Part 2: Program Narrative

A. Stakeholder Input

- ***Steering Committee Functions:*** To perform the steering committee functions, Missouri used the following existing advisory committees and advocacy forums:
  - **The Combined Division of Behavioral Health (DBH) State Advisory Councils**: State statute requires DBH to work closely with the Missouri Advisory Council on Alcohol and Drug Abuse, and the Missouri Advisory Council for Comprehensive Psychiatric Services. DBH asked the two advisory councils to meet jointly for the purpose of fulfilling many steering functions for the Demonstration Project. Twenty-three (58%) of the 40 members of the combined council are individuals in recovery from substance use disorders and/or serious mental illness, or the family members of such individuals. Ten (25%) of the council members represent relevant state and federal agencies, including Protection and Advocacy, the Departments of Health and Senior Services, Corrections, Elementary and Secondary Education, and Social Services; and a federal Veterans Affairs medical center. The remaining seven members (17%) are individual practitioners or representatives of behavioral healthcare provider organizations.
  - **The Missouri Federation of Advocates (Federation)**: an independent coalition of representatives from a variety of advocacy organizations including local chapters of Mental Health America and the National Alliance on Mental Illness (NAMI), The Depression and Bipolar Alliance, the Missouri Association for Social Welfare, and Missouri Protection and Advocacy.
  - **The Missouri Coalition for Community Behavioral Healthcare (Coalition)**: the professional association representing the public community behavioral healthcare organizations with the breadth of services and programs capable of participating in the Demonstration Project.

  The Combined DBH State Advisory Council served as the lead entity in the initial development, and final approval, of the assessment of need that identified the populations of focus and established the array of services and programs, as well as the evidence-based, promising and best practices, to be provided by CCBHCs, and the staffing and accreditation/certification standards that CCBHCs are required to meet. Both the Federation and the Coalition provided input during the needs assessment phase on the draft services, programs, staffing, EBPs, and accreditation/certification requirements. Once the needs assessment was complete and the CCBHC certification requirements finalized, each DBH State Advisory Council continued to monitor the progress of CCBHC certification, PPS rate development and overall implementation of the project, receiving regular updates on progress at their individual, and joint, meetings.

Throughout the planning year, the Director of the Department of Mental Health, the Director of the MO HealthNet Division of the Department of Social Services (Missouri's Medicaid Authority) and the Project Director attended the monthly meetings of the Coalition to review and discuss CCBHC certification and the development of PPS rates. Several provider workgroups were established to inform the development of cost reports and recommend system changes necessary to implement new billing and reporting systems.

The Project Director also met regularly with the Federation to assure continued involvement of key advocacy organizations in the implementation of the certification requirements and Prospective Payment System.

The Project Leadership Team, which includes the directors of the Department of Mental Health, the Division of Behavioral Health, the MO HealthNet Division, the Coalition and their staff, and a representative of the Missouri Primary Care Association (the professional association representing the Missouri Federally Qualified Health Centers (FQHC)) met bi-weekly with the Project Director throughout the Demonstration Project planning phase. The DBH state advisory councils selected a member who is recovering from a substance use disorder, a member recovering from serious mental illness, a member who is the family member of an individual recovering from a substance use disorder, and a member who is a family member of an individual recovering from a serious emotional disturbance; the Coalition selected five member organization CEOs; and NAMI, Mental Health America, and the Missouri Recovery Network also selected representatives, to participate regularly in Leadership Team meetings to assure direct and ongoing input into implementation of the Demonstration Project.

- ***Outreach and Engagement of the Population of Focus:*** As noted above, the combined consumer majority DBH state advisory councils served as the lead entity in the development of the assessment of need. These councils include individuals recovering from serious mental illness or severe emotional disturbances, individuals recovering from serious substance use disorders, and family members of individuals recovering from those disorders. But in order to broaden the involvement and input of individuals in the populations of focus, several additional steps were taken.

  DMH sponsors an annual conference, "Real Voices, Real Choices", designed by, and for, individuals with lived experience with serious mental illness, serious emotional disorders and substance use disorders, and their families. During the spring, the Project Director met with the conference planning committee several times to explain the Demonstration Project, seek input for the needs assessment, and plan a session at the conference that would focus on seeking direct input from individuals with lived experience and their family members. The DMH and DBH directors joined the Project Director at the conference in discussing the Demonstration Project, answering questions, and securing

additional input regarding the design and implementation of the Demonstration Project. Participants identified the opportunity to improve the availability and accessibility of substance use disorder treatment as among the most important potential advantages of the Demonstration Project. Among the most important concerns identified was the limited number of providers who accept Medicaid funding for general health care in certain areas of the state.

DBH also sponsors an annual training institute that was originally designed for community behavioral health direct care staff, and as well as staff from social services and other related support organizations. However, many organizations now support the attendance of individuals receiving services from their organizations. Therefore, the Project Director also participated in a session at this "Spring Training Institute" to explain the Demonstration Project and seek input from individuals with lived experience, and their family members, as well as stakeholders from other social service and related support organizations. Participants identified the increase in the use of peer specialists and family support providers as among the most important potential advantages of the Demonstration Project. The most common concern expressed was that Missouri would miss an important opportunity for system improvement if it is not selected to participate in the Demonstration.

Finally, DBH established a committee with the authority to review and approve those aspects of the CCBHC Application dealing with governance and securing meaningful consumer and family member participation. This committee consisted of:

- Two (2) individuals recovering from mental illness and/or substance use disorders who also serve on the DBH's state advisory councils responsible for advising on issues and services related to mental health and substance use disorder prevention and treatment;

- Two (2) parents of individuals recovering from severe emotional disturbances, one of whom also serves on the DBH's state advisory council responsible for advising on issues and services related to adults with serious mental illness, and children and adolescents with serious emotional disturbances who is the Director of Missouri Families 4 Families;

- One (1) individual who is the family member of an individual recovering from serious mental illness and who represented the St. Louis Missouri chapter of NAMI;

- One (1) individual representing the Kansas City chapter and one (1) individual representing the St. Louis chapter of Mental Health America (MHA);

- One (1) individual representing the Missouri Recovery Network (MRN), an advocacy group working on behalf of individuals recovering from substance use disorders.

See "Meaningful Participation by Consumers and Family Members in CCBHC Governance" (below in Section B) for a description of the findings and recommendations of this committee.

- ***Coordination with State and Federal Agencies:***

State Agencies: As noted above, the Combined DBH State Advisory Council, which fulfilled important steering committee functions, includes members representing key state and federal agencies: Missouri Protection and Advocacy, and the Departments of Health and Senior Services, Corrections, Elementary and Secondary Education and Social Services. As members of the Council, these representatives participated in the design of the CCBHC system, as well as ongoing review of the progress toward implementation. In addition, the Project Director met regularly with the House and Senate Joint Medicaid Oversight Committee during the Planning Year to garner input and keep the Committee informed of progress.

Federally Qualified Health Centers: As also noted above, a representative of the Missouri Primary Care Association participated in the bi-weekly meetings of the Project Leadership Team in order to assure ongoing coordination in the development and implementation of the Demonstration Project with the professional organization representing the state's FQHCs. Four of Missouri's CCBHCs are also FQHCs; several of the remaining Missouri CCBHCs already had close working relationships with their local FQHCs before the beginning of the Demonstration Project planning process; and, as part of the CCBHC Application process, organizations were required to document their care coordination relationships with FQHCs.

Veterans Administration: All but a handful of Missouri counties are included in the Veterans Administration's Heartland Network (Veterans Integrated Service Network (VISN) #15. Five VA Medical Centers in VISN #15 serve Missouri veterans:

- Jefferson Barracks Medical Center in St. Louis
- Harry S. Truman Medical Center in Columbia
- Kansas City Medical Center in Kansas City
- John J. Pershing Medical Center in Popular Bluff
- Dwight D. Eisenhower Medical Center in Leavenworth Kansas serving seven counties in northwest Missouri

The DBH Veterans Services Director participates in the planning of the annual VA Community Mental Health Summits convened by each of the VA Medical Centers, and DBH community behavioral healthcare contracted organizations regularly participate in the annual Summits.

