdown for the school and community-based programs.

Of the 319 children and families who received wraparound in FY15, 154 (48% of total wraparound population) were referred from the District of Columbia Public Schools. 100% of youth served by the school-based wraparound initiative were diverted from placement in PRTF. Of the 165 (52% of total wraparound population) youth receiving wraparound in the community, 158 (96%) youth were diverted from PRTF and continue to receive services within the community and 7 (4% of the sub population) were placed in PRTFs. Of the 319 children who received wraparound services 98% were diverted from PRTF placement.

c. What community-based organizations provide the case management for the Wrap Program? How many children did each serve?

In FY15, DC Choices and two Collaborative agencies through the Healthy Families Thriving Community Council provided High Fidelity Wraparound through a contract with DBH. See chart below. A solicitation for High Fidelity Wraparound was issued in April 2015. As a result of the Request For Proposal (RFP) evaluation process, Choices was selected as the Care Management Entity.

Community-Based Organization	Number of Children Served in FY15	Number of Children Served in FY16
DC Choices	269	188
Healthy Families Thriving Community Council Far Southeast Family Strengthening Collaborative/ Georgia Avenue Collaborative	50	N/A*
Total	319	188

* Healthy Families thriving Community Council is no longer a Wraparound contractor.

d. Please provide any outcome evaluations or reports of the program from the past two years.

See Attachment 1 of 2 - FY 14 Evaluations

Attachment 2 of 2- FY 15 Evaluations

Q74. Please provide an update on DBH's work with OSSE to provide intense wraparound services to students. Which schools have been targeted? What services are provided? How many students at each school were served in FY15 and to date in FY16?

DBH Response:

In FY15, the DC Office of the State Superintendent of Education (OSSE) provided $1,575,284.00 to DBH to support the implementation of High Fidelity Wraparound for one hundred and twenty (120) students in Students Forward Program (formerly Full Service Schools). High Fidelity Wraparound was provided at the following schools: Cardozo EC High School, Elliot Hines Middle School, Hart Middle School, Jefferson Middle School, Johnson Middle School, Kelly Miller Middle School, Kramer Middle School, Sousa Middle School, Stuart Hobson Middle Schools and Stanton Elementary School.

The following services are provided to children, youth and families in the High fidelity Wraparound process:

Individualized Planning - Child and Family Team meetings are conducted for all children referred for wraparound. A multidisciplinary team comprised of the family and representatives of all of the agencies serving the youth attend these meetings. The goal is to develop and individualized support plan to maintain the child within his home and community.

Care Coordination – Enhanced planning and coordination is provided for children and youth who are multi-system involved with histories of high utilization of inpatient, emergency room, psychiatric residential facility high dosage of behavioral health services. Intensive coordination is also provided to youth with a diagnosis of bipolar, or depression and who might have issues related to adherence and discontinuation of certain medications.

Mental Health Rehabilitation Services – Children and youth are linked to a DBH provider to receive any of the following mental health services offered through DBH: diagnostic/assessment, medication/somatic, counseling, community support, crisis/emergency, Community Based Intervention (CBI) levels 1 through 4.

Non-Traditional Supports and Services - Flexible funding is used to provide a wide variety of needed services and supports that are not otherwise funded within the system of care.

DC Choices is the contracted Care Management Entity (CME) responsible for Wraparound in the schools. The Care Coordinators are responsible for service coordination, linkage to appropriate services and monitoring of the service delivery. They also provide interventions and supports to families in crisis. Care Coordinators have access to flexible dollars that can be used to secure a wide array of support and resources for students and their families, ranging from a highly intensive service such as respite to community based mentoring, family mentoring support, sport and club registration as identified in the coordinated plan of care. These funds are used to purchase non-traditional services and supports not otherwise funded and are deemed necessary to keep youth with their families, in their schools and community.

Youth Served in FY15 and FY16

School	FY 15 - Number of Youth Served	FY 16 1st Quarter - Number of Youth Served
Cardozo EC	10	8
Eliot Hine Middle School	15	10
Hart Middle School	27	19
Jefferson Middle School	11	4
Johnson Middle School	17	12
Kelly Miller Middle School	28	20
Kramer Middle School	10	9
Sousa Middle School	10	11
Stanton Elementary School	13	9
Stuart Hobson Middle School	13	10
Grand Total	**154**	**112**

Q75. Please provide the list of services available as part of the Mental Health Rehabilitation Services (MHRS) system. Specifically, please provide a description of each service and indicate whether or not it is available as part of the Medicaid MHRS program, the non-MHRS program, or both. In addition, please provide the FY15 and current reimbursement rates for each service. Please provide any reports or studies used to determine the impact of a decrease in day services rates on community providers

DBH Response:

All MHRS services are available to eligible consumers regardless of coverage. The service array for a consumer is determined by medical necessity.

There are eleven basic MHRS Reimbursable Services. Two new services were added to the MHRS Reimbursable Services: Trauma Focused Cognitive Behavioral Therapy and Child Parent Psychotherapy for Family Violence.

MHRS Service	MHRS Service Description
Diagnostic/ Assessment	A Diagnostic/Assessment is an intensive clinical and functional evaluation of a Consumer's mental health condition that results in the issuance of a Diagnostic Assessment Report with recommendation for service delivery that provides the basis for the development of an Individualized Recovery Plan ("IRP") for adults or an Individualized Plan of Care ("IPC") for children and youth. A Diagnostic/Assessment shall determine whether the Consumer is appropriate for and can benefit from MHRS, based upon the Consumer's diagnosis, presenting problems and recovery goals. The Diagnostic/Assessment shall also evaluate the Consumer's level of readiness and motivation to engage in treatment.
Medication/ Somatic Treatment	Medication/Somatic Treatment services are medical interventions including: physical examinations; prescription, supervision or administration of mental health-related medications; monitoring and interpreting results of laboratory diagnostic procedures related to mental health-related medications; and medical interventions needed for effective mental health treatment provided as either an individual or group intervention. Medication/Somatic Treatment services include monitoring the side effects and interactions of medications and the adverse reactions a Consumer may experience, and providing education and direction for symptom and medication self-management. Group Medication/Somatic Treatment shall be therapeutic, educational and interactive with a strong emphasis on group member selection, facilitated therapeutic peer interaction and support.
Counseling	Counseling services are individual, group or family face-to-face services for symptom and behavior management; development, restoration or enhancement of adaptive behaviors and skills; and enhancement or maintenance of daily living skills. Adaptive behaviors and skills and daily living skills include those skills necessary to access community resources and support systems, interpersonal skills and restoration or enhancement of the family unit and/or support of the family. Mental health support and consultation services provided to Consumers' families are reimbursable only when such services and supports are directed exclusively to the well-being and benefit of the Consumer.
Community Support	Community Support services are rehabilitation supports considered essential to assist the Consumer in achieving rehabilitation and recovery goals. Community Support services focus on building and maintaining a therapeutic relationship with

MHRS Service	MHRS Service Description
	the Consumer. Community Support activities include: 1. Participation in the development and implementation of a Consumer's IRP/IPC and Community Support Individualized Service Specific Plan ("ISSP"); 2. Assistance and support for the Consumer in stressor situations; 3. Mental health education, support and consultation to Consumers' families and/or their support system, which is directed exclusively to the well-being and benefit of the Consumer; 4. Individual mental health service and support intervention for the development of interpersonal and community coping skills, including adapting to home, school and work environments; 5. Assisting the Consumer in symptom self-monitoring and self-management for the identification and minimization of the negative effects of psychiatric symptoms which interfere with the Consumer's daily living, financial management, personal development or school or work performance; 6. Assistance to the Consumer in increasing social support skills and networks that ameliorate life stresses resulting from the Consumer's mental illness or emotional disturbance and are necessary to enable and maintain the Consumer's independent living; 7. Developing strategies and supportive mental health interventions for avoiding out-of-home placement for adults, children and youth and building stronger family support skills and knowledge of the adult, child or youth's strengths and limitations; and 8. Developing mental health relapse prevention strategies and plans.
Crisis/Emergency	Crisis/Emergency is a face-to-face or telephone immediate response to an emergency situation involving a Consumer with mental illness or emotional disturbance that is available twenty-four (24) hours per day, seven (7) days per week. Crisis/Emergency services are provided to Consumers involved in an active mental health crisis and consist of immediate response to evaluate and screen the presenting situation, assist in immediate crisis stabilization and resolution and ensure the Consumer's access to care at the appropriate level. Crisis/Emergency services may be delivered in natural settings and the Crisis/Emergency provider shall adjust its staffing to meet the requirements for immediate response. Each Crisis/Emergency provider shall obtain consultation, locate other services and resources, and provide written and oral information to assist the Consumer in obtaining follow-up services. Each Crisis/Emergency provider shall also be a DMH-certified provider of Diagnostic/Assessment or have an agreement with a Core Services Agency or a Core Services Agency's affiliated Sub provider to assure the provision of necessary hospital pre-admission screening. This service includes Child and Adolescent Mobile Psychiatric Service (ChAMPS) This is a crisis response and stabilization service for all children and adolescents residing in the District of Columbia. The service is available to respond to mental health crisis 24 hours a day, seven day a week.
Day Services	Day Services is a structured clinical program intended to develop skills and foster social role integration through a range of social, psycho educational, behavioral and cognitive mental health interventions. Day Services are rendered only in a DMH-certified Community Mental Health Rehabilitation Services Agency and are not eligible for reimbursement when provided in the home, community setting or residential facility of 16 beds or less. Day Services are curriculum-driven and psycho educational and assist the Consumer in the retention or restoration of community living, socialization and adaptive skills. Day Services include

MHRS Service	MHRS Service Description
	cognitive-behavioral interventions and diagnostic, psychiatric, rehabilitative, psychosocial, counseling and adjunctive treatment. Day Services are offered most often in group settings, and may be provided individually.
Intensive Day Treatment	Intensive Day Treatment is a structured, intensive and coordinated acute treatment program that serves as an alternative to acute inpatient treatment or as a step-down service from inpatient care, rendered by an inter-disciplinary team to provide stabilization of psychiatric impairments. Intensive Day Treatment services are rendered only in a DMH-certified Community Mental Health Rehabilitation Services Agency's site and are not eligible for reimbursement when provided in the home, community setting or residential facility of 16 beds or less. Intensive Day Treatment is time-limited and provided in an ambulatory setting for no less than five hours a day, seven days a week. Daily physician and nursing services are essential components of this service.
Community-Based Intervention	Community-Based Intervention services are time-limited intensive mental health intervention services delivered to children, youth and adults and intended to prevent the utilization of an out-of-home therapeutic resource by the Consumer (i.e., psychiatric hospital or residential treatment facility). Community-Based Intervention is primarily focused on the development of Consumer skills and is delivered in the family setting in order for the Consumer to function in a family environment. These services are available twenty-four hours a day, seven days a week. The basic goals of Community-Based Intervention services are to: 1. Diffuse the current situation to reduce the likelihood of a recurrence, which if not addressed could result in the use of more intensive therapeutic interventions; 2. Coordinate access to covered mental health services; 3. Provide mental health service and support interventions for Consumers that develop and improve the ability of parents, legal guardians or significant others to care for the person with mental illness or emotional disturbance. Community-Based Intervention services shall be multi-faceted in nature and include situation management, environmental assessment, interventions to improve Consumer and family interaction, skills training, self and family management, and coordination and linkage with covered mental health rehabilitation services and supports and other covered Medicaid services in order to prevent the utilization of more restrictive residential treatment. Community-Based Intervention services shall be delivered primarily in natural settings and shall include in-home services. In-home services - regarding medications and behavior management skills; dealing with the responses of the Consumer, other caregivers and family members; and coordinating with other mental health rehabilitation treatment providers - include support and consultation to the Consumer's families and/or their support system, which is directed exclusively to the well-being and benefit of the Consumer. There are four levels of CBI Services. One level is described above the other three levels are described in a-c as follows:
a. Functional Family Therapy	This is a service designed for children and youth between the ages of 10 and 18 with documented histories of moderate to serious behavioral problems that impair functioning in at least one domain of the child/youth's life, e.g. home or school and may be at risk of a disruption in placement. Eligible candidates and their caregiver (s) must be willing to participate in the treatment for its duration. This service is billed under Community-Based Intervention.

