

I: State Information

State Information

Plan Year

Start Year:

2011

End Year:

2013

State DUNS Number

Number

780871430

Extension

I. State Agency to be the Grantee for the Block Grant

Agency Name

Missouri Department of Mental Health

Organizational Unit

Division of Comprehensive Psychiatric Services

Mailing Address

P.O. Box 687

City

Jefferson City

Zip Code

65101

II. Contact Person for the Grantee of the Block Grant

First Name

Rosie

Last Name

Anderson-Harper

Agency Name

Missouri Department of Mental Health

Mailing Address

P.O. Box 687

City

Jefferson City

Zip Code

65101

Telephone

573-526-5890

Fax

573-751-7815

Email Address

rosie.anderson-harper@dmh.mo.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From

7/1/2010

To

6/30/2011

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name

Last Name

Telephone

Fax

Email Address

Footnotes:

I: State Information

Assurances - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name	<input type="text" value="Brent McGinty"/>
Title	<input type="text" value="Deputy Director of Administration"/>
Organization	<input type="text" value="Missouri Department of Mental Health"/>

Signature: _____ Date: _____

Footnotes:

I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (f) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Name	<input type="text" value="Brent McGinty"/>
Title	<input type="text" value="Deputy Director of Administration"/>
Organization	<input type="text" value="Missouri Department of Mental Health"/>

Signature: _____ Date: _____

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements/Certifications (Form 3)

Community Mental Health Services Block Grant Funding Agreements FISCAL YEAR 2012

I hereby certify that Missouri agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

I. Section 1911:

Subject to Section 1916, the State will expend the grant only for the purpose of:

- i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved;
- ii. Evaluating programs and services carried out under the plan; and
- iii. Planning, administration, and educational activities related to providing services under the plan.

II. Section 1912:

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

III. Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

- (A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")
- (B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
- (C) 24-hour-a-day emergency care services.
- (D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
- (E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

IV. Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:

- (1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
- (2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
- (3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:

(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and

(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;

(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;

(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and

(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:

(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

V. Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

VI. Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;

(2) to make cash payments to intended recipients of health services;

(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

VII. Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

VIII. Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and

(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United States Code. [Audit Provision]

(c) The State will:

(1) make copies of the reports and audits described in this section available for public inspection within the State; and

(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

IX. Section 1943:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and

(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);

(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and

(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

Notice: Should the President's FY 2008 Budget be enacted, the following statement applies only to States that received the Mental Health Transformation State Infrastructure Grants:

This Agreement certifies that States that received the Mental Health Transformation State Infrastructure Grants shall not use FY 2008 Mental Health Block Grant transformation funding to supplant activities funded by the Mental Health Transformation Infrastructure Grants.

Name	Keith Schafer
Title	Department Director
Organization	Missouri Department of Mental Health

Signature: _____ Date: _____

Footnotes:

I: State Information

Disclosure of Lobbying Activities (SF-LLL)

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

[Standard Form LLL \(click here\)](#)

Footnotes:

II: Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations

Page 22 of the Application Guidance

Narrative Question:

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the State, intermediate and local levels differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other State agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities as well as youth who are often underserved.

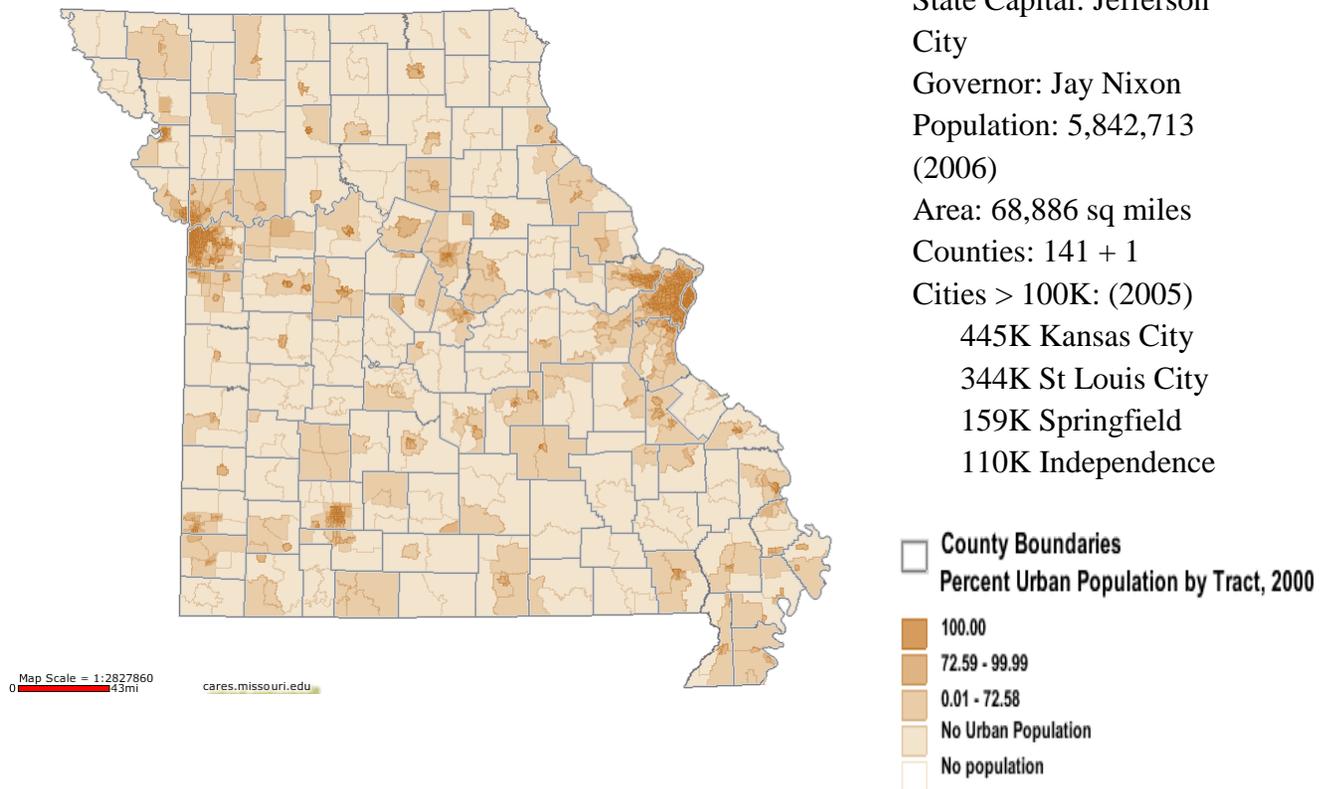
Footnotes:

Planning Steps

Step 1: Assess the strengths and needs of the services system to address the specific populations.

Named after the Siouan Indian tribe meaning "town of the large canoes", Missouri is a Midwestern State, but its culture has some Southern influences, especially in the lower third of the state and away from the urban centers. Missouri earned the nickname "Gateway to the West" because it served as a departure point for settlers heading to the west. It was the starting point and the return destination of the Lewis and Clark Expedition.

As of 2006, Missouri had an estimated population of 5,842,713. For Census year 2000, Missouri's demographic makeup was as follows: Caucasian (84.9 percent) (Caucasian, non-Hispanic (83.8 percent)), African American (11.2 percent), Hispanic (2.1 percent), Asian (1.1 percent), Native American (0.4 percent), Other race (0.9 percent), and Mixed race (1.5 percent). German Americans are a large ancestry group present in most of Missouri. In southern Missouri, most residents are of British ancestry. African Americans are populous in the City of St. Louis and central Kansas City as well as in the southeastern bootheel and some areas of the Missouri River Valley, where plantation agriculture was once important. Missouri Creoles of French ancestries are concentrated in the Mississippi River valley south of St. Louis.



The Bureau of Economic Analysis estimates that Missouri's total gross domestic product (GDP) in 2008 was \$193.7 billion. Per capita GDP in 2008 was \$32,779, 29th in the nation. Major industries include aerospace, transportation equipment, food processing, chemicals, printing/publishing, electrical equipment, light manufacturing, and beer. Tourism, services, and wholesale/retail trade follow manufacturing in importance.

The Department of Mental Health (DMH) is the Missouri agency authorized to develop and implement the public mental health delivery system. It operates under a seven member Mental Health Commission appointed by the Governor. The Commission is responsible for appointing the Department Director with confirmation by the state Senate and advising on matters relating to its operation. Commissioners are appointed to four-year terms by the Governor, again with the confirmation of the Senate. The commissioners serve as principle policy advisors to the department director. The Commission, by law, must include an advocate of community mental health services, a physician who is an expert in the treatment of mental illness, a physician concerned with developmental disabilities, a member with business expertise, an advocate of substance abuse treatment, a citizen who represents the interests of consumers of psychiatric services, and a citizen who represents the interests of consumers of developmental disabilities services.

The DMH has three operating divisions: Division of Comprehensive Psychiatric Services (CPS), Division of Alcohol and Drug Abuse (ADA), and the Division of Developmental Disabilities (DD). Each of the three Divisions has its own State advisory structure and target populations. The CPS and ADA divisions are in the process of integrating into one division.

The Department Director appoints the Director of the Division of CPS. There are five regional hospital systems comprised of nine CPS inpatient facilities. Each hospital system has a single Regional Executive Officer (REO) and each facility within a hospital system has its own chief operating officer (COO). For the provision of community based services, Missouri's 114 counties and the City of St. Louis are subdivided into 25 mental health service areas, each with an Administrative Agent (AA). AA's are community mental health centers responsible for the assessment and provision of services to persons in their designated area and for providing follow-up services to persons released from State-operated inpatient services. The Office of Comprehensive Child Mental Health (OCCMH) was established within DMH in 2004. This office assures the implementation of a Comprehensive Children's Mental Health Service System and is advised by the Comprehensive Child Mental Health Clinical Advisory Council.

There are several State agencies in the Missouri governmental system that DMH collaborates with to assure quality services are provided to consumers; primarily the Department of Social Services (DSS). Missouri DSS is the Medicaid authority for the State. Additionally, the DMH works closely with the Department of Corrections, Department of Health and Senior Services,



Mission

**Prevention, Treatment, and
Promotion of Public Understanding**
for Missourians with mental illnesses,
developmental disabilities, and addictions.

Vision

Hope ▼ Opportunity ▼ Community Inclusion

Missourians receiving mental health services will have the opportunity to pursue their dreams and live their lives as valued members of their communities.

Values



Community Inclusion
Missourians who participate in mental health services are welcomed and equally included in education, work, housing, and social opportunities in their communities.



Accessible, Safe, Affordable, and Integrated Services
Missourians with mental health needs easily access safe, affordable, and integrated medical and behavioral services.



Partners in Personal Service Design
Missourians participating in mental health services are active partners in designing their services and supports.



Effectiveness Measured by Participant Outcomes
The effectiveness of Missouri's mental health services is measured by meaningful outcomes experienced by the people receiving them.



Valued and Motivated Staff
Missourians receive mental health services from competent, motivated, and highly valued staff serving as effective stewards of the public trust.



Prevention and Early Intervention
Emphasizing prevention and early intervention strategies avoids or minimizes the mental health problems of Missourians.



Respected Unique Participant Characteristics
Missourians participating in mental health services are valued for their uniqueness and diversity and respected without regard to age, ethnicity, gender, race, religion, sexual orientation, or socio-economic condition.

January 2008

The DMH Division of CPS operates nine facilities, providing acute, long term rehabilitation and residential care for youth and adults as well as forensic, sexual predator and corrections services for adults. The number of statewide psychiatric beds in Fiscal Year 2011 was 1,203.

CPS is responsible for statewide mental health services. It operates two children and seven adult hospitals. CPS contracts with 26 community-based agencies to provide psychiatric rehabilitation services. ADA contracts with 44 community based organizations to provide the full spectrum of substance related services (prevention through inpatient/residential care). There are a total of 33 ADA-only community contract agencies, 15 CPS-only contractors, and 11 agencies with both a CPS and ADA contracts, that operate close to 200 treatment sites throughout the state. The certification standards of care contain core rules, adopted in 2001, which apply to both ADA and CPS programs. Collaborative annual reviews of joint contracted community organizations are conducted by CPS and ADA staff.

