Department of Behavioral Health

Adult Community Services Review Summary Report FY2014

2014

Community Services Review
Office of Programs and Policy

64 New York Avenue, NE, Washington, DC 20002

Executive Summary

The primary focus of this report is to provide an overview of the results of the Community Service Review (CSR) evaluation completed in 2014 of adult services offered through the District of Columbia Department of Behavioral Health (DBH). This report also highlights demographic, consumer status, and practice outcome changes in the DBH system since the last system-wide review of adult services was completed in 2011.

The CSR is a qualitative review process used to evaluate the quality of services offered through DBH. The review process is a case-based inquiry of services received by individual consumers. Reviewers analyze the facts of a case to score specific indicators following a standardized protocol. The scoring uses a six point scale, with scores of one, two and three considered to be the Unacceptable range and scores of four, five and six to be the Acceptable range.

DBH set a goal for the 2014 CSR of achieving 80% Acceptable on the aggregated system-wide *Overall Practice Performance* score and was able to exceed this by achieving 84% Acceptable; the overall score in 2011 was 81%. This is significant because some of the historically high-scoring agencies were serving a smaller proportion of consumers in 2014 than they did at the time of the 2011 system-wide CSR, while new agencies have been added to the network of providers since 2011, and these new agencies only scored 56% acceptable on *Overall Practice Performance,* which is 38 percentage points lower than the historically high-scoring agencies. It is also noteworthy that major changes were made to the Adult CSR protocol to align the protocol with contemporary best practices, which made some indicators more rigorous, and the *Overall Practice Performance* score still improved with these higher requirements.

The results of the 2014 System-Wide CSR showed that Core Service Agencies (CSAs) were better at planning and delivering of *Mental Health Recovery* (87% Acceptable*)*, and *Community Integration* (80% Acceptable) than planning for *Trauma Recovery* (30% Acceptable) and *Substance Use Recovery* (37% Acceptable). There was also strong planning and delivering in the area of *Managing Chronic Health*, which is important because the DBH system is soon to launch a Health Homes model of service delivery, which emphasizes the collaboration between physical health and mental health services to improve health care outcomes for a consumer. The results of the review also showed some gains on the following indicators: *Cultural Identification & Need, Engagement, Team Formation, Team Functioning,* and *Personal Recovery Goals.*

In 2014, *Overall Consumers' Status* indicator scores were 74% Acceptable, compared to 81% in 2011. Consumers were doing well in the areas of *Safety* (87% Acceptable), *Risk to Self* (82% Acceptable), *Risk to Others* (90% Acceptable), *Receipt of Healthcare* (90% Acceptable) and *Voice & Choice* (90% *Acceptable*). *Substance Abuse Impairment* was a new indicator added to the protocol since 2011, and only 62% of consumers reviewed scored in the Acceptable range on this indicator in 2014. *Work Status* declined slightly from 61% *Acceptable* in 2011 to 58% in 2014. *Functional Life Skills* was also added to the protocol as a new status indicator, and only 66% of consumers scored in the Acceptable range. Consumers' *Mental Health Functioning* was

69% *Acceptable* and remained unchanged from 2011. Consumers' *Social Network Quality* improved from 65% in 2011 to 69% in 2014.

Based on these findings it is evident that, across the system, providers are able to convey respect for their consumers and develop therapeutic working relationships with them. However, there is variability between providers in the quality of assessment skills. As a system, we need to improve how we treat Trauma and Addiction Recovery. Overall, this was the highest system performance has been rated in the decade CSRs have been conducted. DBH needs a develop a strategic growth plan to ensure that the system sustains these gains by ensuring that new agencies are able to offer high-quality services from the beginning and grow at a rate that enables the agencies to sustain high-quality services.

ACKNOWLEDGEMENTS

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Respondents: *Special thanks to the consumers and caregivers for their participation; sharing their unique experience is instrumental in shaping the direction of system and quality improvement strategies for the District of Columbia's Department of Behavioral Health.*

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INTRODUCTION

As part of the Department of Behavioral Health's (DBH) pledge to delivering quality care, the agency has committed to assessing front line practice using a case-based review process. The CSR Unit conducts systematic consumer case-based reviews to assess on-going system-wide strengths and needs and system progress related to improving behavioral health practice in the District of Columbia. Consumer participation is voluntary, and written consent from each consumer is required to allow for exchange of protected health information during the review process.

Since 2003, under the auspices of Human Systems & Outcomes, Inc. (HSO), the Department of Behavioral Health has conducted numerous reviews to identify and improve the quality of care to consumers receiving behavioral health services. Fiscal year 2014 marks the first year that a system-wide CSR process has been completed by the CSR Unit independent of HSO.

Fiscal year 2014 also marks the first system-wide review using an updated version of the protocol. During the summer of 2012, the Adult Community Service Review protocol was substantially revised to align with best clinical practices. A group of clinical staff from DBH, CSAs, and consultants from HSO formed a working group to review and revise the content in the protocol. HSO used the recommendations of the working group to rewrite the protocol and make indicators more explicit. In particular, there was a reconceptualization of the Planning & Implementing practice indicators to provide quantifiable measurement of the planning and implementation of interventions to address the specific clinical issues of *Mental Health Recovery, Addiction Recovery, Trauma Recovery, Safety, Basic Necessities, Life Skills, Education/Work, Community Integration, Managing Chronic Health Needs* and any *Other Needs*. In addition, the Planning & Implementation indicators expanded from a single score to potentially as much as ten scores, depending on how many of the above clinical areas needed to be addressed with each consumer.

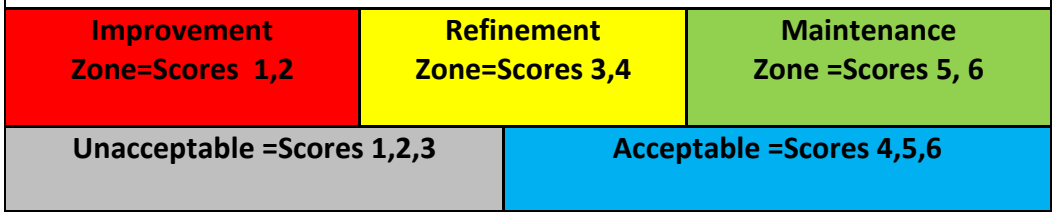
METHODOLOGY

The CSR is a qualitative review process used to evaluate the quality of services offered through DBH. This process yields quantitative data on indicators related to consumer status and system performance. The review process is a case-based inquiry of services received by individual consumers. To show appreciation for participating, each consumer is given a $25.00 gift card to a local merchant. The process is based heavily on face-to-face interviews with all service providers and other key supports involved with an adult consumer. Those interviewees include the consumer and service team members, such as community support workers (CSW), clinical supervisors, psychiatrists, therapists, day program workers, representative payees, housing workers, supported employment specialists, probation officers and vocational rehabilitation specialists. Interviews also include natural supports to the consumer whenever they are involved with a consumer's recovery, such as spouses or significant others, family members, pastors, and whoever the consumers deems a key support.

For each individual case review, the data is collected by a pair of trained reviewers who conduct a clinical record review and interview all team members. The reviewers convene with the service team following all of the interviews to debrief regarding their findings and make recommendations for practice improvement on that case. After completing data collection, reviewers analyze the facts to score specific indicators using the "Quality Services Review for an Adult Participant – Field Use Version 1" protocol. Those scores and the justification are then presented and vetted by two members of the CSR Unit to ensure integrity of the scores.

Figure 1 displays the scoring rubric. For each question deemed applicable in a case, the finding was rated on a 6-point scale, ratings of 1-3 are considered "Unacceptable" and ratings of 4-6 are considered "Acceptable." A second interpretive framework can be applied to this 6-point rating scale, in that, rating of 5 or 6 refers to the "maintenance" zone, meaning the current status or performance is at a high level and should be maintained; a rating of 3 or 4 in the "refinement" zone, meaning the status is at a more cautionary level; and a rating of I or 2 in the "improvement" zone, meaning the status or performance needs immediate improvement. Often times, this three-tiered rating system is described as having case review findings in the "red, yellow, or green zone." Both the three-tiered action zone and the Acceptable vs. Unacceptable interpretive frameworks will be used for the following presentations of aggregate data.