As part of the planning process, the DBH Veterans Services Director and the Project Director consulted with the VISN #15 Behavioral Health Liaison regarding approaches to coordinating Veterans Health Administration and CCBHC services for veterans. DBH subsequently contacted the behavioral health liaison at each of the VISN #15 Medical Centers serving Missouri to discuss the Demonstration Project, the roles and responsibilities of the CCBHCs in serving veterans and coordinating care, the potential for development of provider agreements between CCBHCs and the Medical Centers, and how best to coordinate care. DBH provided each Medical Center with contact information for the corresponding CCBHCs, and also provided each CCBHC with contact information for the relevant Medical Center behavioral health liaison. Prior to implementation of the Demonstration Project on July 1, 2017, CCBHCs are expected to contact the appropriate VA Medical Center behavioral health liaison to discuss the possible development of provider agreements and coordination of care for veterans at the local level. The DBH Veterans Services Director will continue to monitor the development of CCBHC/Medical Center care coordination agreements. Two representatives from the John J. Pershing VA Medical Center in Popular Bluff serve on the combined DBH State Advisory Council which will continue to monitor implementation of Demonstration Project.

Other Professional Organizations: The DMH Director, DBH Director, and the Project Director also consulted with the Missouri Coalition of Children's Agencies (MCCA) during the development of the needs assessment and CCBHC certification standards.

Law Enforcement: The DBH Director regularly updates the Missouri Crisis Intervention Team (CIT) Steering Committee, which includes city and county law enforcement officers from across the state and is tasked with expanding CIT programs in Missouri, regarding DBH initiatives including the proposed 1115 Waiver (see Section E, Goal 3, below) and the Demonstration Project.

Native Americans: Missouri does not have federally recognized Native American tribes, and less than 0.5% of Missouri's population identified themselves as Native American in the last census, making it difficult to identify Native American stakeholders to participate in planning activities.

B. Certifying CCBHCs

- ***The CCBHC Certification Process:*** The SAMHSA CCBHC Certification Criteria were augmented by the Missouri specific populations of focus, service, program, staffing, evidence-based practice, and accreditation/certification requirements derived from the needs assessment initiated and approved by the DBH combined state advisory councils. As a result, in addition to meeting the basic SAMHSA CCBHC Certification Criteria, Missouri CCBHCs are required to:

    - Directly provide an array of services within each of the nine demonstration program CCBHC service categories, except that 24-hr hotline and mobile crisis team services may be provided through a state-sanctioned Designated Collaborating Organization.
    - Comply with Missouri's services, staffing, and quality of care standards for:
        - CMHC Healthcare Homes for children, adolescents and adults (including accreditation by CARF or The Joint Commission as health homes) under the Medicaid health home program; and
        - Community Psychiatric Rehabilitation Centers serving adults with severe, disabling mental illness, and children and adolescents with serious emotional disturbances under the Medicaid rehabilitation option.
    - Be accredited by
        - CARF to provide outpatient mental health and outpatient substance use disorder services for children, adolescents and adults, OR
        - The Joint Commission to provide community behavioral health services, including substance use disorder services for children, adolescents and adults.
    - Directly provide, or contract with a Designated Collaborating Organization to provide, a 24-hour crisis line that is accredited by CARF as a Crisis Information and Call Center for children, adolescents and adults.
    - Directly provide, or contract with a Designated Collaborating Organization to provide, 24-hour mobile crisis teams that are accredited by CARF to provide crisis services for children, adolescents and adults.
    - Directly provide, contract with an organization to provide, or have a referral relationship to access specialized substance use disorder treatment services that are certified by DBH to provide Comprehensive Substance Treatment and Rehabilitation (CSTAR) for adolescents, women and children, and the general adult population under the Medicaid rehabilitation option.
    - Employ certified Peer Specialists and Family Support Providers, and if directly providing CSTAR services, Mo Recovery Support Specialist Peers.

- Employ, or have a referral relationship with, a Community Mental Health Liaison (see Section E, Goal 3, below) to work with law enforcement and the courts to identify individuals in need of behavioral healthcare and divert them from inappropriate and unnecessary incarceration.
- Employ staff participating in the DBH Emergency Room Enhancement initiative to identify individuals in need of behavioral healthcare and divert them from inappropriate and unnecessary hospitalizations (see Section E. Goal 3, below).
- Document that the organization has integrated the use of
    - Motivational Interviewing
    - Cognitive Behavioral Therapy
    - Recovery/Resilience Oriented Psychiatric Rehabilitation
    - Wellness Coaching
    - Medication Assisted Treatment, including waivers to prescribe buprenorphine
    - Integrated Treatment for Co-occurring Disorder (ITCD)
    - Evidence-based tobacco cessation services (Tobacco Treatment Specialist)
    - Eye Movement Desensitization and Reprocessing
- Document that the organization has adopted, or is continuing to work toward the adoption of, additional Evidence-based, Best, and Promising, Practices such as
    - Illness Management and Recovery
    - Parent-Child Interaction Therapy
    - Individual Placement and Support (IPS) employment model
    - Assertive Community Treatment
    - Dialectical Behavior Therapy
    - My Way to Health
    - Supported Housing
- Document that the organization has adopted a trauma-informed approach to care, or that the organization is engaged in the DBH approved trauma-informed care learning collaborative.
- Document that the organization has already participated, or currently is participating, in the DBH approved Zero Suicide Learning Collaborative.

In February, to assist interested organizations in preparing to apply to be recognized as CCBHCs, DBH published a CCBHC Certification guide which included the Missouri specific certification criteria with explanations and interpretations of the criteria, and what would be required for an organization to document compliance with each criterion. DBH also designed a CCBHC Application form that required interested organizations to submit documentation substantiating compliance with the CCBHC certification criteria. In March, DBH provided regional training opportunities for interested organizations

regarding the CCBHC certification criteria, the CCBHC Application, and the CCBHC application process. In April, the CCBHC Application form was distributed to interested organizations that were required to submit completed CCBHC Applications to DBH by June 15th.

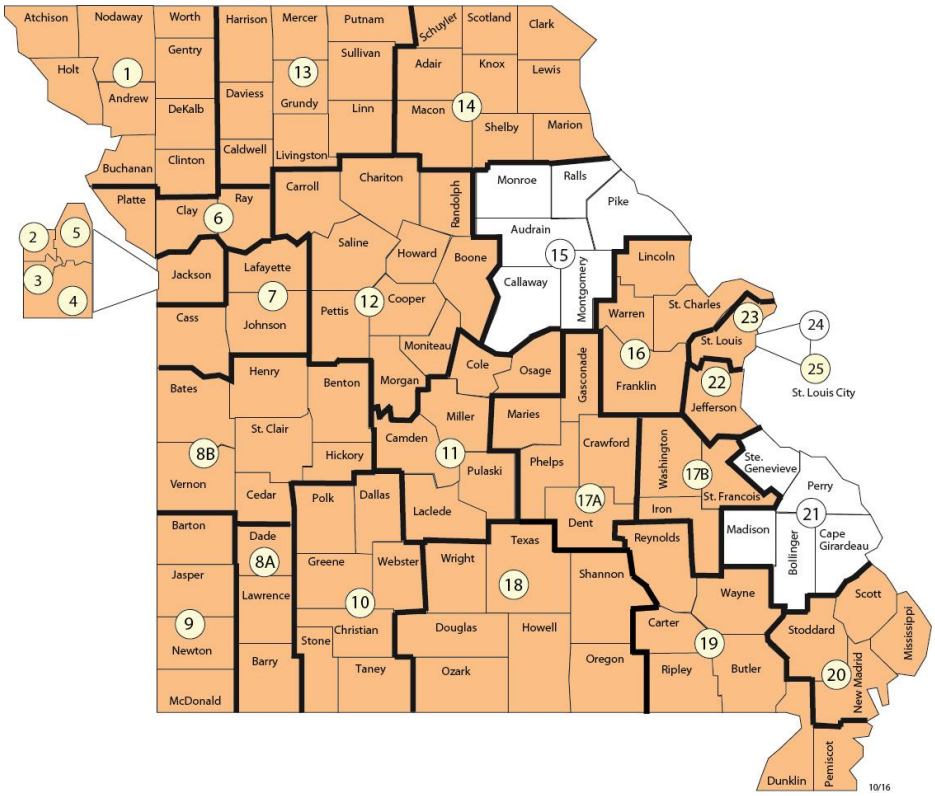
Twenty (20) organizations, serving all but two of the twenty-seven (27) areas designated by DBH as potential CCBHC service areas, submitted CCBHC Applications.