Missouri's 114 counties and the City of St. Louis form 25 mental health service areas each with an administrative agent. These administrative agents are responsible for the assessment and services to persons in their assigned area and to provide follow-up services for persons released from State operated inpatient facilities. Children and youth are provided services in the same way through contracts with administrative agents and State operated children's facilities. A map of the service areas and listing of corresponding community service provider follows the narrative in this section.

Seventeen counties and the city of St. Louis have passed Mental Health Mil Taxes and have Mental Health Boards. Six counties have passed a Children's Services Tax to provide an array of treatment and prevention services. Six additional counties have formed task forces to propose ballot issues in the next year. Six counties are participating with one additional pending in a program that facilitates the use of federal funds to expand the amount of funds and services available in the county. The combined revenue available for services in these counties is approximately \$69 million.

The Division works closely with county boards and local organizations to increase the number of counties offering mental health services. The Division hired a Community Development Manager to work closely with the local Mil Tax Boards and local organizations to increase the number of counties with mil tax monies for mental health services. The Division maintains regulatory and quality control of services purchased by local boards through enforcement of certification standards for those services.

The department continued its suicide prevention efforts by contracting with 14 agencies that serve as Regional Resource Centers to provide suicide prevention services across the state. The Resource Centers have engaged community partners to develop and implement local strategies,

provide public education and training, offer support for survivors, and promote proven practices to help with preventing suicide within their designated service areas.

The department's Access Crisis Intervention (ACI) line is staffed by mental health professionals who can respond to your crisis 24 hours per day and 7 days per week. They will talk with consumers about their crisis and help determine what further help is needed, for example, a telephone conversation to provide understanding and support, a face-to-face intervention, an appointment the next day with a mental health professional, or perhaps an alternative service that best meets your needs. They provide resources or services within the community to provide ongoing care following a crisis. All calls are strictly confidential.

The goals of ACI are:

- To respond to crisis by providing community-based intervention in the least restrictive environment, e.g., home, school.
- To avert the need for hospitalization to the greatest extent possible.
- To stabilize persons in crisis and refer them to appropriate services to regain an optimal level of functioning.
- To mobilize and link individuals with services, resources and supports needed for ongoing care following a crisis, including natural support networks.

The department funds five Drop-In Centers and five Peer Support Phone Lines for persons with mental illness. Jean Campbell, Ph.D., principal investigator of the COSP Multi-site Research Initiative, continues to work as a consultant to determine the fidelity of the Drop-In Centers to peer support evidence based practices as determined by the Fidelity Assessment/Common Ingredients Tool (FACIT). Peer Evaluators have been trained and are currently monitoring the agencies. Results of the findings are helping each program to improve the quality of services delivered.

Drop-In Center Services

Depressive and Bipolar Support Alliance of Greater St. Louis "St. Louis Empowerment Center"

1908 Olive Blvd.

St. Louis, MO 63103

Phone: (314) 652-6100

Fax: (314) 652-6103

Contact: Helen A. Minth

Email: hminth@sbcglobal.net

**Mental Health America of the Heartland
ARK of Friends**

739 Minnesota Avenue
Kansas City, KS 66101
Agency phone: (913) 281-2221
Fax (913) 281-3977
Contact: Simon Messmer
Email: smessmer@mhah.org
Website: www.mhah.org

**NAMI of Southwest Missouri
“The Hope Center”**

1701 S. Campbell
Springfield, MO 65807
Phone: (417) 864-7119
Phone: (417) 864-3027
Toll free: 1-877-535-4357
Fax: (417) 864-5011
Contact: Dewayne Long
Email: eburke@namiswmo.com
Website: www.namiswmo.com

Self-Help Center

7604 Big Bend Blvd., Suite A
St. Louis, MO 63119
Phone: (314) 781-0199
Fax: (314) 781-0910
Contact: Nancy S. Bollinger
Email: selfhelpcenter@selfhelpcenter.org
Website: www.selfhelpcenter.org

**Truman Behavioral Health
“Consumer Run Drop-In Center”**

3121 Gillham Road
Kansas City, MO 64109
Phone: (816) 404-6386
Fax: (816) 404-6388
Contact: Sherri Redding
Email: sherri.redding@tmcmed.org
Website: www.trumanmed.org/sections/content.aspx?SID=28

Warm Lines/Peer Phone Support Services

Mental Health America of the Heartland

“Compassionate Ear Warm line”

Phone: (913) 281-2251

Toll free: 1-866-WARMEAR (1-866-927-6327)

739 Minnesota Avenue

Kansas City, KS 66101

Agency phone: (913) 281-2221

Fax (913) 281-3977

Contact: Petra Robinson

Email: probinson@mhah.org

Website: www.mhah.org

Community Counseling Center’s

Consumer Advisory Board

TLC Warm Line

Phone: (573) 651-3642

Toll free: 1-877-626-0638

402 S. Silver Springs Road

Cape Girardeau, MO 63703

Agency phone: (573) 334-1100

Fax: 573-651-4345

Contact: Judy Johnson

Email: jjohnson@ccntr.com

NAMI of Missouri

WARMLine

Phone: (573) 634-7727

Toll free: 1-800-374-2138

3405 West Truman Blvd., Suite 102

Jefferson City, MO 65109

Agency phone: (573) 634-7727

Fax: (573) 761-5636

Email: mocami@aol.com

Website: www.mo.nami.org

NAMI of Southwest Missouri

“The Hope Center”

Phone: (417) 864-3027

Toll free: 1-877-535-4357

1701 S. Campbell

Springfield, MO 65807

Agency phone: (417) 864-7119

Fax: (417) 864-5011

Contact: Dewayne Long

Email: eburke@namiswmo.com

Website: www.namiswmo.com

Depressive and Bipolar Support Alliance of Greater St. Louis

“Friendship Line”

Phone: (314) 652-6105

Toll free: 1-866-525-1442

2734 Gravois

St. Louis, MO 63118

Agency phone: (314) 865-2112

Fax: (314) 652-6103

Contact: Helen A. Minth

Email: hminth@sbcglobal.net

The mental health system addresses the needs of diverse racial, ethnic and sexual gender minorities as well as youth who are often underserved. For example, the Kansas City Peer Support Warm line has a Spanish speaking employee who provides peer support. A cultural competency plan is being developed with the community mental health centers to address the needs of minorities. Community mental health centers strive to meet the needs of each individual regardless of racial, ethnic or sexual gender identity.

Adult Service System's Strengths

Evidence Based Practices

Integration of Behavioral and Medical Healthcare

Health Reform

Missouri is playing an important role in the design and implementation of the national health reform strategy. Missouri is the first state to submit a Medicaid State Plan Amendment to the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services for Community Mental Health Center Health Care Homes. Missouri is working on obtaining approval of the State Plan Amendment. The State Plan Amendment increases the number of Nurse Care Managers and primary care physician time in each community mental health center. The Plan adds a Healthcare Home Director to each agency. There will be an emphasis on coordinating with primary care doctors and clinics. DMH is in process and will continue to train leadership and treatment teams on healthcare homes clinical and organization issues.

Federally Qualified Health Centers/Community Mental Health Centers

Missouri is continuing to integrate primary and behavioral health care by encouraging co-location of staff in FQHC and CMHC. Originally seven sites were selected to receive \$200,000 a year in state general revenue, each, for a period of three years to integrate primary care into a CMHC setting, and behavioral health services into an FQHC primary care setting. Six of the seven sites involve collaboration between an FQHC and a CMHC. The seventh site involves a single agency which is designated as both a CMHC and FQHC. Technical assistance and training were provided to the sites through the Missouri Coalition of Community Mental Health Centers with funding from an 18 month grant from the Missouri Foundation for Health. The three year initiative involved addressing the issues raised by bringing two systems of care together; understanding, adopting, and implementing successful models of service delivery; and sustainability.

Each FQHC now operates a primary care clinic on site at a CMHC facility. These primary care clinics are generally staffed by a Nurse Practitioner, though in some cases, a physician also provides services on site. The payer mix and hours of operation, as well as number of patients, vary significantly across the primary clinic sites, demonstrating the need to tailor the integration of primary care into a CMHC setting to meet local conditions. The Department promotes a truly

integrated approach, using behavioral health consultants as integral members of primary care teams. Many agencies that were not part of the original project have worked with their local FQHC or Rural Health Clinic to co-locate services. As many as twelve agencies have collaborations.

DMH Net

DMH Net is a disease management initiative created to improve the lives of persons with mental illness in Missouri. This integrated model utilizes health technology in combination with a chronic care approach and existing community resources, to coordinate and integrate behavioral and physical healthcare. The DMH Net initiative is proactive in identifying and addressing chronic medical conditions that keep those with severe mental illness from achieving and maintaining the quality and quantity of life they deserve.

DMH Net is a partnership of the State of Missouri's Department of Mental Health, Missouri Coalition of Community Mental Health Centers, MO HealthNet (Missouri's Medicaid program), and health technology program administrators (Care Management Technologies and ACS Heritage) in an effort to reverse the outcomes revealed in studies that indicate persons with serious mental illness die 25 years earlier than the general population. The majority of decreased life in this population is not due to suicide or mental illness, but from preventable and treatable co-morbid medical conditions.

A new position, nurse liaison, was created to implement and integrate DMH Net into the daily clinical operations of Community Mental Health Centers (CMHCs) or Community Psychiatric Rehab Centers (CPRCs). The nurse liaison supports community support staff (CSSs) and case managers in utilizing the health technology tools and understanding chronic health conditions that greatly impact the recovery of mental health clients. They offer encouragement, training and technical support to the CMHC/CPRC staff, and develop a wellness culture of combined behavioral and physical healthcare for both staff and clients.

The DMH Net initiative helps place Missouri at the forefront of healthcare integration for the population with a severe mental illness. The health technology tools and initiatives aim to identify and address clinical concerns before a client's condition has a chance to worsen. By working together with a dedicated clinical team, DMH Net has been instrumental in improving medical and behavioral outcomes for some of Missouri's most vulnerable citizens.

The primary objective of the nurse liaison is to assist the Community Mental Health Center (CMHC) or the Community Psychiatric Rehabilitation Center (CPRC) with the implementation and integration of the *DMH Net Disease Management Initiative* into the daily clinical operations of the agency for which they are employed.

- (1) The DMH Net health technology tools and initiatives benefit the health of CMHC/CPRC clients by alerting healthcare providers of co-morbid medical and behavioral conditions. The data generated by the technology programs is analyzed and distributed by the nurse liaison to the appropriate treatment team members within the CMHC/CPRC. The nurse liaison coordinates CMHC/CPRC consumer enrollment in such programs and monitors the inclusion of effective healthcare strategies in patient treatment plans.
- (2) To ensure optimal utilization of the programs and initiatives, the nurse liaison provides ongoing encouragement, training and technical support to the staff at the CMHC/CPRC.
- (3) The nurse liaison will be a driving force within the CMHC/CPRC in developing a wellness culture of combined behavioral and physical health by implementing wellness programs and offering health education classes to agency staff and clients.

Behavioral Pharmacy Management Program

The Behavioral Pharmacy Management Program (BPM) assists providers and CMHCs with improving behavioral health prescribing practices for MO HealthNet participants with psychiatric illnesses. The BPM uses beneficiary and prescription data to compare MO HealthNet physician prescribing practices against nationally recognized guidelines. Physicians who deviate from guidelines are notified that their prescribing practices do not conform to the standard of practice, and are sent appropriate educational materials through the BPM mailing. The BPM interventions are consultative and educational – aiming to impart knowledge of best practice in the pharmacological treatment of mental disorders.