Figure 1: CSR Scoring Zones



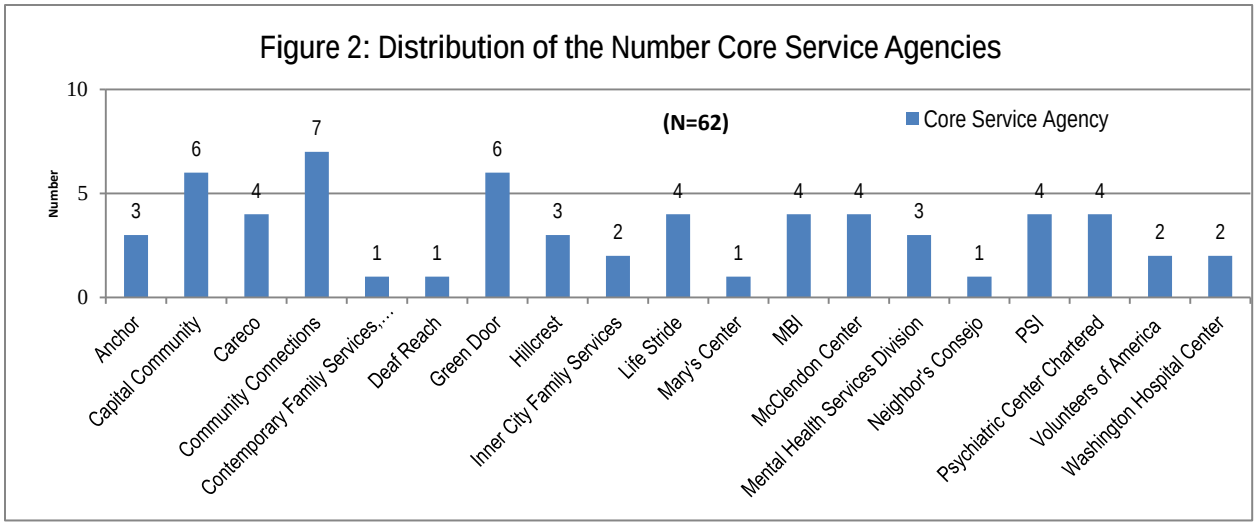
Once the quantitative scores have been validated, the Lead Reviewer submits a written case summary, which tells the "story" of the consumer and his or her services and also provides the justifications of the scores.

Data collection for the 62 cases reviewed was spread over the extended period of April 2013 through September 2014. This aggregated the results of the FY13 Small Agency Focused Review, which consisted of 20 cases, and the FY14 Adult System-wide review so that agencies would not have to be reviewed in consecutive years. The selection criteria for the 20 cases reviewed in FY13 was adult consumers at least 18 years of age who had received one or more face-to-face service billed through the *eCura* billing system between April 2013 and September 2013 from these selected agencies - Capital Community Services, Careco, Life Stride, MBI, and Psychiatric Center Chartered. The FY14 Adult System-wide review used the same sampling method for the 42 cases as previous system-wide reviews, which is to stratify by age, gender and assigned clinical home; however there was a small oversampling of some small agencies and consumers over age 70 after aggregating the 20 cases from FY13 with the 42 cases from FY14.

The 42 cases selected in FY14 had consumers who had one or more face-to-face services billed through the *eCura* system between January 1, 2013 and October 1, 2013 at any service provider.

Description of the Sample

Figure 2 displays the distribution breakdown of the CSAs examined during this review period. The largest number of CSRs were from Community Connections (n=7), followed by Green Door (n=6) and Capital Community (n=6) and six others (Careco, Life Stride, MBI, McClendon Center, PSI, and Psychiatric Center) with four consumers. DBH Adult Services staff requested more data regarding new agencies that had never participated in a CSR and agencies that had two or fewer cases reviewed in the 2011 Adult System-wide CSR. This led to an oversampling of some agencies, some of which were low performers, and this should be taken into account in the overall system results.



There were few changes regarding the demographics of the sample since 2011. The majority of consumers were African-American and over the age of 35; consumers were evenly split between males and females. However, consumers receiving services for more than three years increased by 23% in the 2014 sample. A concerning shift in the demographics in the 2014 sample is the changes in housing placement; 10% more of the sample resided in a Community Residential Facility, and consumers living in their own home or apartment was 8% lower than in 2011, while the number of homeless consumers remained the same, at 8%. (See Appendix A for more details on sample demographics.)

RESULTS

System-wide Results of Consumer Status Indicators

Status indicators measure the quality of the life circumstances for a consumer and the sufficiency of the consumer's living skills during the past 30 days; not every indicator applies to each consumer's needs and situation, thus the Total Applicable number in Table 1 is displayed for each indicator. In general, most consumers were safe, in stable housing, and had stable physical health at the time of their review. *Overall Consumer Status* scored 74% Acceptable, with 45% in the *Maintenance Zone*. Most consumers were *Safe from Harm* (87% Acceptable) and exhibiting low risk behaviors (*Risk to Self* – 82% Acceptable; *Risk to Others* – 90% Acceptable). *Economic Sufficiency* increased by 4% since 2011, to 73%.

Table 1: Adult System-Wide Consumer Status Scores			
	Status of the Person	**Total Applicable**	**Percent Acceptable**
1.	Safety from harm	62	**87%**
2a.	Behavioral risk to self	62	**82%**
2b.	Behavioral risk to others	61	**90%**
3a.	Economic sufficiency	62	**73%**
3b.	Economic management	61	**79%**
4a.	Living arrangement: appropriate	62	**81%**
4b.	Living arrangement: stability	61	**74%**
5a.	Social network: quality	62	**69%**
5b.	Social network: recovery	62	**61%**
6a.	Health: physical status	62	**76%**
6b.	Health: receipt of care	42	**90%**
7.	Substance use	37	**62%**
8.	Mental health status	62	**69%**
9.	Voice & choice	60	**90%**
10.	Functional life skills	29	**66%**
11.	Education/career	18	**61%**
12.	Work status	33	**58%**
13.	Recovery action	60	**70%**
14.	Caregiver functioning	11	**82%**
	OVERALL STATUS	**62**	**74%**

(See Appendix B for description of these *Consumer Status* indicators.)

Two areas, known to be challenges for mental health consumers across the country, where scores continued to lag were *Social Network* (69% Acceptable) and *Work Status* (58% Acceptable). *Social Network* made a small gain of 4% since 2011. It is concerning that *Work*

Status has declined by 3% because DBH committed more resources to improving this score, by expanding the Supported Employment Services and requiring that every consumer be offered these services at the time services are being reauthorized, as well as adding an employment focused day-rehabilitation program.

In recognition of the diverse needs and situations of the consumer population in the DBH system, the revised protocol added a few new Status Indicators. *Substance Use Status* was deemed applicable to 37 consumers in the sample and scored at 62% Acceptable. *Parent and Caregiver Functioning* scored 82% Acceptable. The *Consumer Satisfaction* Indicator was replaced with the new indicator *Voice & Choice*, which is based on the Substance Abuse and Mental Health Services Administration's (SAMHSA) definition of recovery, which emphasizes the empowerment and active participation of service recipients as a means to accelerate recovery. *Voice & Choice* scored 90% Acceptable.

Research has shown that mental health consumers have a high likelihood of suffering from life-shortening chronic medical conditions, and providers have made it a priority to address the medical needs of their consumers[1]. It is not a surprise that 66% of consumers reviewed identified as having at least one medical condition, and 45% of consumers had a current substance abuse/dependence condition. *Physical Health Status* scored 76% Acceptable and *Receipt of Care* scored 90% Acceptable.

System-wide Results of Progress Indicators

Progress indicators measure the areas of a consumer's life that she or he has worked to improve during the six months preceding the review and the rate of progress made during that time. The Progress indicators were modified substantially from the prior protocol reducing the number of measures from nine to seven. (See Table 2 and Appendix B). Overall, consumers were rated as making Acceptable progress in 71% of reviews.

Table 2: System-wide Results of Progress Indicators

	Progress Indicator	Total Applicable	Percent Acceptable
1.	Psychiatric Symptoms	62	69%
2.	Substance Use Impairment	34	56%
3.	Self-Management	60	75%
4.	Community Integration	20	65%
5.	Risk Reduction	30	57%
6.	Other Recovery Goals	42	50%
7.	Overall Progress	62	71%

[1] Robert Wood Johnson Foundation, "Mental Disorders and Medical Comorbidity" *Research Synthesis Report* Number 21, February 2011.

System-wide Results of Practice Performance Indicators

Practice Indicators score the clinical treatment team's effectiveness in various aspects of building therapeutic alliances with the consumer and delivering therapeutic services to the consumer during the 90-day period preceding the review.