As noted above, DBH convened a committee of individuals with lived experience, family members of individuals with lived experience, and representatives of NAMI, Mental Health America, and the Missouri Recovery Network to review and approve the sections of Missouri's CCBHC provider applications that focused on assuring meaningful participation in governing authority functions by individuals**,** family members of individuals recovering from serious mental illness or severe emotional disturbances, and individuals or family members of individuals recovering from substance use disorders, who are either currently receiving or have received in the past, behavioral health services from the organization.

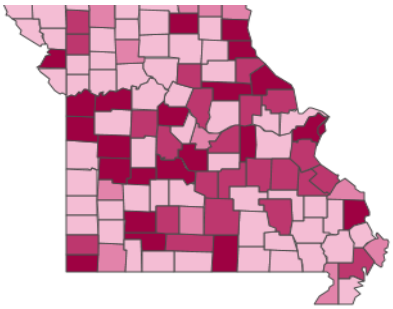
A team of DBH technical experts reviewed the CCBHC Applications for compliance with the CCBHC criteria regarding Staffing, Availability and Accessibility of Services, Care Coordination Agreements, the Scope or Services, Quality and Other Reporting, and Organizational Authority, Governance, and Accreditation.

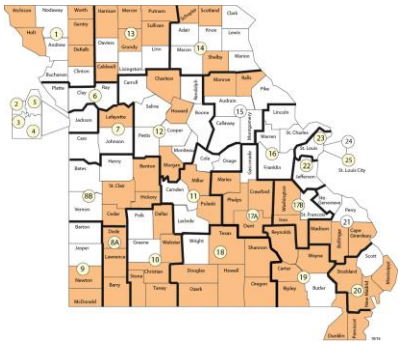
Following the initial reviews, every organization was asked to submit additional information or documentation. In some cases, the review of the supplementary information and documentation resulted in further requests for clarification, or requests for plans of correction demonstrating that the organization would comply with the standards prior to the planned date of implementation of the Demonstration Project on July 1, 2017. The approval of such plans was necessary for two reasons: (1) Several organizations had required accreditation or certification site visits scheduled for early 2017; (2) DBH plans to provide several additional training opportunities in early 2017 that will result in organizations complying with certain requirements, including a number of those regarding evidence-based, promising and best practices.

As illustrated by the shaded areas on the following map, the DBH approved the CCBHC Applications of 19 of the 20 organizations that applied to serve as a CCBHC for 24 of the 27 potential CCBHC service areas.



- ***<u>Diversity of CCBHCs</u>:*** From the beginning it has been Missouri's desire to adopt the CCBHC criteria for our entire public mental health system, and implement a PPS approach statewide. Most of the public community behavioral health organizations already met the majority of the CCBHC criteria. During the planning process, the state worked hard to provide the training and technical assistance necessary to assist all of the organizations to come into compliance with the standards, and to be able to prepare for the conversion to a PPS reimbursement system. Ultimately, organizations serving all but two of Missouri's 27 service areas applied to participate in the demonstration, and DBH determined that organizations serving 24 service areas were in compliance with the CCBHC certification criteria. This includes organizations serving urban and suburban St. Louis (Service Areas #16, #22, #23 and #25) and Kansas City (Service Areas #2-5), and very rural areas, such as Service Area #13 in north central Missouri where county population density ranges from 8 to 29 per square mile. The shaded numbers in the map above indicate areas in which CCBHCs have been designated. Only Service Areas #15, #21, and #24 will not be included in the Demonstration Project. The shaded counties on the map on the right below indicate counties that have been designated as Medically Underserved Areas by HRSA. The dark shaded counties on the map on the left below are counties that have been designated as Mental Health Professional Shortage Areas by HRSA. As these maps demonstrate, Missouri CCBHCs will be serving a number of counties that have been designated by HRSA as medically underserved areas and mental health professional shortage areas.





- ***Facilitating Cultural, Procedural and Organizational Changes:*** Using state funding, DBH contracted with the Coalition to provide training for organizations interested in participating in the Demonstration Project on the following Evidence Based, Best, and Promising Practices:
    - Eye Movement Desensitization and Reprocessing
    - Parent-Child Interaction Therapy
    - Medication Assisted Treatment
    - Motivational Interviewing
    - Enhanced Illness Management and Recovery
    - Wellness Coaching

  DBH also contracted with the Coalition to establish Trauma Informed Care and Zero Suicide learning collaboratives.

  DBH started, and the Coalition assumed responsibility for continuing, a statewide initiative to move the public mental health system from cultural and linguistic competence toward cultural and linguistic proficiency. This effort involves identifying resources and providing training and technical assistance to help organizations continue moving toward proficiency based on the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

- ***The Needs Assessment and Barriers to Treatment:*** Because the populations of focus do not vary by service area, the statewide needs assessment established standards that all CCBHCs are required to meet in terms of services; programs; staffing; evidence-based, promising and best practices; and accreditation/certification. But service areas differ significantly in terms of the cultural, socio-demographic and geographic factors affecting access to care, and service utilization. Therefore, as part of the CCBHC Application, organizations were required to describe the area to be served in terms of cultural, socio-demographic and geographic factors; to identify resulting potential barriers to access to care and service utilization; and to describe their approach to addressing these barriers. Characteristics cited by applicants included:

- High levels of poverty
- High unemployment/underemployment
- Lack of insurance coverage
- High levels of co-occurring physical and behavioral health conditions
- Lack of access to transportation, especially in rural areas
- The potential for isolation, especially in very rural areas
- Significant homeless population
- Growing Hispanic population
- Significant refugee population (e.g. Sudanese)
- Predominantly African American community
- Need for specialized services for the deaf and hearing impaired community

Applicants described both how these characteristics affected access to care and service utilization, and the steps they had taken to address potential barriers related to these characteristics, e.g. establishing homeless outreach services, seeking specialized cultural training for staff, hiring bi-lingual staff, accessing transportation to medical appointments for individuals, developing specialized services for the deaf and hearing impaired community, etc. The sophistication with which applicants identified and addressed potential barriers varied, and was considered as part of the determination of the overall capability of the organization to be recognized as a CCBHC.

- ***Evidenced Based Practices:*** See Attachment 8 for a description and justification of the required evidence-based practices.

- ***Meaningful Participation by Consumers and Family Members in CCBHC Governance:*** As part of the training provided to interested organizations regarding CCBHC certification criteria and the CCBHC Application, DBH outlined the various options for demonstrating that organizational governance ensures meaningful input by consumers, persons-in-recovery and family members, and encouraged organizations to explore a variety of approaches to enhancing meaningful participation.

  As noted above, the committee of consumers and family members who reviewed the CCBHC Applications found that all applicant organizations met one of the required Certification criteria regarding consumer and family member participation in governing body functions. However, the committee members believed that **meeting these criteria do not, by themselves, assure meaningful participation in governing body functions** by individuals with lived experience or family members of individuals with lived experience. The variety of lived experience is such that an array of approaches is needed to capture the breadth of that experience and its relevance to service delivery, program design, and policy development.

Because the committee members believed that assuring meaningful participation is an ongoing challenge, they recommended DBH sponsor training for behavioral health care organization board members in the importance of securing meaningful participation of individuals with lived experience, and family members of persons with lived experience, in program design and development, quality improvement, and governance; as well as ways to secure meaningful input. DBH agreed with this recommendation and is developing mandatory training for all CCBHC boards of directors.

The committee also recommended that DBH sponsor leadership training designed to develop individuals with lived experience, and family members of individuals with lived experience, who can promote the involvement of individuals with lived experience, and family members of individuals with lived experience, in local program design and development, quality improvement, and governance; and who can serve as mentors to other individuals with lived experience, or family members of individuals with lived experience, in participating in local governance functions. DBH also agreed with this recommendation and will require that each CCBHC recruit the following individuals to participate in DBH sponsored leadership training, each of whom are either currently receiving, or have received in the past, behavioral health services from the organization:

- At least one individual, or family member of an individual, recovering from serious mental illness or severe emotional disturbances;

- At least one individual or family member of an individual recovering from substance use disorders; and

- At least one parent/caregiver of a child or youth with serious emotional disturbances.