MHRS Service	MHRS Service Description
b. Multisystemic Therapy (MST)	MST services are intended for children and youth who are experiencing serious emotional disturbance with a documented behavioral concern with externalizing (aggressive or violent) behaviors or a history of chronic juvenile offenses that has or may result in involvement with the juvenile justice system. This level is delivered in accordance with the MST Model. Eligible consumers shall have a permanent care giver who is willing to participate for the duration of the CBI treatment and be at risk for out-of- home placement within thirty (30) days or currently in out-of-hone placement due to the consumer's disruptive behavior, with permanent placement expected to occur within thirty (30) days. This service is billed under Community-Based Intervention.
c. Intensive Home & Community Based Service (IHCBS)	IHCBS services are delivered in accordance with the IHCBS model as adopted by DBH. Eligible consumers for this service have situational behavioral problems that require short-tem, intensive treatment; currently dealing with stressor situations such as trauma or violence and requires development of coping and management skills; recently experienced out-of-home placement that requires development of communication and coping skills to manage the placement change; is undergoing transition from adolescence to adulthood and requires skills and supports to successfully manage the transition; recently discharged from an inpatient setting such as acute hospitalization or psychiatric residential treatment facility or is an adult parent or caregiver with a clinically significant mental health concern and the parent or caregiver will be parenting a child or youth returning from a residential treatment center within the next ninety (90) days. This service is billed under Community-Based Intervention.
Assertive Community Treatment (ACT)	Assertive Community Treatment (ACT) is an intensive integrated rehabilitative, crisis, treatment and mental health rehabilitative community support provided by an interdisciplinary team to children and youth with serious emotional disturbance and to adults with serious and persistent mental illness. ACT services are provided to Consumers in accordance with the IRP/IPC with dedicated staff time and specific staff to Consumer ratios. Service coverage by the ACT Team is required twenty-four (24) hours per day, seven (7) days per week. The Consumer's ACT Team shall complete a comprehensive or supplemental assessment and develop a self-care-oriented Individualized Service Specific Plan (ISSP) (if a current and effective one does not already exist). Services offered by the ACT team shall include: (1) Mental health-related medication prescription, administration and monitoring; (2) Crisis assessment and intervention; (3) Symptom assessment, management and individual supportive therapy; (4) Substance abuse treatment for Consumers with a co-occurring addictive disorder; (5) Psychosocial rehabilitation and skill development; (6) Interpersonal social and interpersonal skill training; and (7) Education, support and consultation to Consumers' families and/or their support system, which is directed exclusively to the well-being and benefit of the Consumer. Assertive Community Treatment shall include a comprehensive and integrated set of medical and psychosocial services for the treatment of the Consumer's mental health condition that is provided in non-office settings by the Consumer's ACT Team. The ACT Team provides community support services that are interwoven with treatment and rehabilitative services and regularly scheduled team meetings.
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)	Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a psychotherapeutic intervention designed to address significant emotional and behavioral difficulties related to traumatic life events. TF-CBT sessions focus on addressing the child's posttraumatic stress disorder, depression, anxiety, externalizing behaviors, sexualized behaviors, feelings of shame, and mistrust. TF-CBT also provides

MHRS Service	MHRS Service Description
	parents or caregivers with the tools needed to reinforce the content covered with the child between sessions and after treatment has ended. Consistent with EPSDT requirements, TF-CBT services are available to individuals under age four (4) and through ages eighteen (18) to twenty (20) who meet the clinical criteria for coverage under the TF-CBT MHRS program and also meet the criteria for program enrollment, but for their age. This service is billable under Trauma Focused Cognitive Behavioral Therapy.
Child and Parent Psychotherapy for Family Violence (CPP-FV)	Child-Parent Psychotherapy for Family Violence (CPP-FV) is a relationship-based treatment intervention to address children's exposure to trauma or maltreatment. CPP-FV sessions are conjoint with the child's parent(s) or caregiver(s) focusing on improving the child's development trajectory CPP-FV helps restore developmental functioning in the wake of violence and trauma by focusing on restoring the attachment relationship that was negatively affected by trauma. CPP-FV is geared toward young children, ages zero (0) through six (6), who suffer from traumatic stress and often have difficulty regulating their behaviors and emotions during distress. This service is billable under Child-Parent Psychotherapy for Family Violence.

Non Medicaid Reimbursable Mental Health Services

PROGRAM	Service Description
Contracted Community Residential Services	DMH has contracts with 4 DMH certified MHRS providers with licensed Community Residential Facilities (CRF) to provide 24 hour supervised care, support and management to 201consumers.
Supported Independent Living	This program provides a safe home setting and community environment for consumers as they recover from mental illness. The goal is to provide assistance to consumers as they move to less restrictive levels of care by providing life skills training designed to support community tenure.
Adult Crisis Stabilization Beds	DMH operates two Residential Crisis Stabilization facilities with the capacity to serve 15 consumers. These structured residential treatment facilities are an alternative to psychiatric inpatient hospitalization for persons in need of acute amelioration of psychiatric symptoms, but who are able to contract for safety and are assessed able to receive this treatment outside of an inpatient setting.
Supported Employment	Supported Employment is an evidence-based employment model for consumers 18 years of age or older with serious and persistent mental illness or serious emotional disturbance. It is seeks to prepare consumer for competitive employment as part of their mental health recovery based treatment. Supported employment consists of community-based employment in integrated work settings that are consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice of the consumer. It is designed for consumers for whom competitive employment has not traditionally occurred, or for whom competitive employment has been interrupted or has been intermittent as a result of a significant disability. Supported Employment has therapeutic service components that are reimbursable under Medicaid. Most Supported Employment services are vocational in nature and are not eligible for Medicaid reimbursement.
Court Urgent Care Clinic (CUCC)	The Court Urgent Care Clinic is located within the DC Superior Court. The clinic serves individuals who have contact with the court system and are found to be in need of mental health services. This includes individuals referred from the District of Columbia Misdemeanor and Traffic Community Court, other criminal Division courtrooms and

PROGRAM	Service Description
	the District of Columbia Pre-Trial Services Agency. Through assessment, evaluation, treatment services and intensive case management, clients are treated and triaged to specific providers within both the public and private delivery systems to meet their short and long term goals.
High Fidelity Wrap Around Services	The purpose of this initiative is to implement community-based alternative services for District youth at risk for or returning from an out of home Psychiatric Residential Treatment Facility (PRTF) placement and for youth who have experienced multiple placements and/or hospitalizations.
Early Childhood Treatment	This program provides mental health services to children between the ages of zero and eight with a primary focus on children between the ages of zero and five years. The program provides early intervention with an array of services designed to prevent, reduce and treat emotional and behavioral problems, promote social and emotional competence in the child and assess and reduce stressors for the parents/family to promote a healthy home environment. The program provides comprehensive assessments for the parent(s), infant and child as well as treatment services, such as psychiatric services, psychotherapy, counseling, case management, play and art therapy, home visitation services (as needed), parenting psycho-education and support groups, and outreach and linkage to other community-based services, as needed. All District of Columbia children are eligible for this program.
Health Futures: Early Childhood Mental Health Consultation	Healthy Futures is an early childhood mental health consultation program providing Center-based and Child and Family Centered Consultation in 27 child development centers throughout the District. Early childhood mental health consultation involves a professional consultant with mental health expertise working collaboratively with early care and education staff, programs and families to improve their ability to prevent, identify, and respond to mental health issues among children in their care. In contrast to direct therapeutic services, ECMHC offers an indirect approach to reducing problem behaviors in young children and, more broadly, promotes positive social and emotional development. An Early Childhood Mental Health Clinical Specialist staffs each Child Development Center one day per week, providing a range of consultative services, as well as referral and linkage to more intensive mental health services as needed.
Health Start Program	The Healthy Start Program is an interagency collaborative partnership between the Department of Health (DOH) and the Department of Mental Health (DMH) that was established to provide a support network for pregnant and parenting women throughout wards 5, 6, 7 and 8, i.e. catchment areas in DC indicating high rates of infant mortality. This project was initiated to reduce infant mortality, provide resources and ensure support for pregnant and parenting women and their children and families. The primary goals of the project are to first identify and reach women who have: 1.) children between the ages of zero and two and 2.) current or past histories of depression and 3.) to provide them with the support necessary to establish both strong attachments with their infant/child and safe, healthy living environments; critical elements towards the promotion of healthy development in infants and children. Through this program, women receive individualized services consisting of: individual and family therapy, psychiatric, psychological, or counseling services and outreach and linkage to additional community services, as needed. This program serves any woman living in Wards 5, 6, 7 and 8. The Healthy Start Project is one of 15 programs of its kind in the country.
Primary Project	The Primary Project is a school-based, early intervention and prevention program designed to enhance school related competencies and reduce social, emotional and school adjustment difficulties in children attending school, grades K-3. Young children with early school adjustment difficulties are identified through the use of carefully developed screening and detection methods. Children with the following observable behaviors are most often appropriate for the program: excessive shyness, anxiety, withdrawal, defiance, moodiness, demonstrated problems engaging other peers in

PROGRAM	Service Description
	positive relationships, demonstrated mild physical aggression or children who generally experience school as unpleasant. Children are systematically screened to identify those with emerging difficulties but may also be recommended for participation in the program by teachers, other school personnel or parent(s). Children who are selected as appropriate candidates for the program and whose parents have given consent are then paired with specially trained Child Associates who work utilizing a child-led play philosophy. Parent(s) are encouraged to communicate directly with the program manager when any questions arise or to schedule a visit to the playroom.
Assessment Center	The Assessment Center evaluators provide mental health consultation services via court-ordered assessments for children, youth and families involved with the Family Division of DC Superior Court. DMH's Assessment Center conducts forensic mental health assessments and evaluations for court involved children and youth in the juvenile justice and child welfare systems. It also provides mental health evaluations for parents and families who have domestic relations cases being heard in the Family Court Division of the DC Superior Court. The mental health professionals conduct the following evaluations: psychological, neurological, psycho-educational, psychiatric, psycho-social and attachment (bonding) evaluations.

The rate reduction for day treatment services has not been implemented. Meanwhile, DBH is using medical necessity as the criterion for participation and is continuing to closely monitor expenditures.

See Attachment. MHRS rates.

Q76. For MHRS Medicaid payments, please identify the average length of time between:

a. Date of service and date the claim was received;
b. Date the claim was received and date the claim was adjudicated;
c. Date the claim was adjudicated and date the claim is warranted for payment; and,
d. Date the claim is warranted for payment and date of the actual payment.

DBH Response:

Please see Attachment. MHRS Medicaid Payments Average Length of Time

Q77. For MHRS local-only claim payments, please identify the average length of time between:

a. Date of service and date the claim was received;
b. Date the claim was received and date the claim was adjudicated;
c. Date the claim was adjudicated and date the claim is warranted for payment; and,
d. Date the claim is warranted for payment and date of the actual payment.

DBH Response:

Please see Attachment. MHRS Local Payment Average Length of Time

Q78: Please provide the monthly MHRS utilization data for FY15 and to date in FY16. Specifically, please include the following:

- *a. A breakdown of Medicaid MHRS vs. non-Medicaid MHRS;*
- *b. For Medicaid MHRS, please provide a breakdown by managed care vs. fee-for-service (and include a breakdown by specific managed care organization);*
- *c. For non-Medicaid MHRS enrollees, please indicate whether the individual had coverage via the DC Healthcare Alliance, or was uninsured; and,*
- *d. For non-Medicaid MHRS enrollees, please provide a breakdown by income.*

DBH Response:

Please see Attachments 1 and 2, MHRS Utilization data for FY15 and to date in FY16, and MHRS Managed Care vs. Fee-for-Service breakdown by MCO payer and Alliance.

All non-Medicaid enrollees are determined for MHRS based on 300% of Federal poverty level for child/youth, and 200% of Federal poverty level for adults.