The CMHC mailing is a spinoff of the BPM mailing, and both are administered by Care Management Technologies (CMT). The CMHC mailing is designed to be used as part of quality improvement programs and for peer-to-peer conversations between the agency directors and/or medical directors and their providers. This particular mailing is sent to the CMHC and/or nurse liaison directly and not to the individual prescribers. It includes information on all prescribers who treat the CMHC patient, both community providers and providers employed by the CMHC.

Metabolic Screening

As of January 1, 2010, Missouri's Community Psychiatric Rehabilitation (CPR) programs implemented a policy to annually screen for metabolic syndrome in adults and children currently taking an antipsychotic medication. The screening is performed by an RN or LPN, and will involve collecting vitals (height, weight, BMI, waist circumference), blood pressure, blood glucose level (fasting blood glucose or Hgb A1c), and lipid panel (HDL, LDL, cholesterol, triglycerides). This data will be documented, and clients with at-risk levels, according to the State of Missouri Consensus (MS) Guidelines for Pre-diabetes and Diabetes, will be referred to a primary care physician for follow-up and treatment. DMH has made this initiative a policy for all DMH providers to practice, and is supported by Missouri Coalition of Community Mental Health Centers, MO HealthNet, CMT and Lilly USA.

Disease Management 3700

The Disease Management 3700 (DM 3700) project is a collaborative two year project between the Department of Mental Health (DMH) and the MO HealthNet Division (MHD), targeting high cost Medicaid clients who have impactable chronic medical conditions. The start date for the project was November 1, 2010. Criteria for inclusion in the project include:

- \$30,000 or greater in combined Medicaid pharmacy and medical costs A diagnosis of Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, or Major Depression- Recurrent
- Are not current clients of DMH
- Have no medical claims for hospice, dialysis, hemophilia, ICFMR
- Have no nursing home claims

The Department has agreed to contact these identified persons, provide outreach and engagement, enroll them in the Community Psychiatric Rehabilitation (CPR) program, and provide necessary services, focusing on community support/case management to coordinate and manage their medical/psychiatric conditions. We believe our services and interventions will reduce the cost to the state of providing care and treatment and improve outcomes for the identified clients. While the outreach and initial enrollment are through the CPS division and the CPR program, if the assessment of the client indicates a substance abuse disorder, individuals may be referred to ADA-CSTAR programs as appropriate. All CPS administrative agents and six affiliate agencies are participating in this project.

MHD is making funding available to pay for Medicaid CPR/CSTAR claims for persons enrolled in this project. Payments of these claims come from that fund source, not from current provider allocations. DMH and MHD intend to target approximately 3,700 clients for this project. Currently over 1500 individuals are enrolled and data is being collected on outcomes.

Leadership

Dr. Joseph Parks, DMH Medical Director, is a key contributor to the National Association of State Mental Health Program Directors (NASMHPD) Issue Papers and Technical Reports. As President of NASMHPD Medical Directors Council, he has brought national attention to the report *Morbidity and Mortality in People with Serious Mental Illness*. “The report reviewed the causes of excess morbidity and mortality in this population and made recommendations to improve their care. This increased morbidity and mortality is largely due to treatable medical conditions caused by modifiable risk factors such as smoking, obesity, substance abuse, psychotropic medication side effects, and inadequate access to medical care. Recent evidence reveals that the incidence of serious morbidity (illness) and mortality (death) in the population with serious mental illnesses has increased. In fact, people with serious mental illnesses are now dying 25 years earlier than the general population. That report asserted that State Mental Health Authority (SMHA) stakeholders needed to embrace two guiding principles:

- *Overall health is essential to mental health.*

- *Recovery includes wellness.*”

Dr. Parks’ collaborative effort with NASMHPD includes the reports:

- *Principles of Antipsychotic Prescribing for Policy Makers, Circa 2008. Translating Knowledge to Promote Individualized Treatment*
- *Obesity Reduction and Prevention Strategies for Individuals with Serious Mental Illness*
- *Measurement of Health Status for People with Serious Mental Illnesses*

Dr. Parks is a national speaker on these and other topics and consults with other states on implementing best practices on integration of behavioral and medical healthcare.

Integrated Dual Disorders Treatment (IDDT)

The DMH understands the importance of implementing evidence based practices to assure excellent care is delivered in Missouri. At least 50% of adults with serious mental illness (SMI) also have a co-occurring substance abuse (SA) disorder. Persons with co-occurring SMI/SA disorders have poor outcomes when served in traditional treatment programs where each disorder is treated by a separate team of providers. The evidence based treatment model of care for persons with co-occurring SMI/SA disorders that is recommended by SAMSHA is Integrated Dual Disorders Treatment (IDDT). In the IDDT model persons receive coordinated, integrated treatment by a single multidisciplinary team including trained specialists in co-occurring disorders.

CPS has encouraged the community mental health centers to adopt this evidence based practice by offering new billing codes for co-occurring treatment. The codes allow for flexibility of services based on individual consumer need even though new monies are not available. The Medicaid approved billing codes are for co-occurring individual counseling, co-occurring group education and group counseling and a supplemental assessment for substance abuse disorders. Twenty agencies with 32 locations statewide have committed to implementing IDDT to fidelity of the model. CPS staff has visited each program to review the baseline fidelity. CPS will continue to monitor IDDT fidelity. CPS will continue to work collaboratively with the Missouri Institute of Mental Health, the Missouri Foundation for Health and the Cadre for Co-Occurring Excellence to move the mental health system to fully integrated treatment for co-occurring psychiatric and substance use disorders.

Assertive Community Treatment

Assertive Community Treatment (ACT) is a necessary part of the service array to serve a specific portion of adults with the most serious and persistent mental illnesses who: 1) are high users of inpatient beds, 2) often have co-occurring alcohol and drug diagnoses, 3) have involvement with the criminal justice system, and 4) are homeless/unstably housed.

The Missouri General Assembly approved funding the EBP of ACT in SFY 2008. Planning meetings occurred with treatment providers to work out implementation issues. Six agencies are currently contracted to provide ACT. The agencies have developed their teams, enrolled consumers and are providing services. DMH has worked with agency staff to identify the high

end users of crisis services. A Missouri variation of the Comprehensive Outcome Measure Program is being used to measure client outcomes on a quarterly basis. Experts from the field such as Michelle P. Salyers, Ph.D., from the ACT Center of Indiana, have made numerous technical assistance visits to Missouri. Additionally, members from each ACT team and CPS employees have shadowed ACT teams in Minnesota to observe how ACT is implemented. Staff of Missouri ACT teams have attended the annual ACTA meeting to stay in touch with developments in the field.

Data show that in the Eastern Region of the state, a subset of ACT clients who were “high users” of Medicaid services reduced spending on services very significantly after ACT enrollment. Homelessness was reduced for all the ACT teams compared with status before ACT. Variations on the ACT model for special populations, such as Forensic consumers, are under development. Additionally, an ACT team is developing in Joplin as a response to the tornado disaster. DMH will continue to monitor fidelity to this model.

Supported Employment

Meaningful work experiences are often central to an individual’s recovery process. Thus, in order to most effectively assist consumers in realizing their employment goals providers must collaborate with Division of Vocational Rehabilitation (VR) vendors to offer evidence-based supported employment services. Using the SAMHSA toolkit and the Dartmouth University experts to facilitate the development of such services, CPS plans to continue implementing system change. The guiding principles for supported employment services for individuals with psychiatric disorders are:

- Eligibility is based on consumer choice.
- Supported employment is integrated with treatment.
- Competitive employment is the goal.
- Job search starts soon after a consumer expresses interest in working.
- Follow along supports are continuous.
- Consumer preferences are important.

Supported Employment services continue in cooperation with Division of Vocational Rehabilitation with the goal of providing clients with the choice to be employed in the competitive workforce. The department received a Johnson and Johnson grant. Technical assistance and fidelity to the SE model are being provided through cooperation with the Dartmouth University national experts.

Illness Management and Recovery

The division is reshaping Psychosocial Rehabilitation programming (PSR) to a wellness, recovery and illness management approach. An enhanced PSR billing rate has been given to seventeen agencies that are providing treatment focusing on core components including

psychoeducation, relapse prevention and coping skills training. The menu of possible wellness/recovery services includes health and wellness approaches, an illness management & recovery approach, the use of Peer Specialists as health coaches, Wellness Recovery Action Planning, or other approaches that support a deeper understanding of recovery.

There has been a lot of interest from the community mental health centers in providing both diabetes conversation maps and smoking cessation groups as part of the new enhanced PSR-IMR service. Twenty agencies have nurses trained to do the diabetes conversation map groups. At least six agencies are currently running smoking cessation groups. The Coalition of Community Mental Health Centers and the American Lung Association recently provided training on smoking cessation. DMH expects many additional agencies to have staff with competencies to conduct smoking cessation groups.

Dialectical Behavior Therapy

The Missouri Department of Mental Health began a wide-scale DBT implementation effort four years ago. In that time, over 3000 clinicians have received introductory and advanced training in the model and approximately 50 DBT teams have been developed in diverse regions and clinical settings in the state. Beginning and advanced “training packages” comprised of leading books, training DVD’s, CD’s, and online programs have been provided to teams in order to structure ongoing self-study in the DBT model.

Currently, efforts are underway to enhance specialized DBT treatment in the areas of substance abuse, eating disorders, and with adolescents and families. International experts have been brought in to provide training in these areas, and ongoing consultation is being provided to numerous agencies that provide services specifically to adolescents and their families. The Department of Mental Health in collaboration with the University of Missouri Psychiatric Center have produced an online training in communication strategies entitled “Validation 101”. The intent is to require this training of all inpatient direct care staff in settings run by the State of Missouri, and to make this training available to any other setting where there is a desire to train staff in effective communication strategies.

In April of 2010 the new www.dbtmo.org website went live. In addition to providing written and online resources for clinicians and consumers of DBT services, it is the place where providers can pursue DBT Certification in the state of Missouri. This certification initiative is an effort to bring all DBT teams practicing in the state of Missouri to a high standard of adherence to the DBT model and to prepare them to meet national certification requirements when those become available in 2012. Dialectical Behavior Therapy introductory and advanced training has occurred throughout the state.

Consumer Operated Services Programs (COSP)

The DMH continues its partnership with Missouri Institute of Mental Health to accelerate multistate Consumer Operated Service Programs (COSP) findings into evidenced-based practice. Jean Campbell, Ph.D. principal investigator of the COSP Multi-Site Research Initiative continues to work with the department to move toward this goal. The department funds, through competitive bid, five drop-in centers and five warm lines.

Previously, each COSP performed a self-assessment utilizing the FACIT (Fidelity Assessment Common Ingredient Tool). Two consumers at each drop-in center were trained to administer the FACIT. Concurrently, the FACIT was revised as a tool specific to warm lines. This revised tool was field tested on each of the five warm lines.

The project formally trained consumers as Peer Evaluators to administer the FACIT to other COSPS funded within this project. A comprehensive curriculum was developed to train these Peer Evaluators. In November 2009, ten consumers attended a week long intensive training in St. Louis. Each state funded COSP designated a consumer to participate in this training and teams of two Peer Evaluators are administering the FACIT to other state funded COSPS. All COSPs have been evaluated by a Peer Evaluator Team. The overall goal for COSPS is to develop, implement and maintain continuous quality improvement within their programs based upon the results of the FACIT. Ongoing training is expected to continue throughout the year for the Peer Evaluator teams. The Peer Evaluators are paid an hourly wage or a stipend for time spent on this project.

All COSPS continue to participate in a monthly teleconference to share ideas and input to the process via a coalition called SCOPE (Supporting Consumer Operated Programs Enhancements). Members share the responsibility of facilitating these meetings; developing agendas, and taking minutes. MIMH maintains a listserv that allows for continued communication and networking of the COSPS. Ongoing on-site visits were accomplished by the department this year for contract compliance and technical assistance. Additional technical assistance has been provided by telephone and email.