Table 3: FY Adult System-Wide Practice Performance Scores			
	Performance Indicator	**Total Applicable**	**Percent Acceptable**
1.	Cultural Identity & Need	62	**90%**
2.	Engagement	62	**89%**
3a.	Teamwork: Formation	62	**87%**
3b.	Teamwork: Function	62	**69%**
3c.	Teamwork: Coordination	62	**73%**
4.	Assessment & Understanding	62	**66%**
5.	Personal Recovery Goals	62	**82%**
6a.	Planning: Mental Health Recovery	62	**87%**
6b.	Planning: Addiction Recovery	31	**52%**
6c.	Planning: Trauma Recovery	36	**31%**
6d.	Planning: Safety	45	**69%**
6e.	Planning: Income/Basic Needs	50	**80%**
6f.	Planning: Life Skill Development	26	**55%**
6g.	Planning: Education or Work	37	**57%**
6h.	Planning: Community Integration	15	**80%**
6i.	Planning: Managing Chronic Health	45	**80%**
6j.	Planning: Other Needs	5	**80%**
7a.	Implementing: Mental Health Recovery	62	**77%**
7b.	Implementing: Addiction Recovery	30	**37%**
7c.	Implementing: Trauma Recovery	20	**30%**
7d.	Implementing: Safety	44	**75%**
7e.	Implementing: Income/Basic Needs	49	**78%**
7f.	Implementing: Life Skill Development	22	**73%**
7g.	Implementing: Education or Work	33	**64%**
7h.	Implementing: Community Integration	16	**81%**
7i.	Implementing: Managing Chronic Health	42	**81%**
7j.	Implementing: Other Needs	6	**66%**
8.	Medication Management	58	**78%**
9.	Transitions & Life Adjustment	23	**57%**
10.	Special Needs for Community Integration	10	**100%**
11.	Ongoing Assessment & Adjustments	62	**53%**
	OVERALL STATUS	**62**	**82%**

(See Appendix C for description of the Practice Performance Indicators.)

The indicators of *Cultural Identity & Need* and *Engagement* were revised in the new protocol to align with SAMHSA's new definition of recovery, which incorporates recent research that indicates when consumers feel their identity is respected and have trust in their providers, those consumer also have better engagement in services. In rewriting these indicators, concepts moved away from the lower threshold of removing barriers and keeping appointments to the higher concepts of building trust and conveying a value for the person and their support network. As a system we continued to meet the higher definition of quality; *Cultural Identity & Need* scored 90% Acceptable, and *Engagement* scored 89% Acceptable. The following quote from the narrative report of a review illustrates the higher quality when interacting around areas of *Engagement* and *Cultural Identity & Need*.

> *"The team understands PB's background and demonstrated an acceptance of his past and openness to him at each stage of his progress. He expressed feeling part of the community at [the agency]."*

Assessment & Understanding scored 66% Acceptable, with half of the scores in the *Refinement Zone* and less than a third of the scores in the *Maintenance Zone*. Some agencies scored well on this indicator, as illustrated by the quote below.

> *"Team members ask appropriate clinical questions and demonstrate a working knowledge of SH's ongoing needs and strengths. The CSW in particular understands when and how best to persuade SH to move beyond her comfort zone, build upon past successes and further develop her ability to navigate independently in the community. As a result, the treatment goals appropriately reflect SH's desires and current abilities."*

Other agencies struggled in the area of assessment, which lowered the aggregate score. Some agencies lacked clinically trained staff that could effectively participate in the assessment of consumers.

> *"His diagnosis has not been updated since intake…There has been no formal psychological, trauma or functional assessment…There is inconsistent information to support consumer's social history and no full understanding of his symptoms."*

The system performed well with *Teamwork: Formation* (87% Acceptable); most teams at mental health providers were engaging collateral providers and natural supports. Staff turnover and vacancies continued to be an issue in the system, which had a negative impact on this score.

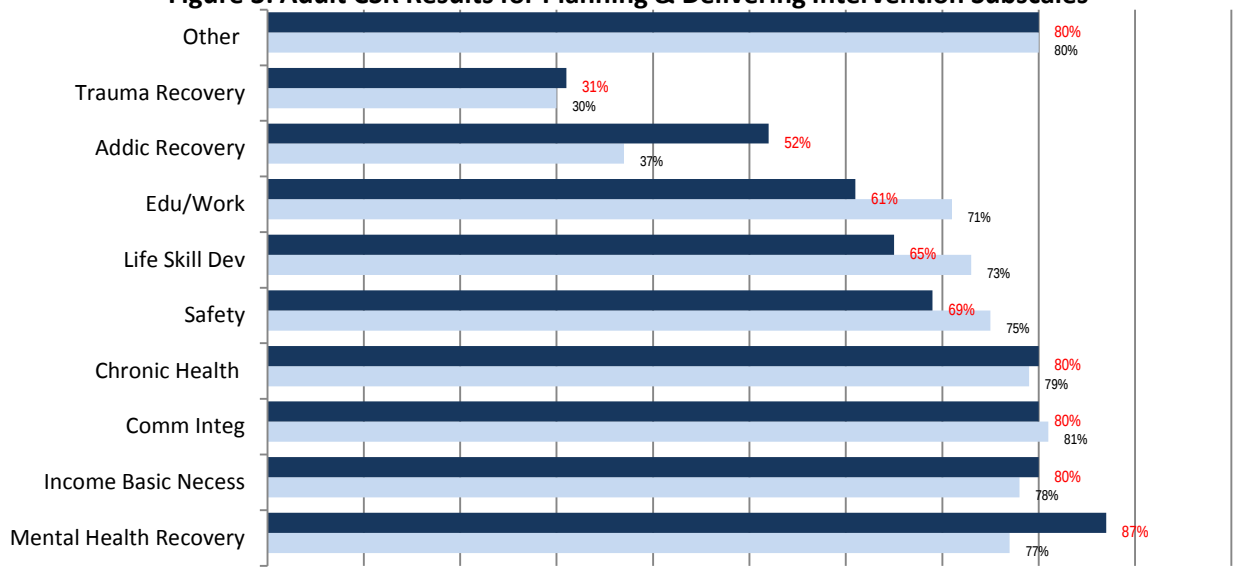
> *"No psychiatrist or CSW is in place… the program director indicates that she has no staff and no ability to do outreach."*

Some teams were working effectively together to support consumers but others had challenges with communication, thus the system scored lower on *Teamwork: Functioning* (69% Acceptable). *Teamwork: Coordination* was only slightly better at 73% Acceptable.

> *"The CSW needs to be empowered to not only bring the team together, but to also ensure that all team members are clear about their respective responsibilities and are held accountable for timely completion of duties. This point is clearly illustrated in the team's inability to arrange for Metro Access transportation, an important goal that has been pending since [this consumer] enrolled in services, nearly a year and a half ago."*

The indicators measuring treatment planning and the implementation of services in the CSR protocol were re-conceptualized to measure the team's ability to treat specific clinical issues and provide more nuanced qualitative data regarding the service planning process and the implementation of intervention strategies in order to better inform DBH's practice improvement activities. The revised indicators now evaluate the planning and delivery of services as they relate to multiple areas of a consumer's life and are considered an expansion of the Individual Recovery Plan indicator used in the previous CSRs between 2004 and 2011. Figure 3 illustrates the results of these indicators in the planning and delivery of specific treatment components of the individual recovery plan (i.e., *Mental Health Recovery, Addiction Recovery, Safety, Education/Work, Community Integration, Managing Chronic Health, Trauma Recovery, Income Basic Necessities, Life,* and *Other Interventions)*.

Figure 3: Adult CSR Results for Planning & Delivering Intervention Subscales



	Mental Health Recovery	Income Basic Necess	Comm Integ	Chronic Health	Safety	Life Skill Dev	Edu/Work	Addic Recovery	Trauma Recovery	Other
% PLANNNG INTERVENTIONS	87%	80%	80%	80%	69%	65%	61%	52%	31%	80%
(N=)of consumers (planning interventions)	62	50	15	45	45	26	28	31	36	5
% DELIVERING INTERVENTIONS	77%	78%	81%	79%	75%	73%	71%	37%	30%	80%
(N=) of consumers (delivering interventions)	62	49	16	29	44	22	24	30	20	5

The reviews found that CSAs were better at planning interventions for *Mental Health Recovery* (87%), *Community Integration* (80%), and *Managing Chronic Health* (80%).

> *"[Consumer's] recent diagnosis of cancer constitutes a major life adjustment. The team was able quickly build a support plan to not only address his medical needs but also to assess the impact of this stressor on other areas of his life and prevented his relapse from derailing his progress."*

Agencies had lower performance when planning interventions for *Safety* (69%), *Education/ Work* (61%), and *Addiction Recovery* (52%).