Q79: *Please provide the name of all certified MHRS providers. For each provider, please provide the following information for FY14, FY15 and to date in FY16:*

- *Whether or not the provider utilizes the Medicaid MHRS program, the locally-funded MHRS program, or both;*
- *The amount of their Human Care Agreements (HCA);*
- *The amount of their purchase orders;*
- *Actual expenditures under the purchase order;*
- *Any modifications that were made to a HCA or purchase order, including an explanation for the modification;*
- *Number of individuals served per purchase order. Please provide a breakdown by Medicaid vs. non-Medicaid enrollees;*
- *Service utilization per purchase order; and,*
- *Any complaints, investigations, or audits of the provider by DBH and the results of any such investigation or audit.*

DBH Response

- Whether or not the provider utilizes the Medicaid MHRS program, the locally-funded MHRS program, or both;
- The amount of their Human Care Agreements (HCA);
- The amount of their purchase orders;
- Actual expenditures under the purchase order;
- Any modifications that were made to a HCA or purchase order, including an explanation for the modification;
- Number of individuals served per purchase order. Please provide a breakdown by Medicaid vs. non-Medicaid enrollees;
- Service utilization per purchase order; and,

See Attachment 1 of 4. Certified MHRS Provider FY14 Claims Status
Attachment 2 of 4. Certified MHRS Provider FY15 Claims Status
Attachment 3 of 4. Certified MHRS Provider FY16 Claims Status
Attachment 4 of 4. Provider Claims Audit Report

Q80: Please provide the following information for MHRS providers for FY14, FY15, and to date in FY16:

- *Rate of claims denial, broken out by provider;*
- *Average length of time between when claims are submitted by providers and when they are determined to be "clean" by DBH;*
- *Average length of time between when a "clean" locally-funded claim is submitted to DBH and when it is adjudicated;*
- *Average length of time between when a "clean" locally-funded claim is adjudicated by DBH and when it is paid;*
- *Rate of "clean" Medicaid claims transmitted by DBH to DHCF within 5 working days of receipt;*
- *Average length of time between when a "clean" Medicaid claim is submitted to DHCF and when it is adjudicated;*
- *Rate of claims paid within 30 days of being warranted, broken out by provider; and,*
- *Average length of time, broken out by Medicaid and non-Medicaid claims, between when a claim is first submitted and when payment is received.*

DBH Response:

The rate of "clean" claims transmitted by DBH to the DHCF within 5 days of receipt is 100%.

Please see FY 15 Question 80. Attachment 1 of 3, Rate of Claims Denial FY 14
FY 15 Question 80. Attachment 2 of 3, Rate of Claims Denial FY 15
FY 15 Question 80. Attachment 3 of 3, Rate of Claims Denial FY 16

Q81. Please provide a list of all programs funded by DBH. Please include:
- *Whether the programs are evidence based; and,*
- *The evaluation methods used to determine the impact of the programs.*

DBH Response

Service/Programs	**Evidence-Based?**	**Evaluation**
Mental Health Rehabilitation Services	Standards set by regulations	DBH conducts annual community service reviews to measure system performance and conducts consumer satisfaction surveys. It also issues a twice yearly report that reviews service utilization and costs.
Assertive Community Treatment Mental Health Rehabilitation Services (MHRS)	Yes	Dartmouth Fidelity Scale- conducted annually
Critical Time Intervention	Yes	Center for Urban and Community Services, Training and Consultation, New York, New York
Supported Employment (MHRS through community support)	Yes	Dartmouth Fidelity Scale- conducted annually
Critical Time Intervention	Yes	Center for Urban and Community Services, Training and Consultation, New York, New York
Supported Residential Services (licensed community residential facilities, supported independent living and rental subsidies	No	Contract specialists conduct annual evaluations of performance of housing operators
Peer Support • Peer drop-in center • Peer specialists training • Peer advocacy	SAMHSA recognized	Consumer surveys are used to evaluate the impact of the programs.
Comprehensive Emergency Psychiatric Program includes mobile crisis services and homeless outreach	No	DBH conducts annual community service reviews to measure system performance and conducts consumer satisfaction surveys. It also issues a twice yearly report that reviews service utilization and costs.
Care Coordination (New Directions)	No	An annual evaluation is based upon progress made on specific outcome measures required by the contract.
Health Homes	Yes	annual evaluation is conducted of improvements an individual's overall quality of health.
Urgent Care Clinic		Annual evaluation of performance of the contractor

Functional Family Therapy (FFT).	Yes	FFT utilizes standardized assessment tools to measure outcomes, the Outcome Questionnaire (OQ, Youth Outcome Questionnaire (Y-OQ) to track and monitor specific youth clinical outcomes and Therapist Outcome measure (TOM) to measure adherence and model fidelity.
Parent Child Interaction Therapy (PCIT)	Yes	PCIT utilizes the Eyeberg Child Behavior Inventory (ECBI), a 36-item parent report scale which measures treatment progress in children between the ages of 2 and 6 and evaluates the long-term effects of PCIT treatment. The Dyadic Parent-Child Coding System (DPICS) is a behavioral coding system that measures the quality of parent-child social interactions.
Trauma Focused-Cognitive Behavior Therapy (TF-CBT)	Yes	UCLA Post-Traumatic Stress Disorder Reaction Index (PTSD-RI) is completed before and after participation in TF-CBT. to measures PTSD Severity Score pre and post treatment. PTSD-RI evaluation component of this measure has 20 items that assess the frequency of occurrence of post-traumatic stress disorder symptoms during the prior month according to both child/youth self-reports and reports of their parents/caregivers (children ages 4-18).
Multi-systemic Therapy(MST) and Multi-systemic Therapy-Problem Sexual Behaviors (MST-PSB)	Yes	The Therapist Adherence Measure - Revised (TAM-R), the Supervisor Adherence Measure (SAM) and the Consultant Adherence Measure
Transition to Independence Process (TIP)	Evidence-Supported	Transition to Adulthood Program Information System (TAPIS) Progress Tracker QUARTERLY v5.0 is a Transition Progress and Outcome Indicators : Employment, Education, Living Situation, Placements, Parenting/Children Status, Program Exit/Return, and YP's Personal and Community Functioning.
Adolescent Community Reinforcement Approach (A-CRA)	Yes	The Global Appraisal of Individual Needs (GAIN)-Initial (GAIN-I or GI) is a bio-psycho-social tool that integrates research and clinical assessment to do diagnosis, placement, individualized treatment planning, program evaluation and meets major reporting requirements.
Intensive Home & Community Based Services (CBI II & III)	Evidence Supported	Annual Fidelity Reviews that measures staff/case ratio cultural competency, training, supervision, service location and intensity compliance
Juvenile Adjudicatory Competency	No	One year post-discharge study is

Program		conducted to determine recidivism for discharge youth.
High Fidelity Wraparound	Promising Practice	Child and Adolescent Needs and Strengths (CANS)
Health Futures: Early Childhood Mental Health Consultation	Yes	• Strengths and Difficulties Questionnaire: Teacher perceptions of the prevalence and severity of children's behavior problems. • Arnett Global Rating Scale of Caregiver Behavior: Assesses the interactions between teachers and the children. • Devereux Early Childhood Assessment (DECA): an assessment completed by teachers and parents for children receiving child-specific consultation services to assess areas of strength and need and to assess change over time.
Primary Project	Yes	Teacher-Child Rating Scale screening tool used to measure the child's functioning in the classroom inTask Orientation, Behavior control, Assertiveness and Peer Social Skills
Assessment Center	No	N/A
School Mental Health Program (SMHP)	Evidence Supported	Child and Adolescent Functional Assessment Scale (CAFAS)/Preschool and Early Childhood Functional Assessment Scale (PECFAS) is conducted at admission, every 90-days and at discharge to determine the child's functioning across eight life domains: At School, At Home, in the Community (delinquency), Behavior Toward Others, Moods/emotions, Self Harm, Substance Use, and Thinking (assessing irrationality)
Juvenile Behavioral Diversion Program	No	Connors Pre and Post Assessment
DC Mental Access in Pediatrics (DC MAP)	Yes	The American Academy Pediatrics Mental Health Practice Readiness Inventory to assess in five domains—community resources, health care financing, support for children and families, clinical information system redesign, and decision support for clinicians. DBH also is conducting surveys to support quality improvement.
Children/Youth Emergency Services	No	Annual evaluation of the performance of the contractor. Monitor number of calls, deployments, response time and diversions from inpatient psychiatric hospitalizations.

Q82. Please provide an updated list of all Evidence-Based Practices and for each EBP please note:

a. The name of each provider who offers it;
b. Each provider's capacity;
c. Each provider's current enrollment;
d. Whether the EBP is Medicaid-reimbursable and if so, under what code or rate;
e. Any quality assessment or outcome measures that have been put in place to assess the program.

DBH Response

EBP and Provider	Medicaid Code/Rate		Capacity	FY16 Enrollment
FFT	**H2033 HU**	**57.42**	**99**	**90**
First Home Care			35	24
Hillcrest Children and Family Center			35	28
(DHS) Parent and Adolescent Support Services	N/A	N/A	29	38
PCIT	**90804**	**Variable MCO rates**	**35**	**34**
DBH PIECE Program			25	15
Mary's Center			10	19
TF-CBT	**H004ST**	**35.74**	**96**	**57**
First Home Care			18	6
Community Connections			24	13
MD/DC Family Resources			15	21
Hillcrest Children and Family Center			22	15
Universal Healthcare			17	2
CPP-FV	**H004HT**	**35.74**	**35**	**35**
DBH PIECE Program			25	33
Post Permanency Center of Adoptions Together			10	2
MST	**H2033**	**57.42**	**36**	**26**
Youth Villages			36	26
MST-PSB	**H2033**	**57.42**	**8**	**4**
Youth Villages			8	4
TIP	**H0036**	**21.97**	**532**	**406**
The Family Wellness Center			15	4
MBI Services Inc			102	85
Life Enhancement Services			39	37
Community Connections			57	102
Family Preservation Services			57	51
Universal Healthcare			66	15
Green Door			20	3

DHS – Teen Parent Assistance Program	N/A*		68	76
Total Family Care Coalition	N/A		68	10
Far Southeast Family Strengthening Collaborative	N/A		40	23
A-CRA	**H2033**	**57.42**	**125**	**62**
Hillcrest Children and Family Center			35	39
LAYC			20	16
Federal City Recovery Services			35	0
Riverside			35	7
TST (Billable under Counseling)	**H0036**	**21.97**	**80**	**34**
Contemporary Family Services			25	6
First Home Care			25	13
MD/DC Family Resources			20	13
PSI			10	2
Total			1043	748

**Not a MHRS Provider*

e. *Any quality assessment or outcome measures that have been put in place to assess the program.*

In FY 15, DBH continued to fine tune the EBP dashboard, designed to track fidelity and effectiveness EBP services. The EBP dashboard closely monitors progress of each evidence-based practice implementation on five key outcome and performance measures: (1) staffing (2) capacity (3) utilization (4) quality and (5) discharges. The dashboard is accessible at http://dbh.dc.gov/service/children-youth-and-family-services.

Evidence-Base Practice	Measurement of Fidelity
Standard Multi-systemic Therapy (MST)	MST uses The Therapist Adherence Measure - Revised (TAM-R), The Supervisor Adherence Measure (SAM) and The Consultant Adherence Measure (CAM).
MST-PSB	Therapist Adherence Measures (TAMs) and other key indicators of adherence are being tracked by the MST Associates consultant and have met model adherence standards.
Functional Therapy (FFT)	FFT utilizes standardized assessment tools to measure outcomes, the Outcome Questionnaire (OQ, Youth Outcome Questionnaire (Y-OQ) to track and monitor specific youth clinical outcomes and Therapist Outcome measure (TOM) to measure adherence and model fidelity.
Trauma Focused-Cognitive Behavior Therapy (TF-CBT)	UCLA Post-Traumatic Stress Disorder Reaction Index (PTSD-RI) is an outcome measure completed before and after participation in TF-CBT. It measures PTSD Severity Score pre and post treatment. PTSD-RI evaluation component of this measure has 20 items that assess the frequency of occurrence of post-traumatic stress disorder symptoms during the prior month according to both child/youth self-reports and reports of their parents/caregivers (for children ages 4-18).
Child Parent Psychotherapy	CPP primarily utilizes the Trauma Symptom Checklist for Young

for Family Violence (CPP-FV)	Children (TSCYC) and the Child Behavior Checklist (CBCL) pre and post treatment among several other assessment tools available to this model.
Parent Child Interaction Therapy (PCIT)	PCIT utilizes the Eyeberg Child Behavior Inventory (ECBI), a 36-item parent report scale which measures treatment progress in children between the ages of 2 and 6 and evaluates the long-term effects of PCIT treatment. The Dyadic Parent-Child Coding System (DPICS) is a behavioral coding system that measures the quality of parent-child social interactions.
Transition to Independence Process (TIP)	TIP uses the following Fidelity QI Tools: • Practice Probe: Personal Effectiveness and Wellbeing (Form for Interviewing three TF's separately). Newly revised. • YP Focus Group Interview Form • TIP Model Organizational survey and interview forms Fidelity is measured 1 year after the provider has been utilizing TIP. Depending on the providers scores on the fidelity review, follow up reviews complete or partial can be initiated as near as 6 months.
Adolescent –Community Reinforcement Approach (A-CRA)	ACRA utilizes a DSR (audio recording) monitored through the EBTx system to review sessions or procedures as fidelity measure. Outcomes can be measured by calculating the number of DSRs that are passed or procedures passed relative to the total rated to get a percentage of fidelity. After certification, fidelity checks are conducted at random to provide clinicians with feedback and supervision to implement the evidence based practice accurately.
Trauma Systems Therapy (TST)	TST utilizes the Child Stress Disorder Checklist of the District of Columbia (CSDC-DC) trauma assessment tool. The CSDC-DC tool gathers firsthand accounts of trauma history, current symptoms and exposures. The tool communicates the extent of the child's trauma history, the extent the trauma history is impacting the child's functioning, and some understanding of the areas in which a child is struggling to emotionally regulate so that specific trauma interventions and approaches can be developed to address the child's challenges. CSDC-DC is administered to children and adolescents ages 2 to 20 years old.