C. Development of enhanced data collection and reporting capacity.

- ***Data and Reporting Capacity & Data Collection Systems including functionality that report on access, quality, scope of services, costs, reimbursement and CQI:*** The main information system for the DMH is the Customer Information Management, Outcomes & Reporting (CIMOR) system. CIMOR boasts a web based front end, providing secure access to a fully normalized relational database model of all client admissions and discharges, program assignments, demographics, services provided and various outcomes reports required by DMH. The scope is all clients receiving any services when those services are funded in part or in whole by DMH. CIMOR is also the front end for Medicaid claims from DBH providers. This system is thus the clearinghouse for the processing of service level claims for DBH services, whether funded by DMH or Medicaid. CIMOR provides all of the source data for the DMH TEDS, URS, and CLD reporting to SAMHSA for the Block Grants.

DMH also maintains a data warehouse of multiple data marts, technically separate from CIMOR but incorporating CIMOR data and datasets from other data sources. Of particular importance to the CCBHC project is the complete warehouse of all CMHC (and future CCBHC) clients Medicaid fee for service claims and managed care encounters. This data warehouse combined with the perception of care data already collected by DMH translates into an existing and developed capacity of data collection on all of the state lead measures required for the CCBHCs.

PPS: The decision to implement a PPS represents an extensive redesign of the Missouri Department of Mental Health's data collection systems, particularly with regard to claims processing and payment. Early in the planning grant, meetings between grant staff, Department staff, and state IT staff were held mapping out the general requirements this would entail. These design and coordination meetings have continued throughout the planning period – often weekly (or more) and during day long sessions, involving state Medicaid staff, provider (CCBHC applicant) staff, EMR vendors and DMH and IT staff. These discussions have resulted in fairly minimal changes to the claims data format the EMR vendors must produce for the agencies to submit to DMH for payment, but a fairly comprehensive change in the subsequent flow and processing of that data.

This flow will require CCBHC's to continue submitting service detail level claims on individual services to DMHs main data collection system (CIMOR), as they currently do, with an additional claim representing the daily "event" for payment of the PPS. CIMOR will review these individual claims against an internal catalog of CCBHC services and when determining a valid PPS event has occurred will submit to state Medicaid both the PPS claim (with established rate for payment) and individual service claims with payment amounts of $0. The PPS claim is what triggers payment, although non CCBHC services will flow through the same system as fee-for-service claims. Retaining this level of service detail submission enables both state Medicaid and DMH to sustain reporting unavoidably linked to those details.

There are many complications to the stripped down model described above: for example, Managed Care, Medicare, third party payors can make payments at the service level and the PPS rate will be discounted accordingly. Much of the design work to date has been around coordinating the data flows and processing between DMH (CIMOR) and Medicaid, Medicaid's third party and Managed Care subsystems, and Medicare – all required to ensure both complete reporting capacity on the services provided and to exclude overpayment scenarios. This work has progressed through the planning period to the point that the initial coding can now begin, and that coding and subsequent testing is likely to require most if not all of the time allowed prior to the planned July 1, 2017 implementation date.

Care Manager/Population Health: Care Manager is a new data collection system piloted during the planning grant period. This system integrates various data feeds and provides a secure portal for CCBHC care management/coordination staff. Data feeds into this system include: metabolic test value information from provider EMR systems; CIMOR demographic, enrollment, and claims data; and, perhaps uniquely, real time notifications to care managers of ER visits and hospitalizations. The ER data comes from surveillance data reported to the state's Health department and hospitalization data is from MO HealthNet's certification process. In both cases this allows for notifications much more rapidly than using claims data. The target date for state wide implementation of this system is July 1, 2017 and will become a significant CCBHC quality improvement effort for care coordination in general and for improvement of hospitalization follow-up rates and metabolic syndrome surveillance in particular.

Providers within Missouri's network of CMHC/CCBHCs currently utilize 13 different EMR vendors. This diversity of local systems presents a significant but manageable challenge for data collection and reporting for those data elements that are currently outside of the scope of existing state data systems. This is another reason for the intermediate system/data layer opportunity presented by the Care Manager platform. Even with Care Manager, a couple of major CCBHC reporting capacity elements remain unavoidably assigned to the local CCBHC systems: Cost Reporting and CCBHC Lead Performance Measures.

Cost Reporting: Under the planning grant DMH has established an annual cost reporting structure for CCBHCs based on the template provided by the grant. DMH has contracted with Mercer, both for design and interpretation of the cost reporting requirements and for subsequent training and technical assistance for CCBHC applicants. Applicants have all submitted first draft cost reports using this template and DMH staff and Mercer have audited the drafts, providing feedback to agencies as necessary for uniform, standard reporting. Subsequent resubmission of final cost reports will become the basis for the setting of CCBHC specific PPS rates. Now that the underlying reporting mechanisms are in place within each participating agency, the overhead for producing the required future annual cost reports will be that much lower for each CCBHC. The state anticipates requiring continued cost reports of other (non CCBHC) CMHCs as part of a longer term goal to shift to a system wide PPS model given a successful demonstration of the new model.

Performance Measures: As mentioned above, the data elements required for the State Lead CCBHC Performance Measures are already in place in existing state data collection systems. Unfortunately, the final specifications of the measures were not available soon enough for draft reports against them to be available before the demonstration grant application is due. However, draft reports using the published specifications for those measures are already being coded, with planned availability early in the demonstration

for use as benchmark rates. The early timing of these reports will be particularly important for those measures that will be used in the Quality Bonus Payment process, in order to allow the local CCBHC Quality Improvement plans to incorporate the metrics and prioritize those areas where improvement is required. All of the measures are potential indicators for both state-wide and local CCBHC CQI plans.

The CCBHC Lead Measures have the most development work remaining, largely because of the diversity of EMR systems in use at the CCBHCs. Early descriptions of required measures were discussed with CMHC/CCBHC leaders at monthly CCBHC Steering Group meetings, even before the final specifications were available. Staff participated on all of the SAMHSA/CMS sponsored data TA calls. Final specifications and standardized reporting templates have been distributed to both CCBHC leaders and EMR vendor staff. The state anticipates continued regular meetings between state and CCBHC and vendor staff to ensure the greatest possible uniformity of data definitions reported for the CCBHC measures. All CCBHC applicants have the capacity to report the required metrics from their systems – it is the actual output to standardized specifications that remains to be developed.

CCBHC Application Requirements: As part of the application process for the state's approval of an agency as a CCBHC, agencies had to make attestations and commitments specific to data collection and reporting. These included the capacity to report each (individually listed) CCBHC Lead Measure for all CCBHC clients (including any served via a DCO agreement) and that they would do so on the timetable required by the state. They also had to attest to robust CQI plans, validated by national certification program(s), and that these CQI programs would specifically include ongoing monitoring of suicide deaths and 30 day hospital readmission rates along with other CMHC/CCBHC indicators for demonstration of improvement in behavioral and physical health outcomes.

Applicants also had to report on all Evidence Based (and best/promising) Practices in place, under development, or planned for development during the demonstration period. The state has established expectations for CCBHCs as reported elsewhere in this application, but also provides direct support for fidelity measurement at the CCBHCs for three of the EBPs listed. This is currently limited to three due to limited state resources and because not all of best practices have fidelity measures established. Additional support to the CCBHCs has been provided by the state via extensive training on Evidence Based, Person Centered, and Recovery Oriented practices during the planning period. These training programs are ongoing.

In summary, while some development remains, Missouri's existing data systems – EMRs at the CCBHCs, CIMOR & MMIS and robust data warehousing at the state level – put the state in solid position to meet all of the data collection and reporting requirements listed in section 5 of the program criteria, including all of the measures specified as

required metrics in Appendix A. This includes data capture and reporting on: (1) consumer characteristics; (2) staffing; (3) access to services; (4) use of services; (5) screening, prevention, and treatment; (6) care coordination; (7) other processes of care; (8) costs; and (9) consumer outcomes.