> *"Despite awareness that LA is actively looking for employment and would like to finish her college degree, no related goals are in written plan. The thought of encouraging her efforts was expressed but lacked any defined follow-up or intended outcome."*

> "Team members do not have a clear sense of the stage of change that AR is operating from currently regarding her addiction and the plan is no longer relevant now that her work schedule has changed her routine."

In terms of delivering interventions, CSAs performed better at *Community Integration* (81%), *Managing Chronic Health* (79%), *Safety* (75%) and *Mental Health Recovery* (77%).

> "There is a clearly stated mental health recovery plan, which was developed with the BF as an active participant…The CSW, when meeting with BF reinforces BF's mental health recovery and addresses ways to maintain progress."

Agencies were less effective when delivering interventions for *Education/Work* (64%), *Addiction Recovery* (37%) and *Trauma Recovery* (30%).

> "Trauma not been addressed with this consumer by way of planning or intervention. During his intake assessment, he disclosed that he witnessed his friend murdered and saw his friend "lying in blood." He says he became intensely terrified, as he saw the assailant and was asked by detectives to testify aaainst him."

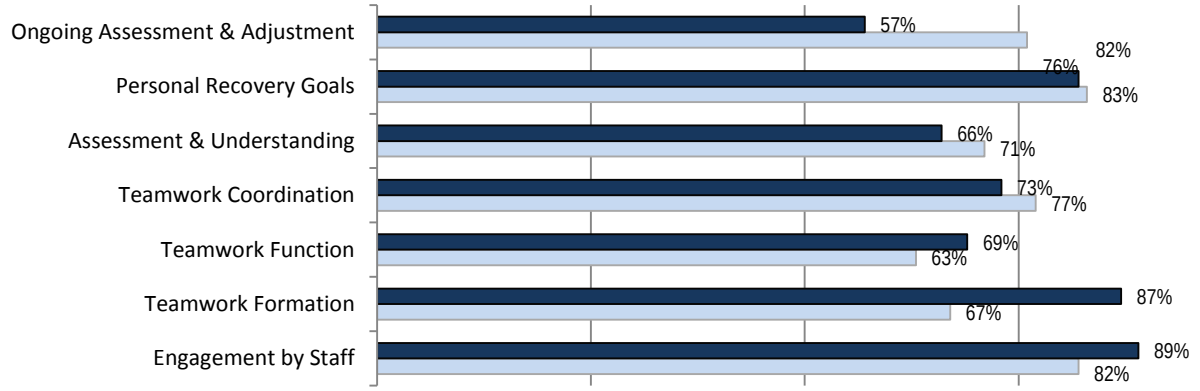
There were some cases where an individual worker, responding to a crisis or consumer request, provided an intervention without prior planning that met a consumer need but may not have been part of the treatment plan or that the team at large was not aware was happening. In these instances, teams were given credit for appropriate services in the *Implementing* score but *Planning* score was rated lower due to concerns about sustainability and continuity of the plan, thus the *Implementing* scores for *Safety*, *Education/Work*, *Life Skills Development* and *Community Integration* exceeded their comparable indicators in performance for *Planning Interventions*.

Comparing 2011 and 2014 System-wide Results of Practice Performance Indicators

Figure 4 illustrates a comparison between 2011 and 2014 of practice performance indicators. Since the last review in 2011, results show that CSAs continue to offer services that are strong at building therapeutic rapport. Performance on *Cultural Identification and Need* increased

from 88% in 2011 to 90% in 2014. In addition, Engagement increased from 82% in 2011 to 89% in 2014.

Figure 4: Results for Selected CSR Adult Practice Indicators (2011 vs. 2014)



	Engagement by Staff	Teamwork Formation	Teamwork Function	Teamwork Coordination	Assessment & Understanding	Personal Recovery Goals	Ongoing Assessment & Adjustment
2014 (N=62)	89%	87%	69%	73%	66%	82%	57%
2011 (N=78)	82%	67%	63%	77%	71%	83%	76%

Team Formation and *Team Functioning* improved in 2014. *Team Formation* increased 20% from 67% in 2011 to 87% in 2014. *Team Functioning* increased by 6% from 63% in 2011 to 69% in 2014. Cases where staff intended to work as a team and found effective ways to continually communicate scored well, as illustrated by this quote from a narrative report.

> *"The CSW shared that she and her supervisor are fairly new to the case but the Psychiatrist provided them with background information regarding the case, during DS' most recent treatment planning meeting. The CSW leads the team's coordination efforts and is fully aware of her role. She had a conversation with the previous CSW to obtain case information."*

Teamwork Coordination scored 73% Acceptable in 2014, a slight decline of 4% since 2011. This indicator measures the effectiveness of team leadership and, in most cases, the CSW was identified as the team leader. A few themes emerged in 2014 cases that scored below the *Maintenance Zone* on *Teamwork Coordination;* either a team leader had not been identified *or* the team leader had not been empowered to hold the rest of the team accountable to the plan or did not track the effectiveness of the plan.

The *Assessment and Understanding* indicator measures the degree to which the clinical team is able to assess and understand the clinical needs and strengths of the consumers. The system-wide performance on the *Assessment & Understanding* indicator declined from 71% in 2011 to 66% in 2014. The consumer's individual recovery goals should be well formulated, measurable and incorporate agreed upon outcomes that guide treatment planning and interventions strategies. In 2014, the *Personal Recovery* indicator decreased by 1% from 83% in 2011 to 82%. *Ongoing Assessment & Plan Adjustment* measures the degree to which the service team is maintaining awareness of the consumer's need, monitoring the delivery of interventions strategies, tracking progress of identified outcomes, and making adjustments and revising strategies is central to the consumer's recovery efforts. In 2014 the *Ongoing Assessment & Plan Adjustment* was 53% Acceptable, which is a decrease from 76% in 2011.

As previously stated, since Planning and Delivering of Interventions indicators have been re-conceptualized since the last system-wide review in 2011; DBH reviewed the data to better understand the impact of these changes on the total average scores for Planning and Delivery of interventions. In 2011, Planning for Interventions was conceptualized as two items (*Individual Recovery Plan & Goodness of Fit*); the average for these two indicators was 78%. In 2014, this indicator was comprised of 10 items (see Appendix C), and the scores were averaged across all applicable items. The Acceptable total *Planning* score was 68%. In 2011, Delivering of Interventions was comprised of two items (*Resource Availability & Treatment & Service Implementation*); the average for these two indicators was 79%. In 2014, this indicator was comprised of ten items (see Appendix C), and the Acceptable total score was 68%.

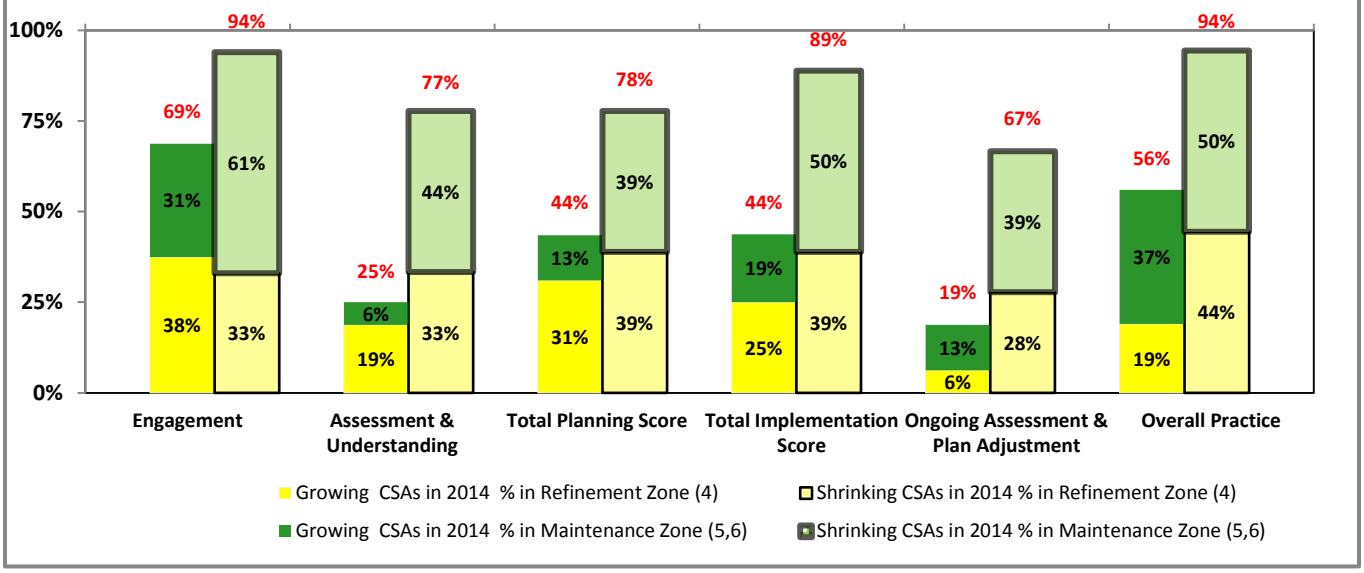
Changing Landscape of Core Service Agencies: Comparison of 2011 & 2014

In comparison to 2011, there were substantial changes in 2014 to the distribution of the consumer population across CSAs (see Appendix D for breakdown of CSAs by number and percent in 2011 & 2014). For example, four new CSAs agencies (MBI, Careco, ICFS, and CFS) that were not providing services in 2011 accounted for 19% of the total consumer population in this sample. Of the 19 CSAs that existed in 2011 and provided services in 2014, 12 agencies saw a decline in their overall consumer population compared to 2011.