Supported Employment

Evidenced Based Practice Supported Employment is a jointly funded program. The Department of Behavioral Health and The Rehabilitation Services Administration provide funding to ten (10) community service providers who serve over 1000 district residents with severe and persistent mental illness. DBH funding is a combination of local dollars and Medicaid reimbursable services. The rate for all services is 74.44 per hour. The billing codes are H2025 (Local dollars) and H2023 (Medicaid).

DBH Supported Employment staff facilitates a nationally recognized Evidenced Based Practice Fidelity Review. The review is comprehensive with measures that highlight best practices that produce employment outcomes with high customer satisfaction. Fidelity Action Plans are implemented for all service below the good to excellent range and are monitored by DBH staff.

Employment Outcomes are collected monthly. Quarterly reports are shared with the Dartmouth College Evidenced Based Practice Center. Outcome data is compiled and compared by program and by State.

Provider	Capacity	Current Enrollment
Anchor Mental Health	120	120
Community Connections	140	140
Contemporary Families Services	120	120
Deaf Reach	40	23
Green Door	140	140
MBI Health Services	60	60
Psychiatric Center Chartered	80	80
Psychiatric Rehab Services	40	40
Pathways to housing	50	40
PSI Family Services	80	60
Totals	870	823

Assertive Community Treatment

Another Evidence Based Practice Program that DBH has is the Assertive Community Treatment (ACT). These services are Medicaid Reimbursable at $38.04/ 15 minutes. Its billing code is HOO39.

Assertive Community Treatment (ACT) is an intensive, integrated, rehabilitative, treatment and community-based service provided by an interdisciplinary team to adults with serious and persistent mental illness. ACT services are provided to consumers in accordance with the Individual Recovery Plan (IRP). ACT Teams involve specific and dedicated staff to consumer ratios. Service coverage by the ACT team is required to have specific program hours but to be available for crisis services 24 hours per day, seven days per week. At least sixty percent (60%) of services are required to be provided to the consumer in non-office settings in the community. Services offered by the ACT Team shall include:

(a) Mental health-related medication prescription, administration, and monitoring
(b) Crisis assessment and intervention
(c) Symptom assessment, management and individual supportive therapy
(d) Substance abuse treatment for consumers with co-occurring addictive disorder
(e) Psychosocial rehabilitation and skill development
(f) Interpersonal, social, and interpersonal skill training
(g) Education, support and consultation to consumers' families and their support system which is directed exclusively to the well-being and benefit of the consumer.

Providers	Capacity	Current Enrollment
Pathways	320	304
Family Preservation	200	154
Green Door	200	202
Community Connection	700	646
Anchor	150	118
Capital Community Services	0	92
Hillcrest	300	189
Total	1870	1705

- As of January 15, 2016 there are 21 ACT Teams
- Capitol Community Services is scheduled to close in March 2016.
- The nineteen (19) remaining ACT Teams have the capacity to accept the ninety-two (92) individuals that are enrolled in Capital Community Services

Each fiscal year every ACT team has a Dartmouth Assertive Community Treatment Review (DACTS). The scale measures the treatment reliability of the teams.

Health Home
The Health Home Benefit Initiative is a service delivery model that focuses on providing individualized, person-centered and recovery-oriented case management and care coordination. A Health Home is the central point for coordinating, collaborating and ensuring communication amongst all relevant parties engaged in the delivery of each consumer's care. The Health Home is responsible for achieving the District of Columbia's Triple Aim Goals:

1. Improving the individual experience of assessing and receiving care;
2. Improving the health of its population; and
3. Reducing the per capita costs of care

Specifically, a Health Home is responsible for:

- Preventing avoidable hospital admissions and readmissions;
- Preventing unnecessary emergency room visits;
- Providing timely transitional follow-up; and
  - Decreasing the overall Medicaid cost for the consumers in the District who have serious mental illnesses (SMI).

Health Home has two Medicaid rates based on the individual's level of need. The rates and the Medicaid codes are S0281-U1, $481.00 Per Person Per Month and S0281-U2, $349.00 Per Person Per Month. The chart below depicts the providers and their capacity. Please note this program began in January 2016 and the enrollment process is underway.

Providers	Capacity
McClendon Center	300
Community Connections	600
Hillcrest Children's Center	300
Medstar Washington Hospital Center	300
Anchor Mental Health Association	300
Green Door	600
The Family Wellness Center, Inc.	300
Psychiatric Center Chartered, Inc	300
Mary's Center	300
Contemporary Family Services	300
TOTAL	3600

Each provider will be evaluated annually to determine their compliance with the Centers for Medicare and Medicaid Services quality measures. DBH has released a second Request for Proposal and the Health Home capacity is estimated to increase to 4,500.

Q83. Please provide an updated list of all Evidence-Based Practices that are considered trauma-informed and for each EBP please note:

a. *The name of each provider who offers it;*
b. *Each provider's capacity;*
c. *Each provider's current enrollment;*
d. *Whether the EBP is Medicaid-reimbursable and if so, under what code or rate;*
e. *Any quality assessment or outcome measures that have been put into place to assess the program.*

DBH Response:

a. *The name of each provider who offers it;*
b. *Each provider's capacity;*
c. *Each provider's current enrollment;*
d. *Whether the EBP is Medicaid-reimbursable and if so, under what code or rate;*

The Chart below represents a list of all the Evidence-Based Practices that are considered trauma-informed.

EBP and Provider	Medicaid Code/Rate		Capacity	FY16 Enrollment
Trauma Focused-Cognitive Behavior Therapy (TF-CBT)	H004ST	35.74	96	57
First Home Care			18	6
Community Connections			24	13
MD/DC Family Resources			15	21
Hillcrest Children and Family Center			22	15
Universal			17	2
Child Parent Psychotherapy for Family Violence (CPP-FV)	H004HT	35.74	35	35
DBH PIECE Program			25	33
Post Permanency Center of Adoptions Together			10	2
Trauma Systems Therapy (TST)	H0004	26.42	80	34
Contemporary Family Services			25	6
First Home Care			25	13
MD/DC Family Resources			20	13
PSI			10	2
Total			211	126

e. *Any quality assessment or outcome measures that have been put in place to assess the program.*

The Chart below represents each quality assessments/or outcome measures utilized by each EBP.

Evidence-Base Practice	Quality Assessment/Outcome Measures
Trauma Focused-Cognitive Behavior Therapy	UCLA Post-Traumatic Stress Disorder Reaction Index (PTSD-RI) is an outcome measure completed before and after participation in TF-CBT. It measures PTSD Severity Score pre and post treatment. PTSD-RI evaluation component of this measure has 20 items that assess the frequency of occurrence of post-traumatic stress disorder symptoms during the prior month according to both child/youth self-reports and reports of their parents/caregivers (for children ages 4-18).
Child Parent Psychotherapy for Family Violence	CPP primarily utilizes the Trauma Symptom Checklist for Young Children (TSCYC) and the Child Behavior Checklist (CBCL) pre and post treatment among several other assessment tools available to this model.
Trauma Systems Therapy	TST utilizes the Child Stress Disorder Checklist of the District of Columbia (CSDC-DC) trauma assessment tool. The CSDC-DC tool gathers firsthand accounts of trauma history, current symptoms and exposures. The tool communicates the extent of the child's trauma history, the extent the trauma history is impacting the child's functioning, and some understanding of the areas in which a child is struggling to emotionally regulate so that specific trauma interventions and approaches can be developed to address the child's challenges. CSDC-DC is administered to children and adolescents ages 2 to 20 years old.

Q84: Please provide an update on the Department's efforts to work with DHCF to allow behavioral health providers to bill for collateral contacts.

DBH Response:

In May of 2013, DBH initiated a comprehensive rate setting review of Mental Health Rehabilitation Services (MHRS) to ensure that the costs associated with the delivery of service whether direct, indirect or costs unique to the provision of a specific service were covered adequately in the reimbursement rate. The total cost of provider staff and the time necessary to document and coordinate services (collateral) were included in the cost to build the rates. The review conducted over several months enlisted five MHRS providers to provide detailed financial materials which were matched against a full year of corresponding MHRS claims for those agencies. The providers were asked to join the review based on the comprehensiveness of their services, size and ability to complete a service sample that was significant to evaluate MHRS.

As a result of the review, it was recommended that a 14.8% improvement in rates overall be effected in order to cover the costs to deliver MHRS Since the MHRS rates are covered under Medicaid, DHCF needed to approve the review's proposed rate structure in order for it to become effective. DHCF fully supported the recommendation and on December 30, 2013, the new rates recommended by the review went into effect.

In addition to building in the cost of collateral contacts in the base rate structure, in FY 2015 DBH reimbursed MHRS providers for community support collateral contacts totaling $667,164.14.

Q85. How many children (0-20) received a service through MHRS during FY15? How does this compare to the number who received a service in FY14?

DBH Response

In FY 15, 5,065 children ages 0-20 received a service through MHRS which is a slight increase over FY 14 when 5,037 children in this age range received an MHRS service.

Q86. *Please provide the following information regarding the Comprehensive Psychiatric Emergency Program (CPEP):*

a. What is the total number of CPEP admissions during FY15 and to date in FY16? Please provide a breakdown by month and note whether or not the individual was brought to CPEP by the police department or other known source (e.g. case worker).

b. What is the average length of stay for a patient at CPEP?

c. The number of individuals served at CPEP linked to substance abuse services during FY15? To date in FY16?

DBH Response:

a. What is the total number of CPEP admissions during FY15 and to date in FY16? Please provide a breakdown by month and note whether or not the individual was brought to CPEP by the police department or other known source (e.g. case worker).

During FY 2015, the Comprehensive Psychiatric Emergency Program had 3,802 admissions and year to date for FY 2016 there have been 981 admissions for a total of 4,783. Of the total number 3,569 were transported by DC MPD and the remaining 1,214 presented via other sources (e.g. social worker, self -presentation.)

Comprehensive Psychiatric Emergency Program – Admission Numbers by Transport Type – FY15													
Transport Method	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**TOT**
Other Transport	63	75	87	89	77	85	82	66	85	81	87	84	961
MPD Transport	262	232	197	218	213	251	240	237	208	273	267	243	2841
Total	325	307	284	307	290	336	322	303	293	354	354	327	3802

Comprehensive Psychiatric Emergency Program Admission Numbers by Transport Type – FY16					
Transport Method	**OCT**	**NOV**	**DEC**	**JAN**	**TOT**
Other Transport	81	71	91	10	253
MPD Transport	241	231	225	31	728
Total	322	302	316	41	981

b. What is the average length of stay for a patient at CPEP?

The average length of stay for FY15 was 23 hours and year to day for FY16 is 25 hours.

c. The number of individuals served at CPEP linked to substance abuse services during FY15? To date in FY16?

In FY 15, 32 consumers were discharged/linked to a drug treatment program. In FY16 to date, seven consumers were discharged/linked to a drug treatment program.

Q87. *What activities did DBH undertake in FY15 and FY16 to date to serve individuals with co-occurring mental health and substance abuse issues? What activities to date in FY15? In your response, please provide an update on the streamlined application and certification process for both mental health and substance abuse providers.*

DBH Response:

DBH continues to strategically approach the process of serving co-occurring mental health and substance use disorder clients by first implementing a universal screening tool to identify clients that are experiencing needs in both areas. In FY15, DBH implemented activities at our access points including the Assessment and Referral Center (ARC), Urgent Care Clinic at Superior Court, Access Help Line, and several community partners to ensure all individuals entering into the DBH system are screened for co-occurring disorders by using an evidence based co-occurring screening tool called the Global Appraisal of Individual Needs- Short Screener (GAIN-SS). The GAIN-SS is a 20 question screening tool which combines four scales (Internalizing Disorder, Externalizing Disorder, Substance Disorder, and Crime/Violence). In addition, DBH issued a policy making the use of GAIN-SS mandatory throughout the entire DBH network.