Best Practice Initiatives

Peer Specialist Certification

CPS has adopted the Appalachian Consulting Group “Georgia Model” for Peer Specialist training and certification. It is the intent of the Division to move the mental health system to a wellness model that empowers service participants to establish their personal mental health goals and manage both their mental health and plan of care through education and supports. Certified Peer Specialists are a part of this process.

CPS has trained a total of 213 individuals with the peer specialist training. One hundred and thirty individuals have passed the certification exam and reached the credential for Certified Missouri Peer Specialist (CMPS). The Medicaid reimbursement rate was increased to incentivize the hiring of Peer Specialists in the CMHCs. The rate is comparable to the community support worker rate. In 2011-2013, additional basic trainings and continuing education trainings are scheduled. Regular conference calls are occurring to provide support to the CMPS. The MIMH is conducting a Proof of Concept evaluation to determine if individuals with CMPS have improved outcomes. CPS has contracted with Wichita State University to provide the web site support for the training and certification process. The web site is www.peerspecialist.org. (See additional details in the State Behavioral Health Advisory Council section)

RESPECT Seminars/Institutes

Creating Communities of Hope begins with RESPECT. Joel Slack, founder of Respect International, LLC, developed the RESPECT Seminar to promote the powerful impact that respect (and disrespect) has on a person recovering from a psychiatric disability. Joel presents personal experiences and shows that RESPECT impacts all of us in our daily lives. His message is relevant to anyone interested in gaining a consumer's perspective regarding mental health and the relationship between service provider and patient. Free public seminars were provided throughout Missouri in 2008-2011 with over 1700 participants across the state.

The Respect Institute is a four-day training program designed to teach consumers of mental health services how to share their own personal stories to educate others. In 2009, Missouri worked in partnership with its state psychiatric regional hospital system to develop an infrastructure to support statewide expansion of the RESPECT Institute and a RESPECT Speakers Bureau in each of its five regions. The Institute and Speakers Bureau developed based upon the successful model established by Chaplain Jane Smith at Fulton State Hospital in Central Missouri and was expanded to include consumer participants from the broader community and across disability groups. Graduates of the program are provided opportunities for public speaking. The DMH Office of Consumer Safety works with Joel Slack, Jane Smith and regional designees to coordinate this statewide expansion.

The St. Louis Regional Health commission has incorporated RESPECT training and policy development extensively into its Eastern Region Behavioral Health Initiative, resulting in board approval of "RESPECT Guiding Principles." The state's Department of Corrections and the U.S. Department of Veterans Affairs also have participated in training.

The final phase of RESPECT consists of the development of a two-part graduate program, which involves (1) training staff and consumers to conduct and to assist in conducting the four-day

RESPECT Institutes and (2) training consumers to conduct RESPECT Seminars based on their own life experiences.

Missouri Transformation also has partnered with NAMI-Missouri to promote statewide expansion of both RESPECT Speakers and NAMI's signature In Our Own Voice (IOOV) Speakers Program. Transformation grant funds will help to support IOOV trainings and NAMI has agreed to waive membership fees for RESPECT graduates who wish to become IOOV speakers.

Mental Health First Aid

Most Missourians understand first aid and what to do if someone is choking, not breathing, or exhibiting signs of another health emergency. However, few people know basic interventions if they encounter a person experiencing mental health distress or a crisis even though they are more likely to encounter such a situation. In Australia, Betty Kitchener and Anthony Jorm developed Mental Health First Aid (MHFA) to teach basic first aid interventions for common mental health problems such as anxiety, bipolar disorder, depression, substance use disorder, or a crisis situation such as suicidal behavior, post trauma distress, drug overdose, panic attack, and the like. Research protocol on participants of the 12-hour MHFA course established that First Aiders demonstrate improved confidence in providing initial help, increased the amount of help given, and displayed reduced stigma regarding mental health disorders. As a result, MHFA has quickly gained international adoption and adaptation.

Missouri worked collaboratively with a team from Maryland and the National Council of Community Behavioral Healthcare to launch the American version of Mental Health First Aid. The MHFA-USA manual, Instructor materials, draft certification standards and business plan have been developed by the national consortium. Additionally, work has progressed with the University of Maryland to identify standards of fidelity for evaluation and teaching both the 12-hour MHFA course and the 5-day Instructor Certification course with consistency.

Missouri has continued to provide leadership across the nation by training Instructors both within the state and in other states. Our trainers offered ten 5-day Instructor training courses certifying 104 individuals as MHFA-USA Instructors in Missouri and 66 in other states. Fifty-two 12-hour MHFA courses were taught with 797 individuals graduating as "First Aiders." A \$300,000 grant was received from the Missouri Foundation for Health to provide the 12-hour MHFA course within faith-based organizations in 17 rural Missouri counties. An "Immersion Project" is underway with the Moberly School District concentrating fiscal and human resources involving MHFA in an effort to make an impact.

Missouri is in the process of certifying additional instructors and First Aiders; releasing curriculum modules targeting audiences in higher education and faith based communities;

identifying Ambassadors for MHFA within the state; completing a business plan for MHFA including viable strategies for sustainability; and, publishing evaluation results of the effectiveness of MHFA. We will continue to contribute to the expansion of Mental Health First Aid USA by assisting with the finalization of standards, curriculum standardization relative to Instructor Certification, the potential for on-line MHFA education and webinars, and the development of curriculum specificity that will enable MHFA to respond to Americans with a variety of backgrounds and orientations.

Communities of Hope Initiative

The Communities of Hope Initiative

<http://missouridmh.typepad.com/transformation/communitiesofhope.html> is a cornerstone of the state's efforts to transform its mental health system to make it more responsive to actual need by using a public health model of service delivery. A public health model provides a continuum of services that focuses on an entire population rather than individuals or their separate illnesses and disabilities. The Communities of Hope Initiative takes transformation to scale by mobilizing communities to develop data-driven mental health and wellness plans, implement targeted interventions with community-specific outcomes, and sustain their efforts through the expansion of existing partnerships.

Contracts were awarded to eight agencies referred to as Mental Health Transformation Support Centers.

- Community Partnership of the Ozarks
- First Call NCADD
- Prevention Consultants
- Randolph County
- Southeast Missouri Behavioral Health
- St. Joseph Youth Alliance
- Tri County

The Transformation Support Centers are working with twenty-one community-based coalitions throughout Missouri. To assist with the sustainability of the Initiative, contractors are required to work with existing coalitions who are already addressing or willing to address mental health-related issues.

The Transformation Support Centers have completed their deliverables: 1) Community Readiness Assessment; 2) Asset/Resource Mapping; 3) Resource & Data Analysis; 4) Comprehensive Plan; and 5) Final Report. A key theme in the final reports was to “include mental health promotion/disease prevention in our educational efforts”. Several of the Support Centers included Mental Health First Aid <http://missouridmh.typepad.com/transformation/firstaid.html> as a resource and tool for their communities and organizations. Each coalition developed a mental health and wellness plan that is community-specific based on the community's assessed stage of readiness, needs assessment

data, resource and gap analysis and the selection of evidence-based interventions based on their locally-identified issues and target populations. The plans are designed to transform the local mental health system – moving away from the primary target of clinical services to one that has a vision of good mental health for all.

Missouri Mental Health Foundation

The Missouri Mental Health Foundation (MMHF) was created in 2007 to provide a singular focus on raising awareness and public understanding to the many issues that impact individuals and families who live with mental illness, developmental disabilities and addiction disorders.

The Foundation is a 501(c)(3) public charity run by its own Board of Directors and a part-time Executive Director. Its mission is to increase public awareness and understanding of mental health conditions and to help dissolve stigma to open doors to treatment and equal opportunity for participation in schools, communities and the workforce.

The public's lack of understanding about mental health conditions and developmental disabilities keeps many Missourians on the sidelines of society and in the shadow of life. Stigma often shapes public policies that limit treatment options. Battling this stigma is the commitment of the Missouri Mental Health Foundation.

The MMHF organizes several activities to create the awareness and public understanding needed to dissolve stigma. Each spring the MMHF hosts the Mental Health Champions' Banquet to recognize three outstanding individuals who have battled through and "championed" mental health issues to become exemplary in their efforts to better their lives and positively impact their communities. Another annual event is the Director's Creativity Showcase in which the Foundation solicits and displays the artistic talents of people served by the Department of Mental Health (DMH). The Showcase helps acquaint the public with the talents of individuals with mental illnesses, developmental disabilities, or addictions disorders. The artwork is created not only for the Showcase, but is also sometimes used as a means of therapy. The MMHF also works with DMH to provide a consumer led conference to address issues important to mental health clients on how they can take more control of their own lives and recovery. In addition to these activities the MMHF also produces public service announcements and hosts important, informational meetings for state legislators with an interest in learning more the mental health system.

A major goal of the Missouri Mental Health Foundation is to identify potential fundraisers and contributors to ensure long-term success and sustainability of the Foundation and its projects. The Foundation makes a difference in *Changing Attitudes and Building Hope* for some of Missouri's most vulnerable citizens.

Crisis Intervention Teams

Across the state of Missouri, Crisis Intervention Teams (CIT) continue to successfully partner with consumers, families and Community Mental Health Centers to help divert persons with mental illness and co-occurring substance abuse disorders from the criminal justice system to treatment and/or services. CIT training in Kansas City, Lee Summit, Columbia, Cass County, Jefferson County, Vernon County, and St. Louis City and County, has resulted in hundreds of law enforcement officers being certified as CIT officers. More than 1,750 local police officers across the state have voluntarily participated in CIT training, allowing officers to better respond to persons in crisis due to mental illness and to get them to treatment, as opposed to arrest and incarceration. CIT officers have responded to more than 9,000 mental health crisis calls with an arrest rate below 5%.

A July 2011 evaluation of 128 Law Enforcement Agencies participating in CIT across Missouri revealed that 83% of CIT intervention dispositions were sent to an Emergency Room or a Behavioral Health Unit for evaluation by a qualified mental health professional and 16% were resolved on the scene. Additionally, arrest dispositions across the state remain low, falling under 5% in the first two quarters of 2011. These and other statewide CIT statistics illustrate the effectiveness of the program and highlight how far our state has come at bridging the gap between the criminal justice and mental health systems.

Disaster Services

The Department of Mental Health as the public mental health authority leads the mental health response to disasters within Missouri. The Department continues to plan for its own facilities and for a statewide response. In addition, DMH is working cooperatively with other state agencies to plan for disasters and public health emergencies as well as to develop and provide training. This has led to earlier screening for mental health issues in first responders and survivors of disasters. A major tornado hit the city of Joplin this year. The mental health response has been compassionate and effective. Additional services such as an ACT team and a Joplin Child Trauma Treatment Center are being implemented in the disaster area. Gov. Jay Nixon announced that his administration is allocating \$2 million to establish the Joplin Child Trauma Treatment Center to provide critical mental health services to children and families impacted by the May 22 tornado.

Services to Families of Veterans

The Department of Mental Health and the Community Mental Health Centers (CMHCs) in Missouri are dedicated to meeting the needs of veterans and their families in a culturally sensitive manner. Nearly all CMHCs are Tri-Care enrolled or have specific providers who provide services through Tri-Care and Tri-West.

The Division continues to work with the Missouri National Guard, Air Guard and Reserves to attend “Yellow Ribbon Events” across the state to provide information about mental health and mental health services for pre-deployed and post-deployed service members and their families.

The DMH Housing Unit also administers in partnership with St. Patrick Center in St. Louis a Veteran’s Administration Grant Per Diem program. The grant provides transitional housing and supportive services for 50 homeless veterans with mental illness and/or substance abuse issues.