- ***The Data Format:*** The cost reports, URS tables, and CCBHC Performance Measure reports (one per CCBHC), will be available in the standard format Excel spreadsheets as established for each of those reports. The cost reports should be available before the close of the second quarter of each new state Fiscal Year (SFY ending June 30) for the prior fiscal year period. This will allow for claims run out to complete the reporting and review of results. URS tables will be available immediately after the existing December 1 timeline each year, so also before the end of subsequent second quarter. CCBHC performance measure data may lag more due to the need to collect half from each CCBHC and add the state lead measures to each file. This will likely translate into needing most, if not all, of the six months after year end allowed for CCBHC reporting to the state and nine months for subsequent reporting to CMS.

  TEDS, CLD, and Claims/Encounter data will be available as delimited text files – mostly due to large file size and the better compression ratios achieved by text file formats. However, if evaluations staff require another format we do have the capacity to export to any common data standard and would only need explicit direction to do so. The TEDS and CLD files could be submitted with existing fields, but will link better to claims/encounter data if we append the existing formats to include DCNs (state Medicaid) and DMH IDs – both are unique to each client but not currently included in TEDS/CLD data files. These can both be available immediately after each quarterly report if needed for TEDS, and after the December 1 annual report for CLD. The claims/encounter/DMH paid service data will include unique client identifiers, date of service, CCBHC service provided, units provided and diagnosis. A fairly wide array of additional data points (from CIMOR and/or DMH data warehouse) can be added if useful to the evaluation, by request. The state generally allows for three months (minimum) run out on late claims for any claims data reported by date of service, so by that standard could make this data available after the first quarter for the prior fiscal year. The state can make it available sooner if needed, but that may translate into missing claims, especially for late in the report period claims, due to the usual lags and run out in the claims data.

  The state can make a specific/secure folder available for evaluation staff to retrieve these files, using the existing MO state FTP system. This will require getting a username/password to the folder for at least one staff in the evaluation, but is fairly routinely done. Alternatively the state could push to a site established by the evaluators so long as comparable security was established. Mailing an encrypted DVD is an option but is generally less desirable, particularly as it is possible that initial review could lead to request for additional data fields.

D. Participation in the national evaluation of the Demonstration Program

- ***Capacity and Willingness to Participate:*** Planning Grant staff participated in all grant sponsored Technical Assistance calls. Consequently the state believes we have a firm grasp on what will be required in order to successfully participate in the National Evaluation. Missouri is fully committed to assisting HHS in the national evaluation of the CCBHCs. The state believes the existing and planned modifications to our information systems place Missouri in a very strong position to do so. The state can fully link program enrollment, services, demographics and many outcomes data sets already. This includes the existing TEDS and CLD datasets reported under the Block Grant, although these will need additional modifiers added beyond those used in Block Grant reporting to link to the rest – and that data is also readily available. The state has access to claims and encounter data for all Missouri Medicaid services whether fee for service of managed care, including the copay claims in Medicaid data for dual eligible clients. This scope includes mental health and substance use disorder services as well as inpatient, emergency and ambulatory services paid for by other than demonstration program funding. The new reporting initiated under the demonstration grant for CCBHC cost reports and performance metrics will also be available for the evaluation.

  The one significant gap that currently exists in Missouri's data is that while we have the copay claims (on dual eligible Medicare/Medicaid clients) thus allowing for full reporting on inpatient, emergency, and ambulatory care services so long as focused on utilization rates, we do not (yet) have access to the full Medicare claims data which leaves the federal cost part of the picture incomplete. The state can append our datasets with Medicare identifiers so that if the national evaluation has direct access to Medicare claims data that linkage would become fairly straightforward. Alternatively, the state would be willing to work with CMS to obtain Medicare claims data for Missouri DMH clients and house that data in the secure DMH data warehouse, and thereby make those linkages ourselves for the national evaluation team. At present the state has only the Missouri Medicaid copay part of the non DMH service provider cost data.

- ***Selection of a Comparison Group:*** Planning Grant staff participated in all of the grant sponsored Technical Assistance calls, including the one in particular that focused largely on comparison group discussion. At the time of the TA call this topic was one of particular concern for Missouri because of our initial plans to convert our statewide network of CMHCs entirely into CCBHCs – making an in-state comparison group very difficult to define. We anticipated perhaps needing to build a comparison group from non CMHC/CCBHC clients based on data mining from Medicaid claims data, and thus being handicapped somewhat by a more limited data set (particularly regarding outcomes not derived from claims) for the comparison group.

However, it is now clear that comprehensive CMHCs serving three of Missouri's 27 service areas will not be participating in the Demonstration Project, and there are several additional organizations providing specialized substance use disorder treatment services or psychiatric rehabilitation and health home services for individuals with serious mental illness that will continue to provide services outside of the Demonstration Project. As a result, the state anticipates having various CMHCs representing both rural and urban service areas continue to get reimbursed under the existing fee for service model. Non-participating CMHCs, and other specialty service providers will remain fully integrated with CCBHC agencies in the CIMOR system, which will in turn allow for full linkage between program enrollment, demographic, claims, encounter and outcomes data for both groups.

A remaining issue for future discussion with the federal evaluation planning team is to consider if any other characteristics should be used to match clients in the comparison group to CCBHC clients, beyond a simpler comparison of CMHC to CCBHC clients: age, gender, ethnicity, rural/urban, prior period service intensity/cost, level of functioning, diagnosis. These are all possibilities now that we anticipate a good sized comparison group with robust data within CIMOR.

- ***Institutional Review Board (IRB) Approval:*** The CCBHC Demonstration Grant's collection and reporting of process and outcome data does not require IRB (Missouri Peer Review Committee) approval during the demonstration period. By Missouri regulation it all falls under the heading of quality and/or program management and does not qualify as client research. The Demonstration Project was discussed with the chair of the committee who documented the above decision in an attached letter. (See IRB letter Attachment 9.) However, we plan to request approval from the Missouri Peer Review Committee once we begin the process of collecting data on a comparison group and prior to submitting that and CCBHC data to the federal evaluation team during year 2 of the demonstration. The chair of the committee requested we hold off on filing that request for their review until closer to the date of that data submission because relevant details could easily evolve over the two plus years between now and then. Even so, as currently defined, the national evaluation qualifies as "retrospective chart review" and not "research" for Missouri and so we anticipate rapid approval from the Peer Review Committee, with this year's early discussion of the project laying the groundwork for that review.

E. The Impact of Participating in the Demonstration Project

Missouri expects participation in the Demonstration Project to have a significant impact on all four of the statutory goals. However, the state believes that demonstrating the impact of the fourth goal (viz. that the availability of CCBHC services will be expanded and that the quality of services increased without increasing net Federal spending) will be dependent on the resources available through the national evaluation. Missouri can certainly demonstrate that the

availability, accessibility, and quality of CCBHC services will be expanded and improved. Based on Missouri's success in implementing health homes and emergency room diversion initiatives, we also believe that the increased costs associated with expanding the availability, accessibility and quality of CCBHC services may be offset by reductions in near term costs associated with appropriate diversions from more costly emergency room and hospital care, and by reductions in the long term healthcare and social costs associated with untreated or undertreated chronic health conditions and health status risks. But it would be difficult to demonstrate that this goal will be achieved without the resources of the national evaluation which will have the time and expertise to collect and analyze the relevant cost data.

Missouri is confident that we can demonstrate that by participating in the Demonstration Project we will achieve the remaining three goals.

Goal 1. Provide the most complete scope of services required in the CCBHC Criteria to individuals who are eligible for medical assistance under the state Medicaid Program.

Providing the most complete scope of services, including evidence-based, best, and promising practices, is important for helping to address the unmet need for services documented in Attachment #2 which describes Missouri's populations of focus for the Demonstration Project.

The SAMHSA CCBHC Certification Criteria set a new, high standard of care; and it is only as a result of participating in the Demonstration Project that the complete scope of required CCBHC services and evidence-based, promising, and best practices will become available and accessible in 24 of Missouri's 27 service areas.

Missouri CCBHCs will be required to directly provide all of the CCBHC services for children, adolescents, and adults, except 24 hour hotline and mobile crisis team services which may be provided by a state sanctioned Designated Collaborating Organization.