The GAIN-SS is an effective means of gathering general behavioral health information on a large population across systems. DBH co-locates a staff at the Child and Family Services Agency (CFSA), to conduct the GAIN-SS assessment and refer individuals needing substance use treatment to the appropriate services. CFSA provides services and family stabilization resources to families and children alleged to be abused and/or neglected through the coordination of public and private partnerships. As a part of its collaboration with APRA around substance use issues, CFSA began screening key segments of its population, both youth and adults, using the GAIN-SS. This process allows CFSA to identify those who are in the greatest need of assessment and expedite those referrals to APRA intake sites.

During FY15, DBH administered 7,806 GAIN-SS to individuals who accessed the SUD system. To date in FY 16, DBH administered 757 GAIN-SS to individuals who accessed the SUD system, and provided treatment services to 3,629 individuals.

In FY15, DBH continued building the infrastructure with the assistance of a grant issued through the Substance Abuse and Mental Health Services Administration (SAMHSA) entitled The 12 Cities Minority AIDs Initiative. This program is built to identify clients who are HIV-positive or at-risk for HIV infection who also have co-occurring behavioral health issues. When a client presents at the Assessment and Referral Center or a mental health Core Service Agency the GAIN-SS is administered as part of the intake process. If a more in depth assessment is indicated on GAIN-SS, a referral to services can be initiated in the same visit, providing high quality service access and maximizing the opportunity for client engagement.

The Assessment and Referral Center has assisted in reconnecting clients to their mental health agencies through DBH's Access Helpline. Co-occurring clients are now able to receive appropriate treatment in a timely manner. The ARC provided Hepatitis C and HIV/AIDS and Hepatitis C education, testing and linkage into primary care.

The goals of this project are to ensure that individuals attempting to access the DBH system of care:

1. Receive HIV screening and testing
2. Receive co-occurring screenings
3. Receive linkages to treatment as appropriate
4. Receive follow-up and continuing care as appropriate
5. Receive immediate access and same day services for HIV positive and High Risk individuals.

The DBH access sites executed activities such as the colocation of client care services for behavioral health and primary care, ensuring that treatment providers have the ability to develop treatment plan(s) for behavioral health and primary care, and adding Clinical Care Coordination to the service menu, which in turn enhances coordinated care between Mental Health and Substance Use Disorder service providers.

In FY15, DBH added Clinical Care Coordination to the SUD service menu. One of the many purposes of this service is to enhance treatment services for individuals with co-occurring disorders (COD). Many individuals with CODs present with somatic medical conditions in addition to their comorbid SUD and mental health disorders. Clinical Care Coordination enhances treatment services by allowing the clinician to construct an integrated treatment plan which may include behavioral health needs, inclusive of somatic, mental and addictions needs.

In FY15,expansion of services included partnering with local hospitals – Psychiatric Institute of Washington, Washington Hospital Center, Providence Hospital and United Medical Hospital Center to conduct Substance Use Disorder (SUD) assessments and referral to the appropriate level of care post hospitalization/detoxification. These hospital are able to stabilize psychiatric symptoms, assess for SUD treatment and refer to DBH certified SUD providers. In addition, SUD partnered with Comprehensive Psychiatric Emergency Program (CPEP) and St. Elizabeth Hospitals so that acutely psychotic patients could obtain a comprehensive psychiatric assessments, stabilization, and hospitalization prior to admission into the SUD treatment services. SUD staff and mental health staff were cross-trained to recognize both SUD and mental health symptoms which expedited and facilitated the client receiving the necessary health care services.

Recovery starts when a District resident begins services through: peer support, recovery coaching, recovery support services, and referrals to recovery community based and faith based programs within the community. Through a small grant, the department developed an advocacy group DC Recovery Advisory Council (DC RAC) in 2013 to advocate and initiate community recovery conversations and drug free events. The council consists of persons in recovery from mental illnesses, substance use disorders, criminal justice re-entry, ex-sex workers, and members of the LGBTQI community. The department partners with Alcoholic Anonymous & Narcotic Anonymous, recovery student groups at local universities; peer run advocacy groups, recovery support services programs located within the District's 8 Wards, and provide funding for 277 housing slots within the local Oxford Houses.

During the 2015 National Recovery Month "Visible, Vocal, Valuable" sponsored by SAMHSA/CSAT the department sponsored over twenty five community events promoting recovery through community conversations with persons in recovery showing the "Anonymous People" and "Life Continued Defeating Depression" videos with panel discussions with persons in recovery including youth and young adults. The citywide community conversations discussed drug use in the community, how to develop prevention strategies, where are more services needed, and how everyone within the community can help. The department was a major partner for the Unite to Face Addiction Rally on the National Mall (October 2015). Over 1,200 consumers in recovery of mental health, substance use disorders and community advocates represented the District at this national event. The Department of Behavioral Health had the largest contingency of persons in recovery at the rally.

On 9/4/15, DBH published final regulations, New Certification Standards for Substance Use Disorder Treatment and Recovery Services, which contain two new levels of care (one outpatient and one residential) requiring that the SUD provider either also be certified by DBH as a mental health provider or have a psychiatrist on staff.

On 9/18/2015, DBH issued notice in the DC Register lifting our moratorium on accepting applications for certification as a mental health or substance use disorder treatment provider. The moratorium lift was designed specifically to elicit applications from providers who are currently providing one set of services so that they could be certified to deliver services in both areas. In other words, DBH is now accepting application from mental health providers who would like to begin adding SUD services, and vice versa. This is in addition to SUD programs that are currently certified under the old certification regulations (Chapter 23) who must apply to be certified under the new regulations (Chapter 63).

DBH has fully moved to using a streamlined application and certification process that improves our ability to certify providers, including those treating co-occurring disorders, in a timely fashion. We utilize a single application and process for all services that the Department certifies. This application removes duplicative requests and allows providers to expand or change the programs for which they are seeking certification simply by describing the program for which they are applying. DBH provided training on the new application and the application process to interested stakeholders in Q4 2015.

Q88. Please provide an update on The 12 Cities Minority AIDS Initiative. How many individuals were served under this initiative in FY15 and FY16 to date?

DBH Response:

The Minority Aids Initiative Targeted Capacity Expansion Project (MAI-TCE) Grant from Substance Abuse and Mental Health Services Administration (SAMSHA) was awarded to twelve cities across the nation. The specific outcomes are to (1) reduce HIV transmission; (2) increase the number of people receiving treatment for substance use disorder, mental health and/or co-occurring substance abuse and mental health disorders; (3) increase the number of people who, receive recovery support services post treatment; (4) increase the number of people who know their HIV status; and (5) increase case management services and referrals to primary HIV care for antiretroviral therapy, primary care and other services for individuals who test positive for HIV. The target populations are minority persons living with HIV or at high risk of HIV infection with co-occurring conditions of substance use disorder and/or serious persistent mental illness.

During the life of the grant, 16,000 individuals were offered the opportunity to be tested—14,446 or 90 per cent were tested. Of this number, 124 tested positive, 328 individuals self-identified that they were HIV positive, and 2,274 were considered high risk for contracting HIV as a result of self-reported risky behaviors. Both the positive and high-risk groups were offered substance use disorder, mental health, primary health, and community services

The SAMHSA grant expired on October 1, 2015. The Initiative will continue with local and other grant funds dedicated to the prevention, treatment of HIV and the reduction of high risk behaviors.

Q89. Please provide a list and narrative description any DBH partnerships with District agencies in FY15 and to date in FY16 to address co-occurring mental health and substance abuse issues for DBH consumers. In addition, please provide the number of individuals served, the types of services, programs or activities available, and the employee/s responsible for coordinating the partnership.

DBH Response:

The Department of Behavioral Health has developed partnerships with the Department of Health (DOH) and the Department of Human Services (DHS) to implement a network of integrated, behavioral health and primary care services for residents at risk for or living with HIV/AIDS with mental health, substance use disorder, or co-occurring disorders.

In FY 14, the Global Assessment of Individual Needs (GAIN-SS) GAIN-SS was piloted with two providers. The GAIN-SS is a screening tool designed to screen for possible psychiatric related disorders, substance related disorders as well as other maladaptive behavioral functioning. In FY 15, the use of this screening tool was expanded system wide.

In FY2015, nearly 19,000 GAIN-SS screenings were performed, and during the first quarter of FY 2016, more than 4,800 screenings have taken place.

Collaboration between CFSA and DBH: CFSA

DBH expanded its collaboration with the Child and Family Services Agency (CFSA) to address the substance use disorder needs of its clients. In FY 15, through the mobile assessor, DBH administered 67 assessments to mothers of CFSA clients, and 43 assessments to date in FY 16.

Collaboration between DBH and ICH

DBH is collaborating with the District's Interagency Council on Homelessness (ICH) to implement the Cooperative Agreement to Benefit Homeless Individuals (CABHI) grant. The District received $3 million per year for three years, totaling a grant award amount of $9 million. This grant will allow the District to enhance services for people who experience chronic homelessness. The program will target (1) people who experience chronic homelessness and who also have substance use disorders, serious mental illnesses (SMI), or co-occurring mental health and substance use disorders; and (2) veterans who experience homelessness or chronic homelessness and have substance use disorder(s), SMI, or co-occurring mental and substance use disorders. The target is 300 individuals each year for a total of 900.

Collaboration between DBH and FEMS

DBH collaborated with Fire and Emergency Medical Services (FEMS) to conduct a pilot study using Screening, Brief Intervention, and Referral to Treatment (SBIRT) for District residents in potential crisis from an opiate overdose. SBIRT is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. Information on individuals found to have overdosed responded positively to Narcan were referred to DBH. Within three to five days, DBH dispatched an outreach team comprised of health care and social work personnel only. Participation in the screening was voluntary and the

outreach team SBIRT engaged 84 individuals. DBH currently is reviewing options to sustain the program.

Collaboration between DBH and DOH: Heroin Task Force
The purpose of the Heroin Task Force is to decrease the morbidity and mortality from opioid use and addiction in the District of Columbia through a multi-disciplinary approach. This workgroup brings leaders together across both District and Federal agencies to make policies which will 1) decrease the number of overdoses from opiates in the District; 2) decrease the number of deaths due to opiate overdose in the District; 3) expand access to naloxone; and 4) increase participation in Medication Assisted Treatment. The task force meets monthly and is led by DBH and DOH.

Collaboration between DBH and DOH: Marijuana Task Force:

The Directors of the Departments of Behavioral Health and Health co-chair the Marijuana Task Force which oversaw the development of an educational campaign about Initiative 71 that focused on the health consequences of underage marijuana use and the link to physical and emotional well-being.

Q90: What activities did DBH undertake in FY15 to serve veterans? What activities to date in FY16? Please provide a list and narrative description of any DBH partnerships with District agencies in FY15 and to date in FY16 to serve the mental health needs of veterans. In addition, please provide the number of individuals served, the types of services, programs or activities available, and the employee/s responsible for coordinating the partnership.

DBH Response:

In FY 15, one hundred and sixty seven (167) individuals enrolled in the public mental health system self-identified as veterans. Of those, 51 actively received treatment in FY14 and to date in FY15. The DBH services used by the veterans are community support, medication somatic service and Assertive Community Treatment (ACT) services, supported employment, crisis intervention services and transitional services from hospital care to community-based services.

DBH and its community providers continue to work closely with the Veterans Administration (VA) to ensure that veterans with active benefits are able to remain in the VA system and receive necessary mental health services. DBH also provides training for VA employees. Saint Elizabeths psychiatry residents rotate through the VA, and military residents rotate through the emergency psychiatric facility (CPEP). In addition, the DBH works with the Substance Abuse and Mental Health Administration (SAMHSA) Policy Academy on Working with Military and Veterans. The purpose of the academy is to develop strategies within the District and throughout the country to improve mental health and health care services, education, economic security and to decrease criminal justice involvement and homelessness among veterans.

DBH is collaborating with the District's Interagency Council on Homelessness (ICH) to implement a federal Cooperative Agreement to Benefit Homeless Individuals (CABHI) three – year, $9 million grant. The targeted receiving population includes veterans who experience homelessness or chronic homelessness and have substance use disorders, mental illnesses or co-occurring mental and substance use disorders.

Oscar Morgan, Director of Adult Services, is responsible for this program.