Child Service System’s Strengths

CAFAS

The Child and Adolescent Functional Assessment Scale (CAFAS) is designed to measure impairment in the day-to-day functioning in children and adolescents in kindergarten through the 12th grade who have, or are at risk for emotional, behavioral or psychological problems. There are 8 subscales on the CAFAS measuring functioning at home, school/work, community, behavior towards others, moods/emotions, self-harm, thinking and substance use. In addition to the scales noted above, the CAFAS includes two Caregiver subscales that assess how the child’s material needs are met and the family’s psychosocial resources relative to the child’s needs. With the use of the CAFAS strengths and goals can also be identified that culminate in the creation of a treatment plan tied to the child’s specific needs and strengths. Implementation of the CAFAS to determine eligibility in the intensive-community based services (Children’s Community Psychosocial Rehabilitation/CPR) became statewide in January of 2009 and is accessible electronically to all division providers. The intent was to move towards basing eligibility more on functional impairments as opposed to purely diagnostic criteria. The treatment plan generated by the CAFAS has been approved for use by the Division. Individual providers are using the CAFAS to assess progress in treatment, classify cases to guide specific treatment protocols, creation of a treatment plan, to aid in determination of service need or level of care and as an outcome measure. Agencies are also beginning to use this for continuous quality improvement to insure effective and meaningful services for children/adolescents are provided. The CAFAS is one of the outcome measures for the SAMHSA Children’s Proof of Concept to measure the impact of Family Support (see below) on children’s functioning. The Division began training this year on the Preschool and Early Childhood Functional Assessment Scale as we begin to develop services for young children.

Family Support

This service focuses on the development of a support system for parents of children with serious emotional disorders. Activities are directed and authorized by the child’s treatment plan. Activities include: assisting and coaching the family to increase their knowledge and awareness of the child’s needs; enhance problem solving skills, provide emotional support; disseminate information; linkage to services and parent to parent guidance. The individual providing family

support works closely with the wrap around facilitator and care coordinator to obtain outcomes at the family level.

This service was added to our Community Psychiatric Rehabilitation Program in January 2008 to be eligible for funding under Medicaid. This year concerted efforts have been directed towards developing core curriculum and competencies for Family Support Workers and offering statewide trainings to Family Support Workers and agency supervisors to integrate this service into the continuum of care. Quality and fidelity will be monitored through the CPR certification process. Through the System of Care Cooperative Agreement, an additional component of Family Support is being examined that would make a Family Support Partner the “front door” to services. The Family Support Partner would have initial contact with the family, identify the needs of the family, and connect the family with appropriate natural or community supports in lieu of or in addition to mental health services. The goal is to assist the family and ideally prevent deeper penetration into the mental health service system.

Treatment Family Home

Comprehensive Psychiatric Services (CPS) is in the process of refining and enhancing their Treatment Family Home model. While Treatment Family Homes has been a key community based service within CPS for many years, its implementation and funding mechanisms have varied across the state. In order to provide a more consistent, cohesive Treatment Family Home (TFH) service across the state, CPS is redesigning its model to maximize therapeutic effectiveness while minimizing restrictiveness through consultation with Mary Grealish, M.Ed., Community Partners, Inc. The main focus is to switch to a more professional model with active treatment implementation and management through the TFH. This year the Division has worked on development of the Missouri “Toolkit for Treatment Family Home Care” and revising and updating contracts consistent with the toolkit. In this next year the Division will certify Treatment Family Home train-the-trainers and provide training to providers on the “Toolkit”. Additionally implementation of the toolkit will be monitored through CPS annual compliance review. CPS has proposed including Treatment Family Homes in the rehab option through Medicaid as well as offering a more intensive version called Professional Parent Homes as an alternative to inpatient and/or secure residential placements.

Quality Service Review

As a mechanism to measure the development and implementation of a high quality service system based on system of care principles and practices Missouri selected the Quality Service Review (QSR). The QSR, designed by Dr. Ivor Groves and adapted to Missouri, measures the quality of interactions between frontline practitioners, children and their families and the effectiveness of the services and supports provided. This process has a strong history in Missouri as it has been used by the Department of Social Services (DSS) for Practice Development Review (PDR).

The process used for measurement is a qualitative evaluation method that uses two primary sources of information, in-depth child qualitative reviews and stakeholder interviews, to assess the effectiveness of the system as well as its impact on children and families who are being served by the System of Care (SOC) in meeting their treatment, behavioral and educational objectives and goals. The QSR basically outlines and measures the implementation of the state's model of practice for children's mental health. To test the system, a sample of children is drawn from the children currently being served by the system of care and trained reviewers review the record and conduct interviews with the child, parent, and other people and agencies that are providing services to the child. In addition, the review team leader conducts focus groups with parents, staff from the child-serving agencies, SOC leadership, and Family Court. During the focus groups, the team leader gathers information about how effectively the agencies work together, how satisfied parents are with how the system performs, and how well frontline therapists and staff are able to accomplish their jobs. The focus groups also identify the barriers they encounter in either receiving services or in delivering appropriate services.

The QSR has been applied to areas of the state in which a sanctioned system of care team functions. The results of the review are shared with the community stakeholders as well as with the SOC team to guide the focus of community priorities in enhancing the system of care. All results are forwarded to the state Comprehensive System Management Team (CSMT) to identify strengths and weaknesses and to inform future policy development related to funding, practice and coordination. Although funding to support this review process is remains tenuous, the CSMT has confirmed their view that the QSR is the guiding light to the status of the system and will guide their work in future policy and practice development.

Public Health Model of Children's Mental Health

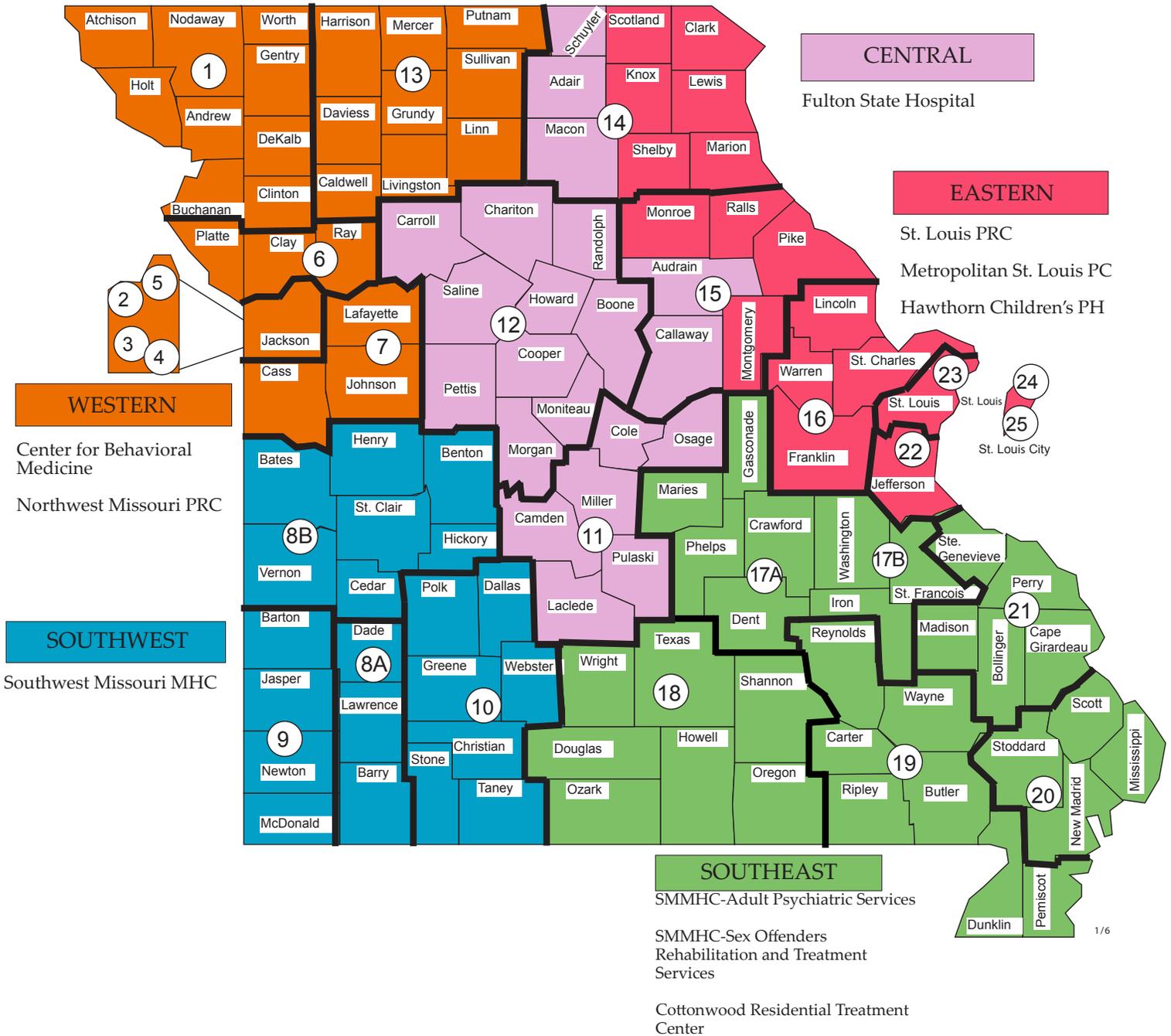
The Division's Children's Services has led the way for the Department in examining and implementation of a public health model. This was initiated through a partnership with the Department of Health and Senior Services four years ago to implement a training initiative for school nurses on mental health issues. Through continuous and growing partnerships it has morphed into a major initiative that is now working with communities in providing training, technical assistance and support funding to create continuous surveillance systems that allow a community to identify their mental wellness and health priorities; developing effective policies to address these priorities; and ongoing monitoring systems to assess the real impact of the policies. Children's leadership has attended multiple public health training academies to become immersed in this model and shape its application to children's mental health. Several initiatives are looking at how the state can partner with community entities such as children's and/or mental health tax boards to create a connected continuum of care ranging from promotion to prevention, early identification and intervention to enhancing services for youth with significant needs. One model being developed, in partnership with the Department of Elementary and Secondary

Education, is in the area of school mental health services in partnering with schools who have implemented Tier 1 of the Positive Behavior Interventions and Supports with fidelity and wish to move on enhancing services at the Tier 2 and Tier 3 levels (Targeted and Intensive respectively).

MISSOURI DEPARTMENT OF MENTAL HEALTH

Division of Comprehensive Psychiatric Services

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CPS FACILITY LISTING –July, 2011

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Mark Stansberry, Director
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Affiliated Centers (#25)

Places for People, Inc.
4130 Lindell Blvd.
St. Louis, MO 63108-2914
Francie Broderick, Exec. Director
314-535-5600
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Email: fbroderick@placesforpeople.org

Independence Center
4245 Forest Park Ave.
St. Louis, MO 63108
J. Michael Keller, Executive Director
314-533-4245
Fax: 314-533-7773
Email: mkeller@independencecenter.org

ADAPT of Missouri
2301 Hampton
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Revised: July 15, 2010

II: Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system

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Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:

Step 2: Identify the unmet service needs and critical gaps within the current system.

Missouri's current economic condition will prove problematic in the coming fiscal year. Due to the past budget reductions, tough decisions have been made regarding closure of acute care settings and emergency rooms operated by the department. Missouri has closed its two remaining psychiatric emergency rooms and five acute psychiatric units in St. Louis and Farmington. In 2010, DMH closed its ERs and acute units in Columbia and Kansas City. The closures place an additional stress on community providers. To offset these closures community housing options have increase and intensity of mental health services options have been enhanced such as Assertive Community Treatment Teams. The CPS Budget for FY2012 is \$445,884,113.

The CPS SAC has identified an unmet service need as underfunding for the Consumer Operated Services Programs (COSP) for the Drop-In Centers and Peer Phone Support Warm Lines. Many of the individuals using these services are not connected to other mental health services. The SAC would like to see increased funding for those services. DMH is exploring other funding options such as Medicaid payments for the eligible services provided.

Other unmet needs identified by the CPS SAC include limited access to psychiatrists. Recruitment and retention of psychiatrists and nurse practitioners remains a challenge due to low reimbursement rates and high demand for these positions. Telemedicine is currently being used by some agencies in some areas and the department is looking for way to expand these services.

The prevalence information demonstrates a low penetration rate. Missouri is only meeting 24% of the need for adult mental health services based on the SMI prevalence rates and 16% for children with SED.