Attachment #5 provides a complete list and description of all the CCBHC services and programs that will be included in the Demonstration Project. Attachment #5 also illustrates how each service or program relates to one or more of the nine required CCBHC service categories. Attachment A provides a complete list of the required CCBHC evidence-based, best, and promising practices.

From the beginning, Missouri committed to adopting the SAMHSA CCBHC Certification Criteria for the entire public mental health system. Although many of the required services and practices were already generally included in the scope of services and practices of Missouri's public community behavioral health centers; we recognized that participating in the Demonstration Project would require significant expansion of the scope of services and practices

available in some services areas. In particular, participating in the Demonstration Project would require the following additions to the scope of services and practices provided by several community behavioral health centers:

- Peer and family supports
- Outpatient substance use disorder treatment
- Medication Assisted Treatment including the ability to prescribe buprenorphine
- Integrated Treatment for Co-occurring Disorders
- Eye Movement Desensitization and Reprocessing
- Tobacco Treatment Specialists
- Trauma Informed Care
- Suicide Prevention: best practices for improving care and safety for individuals at risk

DBH established an ambitious training and technical assistance program to assist organizations in developing the capacity to provide these required services and practices. This training and technical assistance program was already in place when we applied for a Planning Grant and will continue throughout the Demonstration Project. If Missouri were not preparing to participate in the Demonstration Grant, we would not have adopted the SAMHSA Certification Criteria and would not have committed to this training and technical initiative. To demonstrate that participating in the Demonstration Project will result in achieving the goal of providing the most complete scope of CCBHC services and practices, we have selected the following measures.

Peer Supports, Peer Counseling, and Family Supports

Missouri CCBHCs are required to employ Certified Peer Specialists (specially trained individuals with lived experience who serve adults affected by serious mental illness) and Family Support Providers (specially trained parents with lived experience who serve the families of children with serious emotional disturbances).

A survey conducted in January 2015, as we were beginning to prepare for participation in the Demonstration Project, found that less than half of the organizations that are now being recognized as CCBHCs employed Certified Peer Specialists, and less than a third employed Family Support Providers. As a result of the significant increase in recruitment and training opportunities for peer and family support providers and the individuals who would be supervising them at community behavioral health providers, the services provided by Certified Peer Specialists and Family Support Providers will be part of the scope of services available in all service areas participating in the Demonstration Project. The source of the baseline is the survey conducted in January 2015. The source of the projection is the approved CCBHC applications.

% of CCBHC service areas in which Certified Peer Specialists are employed by an organization recognized as a CCBHC

- Baseline (January 2015): 46% of service areas (11/24)
- Projected (July 2017): 100% of service areas (24/24)

% of CCBHC service areas in which Family Support Providers are employed by an

organization recognized as a CCBHC

- Baseline (January 2015): 29% of service areas (7/24)
- Projected (July 2017): 100% of service areas (24/24)

Outpatient Substance Use Disorder Treatment

Missouri CCBHCs are required to provide outpatient substance use disorder treatment services for children, adolescents and adults that are accredited by CARF or The Joint Commission (TJC), or that comply with DBH outpatient substance use disorder treatment services program certification standards until such time as they are accredited by CARF or TJC. In January, 2015, when we were beginning to prepare for participation in the Demonstration Project, 58% of the organizations being recognized as CCBHCs were providing appropriately accredited or certified outpatient substance use disorder treatment services. The source of the baseline is DBH accreditation/certification records as of January 2015. The source of the projection is the approved CCBHC applications.

% of CCBHC service areas with outpatient substance use disorder treatment services accredited by CARF/TJC, or that comply with DBH outpatient substance use disorder treatment program certification standards, for children, adolescents and adults.

- Baseline (January 2015): 58% of service areas (14/24)
- Projected (July 2017) 100% of service areas (24/24)

Medication Assisted Treatment

Although the exact numbers were not known, it was clear that prior to our commitment to participating in the Demonstration Project, there was a limited number of community behavioral centers that provided MAT, and especially a limited number with the ability to prescribe buprenorphine. Consequently, this year the Coalition's fourth annual Physician's Institute was designed to stimulate interest in and, promote understanding of, the use of MAT and prescribing buprenorphine. This coming spring, prior to implementation of the Demonstration Project, Missouri will be participating the SAMHSA/HRSA initiative to provide free training for physicians in MAT including the required 8-hour (4 hours online and 4 hours face-to-face) waiver training that is needed for physicians to prescribe and dispense buprenorphine for the treatment of opioid use disorders as well as the other FDA approved addiction medications

As a measure demonstrating that participation in the Demonstration Project will result in an increase in the availability of MAT and buprenorphine in particular, we propose to use the percentage of CCBHC service areas with non-voided, non-deleted MAT medication and buprenorphine prescription billings in non-detox setting. The baseline is the year prior to preparations for participation in the Demonstration Project began (state Fiscal Year 2015). The projection is for the first full year of the Demonstration Project (state Fiscal Year 2018.)

% of CCBHC service areas with MAT prescription billings

- Baseline (SFY'15) 67% of service areas (16/24)
- Projected (DY1) 100% of service areas (24/24)

% of CCBHC service areas with buprenorphine prescription billings

- Baseline (SFY'15) 33% of service areas (8/24)
- Projected (DY1) 100% of service areas (24/24)

Integrated Treatment for Co-occurring Disorders

DBH has adopted the SAMHSA Toolkit, including the fidelity tool, approach to establishing and monitoring ITCD program sites. All CCBHCs are required to have implemented ITCD to fidelity, as demonstrated by a "fair" or "good' fidelity score, or to be actively engaged in implementing ITCD with demonstrable movement toward fidelity by July, 2017, the planned date of implementation of the Demonstration Project, and to demonstrate fidelity by the end of the Demonstration Project (July, 2019). The baseline is the percentage of CCBHCs actively engaged in implementing ITCD and the percentage of CCBHCs who had adopted ITCD to fidelity as of June, 2016. The percentage of service areas in which the CCBHC is actively engaged in adopting ITCD and the percentage of service areas in which the CCBHC has adopted ITCD to fidelity will be determined by a review of DBH fidelity review records.

% of service areas in which the CCBHC is actively engaged in adopting or has already adopted, ITCD

- Baseline (June 2016): 70% of service areas (17/24)
- Expected (July 2017): 100% of service areas (24/24)

% of service areas in which the CCBHC adopted ICTD to fidelity

- Baseline (June 2016): 46% of service areas (11/24)
- Expected (July 2019): 100% of service areas (24/24)

Eye Movement Desensitization and Reprocessing (EMDR)

CCBHCs are required to employ clinicians appropriately trained in the use of EMDR within three months of participating in the Demonstration Project (i.e. by October 2017). Prior to January 2015 when the decision was made to participate in the Demonstration Project, EMDR was not required, no training was being provided in the use of EMDR, and no data was collected on the number of clinicians trained in its use. DBH began providing EMDR training during the planning grant period, and will continue providing training free of charge to CCBHC clinicians throughout 2017. The baseline is the percentage of service areas with a CCBHC clinician who had been trained in EMDR at the time organizations submitted CCBHC applications (June 2016). In October 2017, CCBHCs will be required to report the number and names of the CCBHC clinicians trained in the use of EMDR which will be verified by comparing the names of the individuals reported with the list of individuals who have successfully completed DBH EMDR training.

% of service areas with CCBHC clinicians trained in the use of EMDR

- Baseline (June 2016): 63% of service areas (15/24)

- Expected (October 2017): 100% of service areas (24/24)

Tobacco Treatment Specialists (TTS)

Missouri has adopted the Tobacco Treatment Specialist Certification Training program developed and administered by the Mayo Clinic Nicotine Dependence Center. All CCBHCs are required to employ Tobacco Treatment Specialists by the planned date of implementation of the Demonstration Project. Training will continue to be provided this spring so that all CCBHCs can comply with this requirement. The baseline is the percentage of service areas with a CCBHC clinician trained as a Tobacco Treatment Specialist at the time organizations submitted CCBHC applications (June 2016). In June 2017, CCBHCs will be required to report the number and names clinicians who have been trained as Tobacco Treatment Specialists which will be verified by comparing the names of the individuals reported with the list of individuals who have successfully completed DBH TTS training.