Q91. What activities did DBH undertake in FY15 to serve the elderly? What activities to date in FY16? Please provide a list and narrative description of any DBH partnerships with District agencies in FY15 and to date in FY16 to serve the mental health needs of the elderly. In addition, please provide the number of individuals served, the types of services, programs or activities available, and the employee/s responsible for coordinating the partnership.

DBH Response:
In FY15 to date, DBH provided a range of mental health Mental Health and Rehabilitative Services (MHRS) services for 903 individuals over the age of 65. In addition, a description of some other services provided to this population is as follows:

Pre-Admission Screening/Resident Review (PASSR). As the public mental health authority, DBH is responsible for the PASRR (Pre-Admission Screening/Resident Review) level II, which is required for any individual with mental illness entering or being discharged from a nursing facility or who is in a nursing facility and has a change in condition in either their mental health or functional abilities. Forty-one (41) PASSRs were conducted for individuals over the age of 65. Of those nine were for individuals discharged from nursing home level of care. From October 2014 to December 31, 2015, 18 PASSR have been completed; three were for individuals discharge from nursing homes level of care.

Responsible Staff: Chaka Curtis

On January 1, 2016 DBH in conjunction with the Department of Health Care Finance launched the Health Home Medicaid Benefit for persons with Serious Mental Illnesses. Individuals who are 65 years or older enrolled in this initiative will receive case management and care coordination of the behavioral health, physical health and social service needs. With an emphasis on physical health care, it the expected outcomes are:

- Preventing avoidable hospital admissions and readmissions;
- Preventing unnecessary emergency room visits;
- Providing timely transitional follow-up; and
- Decreasing the overall Medicaid cost for the consumers in the District who have serious mental illnesses (SMI).

Another key element of this Initiative is the provision of educational training and consultation geared toward helping individuals establish and achieve healthy life-styles, actionable goals for illness management and recovery.

Responsible Staff: Tippi Hampton

Illness Management and Recovery (IMR) Pilot. In the fourth quarter of FY14, DBH launched a pilot program for elderly individuals with mental illness to assist them in developing self-management and recovery skills. Participants receive instruction based upon the IMR curriculum that is used to help people develop personal strategies for coping with mental illness and to move forward with their life. IMR has been identified as an evidence-based practice. It includes a combination of motivational, educational and cognitive behavioral techniques. It is

delivered in either an individual or group format. Each person involved in the program also receives a "Health Buddy" which is a telehealth device that collects and transmits health management information. The person is able to provide a nurse care manager with information about their physical and mental health condition on a daily basis from their home. The nurse can provide telephonic support or deploy a mental health worker to the person's home if required to address any issues identified.

Responsible staff: Oscar Morgan

Green Door is the DBH contractor responsible for implementing this pilot program. The focus of this effort is on improving the health status of individuals who have SMI and who also may have one or more physical health conditions. Start-up activities were conducted during FY 14. In FY15, 85 individuals received services. The vendor that supplied the Health Buddy discontinued this device; therefore the pilot was not brought to scale in FY16.
The IMR evidenced-based curriculum and skill development process can be implemented independently of the telehealth device. Consideration is being given to incorporating IMR as a Health Home practice.

Interagency Partnerships. DBH has developed a Memorandum of Agreement (MOA) with District of Columbia agencies including the DC Office on Aging (DCOA), and Department of Health Care Finance DHCF to move individuals, most of whom are elderly, out of nursing homes and community hospitals into the community. DBH's role is to ensure that individuals enrolled in the mental health system receive appropriate transitional and ongoing services and supports that assist them in functioning effectively in the community. DBH mental health providers are responsible for coordinating all available community services and managing the delivery of care to individuals assigned to their agency. In addition, DBH's Integrated Care Division monitors community placements for up to 120 days of step-down from a nursing home to assure services are provide timely.

The DBH participates as a member of the District's Age Friendly Initiative which is chaired by the Deputy Major and the President of George Washington University. This Initiative is geared toward promoting active and healthy aging for District residents. The specific areas for which DBH are:

- Introduce or expand primary mental health screening programs for older adults
- Provide training on behavioral health for counselors and aides working in hospitals and home-based care units
- Expand number of peer counselling and support programs and increase the number of older adult peer counselors.

Responsible Staff: Oscar Morgan

Q92. Please provide an update on the Illness Management and Recovery Pilot program for elderly individuals with mental illness designed to assist them in developing self-management and recovery skills. How many individuals have been enrolled in this program in FY15 and FY16 to date?

DBH Response:

Illness Management and Recovery (IMR) Pilot. In the fourth quarter of FY14, DBH launched a pilot program for elderly individuals with mental illnesses to assist them in developing self-management and recovery skills. Participants receive instruction based upon the IMR curriculum that is used to help people develop personal strategies for coping with mental illness and to move forward with their lives. IMR has been identified as an evidence-based practice. It includes a combination of motivational, educational and cognitive behavioral techniques. It is delivered in either an individual or group format. Each person involved in the program also receives a "Health Buddy" which is a telehealth device that collects and transmits health management information. The person is able to provide a nurse care manager with information about their physical and mental health condition on a daily basis from their home. The nurse can provide telephonic support or deploy a mental health worker to the person's home if required to address any issues identified.

Green Door was the DBH contractor responsible for implementing this pilot program. The focus of this effort is on improving the health status of individuals who have SMI and who also may have one or more physical health conditions. Start-up activities were conducted during FY 14. In FY15, 85 individuals received services. The vendor that supplied the Health Buddy discontinued this device; therefore the pilot was not brought to scale in FY16.

The IMR evidenced-based curriculum and skill development process implemented independently of the telehealth device. Consideration is being given to incorporating IMR as a Health Home practice.

Q93. What activities did DBH undertake in FY5 to serve the low income populations in the District? What activities to date in FY16? Please provide a list and narrative description any DBH partnerships with District agencies in FY15 and to date in FY16 to serve the mental health needs of low income District residents. In addition, please provide the number of individuals served, the types of services, programs or activities available, and the employee/s responsible for coordinating the partnership.

DBH Response:

DBH serves residents who meet the income guidelines which is 200 per cent of the federal poverty level for adults and 300 percent for children. The majority qualify for Medicaid—those who do not are supported with all local dollars. In FY 15, about 23,400 individuals received at least one mental health service. To date, in FY16, we are on track to serve about the same number. All enrolled individuals based upon individualized needs are eligible to receive the full range of services and supports offered by DBH.

The employees responsible for coordinating these services are: Oscar Morgan, Director of Adult Services and Denise Dunbar, Director of Child, Youth and Family Services, and Marquitta Duvernay, PhD. Deputy Director, Addiction Prevention Recovery Administration.

Q94. What activities did DBH undertake in FY15 to serve LGBTQ individuals in the District? What activities to date in FY16? Please provide a list and narrative description of any DBH partnerships with District agencies in FY15 and to date in FY16 to serve the mental health needs of LGBTQ individuals. In addition, please provide the number of individuals served, the types of services, programs or activities available, and the employee/s responsible for coordinating the partnership.

DBH Response:

DBH supports and works with our community partner Helping Individual People Survive (HIPS) to provide recovery support services, advocacy and substance use disorders treatment referrals to the LGBTQI population. HIPS is a nonprofit community program located in Ward 6. HIPS mission is to assist female, male, and transgender individuals engaging in sex work lead healthy lives. Utilizing a harm reduction model, HIPS programs strive to address the impact that HIV/AIDS, STIs, discrimination, poverty, violence and drug use have on their lives. Three nights a week, from 9:00pm until 5:00am, HIPS staff and volunteers, provide education and counseling, and distribute safety materials, clothing and food to sex workers on the streets. HIPS also provides referrals, help for parents of persons engaged in sex work and emergency housing assistance.

The School Mental Health Program provides services and supports tailored to address the issues faced by LGBTQ youth. The following activities were conducted:

Too Good for Violence: During SY 14-15 the SMHP implemented the program in 29 schools and to date in SY 15-16 in 17 schools. Too Good for Violence is a Substance Abuse and Mental Health Services Administration (SAMHSA) approved, evidence-based violence prevention program is designed to reduce aggression and improve the behavior of elementary, middle and high school students. It emphasizes four areas: conflict resolution, anger management, respect for self and others, and effective communication.
Signs of Suicide: SOS is a depression awareness and suicide prevention program that teaches how to ACT (Acknowledge, Care and Tell) when a person or friend experiences symptoms of depression or suicide. It also includes information regarding the statistics of suicide among youth in the LGBTQ population. SOS was implemented in eight schools last school year and three schools to date in SY15-16.

Individual and Group Therapy – SMHP clinicians provide individual and group therapy to youth who identify as LGBTQ.

Work with School Climate Teams. At Jefferson Academy in honor of National Bullying Prevention Month facilitated classroom presentations entitled, "Recognizing and Reducing Bullying Behavior."; at Cardozo High School planned the annual Pride Day. Clinicians also have provided presentations to address bullying and cyber- bullying.

C**o-facilitated Gay Straight Alliance (GSA) Meetings. Cl**inicians facilitated clubs and groups at four schools to support LGTBQ students.

Q95: Please provide the following information with respect to St. Elizabeths. Please provide a breakdown by civil and forensic programs.

a. Monthly census at St. Elizabeths for FY15 and to date in FY16;
b. Number of admissions, by month, for FY15 and to date in FY15;
c. Number of discharges, by month, for FY15 and to date in FY16; and,
d. Average length of stay.

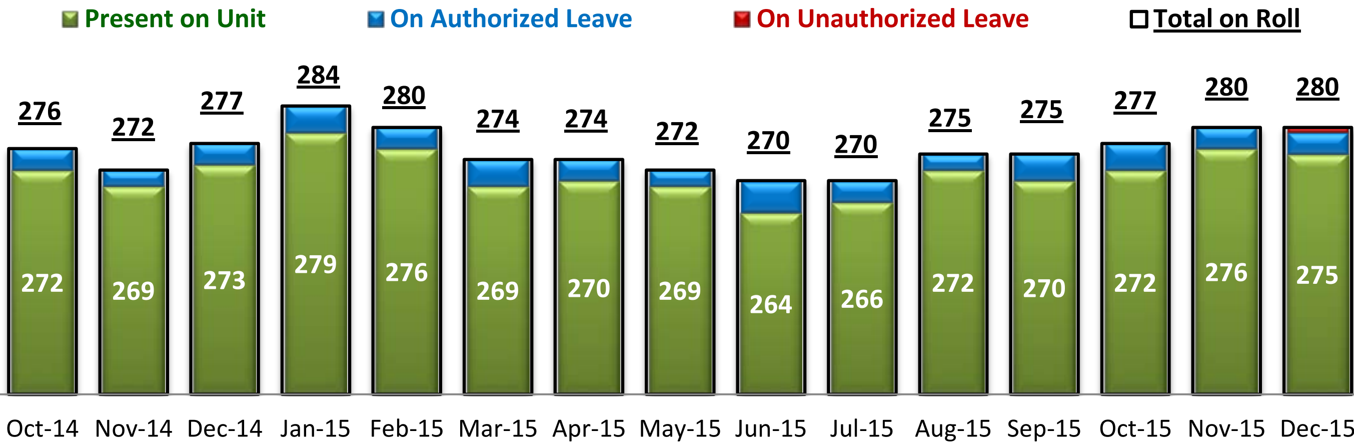
DBH Response:

1) Census (Oct-2014 ~ Dec-2015)

The census is affected by the number of admissions and discharges. Prior to FY13, the average daily census (ADC) at the Hospital declined consistently for several years accompanied by a steady decrease in the number of admissions. The declining trend of admissions, however, was reversed in FY13 and the number of admissions continued to increase in FY14 and FY15, contributing to a consistently high average daily census. This pattern continues to date in FY 16 resulting in a further increase in the average daily census during the first three months of FY16.

In January 2015, the ADC reached 284, the highest level since November 2011. The ADC then gradually decreased from January –July 2015, in part a result of the concerted efforts to discharge several long-term post trial residents who had been in care for over a decade. However, since August 2015, the Hospital began to experience significant challenges in discharging individuals in care to the community while the number of admissions remained high. (See #3 below for specific data on the decline in discharges) Consequently, the ADC gradually increased beginning in the summer 2015 and was hovering around 280 during the first quarter of FY16.