Missouri Department of Mental Health
 2009 Estimated Census Data and Prevalence Rates
 FY2011 Clients Served By Service Area

SA	Tot. Est. Popn	Adults	Children	Adlt Prevalence	Child Prevalence	SMI Adults Served	SED Child Served	Rural	Rural
	2009			at 5.4%	at 7%	FY11	FY11	Adult	Child
01	181,178	140,490	40,688	7,586	2,848	1,631	998	1,631	998
02	0			0	0	3,073	549		
03	0			0	0	1,381	364		
04	0			0	0	1,335	335		
05	0			0	0	1,228	215		
KCsub	705,708	531,871	173,837	28,721	12,169	3,411	1,450		
KC	705,708	531,871	173,837	28,721	12,169	10,428	2,913		
06	342,404	257,163	85,241	13,887	5,967	2,847	456	2,847	456
07	185,413	139,244	46,169	7,519	3,232	1,024	511	1,024	511
08	190,132	144,842	45,290	7,821	3,170	2,186	657	2,186	657
09	209,749	155,211	54,538	8,381	3,818	3,239	1,105	3,239	1,105
10	510,347	393,087	117,260	21,227	8,208	3,810	1,412	3,810	1,412
11	235,951	180,252	55,699	9,734	3,899	1,468	419	1,468	419
12	326,063	252,576	73,487	13,639	5,144	2,854	633	2,854	633
13	77,964	58,979	18,985	3,185	1,329	1,125	334	1,125	334
14	105,114	80,970	24,144	4,372	1,690	1,373	431	1,373	431
15	118,014	90,688	27,326	4,897	1,913	1,461	521	1,461	521
16	541,426	403,264	138,162	21,776	9,671	3,088	1,258	3,088	1,258
17	203,349	156,337	47,012	8,442	3,291	2,707	577	2,707	577
18	122,967	93,743	29,224	5,062	2,046	1,244	189	1,244	189
19	128,562	96,853	31,709	5,230	2,220	1,259	233	1,259	233
20	100,670	76,088	24,582	4,109	1,721	1,340	608	1,340	608
21	134,528	103,753	30,775	5,603	2,154	2,962	682	2,962	682
22	219,046	164,958	54,088	8,908	3,786	1,866	230	1,866	230
23	992,408	758,813	233,595	40,976	16,352	3,607	734	3,607	734
24	0			0	0	2,441	253		
25	0			0	0	2,435	153		
STLsub	356,587	277,060	79,527	14,961	5,567	1,230	359		
STL	356,587	277,060	79,527	14,961	5,567	6,106	765		
Out of State						138	5		
Unknown						89	2		
TOTAL	5,987,580	4,556,242	1,431,338	246,037	100,194	57,852	15,673	41,091	11,988
			0						
RURAL (EXCLUDES COUNTIES 095 & 510)	4,925,285	3,747,311	1,177,974	202,355	82,458				

Of
 SED/SMI
 estimates
 Adult 23.51
 RuralAdult 20.31
 Children 15.64
 RuralCild 14.54

The Missouri Behavioral Health Epidemiology Workgroup (MO-BHEW) has the mission to:

- To create and implement a systematic process for gathering, reviewing, analyzing, integrating, and monitoring data that will delineate a comprehensive and accurate picture of behavioral health issues in the State and its communities;
- To inform and guide behavioral health prevention policy, program development and evaluation in the State; and
- To disseminate information to State and community agencies, to targeted decision-makers, and to the public.

The MO-BHEW's goals are to:

- Use population-based behavioral health data to guide and improve policymaking, program development, and outcomes monitoring.
 - Assess data needs and data gaps.
 - Enhance capacity to use behavioral health data.
 - Promote data driven decision-making at the state and local level.
 - Provide advocacy tools for community coalitions.
 - Improve access and user interface with data and data products.
 - Increase dissemination of data and analyses, in particular, to those stakeholders critical to the shaping of Missouri's prevention infrastructure.
- Facilitate interagency and community collaboration for the collection, analysis, interpretation, and utilization of mental health and substance abuse related data.
 - Ensure that the response of the MO-BHEW is culturally competent.
 - Ensure that the MO-BHEW perspective is inclusive of all aspects of the causes and consequences of mental illness and substance abuse.
 - Promote common standards.
 - Reduce duplicative data collection efforts among state agencies and partners to the degree possible.
 - Promote data sharing.
 - Provide outreach to other organizations with an interest in behavioral health data.

Current MO - BHEW membership includes:

Name	BHEW Position	Title	Agency
Susan Depue	chairperson	Research Assistant Professor	Missouri Institute for Mental Health
Angie Stuckenschneider	member	Prevention Director	Missouri Department of Mental Health - Division of Alcohol and Drug Abuse
Christie Lundy	member	Research Coordinator	Missouri Department of Mental Health - Division of Alcohol and Drug Abuse

Clive Woodward	member	Director of Quality Improvement	Missouri Department of Mental Health - Division of Comprehensive Psychiatric Services
Rebecca Kniest	member	Research Analyst	Missouri Department of Social Services - Research & Evaluation
Ron Beck	member	Director	Missouri State Highway Patrol - Statistical Analysis Center
Sarah Patrick	member	State Epidemiologist	Missouri Department of Health and Senior Services - Division of Community and Public Health
Anne Janku	member	Research Manager	Office of State Courts Administrator
Liz Sale	member	Research Associate Professor	Missouri Institute for Mental Health
Bill Elder	member	Director	Office of Social and Economic Data Analysis
Michael McBride	member	Underage Drinking Prevention Coordinator	Partners in Prevention
Randy Smith	data support		Missouri Department of Mental Health - Division of Alcohol and Drug Abuse

II: Planning Steps

Table 2 Step 3: Prioritize State Planning Activities

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Start Year:

End Year:

Number	State Priority Title	State Priority Detailed Description
1	Evidence Based Practices	Continue to implement evidenced based practices statewide for adults with SMI and Children with SED
2	Healthcare Homes	Implement Health Care Home Initiative
3	Recovery Oriented Services	Continue to implement recovery oriented services

Footnotes:

II: Planning Steps

Table 3 Step 4: Develop Objectives, Strategies and Performance Indicators

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Start Year:

End Year:

Priority	Goal	Strategy	Performance Indicator	Description of Collecting and Measuring Changes in Performance Indicator
Evidence Based Practices	Implement evidence based practices statewide	Adults Continue implementation of six Assertive Community Treatment Teams Continue implementation of Integrated Dual Disorders Treatment in 20 agencies Continue implementation of Supported Employment programs in six agencies Continue implementation of Dialectical Behavior Therapy statewide Continue implementation of Consumer Operated Services Programs to fidelity Children Continue implementation of Treatment Family	Number of agencies implementing EBP	Measure number of agencies implementing EBP

Homes Continue implementation of System of Care programs

Healthcare Homes

Implement Healthcare Homes Initiative

Missouri is playing an important role in the design and implementation of the national health reform strategy. Missouri is the first state to submit a Medicaid State Plan Amendment to Health and Human Services, Centers for Medicare and Medicaid Services for Community Mental Health Center Health Care Homes.

Implementation of Health Care Homes

Missouri is working on obtaining approval of the State Plan Amendment. DMH will continue to train leadership and treatment teams on healthcare homes clinical and organization issues.

Recovery Oriented Services

Partner With Individuals in Recovery

Missouri will continue to partner with individuals in recovery from mental illness and substance abuse disorders to guide the behavioral health system and promote individual, program and system-level approaches that foster health and resilience; increase permanent housing, employment, education, and other necessary supports; and reduce barriers to

Certified Missouri Peer Specialists; Consumer Operated Services Programs; RESPECT Institute

DMH will increase the number of Certified Missouri Peer Specialists trained. DMH will maintain the Consumer Operated Services Programs. DMH will continue to train individuals as RESPECT speakers.

social inclusion.

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 Services Purchased Using Reimbursement Strategy
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Start Year:

End Year:

Reimbursement Strategy	Services Purchased Using the Strategy
Encounter based reimbursement	MHBG dollars are spent on mental health services on a fee-for-service basis.
Grant/contract reimbursement	MHBG dollars are spent on suicide prevention activities with a contract reimbursement methodology.

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5 Projected Expenditures for Treatment and Recovery Supports

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Start Year:

End Year:

Category	Service/Activity Example	Estimated Percent of Funds Distributed
Healthcare Home/Physical Health	<ul style="list-style-type: none"> • General and specialized outpatient medical services • Acute Primary Care • General Health Screens, Tests and Immunization • Comprehensive Care Management • Care coordination and health promotion • Comprehensive transitional care • Individual and Family Support • Referral to Community Services 	<10% <input type="text"/>
Engagement Services	<ul style="list-style-type: none"> • Assessment • Specialized Evaluation (Psychological and neurological) • Services planning (includes crisis planning) • Consumer/Family Education • Outreach 	<10% <input type="text"/>
Outpatient Services	<ul style="list-style-type: none"> • Individual evidence-based therapies • Group therapy • Family therapy • Multi-family therapy • Consultation to Caregivers 	10-25% <input type="text"/>
Medication Services	<ul style="list-style-type: none"> • Medication management • Pharmacotherapy (including MAT) • Laboratory services 	<10% <input type="text"/>
Community Support (Rehabilitative)	<ul style="list-style-type: none"> • Parent/Caregiver Support • Skill building (social, daily living, cognitive) • Case management • Behavior management • Supported employment • Permanent supported housing • Recovery housing • Therapeutic mentoring • Traditional healing services 	51-75% <input type="text"/>
Recovery Supports	<ul style="list-style-type: none"> • Peer Support • Recovery Support Coaching • Recovery Support Center Services • Supports for Self Directed Care 	<10% <input type="text"/>
Other Supports (Habilitative)	<ul style="list-style-type: none"> • Personal care • Homemaker • Respite • Supported Education • Transportation • Assisted living services 	N/A <input type="text"/>

- Recreational services
- Interactive Communication Technology Devices
- Trained behavioral health interpreters

Intensive Support Services

- Substance abuse intensive outpatient services
- Partial hospitalization
- Assertive community treatment
- Intensive home based treatment
- Multi-systemic therapy
- Intensive case management

<10% 6

Out-of-Home Residential Services

- Crisis residential/stabilization
- Clinically Managed 24-Hour Care
- Clinically Managed Medium Intensity Care
- Adult Mental Health Residential
- Adult Substance Abuse Residential
- Children's Mental Health Residential Services
- Youth Substance Abuse Residential Services
- Therapeutic Foster Care

N/A 6

Acute Intensive Services

- Mobile crisis services
- Medically Monitored Intensive Inpatient
- Peer based crisis services
- Urgent care services
- 23 hour crisis stabilization services
- 24/7 crisis hotline services

N/A 6

Prevention (Including Promotion)

- Screening, Brief Intervention and Referral to Treatment
- Brief Motivational Interviews
- Screening and Brief Intervention for Tobacco Cessation
- Parent Training
- Facilitated Referrals
- Relapse Prevention /Wellness Recovery Support
- Warm line

N/A 6

System improvement activities

N/A 6

Other

N/A 6

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6 Primary Prevention Planned Expenditures Checklist

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Start Year:

End Year:

Strategy	IOM Target	Block Grant FY 2012	Other Federal	State	Local	Other
Information Dissemination	Universal	\$ <input type="text"/>				
Information Dissemination	Selective	\$ <input type="text"/>				
Information Dissemination	Indicated	\$ <input type="text"/>				
Information Dissemination	Unspecified	\$ <input type="text"/>				
Information Dissemination	Total	\$	\$	\$	\$	\$
Education	Universal	\$ 146,000	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Education	Selective	\$ <input type="text"/>				
Education	Indicated	\$ <input type="text"/>				
Education	Unspecified	\$ <input type="text"/>				
Education	Total	\$ 146,000	\$	\$	\$	\$
Alternatives	Universal	\$ <input type="text"/>				
Alternatives	Selective	\$ <input type="text"/>				
Alternatives	Indicated	\$ <input type="text"/>				
Alternatives	Unspecified	\$ <input type="text"/>				
Alternatives	Total	\$	\$	\$	\$	\$
Problem Identification and Referral	Universal	\$ <input type="text"/>				
Problem Identification and Referral	Selective	\$ <input type="text"/>				
Problem Identification and Referral	Indicated	\$ <input type="text"/>				
Problem Identification and Referral	Unspecified	\$ <input type="text"/>				
Problem Identification and Referral	Total	\$	\$	\$	\$	\$