% of service areas with a CCBHC clinician trained as a Tobacco Treatment Specialist
- Baseline (June 2016): 50% of service areas (12/24)
- Expected (July 2017): 100% of service areas (24/24)

Trauma Informed Care

Missouri has adopted a developmental framework for the adoption of a trauma-informed approach which involves becoming trauma aware, and moving to becoming trauma sensitive, trauma responsive, and, finally, to being fully trauma informed. The framework describes processes that characterize each stage of development and identifies indicators for determining the extent to which an organization has fully integrated the principles and processes of its stage. By July, 2017, all CCBHCs are required to be actively engaged in adopting a trauma-informed approach to care by participating in the DBH- approved Trauma Informed Care Learning Collaborative or by participating in another DBH- approved initiative. There are 19 organizations that have been recognized as CCBHCs serving 24 service areas. The baseline is the percentage of CCBHCs engaged in a DBH approved Trauma Informed Care initiative at the time organizations submitted CCBHC applications (June 2016). The percentage of service areas in which the CCBHC is actively engaged in adopting Trauma Informed Care will be determined by a review of the DBH Trauma Informed Care Learning Collaborative membership, and other DBH- approved Trauma Informed Care initiatives.

% of CCBHCs actively engaged in a DBH approved Trauma Informed Care initiative
- Baseline (June 2016): 68% of CCBHCs (13/19)
- Expected (July 2017): 100% of CCBHCs (19/19)

Suicide Prevention Learning Collaborative

In the spring of 2016, Missouri launched the Zero Suicide Academy designed to help agencies learn how to incorporate best and promising practices into their organizations processes to improve care and safety for individuals at risk. By July 2017, all CCBHCs are required to be

actively engaged in the Zero Suicide Learning Collaborative. The baseline is the percentage of CCBHCs participating in the Zero Suicide Academy at the time organizations submitted CCBHC applications (June 2016). The percentage of service areas in which the CCBHC is actively engaged in the Zero Suicide Learning Collaborative will be determined by a review of the DBH Zero Suicide Learning Collaborative membership

% of CCBHCs actively engaged in the Suicide Prevention Learning Collaborative

- Baseline (June 2016): 68% of CCBHCs (13/19)
- Expected (July 2017): 100% of CCBHCs (19/19)

Goal 2. Improve availability of, access to, and participation in, services described in subsection (a) (2) (D) to individuals eligible for medical assistance under the State Medicaid program.

Improving the availability of, access to, and participation in, CCBHC services is critical to helping to address the unmet need for services documented in Attachment #2 which describes Missouri's populations of focus for the Demonstration Project.

Providing the most complete scope of CCBHC services and practices (Goal 1) necessarily results in improving the availability of and access to CCBHC services and practices (Goal 2). But improving the availability and accessibility of services can be measured in more ways that simply counting the number of service areas in which a service or practice is available. Demonstrating that participation in the Demonstration Project will result in the achievement of Goal 2 also requires demonstrating growth in the number of individuals who actually receive services. The state has selected the following measures to demonstrate that participation in the Demonstration Project will achieve Goal 2 in Missouri.

<u>Peer Supports, Peer Counseling, and Family Supports</u>

Missouri proposes to track the number of Certified Peer Specialists/Family Support Providers employed by CCBHCs. The baseline measures regarding the number of peer and family support providers employed by CCBHCs is the number employed by CCBHCs in January, 2015 as reported in a survey conducted as we began preparing to participate in the Demonstration Project. The number Certified Peer Specialists/Family Support Providers at implementation of the Demonstration Project is based on the approved CCBHC applications. Because DBH will continue to recruit and train Certified Peer Specialists and Family Support Providers, we believe 25% to be a conservative estimate in the growth in the number of CCBHC peer and family support providers by the end of the Demonstration Project (July 2019).

# of Certified Peer Specialists employed by organizations recognized as CCBHCs

- Baseline (January 2015): 26
- At implementation (July 2017): 46
- Projected (July 2019): 58

Result: 123% increase in Certified Peer Specialists from January 2015 to July 2019

# of Family Support Providers employed by organizations recognized as CCBHCs
- Baseline (January 2015): 18
- At implementation (July 2017): 39
- Projected (July 2019): 49

Result: 172% increase in Family Support Providers from January 2015to July 2019

Peer and family support providers have a number of responsibilities and fill a number of roles. Providing one-on-one support for individuals or families is only one such responsibility, but tracking the number of individuals receiving individual peer or family supports is one way to measure the impact of providing these supports. The baseline for this measure is the number of unduplicated individuals/families receiving one-on-one peer or family supports in state Fiscal Year 2016. By July 2017, eight more service areas will have Peer Specialists (a 53% increase) and 10 more service areas will have Family Support Providers (a 77% increase) than at the beginning of state Fiscal Year 2016. However, since many of these individual's will only have provided service for a portion of SFY'17, we would not expect growth in the number of individuals/families receiving peer/family supports commensurate with the growth in the number of Peer Specialists and Family Support Providers until SFY'18. Taking SFY'16 as the baseline, we project modest growth (15%) in the number of individuals/families receiving one-on-one peer/family supports in SFY'17, but expect this number to grow commensurate with the number of new Peer Specialist and Family Support Providers in SFY'18. We also expect the number of Peer Specialists and Family Support Providers to continue to grow. Therefore, the state expects modest growth (15%) in the number of individuals/families receiving peer/families support to continue to grow in SFY'19. This data is derived from individual services provided and submitted by contractors to DBH on invoices. This data will continue to be reported and collected throughout the Demonstration Project as back-up documentation for PPS invoices.

# of unduplicated individuals receiving individual peer support services
- Baseline SFY'16: 1,324
- Projected SFY'17: 1,467
- Projected DY1: 2,245
- Projected DY2: 2,581

Result: 95% increase in the number of individuals receiving one-on-one peer support services from SFY'16 to DY2

# of unduplicated families receiving individual family support services
- Baseline SFY'16: 708
- Projected SFY'17 814
- Projected DY1: 1,440
- Projected DY2: 1,657

Result: 134% increase in the number of families receiving one-on-one family support services from SFY'16 to DY2

Outpatient Substance Use Disorder Treatment

The number of service areas with accredited/certified outpatient substance use disorder treatment services for children, adolescents and adults is expected to increase by ten (a 71% increase). However, since many of these outpatient programs will only be in operation for a portion of SFY'17, and since some of this expansion only relates to services for children and adolescents, we would not expect growth in the number of individuals receiving outpatient substance use disorder services to be commensurate with the growth in the number of new outpatient programs until SFY'18. Taking SFY'16 as the baseline, we project very modest growth (10%) in the number of individuals receiving outpatient substance use disorder treatment services, but expect this number to grow more nearly commensurate with the number of new outpatient substance use disorder treatment programs in SFY'18.[1] Thereafter we would expect only very modest growth (10%) in the number of individuals receiving outpatient substance use disorder treatment. This data is derived from individual services provided by contractors to DBH on invoices. This data will continue to be reported and collected throughout the Demonstration Project as back-up documentation for PPS invoices.

# of individuals receiving outpatient substance use disorder treatment

- Baseline SFY'16: 14,009
- Projected SFY'17: 15,410
- Projected DY1: 23,115
- Projected DY2: 25,426

Result: 82% increase in the number of individuals receiving outpatient substance use disorder services from SFY'16 to DY2

Medication Assisted Treatment

In State Fiscal Year 2015, buprenorphine was prescribed in seven of the 24 service areas that will be participating in the Demonstration Project. Beginning in SFY'17, CCBHCs will have the capacity to prescribe buprenorphine in all 24 service areas, a 243% increase compared to SFY'15. The baseline data is derived from non-voided, non-deleted billings for prescriptions of buprenorphine in non-detox settings in SFY'15. The SFY'18 projection is based on a 243% increase in the capacity to prescribe buprenorphine beginning in SFY'18. A very modest increase of 10% is projected for SFY'19.

# of individuals prescribed Buprenorphine

- Baseline (SFY'15): 521
- Projected DY1: 1,219
- Projected DY2: 1,341

[1] Because some of the expansion in new outpatient substance use disorder treatment programs includes service areas which already have outpatient substance use disorder services for adults, the actual growth in individuals receiving services is likely to be less than the 64% growth in services with accredited/certified programs. i.e. new programs are only being developed for children and adolescents, not for adults in these areas. Therefore, we have utilized 50% instead 71% as a growth factor.