Number of Individuals Served on a Given Day (Oct-2014 ~ Dec-2015)



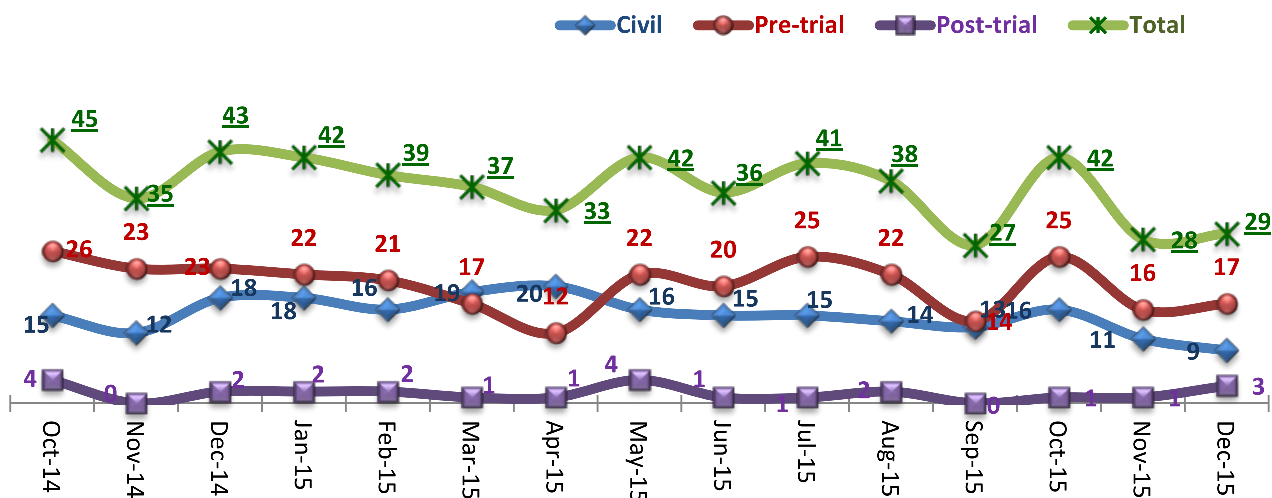
2) Admissions (Oct-2014 ~ Dec-2015)

The trend of a reduction in the number of monthly admissions that had continued for several years was reversed in FY13, and the number of monthly admissions continued to increase steadily in FY14 and FY15. The total number of admissions in FY12 was 400 (33 per month), increased to 423 (or 35 per month) in FY13, 434 (or 36 per month) in FY14, and 458 (or 38 per month) in FY15. This trend was reversed somewhat during the first quarter of FY16, however, as the number of admissions decreased to 33 per month. However, because there was an even greater decrease in the number of discharges during the first quarter of FY 16, census remains high.

This increase of admissions to the Hospital FY15 is driven primarily by an increase of forensic pre-trial admissions, those sent by the Superior Court for competency evaluation and/or restoration prior to stand trial on criminal charges. The monthly average number of pre-trial admissions during FY13 was 15. The number of pre-trial admissions started to increase in FY14 (19 per month) and increased further in FY15 (21 per month).

The number of pre-trial admissions marginally declined in the first quarter of FY16 (19 per month). It should be noted, however, that this decrease of admissions in the last few months is attributed more to the unavailability of bed space for pretrial individuals due to a continued high census at the Hospital. Throughout the first quarter of FY16, there was a waiting list for admissions every day during this period; had bed space been available, the number of admissions in the first quarter of FY 16 would have likely equaled or exceeded FY15 levels. It should also be noted that the time spent on the waiting list for admissions increased significantly in first quarter FY16 and this trend continues to date.

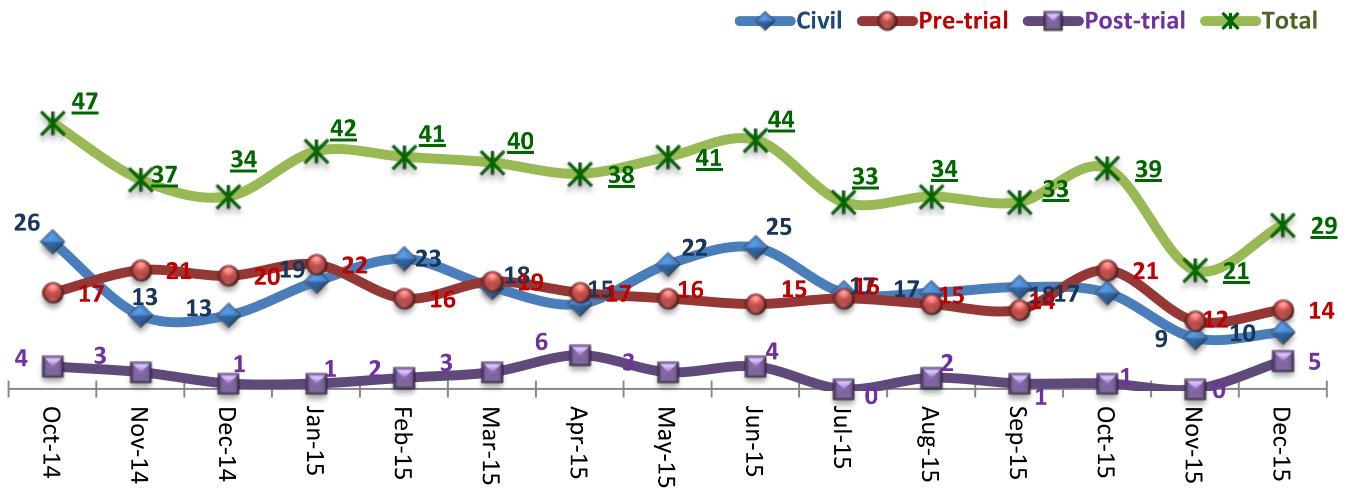
Number of Admissions during Month (Oct-2014 ~ Dec-2015)



3) Discharges (Oct-2014 ~ Dec-2015)

The number of discharges increased from a total of 429 (or 36 per month) in FY14 to a total of 464 (or 39 per month) in FY15. The number of FY15 discharges was slightly higher than the number of FY15 admissions (a total of 458). The number of discharges was high during the first three quarters of FY15 but discharges began to decrease noticeably during the last quarter of FY15 and the first quarter of FY16. This declining trend of discharges resulted in an increase of census in the last six months. The decrease in the number of civil discharges reached a significant low (9) in November 2015 and was only slightly better in December 2015.

Number of Discharges during Month (Oct-2014 ~ Dec-2015)



4) Length of Stay (LOS)

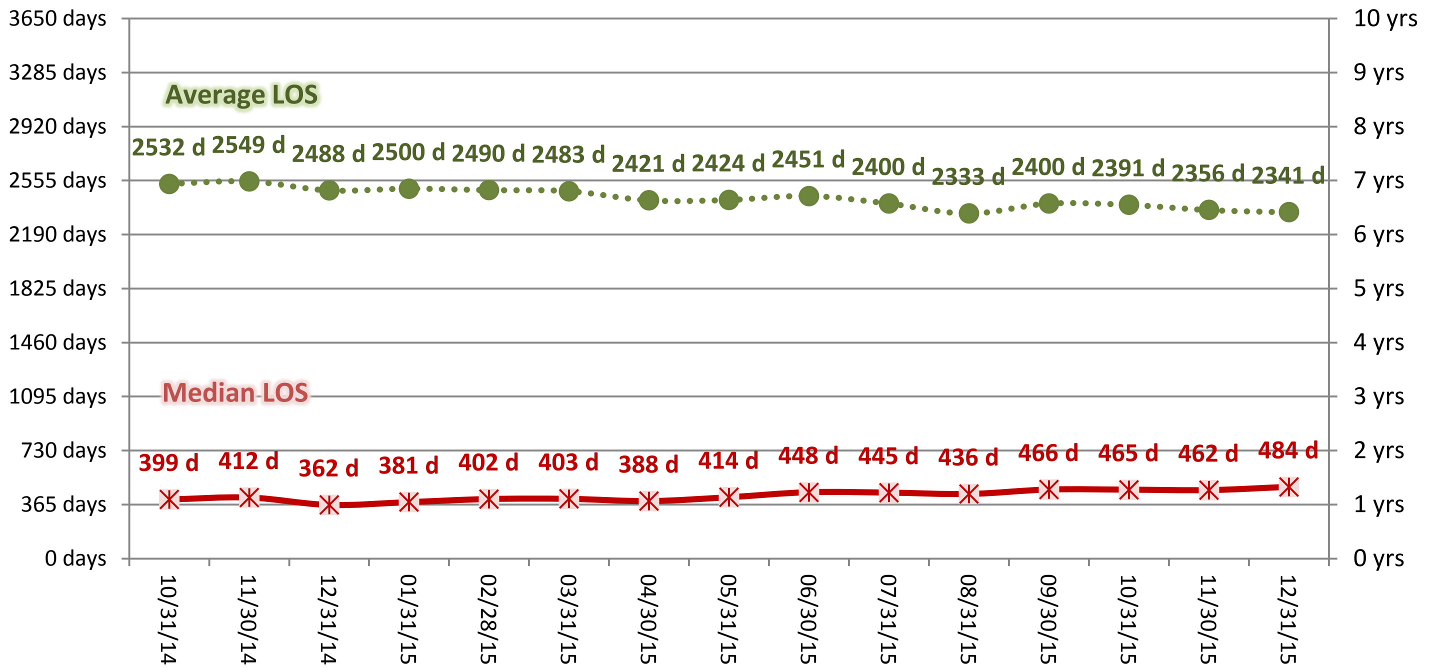
The average (mean) length of stay (LOS) at the Hospital has been always much longer than the median (midpoint) LOS[1]. The average LOS can be easily skewed because it can be affected disproportionately by a few individuals who have been hospitalized for an extended period of time. While we always monitor and will present the average LOS data herein, we rely more often on the median LOS as it helps us to assess the central tendency more accurately.

Overall, the length of stay (both average and median) for individuals in the Hospital's care significantly shortened in FY14. The average LOS continued to decline during FY15 and the first quarter of FY16. However, the trend of the median LOS was reversed in FY15, gradually increasing, particularly over the past six (6) months. This trend reflects the census and discharge trend presented above: discharges of several long-term patients that occurred in the first half of 2015 resulted in a decrease of the 'average' LOS. However, a decrease of overall number and timeliness of discharges in the last six (6) months contributed to an increase of 'median' LOS. The median LOS for those remaining in care as of October 31, 2014 (15 months ago) was 399 days (approximately 13 months), meaning 50% of the individuals in care had been residing at the Hospital for longer than 13 months. Since the median LOS increased throughout the year in FY15 and to date in FY16, it reached its highest point since July 2014 at 484 days (approximately 16 months) on December 31, 2015.

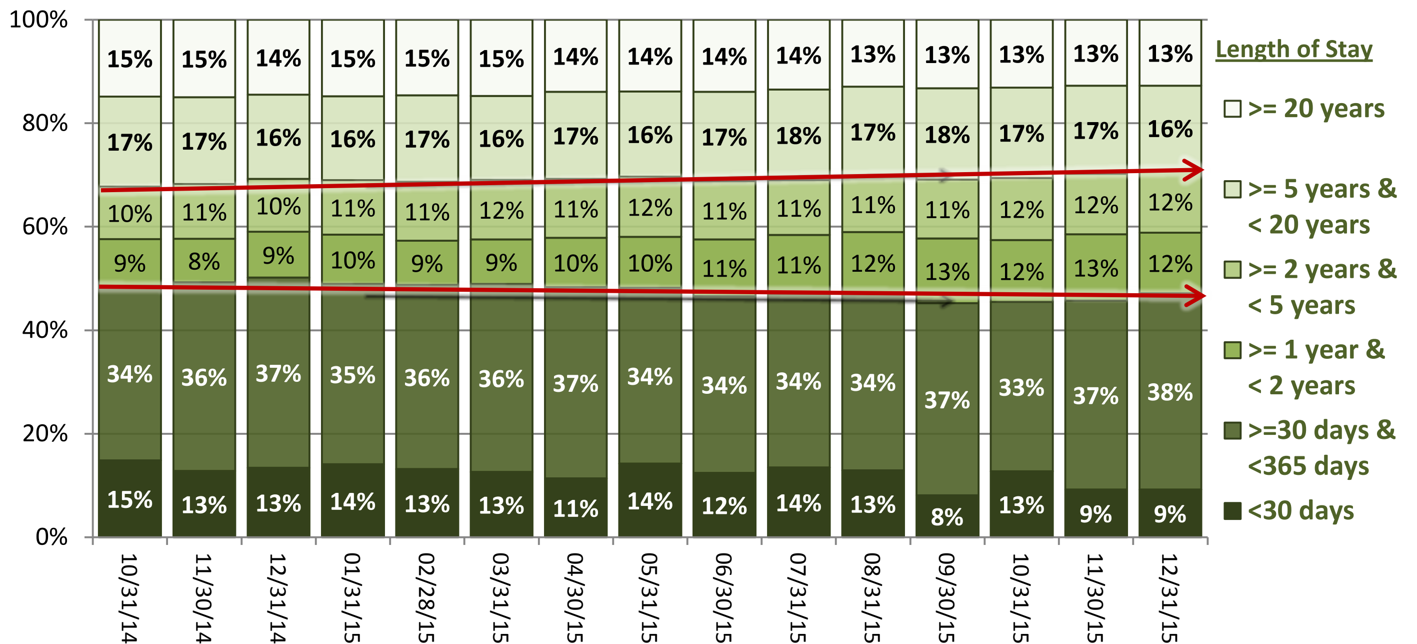
The trend of this increase in the median LOS along with the decrease in the average LOS is also demonstrated well in the length of stay distribution chart. The proportion of those who had been in care for five (5) years or longer decreased throughout the year, lowering the average LOS of the overall population. However, the percentage of those who had been in care for more than a year and less than five years noticeably increased, raising the mid-point (median) LOS.