A comparison was completed on CSAs that had a 3% or more increase or decrease in their proportion of the overall mental health population from 2011 to 2014. There were four CSAs (Careco, Capital Community Services, Inner City Family Services (ICFS), and MBI) that account for 30% of the 2014 overall consumer mental health population, whereas in 2011 these agencies only accounted for 3% of the consumer population. Three of these CSAs (Careco, IFCS, and MBI) were not MHRS contracted providers in 2011. In contrast, four agencies (i.e., Community Connections, Green Door, Mental Health Services Division, and Washington Hospital Center) that were in existence in 2011 saw at least a 3% or more decline in the number of consumers receiving mental health services in 2014 with their respective agencies. In 2014, these four CSAs provided services to 35% of the overall consumer mental health population compared to 51% in 2011, a decrease of 16% (see Appendix E).

To better understand how the change in the composition of CSAs from 2011 to 2014 and its impact on practice, a comparison review was conducted on key practice indicators. These indicators have the greatest impact on consumer participation and outcomes (i.e., *Engagement, Assessment & Understanding, Ongoing Assessment & Plan Adjustment, Overall Practice Performance, Total Planning Intervention Score, and Total Implementing Interventions Score*) [2]. Figure 5 displays the aggregate scores of agencies in 2014 that were either new or had at least a 3% or greater increase in their overall consumer population in 2014 (henceforth referred to as growing agencies) and agencies with a 3% or greater decrease in their overall consumer population in 2014 when compared to 2011 (henceforth referred to as shrinking agencies). This chart displays the breakout of the *Acceptable* scores between the *Refinement Zone* and the *Maintenance Zone* (see Figure 1.) to show a sharp contrast in the quality of services between these two groups. The shrinking agencies not only have much higher percentages of *Acceptable* scores, these agencies also have significantly more scores in the *Maintenance Zone,* which is what the DBH system is striving to achieve. DBH must think strategically about how to increase system capacity and support new agencies to establish quality services and develop at rates that allow them to achieve the goal of having all scores within the Acceptable range with a majority falling in the *Maintenance Zone*.

Figure 5: Shrinking CSAs (n=17) vs. Growing (n=16): Breakout of Acceptable Scores by Percentage in the Refinement Zone (4) & Maintenance Zone (5,6) on Selected Practice Indicators (FY2014)



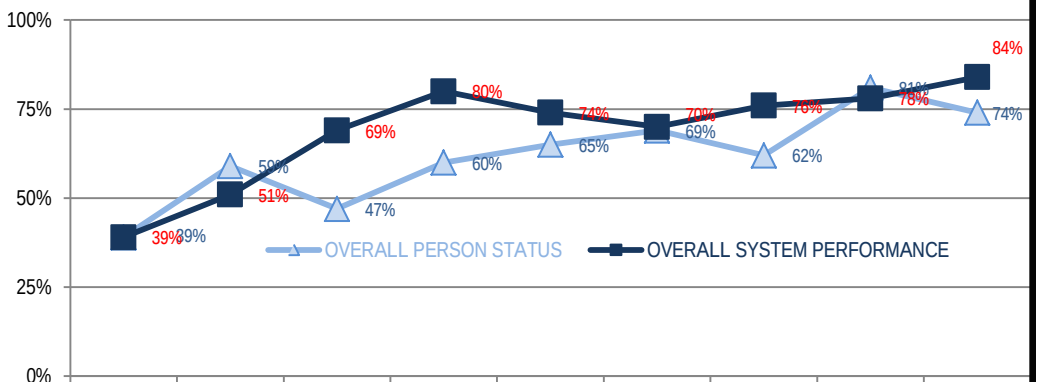
Overall Person Status and Practice System Performance 2004-2014

In the decade that DBH has been conducting CSRs, both consumer status and system performance have steadily increased, with 2014 having the highest ratings yet. Figure 6

[2] The Total Planning Intervention Score and Total Implementing Intervention Score are a composite index of the following practice indicators: (1) Mental Health Recovery, (2) Addiction Recovery, (3) Trauma Recovery, (4) Safety, (5) Income/Necessities, (6) Life Skill Development, (7) Education/Work, (8) Community Integration, (9) Chronic Health, and Other Interventions. The index is based on the practice indicator ratings discussed earlier.

illustrates the Acceptable rating percentages between 2004 and 2014 for the *Overall Person Status* and *System Performance*. During the aforementioned period, the *Overall Person Status* has ranged from a low of 39% in 2004 to a high of 81% in 2011, and the *Overall System Performance* ranged from a low of 39% in 2004 to a high of 84% in 2014. In the three years since the previous adult review in 2011, the *Overall Person Status* indicator decreased by 7%, and the *Overall System Performance* increased by 6%.

Figure 6: Adult Overall Person Status and System Performance 2004-2014



	2004 (N=41)	2005 (N=51)	2006 (N=50)	2007 (N=56)	2008 (N=88)	2009 (N=88)	2010 (N=85)	2011 (N=78)	2014 (N=62)
OVERALL PERSON STATUS	39%	59%	47%	60%	65%	69%	62%	81%	74%
OVERALL SYSTEM PERFORMANCE	39%	51%	69%	80%	74%	70%	76%	78%	84%

IMPLICATIONS FOR PRACTICE IMPROVEMENT

Based on findings from this system-wide examination of the practice of CSAs in the District of Columbia, there are several implications for practice improvement for consumers and families served by the behavioral health system.

The *Overall System Performance* score increased from 2011 to 2014, and several practice indicators were trending in the right direction. In 2014, the DBH system demonstrated improvements in *Engagement, Teamwork Formation & Team Function*, and *Personal Recovery;* these skills are the starting place for good therapeutic rapport with consumers. Providers were doing well with treating mental health recovery and addressing the basic needs of consumers. However, there were a number of areas of practice that needed development to improve quality system-wide, this includes services for addiction recovery and trauma recovery. It is important that DBH continue active efforts for improvement so all consumers in the system receive the quality services they deserve.

DBH may need to develop a strategic plan for providing technical assistance to new providers and managing the growth of those agencies over time. In 2014, approximately one in five consumers was served by a core service agency that was not in existence at the time of the last system-wide review of adults in 2011. Some of these agencies did not perform as well as agencies that have been providing services for a longer period of time, and it is imperative to find the root cause for lower practice performance at each of these agencies in order to

ameliorate it. Additional data points should be examined to determine the cause of inadequate practice whether it is the result of untrained or unsupervised staff, excessive caseloads or other factors; this information would then better inform DBH planning.

DBH is preparing to launch a campaign to institute a Person-Centered model of care, which puts emphasis on the skills of assessing, treatment planning and delivering services. These results demonstrate that this effort is needed given the decrease in the practice of Assessment *& Understanding*, which plays a central role in the identification of underlying issues such as trauma, substance abuse, and medical issues that might thwart personal recovery efforts. Moreover, a comprehensive assessment is critical in the identification of strength based personal assets, familial and community level protective mechanisms that support the personal recovery process. Fortunately, DBH is already pursuing training in these areas under the Person-Centered Planning initiative and this may address the disparity between some agencies in the quality of assessments and services.