Result: 157% increase in individuals prescribe Buprenorphine between SFY'15 and DY2

Metabolic Screening

All of Missouri's CCBHCs have been operating as CMHC Healthcare Homes since January 2012, and therefore have been conducting metabolic screening at least annually for all health home enrollees. Under the Demonstration Project, the number of individuals requiring metabolic screening is expected to increase modestly (15% each year). CMHC Healthcare Homes enter metabolic screening data into a statewide data base that is updated monthly so DBH can easily track and report the number of screenings, as well as the results of screenings in order to track improvements. CCBHCs will be required to enter metabolic screening for all individuals who require this level of monitoring, not just individual's enrolled in their CMHC Healthcare Home, during the Demonstration Project. August 2016 is the most recently completed data for metabolic screens and will serve as the baseline for this measure.

# of individuals receiving metabolic screening

- Baseline(August 2016): 22,042
- Projected(July 2017): 25,348
- Projected(July 2018): 29,150
- Projected(July 2019): 33,523

Result: a 52% increase in metabolic screenings from August 2016 to July 2019

Hospital, Emergency Room, and Criminal Justice System Diversion

Under the Demonstration Project, Missouri is expanding its Emergency Room Enhancement (ERE) initiative. The ERE initiative, described in greater detail below, has been effective in identifying individuals with behavioral health disorders who are high utilizers of emergency room services, engaging them in behavioral health treatment, and reducing ER visits, hospitalizations, homelessness, unemployment, and arrests. With the expansion of the ERE initiative, DBH expects to see significant reductions in ER visits, hospitalizations, homelessness, unemployment, and arrests for approximately 585 new individuals a year by DY2. (See Goal 3 for a more detailed explanation and justification of this expected outcome.)

Increased Participation in CCBHC Services

In addition to the projected growth in individuals receiving specific CCBHC services, Missouri anticipates an overall growth in the number of individuals receiving CCBHC services. In addition to individuals who receive services supported by Medicaid, Medicare and DBH funding, the organizations that will be serving as CCBHCs provide services to individuals with a variety of other funding sources including private insurance, county and

city dedicated taxes, and self-pay. However, DBH only collects data on individuals served with Medicaid, Medicare, and DBH funding. Therefore, although the total number of individuals supported by all funding sources who are served by CCBHCs is expected to grow under the Demonstration Project, DBH can only measure the growth in individuals served with Medicaid, Medicare and DBH funding. The baseline will be state Fiscal Year 2016. No growth is expected in SFY'17. But at least a 2% growth in total individuals served with Medicaid, Medicare, and DBH funding is expected in each year of the Demonstration Project.

# of individuals served with Medicaid, Medicare, and DBH funding

- Baseline (SFY'16): 85,573
- Expected DY1: 87,284
- Expected DY2: 89,030

Result: a 4% growth in total individuals served between baseline and DY2

Goal 3. Improve availability of, access to, and participation in assisted outpatient mental health treatment in the state.

Missouri has had two types of court ordered outpatient treatment programs for several years: (1) specialty "drug courts" and "mental health courts" in which individuals agree to participate in treatment in order to receive a suspended sentence for a crime to which they have pled guilty, and (2) a civil outpatient commitment statute that allows an individual who has been involuntarily committed to a hospital to be released to receive community-based treatment under conditions established by a court. Missouri's specialty drug and mental health courts have been very successful in engaging individuals in treatment and diverting them from incarceration. Missouri's civil involuntary commitment statute, however, has rarely been used.

Specialty drug and mental health courts, and civil outpatient commitment, all work to engage individuals in treatment after they have already been charged with a crime and pled guilty, or after having been involuntarily committed for hospitalization. In 2013, Missouri began implementing the following new initiatives that are now being rolled into the Demonstration Project. These initiatives are designed to fulfill the objectives of "assisted outpatient treatment", as described in Section 224(c)(2) of PAMA, **"to reduce hospitalization, homelessness, incarceration and interaction with the criminal justice system while improving the health and social outcomes of the patient"** by intervening before individuals are charged with a crime or committed to a hospital.

- *Community Mental Health Liaison (CMHL) Program.* The goal of the CMHL program is to form strong community partnerships between community behavioral health centers, law enforcement, and the courts to save valuable resources that might otherwise be expended on unnecessary jail, prison, and hospital stays, and to improve outcomes for

individuals with behavioral health issues. Thirty-one specially trained mental health professionals located in community behavioral health centers across the state work directly with law enforcement and the judicial system to connect people in behavioral health crises with services in order to avoid unnecessary hospitalization and incarceration.

- *Emergency Room Enhancement (ERE) Project.* This initiative is designed to identify individuals with behavioral health conditions who access hospital emergency rooms as their primary source of treatment for their behavioral and physical health needs, and to engage them in ongoing treatment designed to coordinate care for the whole person by addressing their behavioral and physical health, as well as basic human needs.

Because a significant percentage of the individuals identified through the ERE and CMHL initiatives were young adults (ages 21-35) in need of behavioral health treatment, Missouri included this as one of the five populations of focus for its CCBHC PPS Demonstration Initiative. Because many of these individuals were uninsured, Missouri has applied for a Section 1115 Waiver to enroll approximately 1,000 of these young adults in Medicaid annually to receive a benefit package including both outpatient physical health services (excluding Emergency Room visits), and a comprehensive array of community behavioral health services designed to meet the needs of individuals with serious mental illness and/or substance use disorders. This Waiver request is currently awaiting CMS approval**.**

The Wavier will only cover the cost of the services provided to enrolled individuals; not the cost of the outreach and engagement services provided by Community Mental Health Liaisons and ERE Teams. These costs have been built into the PPS rates of the participating CCBHCs.

Since the inception of the program, CMHLs have had 35,000 contacts with law enforcement and court personnel, provided 450 trainings for more than 5,600 peace officers, and made 29,700 referrals of individuals for behavioral health treatment.

Fifteen (15) of the 24 CCBHC service areas are currently participating in the seven sites engaged in the ERE initiative. In SFY'16, ERE teams engaged 3,565 individuals with behavioral health issues that were using hospital emergency rooms to access treatment.[2] The age of the individuals engaged by ERE teams ranged from 17-87 years (average 37.9 years). Engaged individuals were evenly divided by gender (53.1% male), and largely White (76%) and uninsured (53.4%), though 36.5% had Medicaid and 10.9% had Medicare coverage. Approximately one-quarter of consumers (26.7%) were homeless. Few have had military involvement (4.3%). They presented with a variety of complicated symptoms. Over three-quarters exhibited psychological difficulties (83.4%), 37.9% had substance use problems, and

[2] All statistics cited come from the "ERE Annual Report – Year 3" developed by the Missouri Institute of Mental Health (MIMH) of the University of Missouri-St. Louis.

23.2% expressed suicidal ideation. About one-third (33.4%) had co-occurring presenting concerns. At three-months, 52% of the individuals initially contacted by the ERE teams were still engaged in services. ERE teams showed significant impacts in the following areas:

- Engaged in Treatment: 99% after 3 months, and 70% after 6 months
- Reduction in ER visits: 55% after 3 months, and 67% after 6 months
- Reduction in Hospitalizations: 55% after 3 months and 69% after 6 months
- Reduction in Homelessness: 59% after 3 months and 75% after 6 months
- Reduction in Unemployment: 20% after 3 months and 26% after 6 months
- Reduction in Arrests: 41% after 3 months and 52% after 6 months

The Demonstration Project will result in establishing ERE teams in the nine remaining CCBHC service areas. These service areas have much smaller total populations, and the ERE teams for these areas are expected to engage about 1,125 individuals a year compared to the 3,656 engaged by the existing ERE teams. Assuming the same success in connecting individuals to service, and in achieving outcomes after three years of operation, by July 2019 (the end of DY2), we project that about 585 new individuals will be engaged in service and will experience outcomes similar to those experienced by individuals engaged by ERE teams in the current service areas. Dark shaded areas on the following map indicate areas that already have ERE teams. Light shaded areas indicate areas where ERE teams will be added.