Community-Based Process	Universal	\$ <input type="text"/>				
Community-Based Process	Selective	\$ <input type="text"/>				
Community-Based Process	Indicated	\$ <input type="text"/>				
Community-Based Process	Unspecified	\$ <input type="text"/>				
Community-Based Process	Total	\$	\$	\$	\$	\$
Environmental	Universal	\$ <input type="text"/>				
Environmental	Selective	\$ <input type="text"/>				
Environmental	Indicated	\$ <input type="text"/>				
Environmental	Unspecified	\$ <input type="text"/>				
Environmental	Total	\$	\$	\$	\$	\$
Section 1926 Tobacco	Universal	\$ <input type="text"/>				
Section 1926 Tobacco	Selective	\$ <input type="text"/>				
Section 1926 Tobacco	Indicated	\$ <input type="text"/>				
Section 1926 Tobacco	Unspecified	\$ <input type="text"/>				
Section 1926 Tobacco	Total	\$	\$	\$	\$	\$
Other	Universal	\$ <input type="text"/>				
Other	Selective	\$ <input type="text"/>				
Other	Indicated	\$ <input type="text"/>				
Other	Unspecified	\$ <input type="text"/>				
Other	Total	\$	\$	\$	\$	\$

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 7 Projected State Agency Expenditure Report

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Start Year:

End Year:

Date of State Expenditure Period From:

Date of State Expenditure Period To:

Activity	A. Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance Abuse Prevention and Treatment	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
2. Primary Prevention	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
3. Tuberculosis Services	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
4. HIV Early Intervention Services	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
5. State Hospital		\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
6. Other 24 Hour Care	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
7. Ambulatory/Community Non-24 Hour Care	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
8. Administration (Excluding Program and Provider Level)	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
9. Subtotal (Rows 1, 2, 3, 4, and 8)	\$	\$	\$	\$	\$	\$
10. Subtotal (Rows 5, 6, 7, and 8)	\$	\$	\$	\$	\$	\$
11. Total	\$	\$	\$	\$	\$	\$

Footnotes:

Table 7 will be completed for the SAPT Block Grant. For the Mental Health Block Grant \$146,000 is spent on Suicide Prevention, 5% on CPS Administration and the remaining dollars spent on community based mental health treatment services.

III: Use of Block Grant Dollars for Block Grant Activities

Table 8 Resource Development Planned Expenditures Checklist

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Start Year:

End Year:

Activity	A. Prevention-MH	B. Prevention-SA	C. Treatment-MH	D. Treatment-SA	E. Combined	F. Total
1. Planning, Coordination and Needs Assessment	\$ <input type="text"/>		\$ <input type="text"/>			\$
2. Quality Assurance	\$ <input type="text"/>		\$ <input type="text"/>			\$
3. Training (Post-Employment)	\$ <input type="text"/>		\$ <input type="text"/>			\$
4. Education (Pre-Employment)	\$ <input type="text"/>		\$ <input type="text"/>			\$
5. Program Development	\$ <input type="text"/>		\$ <input type="text"/>			\$
6. Research and Evaluation	\$ <input type="text"/>		\$ <input type="text"/>			\$
7. Information Systems	\$ <input type="text"/>		\$ <input type="text"/>			\$
8. Total	\$	\$	\$	\$	\$	\$

Footnotes:

MHBG dollars are spent on direct care services, suicide prevention and administration.

IV: Narrative Plan

D. Activities that Support Individuals in Directing the Services

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Narrative Question:

SAMHSA firmly believes in the importance of individuals with mental and substance use disorders participating in choosing the services and supports they receive. To achieve this goal, individuals and their support systems must be able to access and direct their services and supports. Participant direction, often referred to as consumer direction or self direction, is a delivery mode through which a range of services and supports are planned, budgeted and directly controlled by an individual (with the help of representatives, if desired) based on the individual's needs and preferences that maximize independence and the ability to live in the setting of his/her choice. Participant-directed services should include a wide range of high-quality, culturally competent services based on acuity, disability, engagement levels and individual preferences. The range of services must be designed to incorporate the concepts of community integration and social inclusion. People with mental and substance use disorders should have ready access to information regarding available services, including the quality of the programs that offer these services. An individual and their supports must be afforded the choice to receive services and should have sufficient opportunities to select the individuals and agencies from which they receive these services. Person centered planning is the foundation of self-direction and must be made available to everyone. The principles of person centered planning are included at www.samhsa.gov/blockgrantapplication. Individuals must have opportunities for control over a flexible individual budget and authority to directly employ support workers, or to direct the worker through a shared employment model through an agency. People must have the supports necessary to be successful in self direction including financial management services and supports brokerage. In addition, individuals and families must have a primary decision-making role in planning and service delivery decisions. Caregivers can play an important role in the planning, monitoring and delivery of services and should be supported in these roles. In the section below, please address the following:

- Either summarize your State's policies on participant-directed services or attach a copy to the Block Grant application(s).
- What services for individuals and their support systems are self-directed?
- What participant-directed options do you have in your State?
- What percentage of individuals funded through the SMHA or SSA self direct their care?
- What supports does your State offer to assist individuals to self direct their care?

Footnotes:

Activities that Support Individuals in Directing the Services

The Vision of the Missouri DMH is Hope * Opportunity * Community Inclusion. Missourians receiving mental health services will have the opportunity to pursue their dreams and live their lives as valued members of their communities.

The Values of DMH firmly support the importance of individuals with mental and substance use disorders participating in mental health services as active partners in designing their services and supports. The Values of DMH include:

Community Inclusion

- Missourians who participate in mental health services are welcomed and equally included in education, work, housing, and social opportunities in their communities.

Accessible, Safe, Affordable, and Integrated Services

- Missourians with mental health needs easily access safe, affordable, and integrated medical and behavioral services.

Partners in Personal Service Design

- Missourians participating in mental health services are active partners in designing their services and supports.

Effectiveness Measured by Participant Outcomes

- The effectiveness of Missouri's mental health services is measured by meaningful outcomes experienced by the people receiving them.

Valued and Motivated Staff

- Missourians receive mental health services from competent, motivated, and highly valued staff serving as effective stewards of the public trust.

Prevention and Early Intervention

- Emphasizing prevention and early intervention strategies avoids or minimizes the mental health problems of Missourians.

Respected Unique Participant Characteristics

- Missourians participating in mental health services are valued for their uniqueness and diversity and respected without regard to age, ethnicity, gender, race, religion, sexual orientation, or socio-economic condition.

Code of State Regulations (CSR) also supports individuals in directing their services. Some examples of CSR that require participant directed services include the following.

9 CSR 10-7.010 Treatment Principles and Outcomes

(4) Essential Treatment Principle—Therapeutic Alliance.

(A) The organization shall promote initial attendance, engagement and development of an ongoing therapeutic alliance by—

1. Treating people with respect and dignity;

2. Enhancing motivation and self-direction through identification of meaningful goals that establish positive expectations;
3. Working with other sources (such as family, guardian or courts) to promote the individual's participation;
4. Addressing barriers to treatment;
5. Providing consumer and family education to promote understanding of services and supports in relationship to individual functioning or symptoms and to promote understanding of individual responsibilities in the process;
6. Encouraging individuals to assume an active role in developing and achieving productive goals; and
7. Delivering services in a manner that is responsive to each individual's age, cultural background, gender, language and communication skills, and other factors, as indicated.

(5) Essential Treatment Principle—Individualized Treatment.

(A) Services and supports shall be individualized in accordance with the needs and situation of each individual served.

(8) Essential Treatment Principle—Recovery.

(A) Services shall promote the independence, responsibility, and choices of individuals.

1. An individual shall be encouraged to achieve positive social, family and occupational/educational functioning in the community to the fullest extent possible.
2. Every effort shall be made to accommodate an individual's schedule, daily activities and responsibilities when arranging services, unless otherwise warranted by factors related to safety or protection from harm.
3. Individuals shall be encouraged to accomplish tasks and goals in an independent manner without undue staff assistance.

Several initiatives have promoted participant-directed services. Missouri had a Person Centered Planning grant that provided many opportunities statewide for training on person centered treatment planning. Person centered planning was included as part of statewide compliance training for all treatment supervisors. Person centered learning collaboratives continue even though the grant has ended. Wellness Recovery Action Planning (WRAP) was provided throughout the state during the grant and certified trainers continue to provide WRAP trainings.

The Peer Specialist Basic Training teaches Certified Missouri Peer Specialists (CMPS) to listen to their peers and assist them in creating individualized goals that they want to achieve. Recently, a Peer Specialist Wellness Coaching was provided to select CMPS. The wellness training focused on motivational interviewing skills and provided a structure to assist service participants in setting their own recovery wellness goals.

Family Support Providers have been trained to assist family members of children/youth receiving services in obtaining the services they need. This service focuses on the development of a support system for parents of children with serious emotional disorders. Activities are directed and authorized by the child's treatment plan. Activities include: assisting and coaching the family to increase their knowledge and awareness of the child's needs; enhance problem solving skills, provide emotional support; disseminate information; linkage to services and parent to

parent guidance. The individual providing family support works closely with the wrap around facilitator and care coordinator to obtain outcomes at the family level.

Professional staff has received training on Motivational Interviewing for many years. With the introduction of evidence based practices, motivational interviewing skills and stages of change are key components. The Healthcare Home initiative is providing additional opportunities for training on motivational interviewing skills and assisting individuals in working towards their individualized recovery goals.

IV: Narrative Plan

E. Data and Information Technology

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Narrative Question:

Regardless of financing or reimbursement strategy used, unique client-level encounter data should be collected and reported for specific services that are purchased with Block Grant funds. Such service tracking and reporting is required by SAMHSA to be reported in the aggregate. Universal prevention and other non-service-based activities (e.g. education/training) must be able to be reported describing the numbers and types of individuals impacted by the described activities. States should to complete the service utilization Table 5 in the Reporting Section of the Application. States should provide information on the number of unduplicated individuals by each service purchased with Block Grant Funds rather than to provide information on specific individuals served with Block Grant funds. In addition, States should provide expenditures for each service identified in the matrix. If the State is currently unable to provide unique client-level data for any part of its behavioral health system, SAMHSA is requesting the State to describe in the space below its plan, process, resources needed and timeline for developing such capacity. States should respond to the following:

- List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provide information on one or more of the following:
 - Provider characteristics
 - Client enrollment, demographics, and characteristics
 - Admission, assessment, and discharge
 - Services provided, including type, amount, and individual service provider
 - Prescription drug utilization
- As applicable, for each of these systems, please answer the following:
 - For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?
 - Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?
 - Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?
 - Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?
 - Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?
- As applicable, please answer the following:
 - Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?
 - Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?
 - Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?
 - Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?
 - Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?

In addition to the questions above, please provide any information regarding your State's current efforts to assist providers with developing and using Electronic Health Records.