DBH may want to examine the content of trainings and technical assistance currently offered to providers to ensure that each provider has a core level of competency in the full range of clinical issues common to the population. Findings for planning and delivering of interventions strategies - which are inextricably linked to personal recovery goals and system wide practice outcomes - were mixed. For example, CSAs appeared to be engaged in adequate planning/delivering of intervention strategies related to *Mental Health Recovery, Community Integration*, *Income Basic Necessities,* and *Managing Chronic Health* concerns, practice for these categories met or exceeded 80% Acceptable performance for consumers. The percent of consumers in the Acceptable range for *Trauma Recovery* & *Addiction Recovery* was near or below 50%, indicating that more education regarding these clinical issues is urgently needed.

Since 2011, DBH committed additional resources toward the improvement of consumer's housing and work status, but the consumers in the 2014 System-wide CSR did not improve in these areas. DBH may need to explore other data points to determine if the findings from the CSR reflect the system at large and whether resources are being implemented effectively.

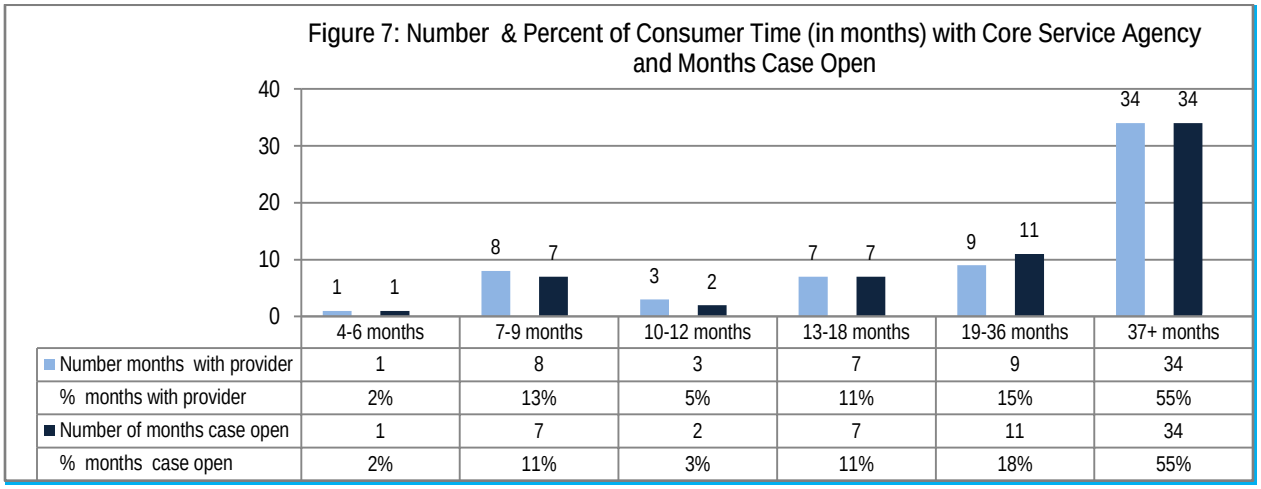
CONCLUSION

This report provided a snapshot of system-wide practice in the District of Columbia Behavioral Health System. During 2014, there were several noteworthy system wide findings, compared to 2011; there was a decrease in *Overall Consumer Status*. There was an increase in *Overall System Practice*, despite the changing landscape of providers during that period of time. New CSAs may require additional consultation and support if the system is going to make greater gains in the quality of services. There were noticeable improvements in practice indicators such as *Engagement, Teamwork Formation* & *Teamwork Function*, and *Personal Recovery* in 2014 compared to 2011 which suggests the District is moving in the right direction as it continues to work to improve its behavioral health system. DBH must ensure the Person-Centered Treatment model is effectively implemented to improve the providers' skills of assessment and treatment planning ultimately increasing the overall quality of practice provided.

Appendix A: 2014 Sample Demographics

Table 4. Age Distribution of Consumer Interviewed for Community Service Reviews in 2014		
Age Group	**Number**	**Percent**
18-29 years old	9	15%
30-49 years old	22	35%
50-69 years old	23	37%
70+ years old	8	13%
Total	**62**	**100%**

Table 5. Distribution of Current Living Arrangement of Consumers in 2014		
Living Arrangements	**Number**	**Percent**
Own/personal home	26	42%
CRF	10	16%
Kinship/relative home	8	13%
Homeless/shelter	5	8%
Supported living	4	6%
Friend's home	3	5%
Rooming House	2	3%
Skilled Nursing Facility	1	2%
Substance abuse treatment facility	1	2%
Transitional Living	1	2%
Total	**62**	**100%**



	4-6 months	7-9 months	10-12 months	13-18 months	19-36 months	37+ months
Number months with provider	1	8	3	7	9	34
% months with provider	2%	13%	5%	11%	15%	55%
Number of months case open	1	7	2	7	11	34
% months case open	2%	11%	3%	11%	18%	55%

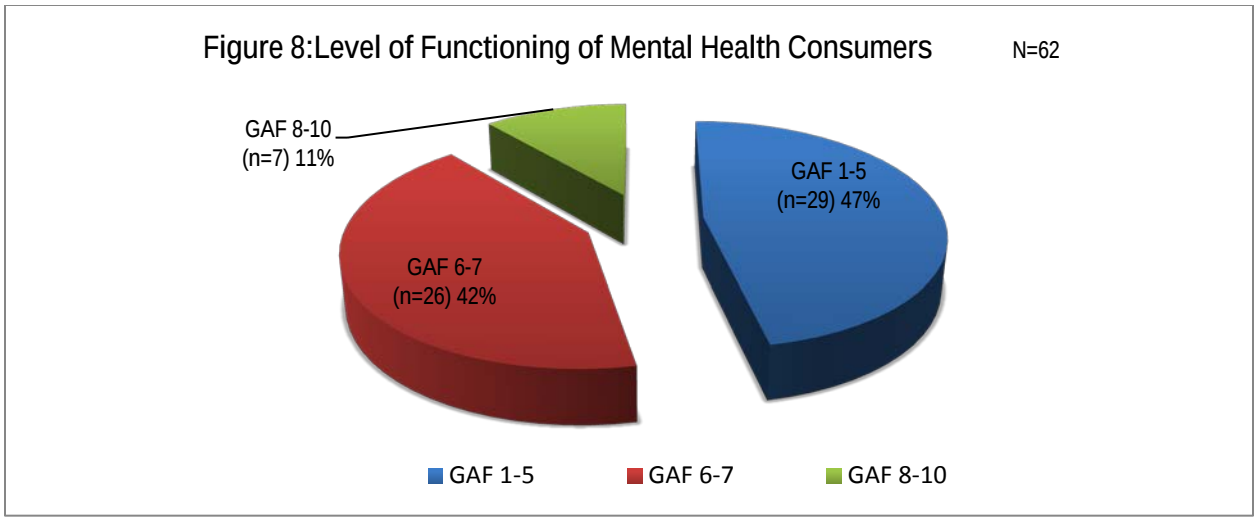


Figure 8:Level of Functioning of Mental Health Consumers
N=62
GAF 8-10
(n=7) 11%
GAF 1-5
(n=29) 47%
GAF 6-7
(n=26) 42%
GAF 1-5
GAF 6-7
GAF 8-10

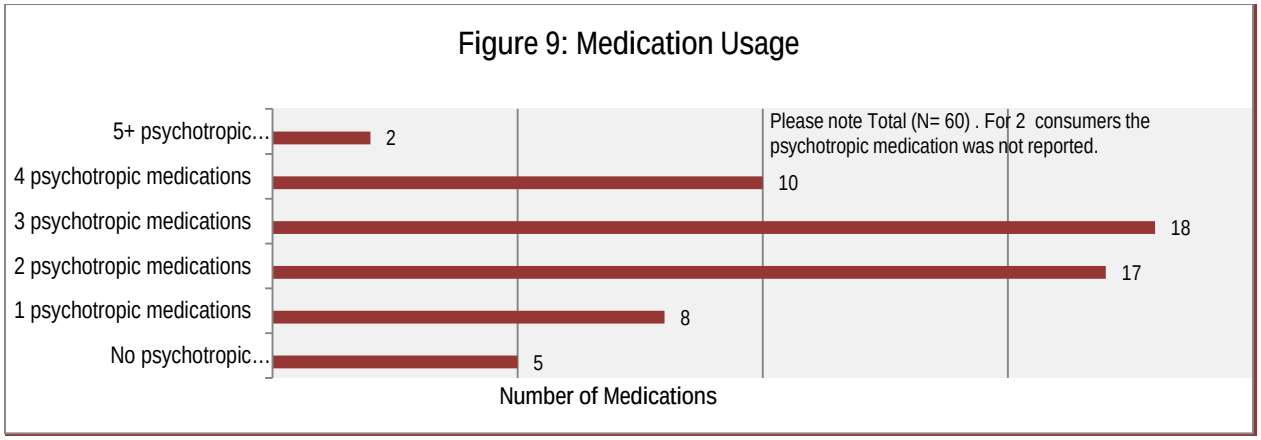


Figure 9: Medication Usage
5+ psychotropic…
4 psychotropic medications
3 psychotropic medications
2 psychotropic medications
1 psychotropic medications
No psychotropic…
2
10
18
17
8
5
Please note Total (N= 60) . For 2 consumers the psychotropic medication was not reported.
Number of Medications