[1] Median length of stay means that half the individuals' length of stay was less than those number of days, and the length of stay for the other half of individuals exceeded those number of days.

Length of Stay for Individuals Remaining in Care at End of Month (10/31/14 ~ 12/31/15)



Length of Stay Distribution for Individuals Remaining in Care (10/31/14 ~ 12/31/15)



Q96. How many individuals are currently receiving hospital discharge support in order to move back into the community? What are some of the barriers to discharge and what steps have been taken to address these barriers?

DBH Response

In FY 15, there were 464 individuals who were discharged from Saint Elizabeths, with 138 of them receiving hospital discharge support from Adult Services. In FY 16, through December 31, 2015, there have been 89 individuals discharged, with 59 of those receiving discharge supports from Adult Services. As of December 3, 2015, there were 282 individuals in Saint Elizabeths Hospital, and 126 of whom were receiving discharge support. These individuals receiving discharge support are not necessarily clinically ready for discharge, but are those for whom the discharge planning process has been initiated due to clinical progress made or in anticipation of forensic (court ordered) discharge.

The most prominent barrier to discharge is the number of available SRR placements available. As of December 31, 2015 there were 27 individuals receiving hospital discharge support and will be prioritized for community placement. In February 2014, the Department launched the Clinical Review and Monitoring Step-Down Project, which assesses and moves consumers to more independent levels of housing. While this Project has moved 25 individuals to lower levels of housing, this has not kept pace with the number of SRR referrals during its existence.

Complex medical needs and mobility concerns are also barriers to discharge. The Department currently has an RFP out for 10 Intensive Residential (IR), which is a higher level of housing intended for consumers who meet an SRR level of placement but also have more complicated medical concerns than are typically managed in an SRR placement. The provider chosen will have placements that are wheelchair accessible or can address the needs of individuals with mobility concerns.

Administrative barriers to discharge have been addressed by updating discharge protocols and identifying additional staff to assist with the discharge process. Additionally, weekly meetings with providers have been initiated to ensure that our outpatient providers are performing their responsibilities in the discharge process.

Q97. Have you completed FY15 Provider Scorecards? If so, please attach. If not, please explain why Provider Scorecards were not completed.

DBH Response:

The annual Provider Scorecard is based on data from the prior fiscal year. DBH plans to publish the FY 15 Provider Scorecard in June 2016. The Office of Accountability (OA) is now collecting and analyzing data. After completion of the scoring, OA will meet with each provider to discuss the Scorecard process and review the final score. The FY 14 Scorecard was published in FY 15 and is posted on the DBH website. The Scorecard is attached.

See Attachment. FY 14 Provider Scorecard

Q98. Please attach the FY15 Community Service Review results of the children/youth. Please explain when the targeted review of adults will be conducted. In addition, please describe the process for substance use disorder services.

DBH Response

During FY15, a Community Service Review (CSR) was conducted with 85 children and youth between January and July. Eighty were completed by DBH, two were completed with the Child Family Services Agency (CFSA), and three were completed by CFSA. This was the first system-wide review using the new protocol developed with CFSA, which enables both agencies to share the data collected. The CSR review protocol was revised substantially to reflect best clinical practices. For example, several indicators were broken out to get measures of how well the individuals that made up the whole family system were served.

A target review of Adult Services was conducted during July and August 2015 which focused on adults aged 65 and older who participate in day rehabilitation services. Eight reviews were completed. This population was chosen because this demographic group consistently utilizes the most units of day services. The purpose of the review was to explore the needs of this group and examine what role day services plays in their treatment to guide future service planning for this group. The overall practice performance scored 75% acceptable. The qualitative data reported that participation in day treatment services appears to be the only significant source of social interaction and social support for most of the consumers reviewed. Many consumers appeared to have few natural supports and limited opportunities to develop social relationships beyond their participation in day treatment activities. This review suggests that day treatment is meeting an important need for this population and it needs to be better integrated with other supports and treatments received by an individual.

A workgroup was established to develop qualitative evaluations of substance use disorder services. The process includes integrating the measurement of service quality into the discussion of adapting services to a Medicaid fee-for-service model. Also, the person-centered treatment model will be the basis for the protocol to measure the quality of substance use disorder services. Because of the focus on developing and implementing the new Chapter 63 regulations for substance use disorder providers and trainings for providers to prepare for certification, the workgroup was slowed. DBH projects the written protocol and evaluation process will be developed by September 30, 2016, and pilot evaluations will begin in the new fiscal year.

See Attachment. Child/Youth FY 15 CSR

Q99. Please provide an update on any other new evaluations DBH is utilizing to determine whether mental health interventions have had good outcomes for children/youth.

DBH Response

On November 1, 2014, DBH implemented the use of the Child and Adolescent Functional Assessment Scale (CAFAS) and the Preschool and Early Childhood Functional Assessment Scale (PECFAS) across all child-serving mental health providers. CAFAS/PECFAS is a standardized assessment tool for assessing children and youth day-to-day functioning and for tracking changes in functioning over time. The tool is completed by a practitioner based on information from routine clinical evaluation providing a comprehensive and objective assessment focusing on observable behaviors. The CAFAS/PECFAS is backed by over 20 years of research supporting its validity and sensitivity to detecting change in behaviors. It is widely used to inform decisions about type and intensity of treatment, level of care, placement and need for referral.

On December, 1, 2015 the CAFAS was also implemented for the adolescent substance use disorder treatment providers (ASTEP- Adolescent Substance Use Treatment Enhancement Program), thus ensuring that youth receiving either mental health or substance use services will have a common functional assessment.

Q100. Please provide an update on the work DBH's Integrated Care Division in discharge planning efforts at Saint Elizabeths. Elaborate on any new projects that were undertaken in FY15 and to date in FY16.

DBH Response

In FY15 care coordination services provided by the DBH Integrated Care Division focused on providing timely community-based services to adults following discharge from a psychiatric facility. Four hundred and sixty-four (464) individuals were discharged from Saint Elizabeths Hospital with 138 receiving discharge support from the DBH Integrated Care Division during the fiscal year. In FY 16, through December 31, 2015, there have been 89 individuals discharged, with 59 of those receiving discharge supports from Adult Services.

The Integrated Care division tracks individuals leaving a psychiatric inpatient unit after an involuntary admission or being discharged from Saint Elizabeths. The Integrated Care Division strives to assist individuals who are discharged with obtaining appointments with Core Service Agencies within seven (7) days of discharge. The Integrated Care Division also follows to see if the same individuals are seen a second time within thirty days of being discharged. Sixty two percent (62%) received a service within seven (7) days and seventy four percent (74%) received a service within 30 days.

In FY16 DBH will procure 10 beds for individuals who have physical health conditions that exceed the clinical care capacity of existing residential providers but whose conditions are not appropriate for nursing home level care.

Q101. Please provide an update on the New Direction Program which focuses on community re-integration efforts for long-term SEH patients. How many individuals were served by this program in FY 15 and to date in FY 16?

DBH Response

The New Directions Program is currently operated by Anchor Mental Health Association and is also referred to as the Integrated Community Care Project (ICCP). The ICCP continues to provide comprehensive care to individuals with serious and persistent mental illnesses who have had long-term hospitalizations at Saint Elizabeths Hospital (SEH). Intensive clinical and social rehabilitation services are provided to individuals leaving the hospital and re-entering the community from long-term and often recurrent, hospitalizations. The goal is to support community integration and maintenance of community tenure. The specific objectives established for the program are to:

- Reduce recidivism and length of stay within institutional settings such as psychiatric hospitals, correctional facilities and nursing homes;
- Increase community tenure;
- Establish social support networks and natural supports to assist individuals with serious and persistent mental illness to live successfully within the community;
- Assist individuals in developing the functional and social skills necessary to live in the least restrictive environment; and to
- Effectively manage their mental illness and other co-occurring conditions.

The ICCP served 30 individuals in FY 15. At the end of the first quarter of FY 16, twenty-nine (29) individuals were in enrolled in the ICCP. Of the twenty-nine, nineteen (19) have had no readmissions to Saint Elizabeths Hospital during calendar year of January 2015 – December 2015. Ten individuals had fourteen separate readmissions during the same time period but were able to return to the community following hospitalization.

The DBH Integrated Care Division meets bi-monthly with representatives from SEH and Anchor to assess individuals residing in the hospital potential for participating in this program as well as to review the progress of those enrolled.

Q102. Please provide an update on the number of Community Residential Facilities certified or operated by DBH. In your response, please indicate the number of CRFs in each Ward.

DBH Response

Please see the chart below which provides the number of currently licensed Mental Health Community Residence Facilities in each ward.

Ward	CRFs
1	6
2	0
3	2
4	14
5	16
6	12
7	26
8	33
Grand Total	**109**

Q103. Please provide an update on all of the goals and activities described in Appendix A of the Department of Mental Health's Strategic Housing Plan for 2012-2017, clearly identifying which actions have been completed, and on what timeframe.

DBH Response

See Attachment. Strategic Housing Planning Appendix A Updates

Q104: Please describe the adequacy of DBH's existing supportive housing capacity to meet the needs of adults with severe and persistent mental illness.

DBH Response:

The District of Columbia is a national leader in providing supported housing for individuals with mental illnesses. In FY15, a total of 2,820 people were in supported housing including supported residences, and rental subsidies. In FY 16, fifty new and renovated affordable housing units will be added. In addition, through its collaboration with the D.C. Department of Housing and Community Development (DHCD), DBH is providing capital funds to support housing set asides in new developments for people with mental illnesses. Currently, 152 units are in the various stages of development, including 17 under construction, 99 units from the 2013 Consolidated NOFA, and 36 units from the 2014 Consolidated NOFA. Despite this growth, demand continues to exceed availability. DBH prioritizes support to individuals who are homeless, moving from Saint Elizabeths Hospital, or relocating to a more independent living environment.

Q105. Please identify the unduplicated number of clients served by each provider organization certified by APRA for the drug treatment for FY2015 and FY16 to date.

DBH Response

Agency Name	UNDUPLICATED COUNT FOR FY2015	UNDUPLICATED COUNT FOR FY2016
Access Housing Inc.	54	3
Andromeda	597	198
Angels and Associates, Inc	252	108
APRA Intake Agency(Internal)	5,844	1,646
Calvary Healthcare Inc	124	20
Child and Family Services Agency(Int)	74	0
Clean and Sober Streets	310	106
Community Connections	52	12
DC Recovery Community Alliance	715	101
Department of Behavioral Health(Internal)	576	54
Family & Medical Counseling Service	586	90
Federal City Recovery	982	255
Found. for Contemporary Drug Abuse	165	32
Good Hope Institute	115	48
Hillcrest Children & Family Center	189	55
Holy Comforter St. Cyprian	717	186
LaClinica Del Pueblo	64	17
Latin American Youth Ctr.	46	11
LIFE STRIDE	65	20
Maryland Treatment Center	50	11
Pilgrim Rest	18	9
Providence Hospital	584	169
Psychiatric Institute of Washington	1,055	335
Riverside Treatment	48	15
Safe Haven Outreach Ministry	217	63
Salvation Army	598	129
Samaritan Inns	256	106
So Others Might Eat (SOME)	345	91
TOTAL FAMILY CARE COALITION	79	0
United Planning Organization	181	44