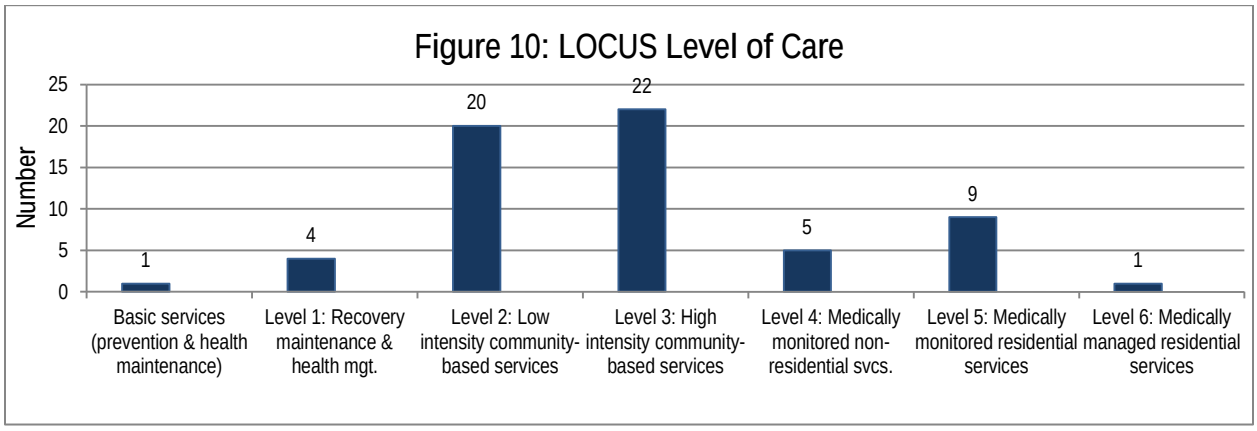
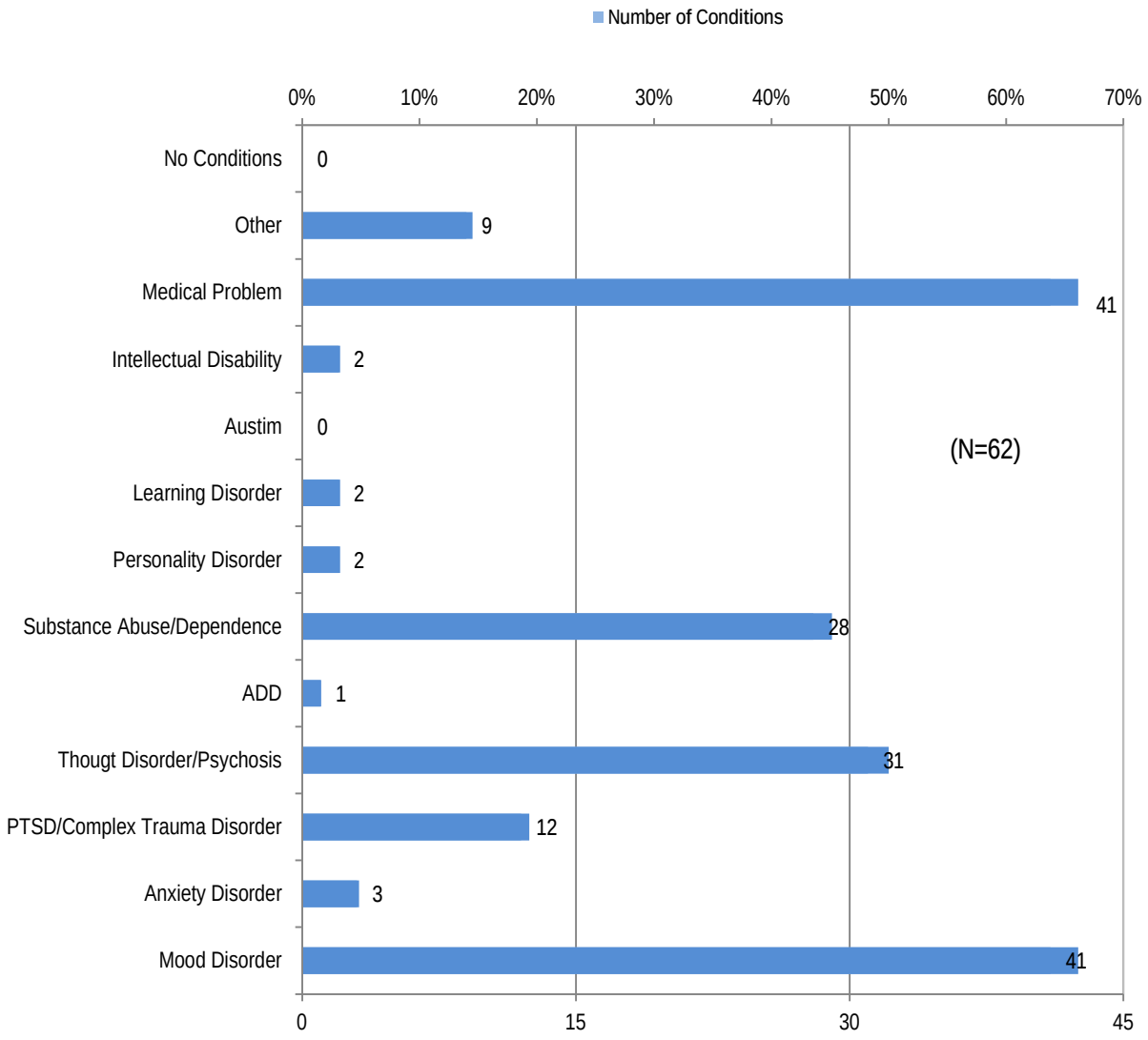


Figure 10: LOCUS Level of Care
Number
25
20
15
10
5
0
1
4
20
22
5
9
1
Basic services (prevention & health maintenance)
Level 1: Recovery maintenance & health mgt.
Level 2: Low intensity community-based services
Level 3: High intensity community-based services
Level 4: Medically monitored non-residential svcs.
Level 5: Medically monitored residential services
Level 6: Medically managed residential services

Figure 11:Frequency of Medical Problems and Psychiatric Conditions among Consumers (some consumers have multiple conditions)



Appendix B: Description of Person Status Indicators

Safety from Harm by Others: This indicator examines the degree to which person is free from risk of harm from others and includes factors such as neglect, abuse, and exploitation by others.

Behavioral Risk to Self or Others: This indicates measures the degree to which a consumer is not engaging in situations or behaviors that place him/her risk to harm self or others.

***Economic Security & Personal Management*:** It is important to understand the degree to which consumers are meeting and managing their basic financial needs required to cover basic living necessities.

***Living Arrangement (Stability and Appropriateness)*:** This indicator examines the extent to which consumers' current living situation is appropriate and least restrictive and supports their recovery.

Social Network: This indicator refers to extent to which the consumer is connected to meaningful and supportive social networks such as family and friends that enhance their recovery efforts.

Health Status (Physical Status & Receipt of Care)*:* The health status indicators capture the degree to which the consumer is maintaining their current health and receiving adequate care given their medical treatment history.

Substance Use Status: Reviewers examined alcohol and drug use patterns among consumers and the degree to which they were abstaining from alcohol and drugs.

Mental Health Functioning*:* This item assessed consumers' pattern of regulating and managing emotional, behavioral, and thoughts that may negatively impair relationships with others and participation and decision-making in life activities.

Appendix C: Description of Progress Indicators

Reduction of Psychiatric Symptoms: Degree to which any troublesome symptoms of mental illness are being reduced, coped with, and personally managed by this person.

Reduction of Substance Abuse Impairment: Degree to which the person is making progress in reducing substance use and related impairments, avoiding relapse, and improving life choices that promote recovery.

Improved Self-Management: Degree to which the person has been making progress in use of coping skills, impulse control, activities of daily living, relapse prevention, and self-management in the community.

Improved Community Integration: Degree to which the person has been making progress in participating in more daily life activities in the community with persons who are not disabled and in settings where other non-disabled adults are engaging in those kinds of activities.

Reduction of Life Disruptions: Degree to which a reduction of life disruptions resulting from external sources of harm, self-endangerment, use of chemical substances, hospitalization, and/or from engaging in illegal activities has been demonstrated by this person.

Progress Toward Other Recovery Goals: Degree to which the person is making progress toward attainment of other personal recovery goals that should be stated in his/her recovery plan.

Appendix D: Description of Practice Performance Indicators

***Cultural Identification & Need*:** This is one of the indicators that was re-conceptualized in the current protocol, as the previous indicator only measured the teams effort to overcome cultural barriers to engagement, if any existed. This indicator now uses a definition of culture here that is more broadly defined and refers to the degree to which the "identity of the person and, where appropriate, the person's family or caregiver have been identified and understood; the natural, cultural, or community supports appropriate for this person are identified and engaged. Necessary supports and services provided are culturally appropriate." (Human System & Outcome, Inc., 2013, p.54).

***Engagement Efforts by Staff**:* Community Service Reviews track the engagement and outreach efforts made by CSA staff to increase and sustain consumer participation in their own treatment process. The new definition was expanded to measure how active engagement strategies are actualized through the development of trusting therapeutic relationships that supports consumer's individual aspirations and goals developed in the recovery process.

***Teamwork Formation**:* Appropriate team formation refers to the selection of the 'right' people who have the necessary skills and knowledge that are able to effectively assist in the planning, organizing, and execution of services in the person centered planning and treatment process.

***Teamwork Functioning**.* A critical component to a consumer's recovery can be the degree of support that he receives from the service team. Specifically, the degree to which the members of the team communicate and collaborate in a unified manner in "identifying needs, setting recovery goals, planning recovery strategies and services that will enable the person to gain functional living skills, and increase social integration and productivity in support of the person's recovery goals" (Human System & Outcome, Inc., 2013, p. 58).

***Teamwork Coordination**:* One of several new indicators, team coordination is necessary in the preparation, planning, and facilitation of teamwork activities related to the organization and delivery of person-centered care to consumers. An essential element of team coordination is the leadership needed to ensure identified interventions and efforts are coordinated amongst the team which ultimately advance the consumer's personal recovery effort.

Assessment & Understanding: The identification of events and stressors that impact and influence an individual's life, as well as those individual assets and environmental supports that cultivate and promote personal recovery are essential to improving and sustaining long term mental health functioning and well-being. The assessment and understanding indicator measures the degree to which the clinical team is able to understand the needs, strengths of the consumer.

Personal Recovery Goals: The consumer's individual recovery goals should be well formulated, measurable and incorporate agreed upon outcomes that guide treatment planning and interventions strategies

Planning Interventions: The degree to which the person's team has established clearly specified interventions (i.e., strategies with actions, resources, schedules) detailed in written plans that are based on the person's assessed needs and preferences; and used to guide intervention processes for assisting the person attain planned outcomes for well-being, functioning, sustaining supports, to ten clinical areas (defined below) and an individual score is given to all the applicable areas identified and personal aspirations for a better life. For the purpose of the review, planning is broken out in the assessment of the consumer reviewed.

a. *Mental Health Recovery*. A primary focus of this measure is the reduction and management of psychiatric symptoms that impair functioning in daily activities. The integration of psychiatric medication and counseling are useful intervention strategies to reduce symptoms and develop coping strategies.
b. *Addiction Recovery.* This measure addresses substance use dependency, relapse prevention, and addiction recovery. This would include consumers with co-occurring disorders.
c. *Trauma Recovery.* A focus of trauma recovery is the use of intervention strategies and supports that address the deleterious impact of exposure to complex trauma. These may include safety planning, cognitive, behavioral strategies, social supports, and psychotropic medications.
d. *Safety.* The monitoring of consumers' safety is paramount. The review of aspects of a consumer's safety may include behavioral crisis (behaviors in which consumer places himself or others at risk of harm), health crisis (a situation in which person's life is at risk if immediate medical care is not provided), or safety (e.g., domestic violence). Any of these situations may be chronic or acute and require ongoing planning and monitoring and *the identification of early signs that a new episode is emerging.*
e. *Income & Basic Necessities.* May include strategies for work, earned income, securing and managing benefits, obtaining housing, food stamps, housing, income maintenance, healthcare, medicine, or childcare. Reliable and consistent sources of income are necessary supports to achieve well-being and in order to maintain basic necessities.
f. *Functional Life Skills Development.* This indicator involves skill-specific training and direct support to acquire, apply, and sustain functional life skills in daily living situations which would include activities of daily living.
g. *Education or Work*. This indicator examines the engagement of consumers in educational activities, career development, employment and volunteer related activities.
h. *Community Integration.* For some adults, recovery includes regaining degrees of community integration. Community integration involves making decisions about choice of life activities and experiencing life activities in mainstream settings as do other adults who do not have disabilities. Aspects of community integration include engaging in normal life activities outside of an institution or provider agency that involve having interactions with non-disabled persons who are engaged in the same activities
i. *Managing Chronic Health Concerns*. A primary focus of this indicator is on ensuring that consumer has the necessary access to

j. *Other Interventions.* This indicator is for other strategies that are outside of the ten areas identified above.

Implementing Interventions: The implementation of planned interventions is sufficient and effective in helping the person reach the levels of well-being, functioning, sustaining supports, and life aspirations defined in personal recovery goals and treatment objectives for meeting near-term needs. Where necessary, reasonable efforts are being undertaken by the team to secure or develop any needed but unavailable supports, services, or resources. This indicator is divided into the same ten clinical areas as defined in *Planning Interventions.*

Medication Management: Use of any psychiatric/addiction control medication for this person are necessary, safe, and effective. The person has a voice in medication decisions and management. The person is routinely screened for medication side effects and treated when side effects are detected. Use of medication is being conducted with other treatment modalities and with any treatment for any co-occurring conditions (e.g., seizures, diabetes, asthma/COPD, GERD, HIV).

Transitions & Life Adjustments*:* The currently in-progress or next life change transition for the person is being planned, staged, and implemented to assure a timely, smooth, and successful adjustment for the person after the change occurs. Transitional staging plans/arrangements are being made to assure a successful transition and life adjustment in daily settings.

Support for Community Integration. The array of home and community-based supports provided to this person is sufficient to meet the person's preferences and to assist him/her to stay within the community given his/her array of special needs.

Ongoing Assessment & Plan Adjustmen*t*: Ongoing Assessment and Plan Adjustment was another new practice indicator added to the protocol in 2013. This indicator measures the degree to which the service team is maintaining awareness of the consumer's need, monitoring the delivery of interventions strategies, tracking progress of identified outcomes, and making adjustments and revising strategies is central to the consumer's recovery efforts

Appendix E: Core Service Agencies Number/Percent of the Total District of Columbia Consumer Populations in 2011 & 2014

	2011		2014	
Agency Name	**Number**	**Percent**	**Number**	**Percent**
Anchor Mental Health	799	7%	919	8%
Capital Community Services	399	3%	1393	11%
Careco	N/A	N/A	838	7%
Community Connections	2846	24%	2014	17%
Contemporary Family Services	N/A	N/A	72	1%
Green Door	1544	13%	1214	10%
Family Matters	81	1%	118	1%
Family Preservation	198	2%	16	0%
Fihankra Place	783	7%	N/A	N/A
First Home Care Corporation	183	2%	100	1%
Hillcrest	772	6%	519	4%
Inner City Family Services	N/A	N/A	415	3%
Latin American Youth Center	21	0%	N/A	N/A
Launch	120	1%	N/A	N/A
Life Enhancement Services	N/A	N/A	4	0%
Life Stride	397	3%	208	2%
Mary's Center	120	1%	42	0%
MBI	N/A	N/A	954	8%
McClendon	600	5%	653	5%
MD/DC Family Resource	N/A	N/A	14	0%
Mental Health Services Division (35K Street NE)	802	7%	444	4%
Neighbors Consejo	59	1%	86	1%
Progress Life	5	0%	N/A	N/A
PSI	513	4%	1149	9%
Psychiatric Center Chartered	261	2%	190	2%
Pathways To Housing	267	2%	43	0%
Scruples	86	1%	N/A	N/A
Universal	150	1%	83	1%
Volunteers of America	246	2%	214	2%
Washington Hospital Center / Behavioral Health Service	868	7%	438	4%
Total	**12120**	**100%**	**12140**	**100%**