Footnotes:

Data and Information Technology

DMH Health Technology Tools

CIMOR

In October 2006, the Department of Mental Health (DMH) replaced approximately 15 legacy systems with a web-based information system called Customer Information Management Outcomes and Reporting (CIMOR) system. CIMOR provides for the intake and tracking of consumers, state facility bed management, event tracking for incidents impacting consumer safety, clinical screening and assessments, recording of diagnostic information for both DSM-IV and ICD-9 code sets, tracking of court commitments, recording of clinical encounters, authorization request and approval processes, maintenance and tracking of department funding and program expenditures, claims adjunction and payment, voucher management for the federal Access to Recovery III program, tracking of Medicaid benefit eligibility, consumer banking for management of consumer funds held in trust by state facilities, provider management, standard means test (SMT) application, outcomes reporting, and waiting lists. CIMOR was designed to comply with federal security and privacy requirements. Security in CIMOR is role-based and access to screens and functions is dependent upon one's job duties. CIMOR interfaces with Medicaid eligibility data from the Department of Social Services to determine benefits eligibility and with social security number (SSN) data from the Social Security Administration for SSN verification. CIMOR assigns consumers a unique identifier that is permanently attached to the consumer and is used by all three DMH divisions. As of April 2011, all three divisions of the DMH are using CIMOR.

The CIMOR system continues to evolve. The Division anticipates more reliance on internal data analysis and reporting in support of monitoring activities. The Director of Quality and Data Analytics has regular contact with Department of Social Services staff to coordinate data sharing.

The SAMHSA Mental Health Block Grant Monitoring Report from March 2011 commented extensively on the CIMOR system.

“The implementation of the Customer Information Management, Outcomes, and Reporting (CIMOR) system is a major accomplishment for DMH. The level of integration of clinical and financial data within CIMOR greatly enhances the opportunity for data-driven decision-making and offers a much finer grain of control than the old legacy system offered.”

“The implementation of CIMOR has also increased revenue maximization efforts on the part of CPS. Behind every service encounter in CIMOR are possible revenue streams. The business rules within CIMOR are designed to draw down payments from different sources based upon which sources can be charged for that service and which revenue source needs to be utilized first. The billing of services to ineligible payment sources is virtually eliminated. The CIMOR is also designed to regularly check a client's Medicaid eligibility status against the Department of Social Services database and re-bill any Medicaid-eligible services that may have been missed.”

“With full implementation of CIMOR, the staff of CPS believes that they will have comprehensive data available to meet the State’s information needs for planning, quality improvement, decision-making, and monitoring activities. By summer 2011, CPS expects to have all of its inpatient and community providers entering all enrollments and demographic, program, and service-level details and outcomes data directly into the integrated CIMOR system. The final stage, which is currently underway, is the transition from an interim Medicaid claims database that allowed batch submission to batch submission of Medicaid claims into CIMOR. A phased transition was necessary because of the extraordinary amount of technical assistance required agency by agency to ensure a successful transition for all agencies required to submit data into CIMOR. The CPS information technology technical assistance staff have provided Web-based training, met regularly with financial officers of local mental health centers and State facilities, and developed extensive reports identifying CIMOR business rule violations at the claims level for agencies to identify problem areas in local systems ahead of making the transition to CIMOR.”

“The CIMOR is constructed in such a way that individual agencies will be able to access and run reports for their own data. They will also be able to see how they compare to statewide totals. Security rules are in place to create various levels of authorization to data within the system, with limited access to the highest levels of security. The Director of Quality and Data Analytics regularly attends several regular meetings where data are shared. These meetings include the SAC and the Coalition of Community Mental Health Centers.”

“As noted in the Quality Improvement and Decision Support section, the CIMOR system will allow CPS to collect client and service data at a client-specific level. The CIMOR and SAM II system will provide a fully integrated view of the service system, clients and outcomes. Data collected from the CMHCs and other community providers are analyzed for service trends, contract status, and appropriate service level. The CPS does not have any issues with its ability to meet all the reporting requirements of the MHBG.”

“The MHBG contracts with providers are purchase-of-service contracts with specific services being eligible for payment. The business rules within the CIMOR system prevent the providers from billing for services that are ineligible MHBG expenditures.”

CyberAccess

CyberAccess (Cyber) is a web-based, HIPAA compliant portal that enables users to view the complete medical and drug claim history for MO HealthNet fee-for-service participants. The claim history is extracted from paid claims and goes back approximately two years. Cyber provides valuable health information on prescriptions, procedures, diagnoses and services that a client has received from other MO HealthNet providers in the state. Cyber is updated on a daily basis and is administered by ACS.

With this tool the nurse liaison and other community mental health center users are able to identify clinical issues that affect client care. The application displays alert messages when clients may be noncompliant with medication refills and/or treatment plans. A patient profile

can be extracted from Cyber which provides a summary of the client's medical, behavioral and drug claim data. Cyber allows the nurse liaison and other CMHC/CPRC medical staff to determine if a drug is a preferred agent or requires an edit override. Prior authorizations can also be obtained electronically for medications, durable medical equipment (DME) and imaging services.

Behavioral Pharmacy Management Program

The Behavioral Pharmacy Management Program (BPM) assists providers and CMHCs with improving behavioral health prescribing practices for MO HealthNet participants with psychiatric illnesses. The BPM uses beneficiary and prescription data to compare MO HealthNet physician prescribing practices against nationally recognized guidelines. Physicians who deviate from guidelines are notified that their prescribing practices do not conform to the standard of practice, and are sent appropriate educational materials through the BPM mailing. The BPM interventions are consultative and educational – aiming to impart knowledge of best practice in the pharmacological treatment of mental disorders.

The CMHC mailing is a spinoff of the BPM mailing, and both are administered by Care Management Technologies (CMT). The CMHC mailing is designed to be used as part of quality improvement programs and for peer-to-peer conversations between the agency directors and/or medical directors and their providers. This particular mailing is sent to the CMHC and/or nurse liaison directly and not to the individual prescribers. It includes information on all prescribers who treat the CMHC patient, both community providers and providers employed by the CMHC.

Disease Management Report

The Disease Management Report is sent quarterly to the CMHC and/or nurse liaison, and is administered by CMT. The report analyzes the MO HealthNet paid claims related to ten targeted disease management quality indicators, and flags CMHC clients who are not receiving the recommended disease management services and/or medications identified by those indicators.

The ten disease management quality indicators currently targeted are:

1. Use of inhaled corticosteroid medications by persons with a history of COPD or Asthma
2. Use of ARB or ACEI medications by persons with a history of CHF
3. Use of beta-blocker medications by persons with a history of CHF
4. Use of statin medications by persons with a history of CAD
5. Use of H2A or PPI medications for no more than 8 weeks by persons with a history of GERD
6. Fasting lipid profile completed within the past 12 months for patients with CAD
7. Dilated retinal exam completed within the past 12 months for patients with diabetes
8. Urinary microalbumin test completed within the past 12 months for patients with diabetes
9. At least 2 Hbg A1c tests completed within the past 12 months for patients with diabetes
10. Fasting lipid profile completed within the past 12 months for patients with diabetes

Medication Adherence Report

The Medication Adherence Report is sent quarterly to the CMHC and/or nurse liaison and is administered by CMT. The report includes Medication Possession Ratios (MPRs) for several different classes of medications that are used to treat chronic conditions. Currently these include: antipsychotics, mood stabilizers, diabetes medications, anti-hypertensives,

cardiovascular medications and COPD medications. The report lists all CMHC patients who have adherence concerns with any of the aforementioned medications. Only drugs with MPRs of less than 0.8 are listed in the report. (MPRs of 0.8 or higher are considered “adherent” and are not displayed in the report.)

Health Reform

Each Community Mental Health Center was required to complete an application to become a Healthcare Home in Missouri. As part of the application each agency was required to specify if their agency uses an electronic health record.

Medical Records

a. If the CMHC uses an electronic health record (EHR): i. What vendor do you use? ii. Does it meet meaningful use? iii. When was it implemented? iv. What functions does it serve? Comments (optional):
b. If the CMHC does not use an EHR, does the CMHC have plans to implement an EHR? i. In 2011? ____Yes ____No ii. In 2012? ____Yes ____No Comments (optional):
c. Are you a member of a Regional Health Information Exchange, if so which one? Comments (optional):
d. How many CyberAccess registered users do currently have total for the CMHC? e. Who are your registered CyberAccess Practice/Site Administrator(s) employed by your organization?

The majority of agencies are using EHR. DMH will continue to assess the data provided and offer technical assistance to agencies not currently using EHR.

IV: Narrative Plan

F. Quality Improvement Reporting

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Narrative Question:

SAMHSA expects States to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures that will describe the health of the mental health and addiction systems. These measures should be based on valid and reliable data. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, reflect their evidence of effectiveness. The State's CQI process should also track programmatic improvements; and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to critical incidents, complaints and grievances. In an attachment, please submit your State's current CQI plan.

Footnotes:

Quality Improvement Reporting

DMH CPS continues to collect and use the National Outcome Measures (NOMS) in continuous quality improvement. A CPS SAC Data Committee meets monthly to review the data and report to the larger Council. The committee has recently reviewed the final URS tables and the Director of Data Analytics will be presenting the data to SAC as he does on a regular basis. The Data Committee has been working on revisions to the Adult and Child Status Reports. This information is entered into CIMOR to track individual client progress. Consumer Satisfaction Surveys are collected on a continuous basis. Data is continuously analyzed and presented in multiple forums.

One example of CQI is the Disease Management 3700 project that heavily utilized data for continuous quality improvement. The lists of clients chosen for the project used Medicaid and DMH databases. Agencies reported monthly on status of outreach activities for each individual selected. Outcome and cost data are currently being collected and analyzed to continuously improve the process to reach the right individuals with the right services. Monthly meetings are conducted with DM 3700 contact in each community mental health center to discuss success and barriers. The call is a chance for problem solving and sharing of ideas.

DMH has a Strategic Plan posted at <http://dmh.mo.gov/docs/opla/DMHStratPlan.pdf>

The Plan includes strategies and performance measures for each goal.

The Event Management Tracking (EMT) system is used to collect and track information on abuse and neglect in both community and facility settings. This information is reviewed by leadership on a regular basis to track trends and problems. Additionally, a CATS system is used to track client grievances that come in through a client grievance phone line. This data is reviewed and tracked on a regular basis by the CPS ADA Deputy Director.

IV: Narrative Plan

G. Consultation With Tribes

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Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it is to engage in regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have Tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues. For the context of the Block Grants, SAMHSA views consultation as a government to government interaction and should be distinguished from input provided by individual Tribal members or services provided for Tribal members whether on or off Tribal lands. Therefore, the interaction should include elected officials of the Tribe or their designee. SAMHSA is requesting that States provide a description of how they consulted with Tribes in their State. This description should indicate how concerns of the Tribes were addressed in the State Block Grant plan(s). States shall not require any Tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for Tribal members on Tribal lands.

Footnotes:

No federally recognized Tribes or Tribal lands exist within Missouri's borders.

IV: Narrative Plan

H. Service Management Strategies

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Narrative Question:

SAMHSA, similar to other public and private payers of behavioral health services, seeks to ensure that services purchased under the Block Grants are provided to individuals in the right scope, amount and duration. These payers have employed a variety of methods to assure appropriate utilization of services. These strategies include using data to identify trends in over and underutilization that would benefit from service management strategies. These strategies also include using empirically based clinical criteria and staff for admission, continuing stay and discharge decisions for certain services. While some Block Grant funded services and activities are not amenable (e.g. prevention activities or crisis services), many direct services are managed by other purchasers.

In the space below, please describe:

1. The processes that your State will employ over the next planning period to identify trends in over/underutilization of SABG or MHBG funded services
2. The strategies that your State will deploy to address these utilization issues
3. The intended results of your State's utilization management strategies
4. The resources needed to implement utilization management strategies
5. The proposed timeframes for implementing these strategies

Footnotes:

Service Management Strategies

CIMOR

Over and under utilization on Block Grant dollars is not a problem in Missouri. The SAMHSA Mental Health Block Grant Monitoring Report from March 2011 states:

“The implementation of CIMOR has also increased revenue maximization efforts on the part of CPS. Behind every service encounter in CIMOR are possible revenue streams. The business rules within CIMOR are designed to draw down payments from different sources based upon which sources can be charged for that service and which revenue source needs to be utilized first. The billing of services to ineligible payment sources is virtually eliminated. The CIMOR is also designed to regularly check a client’s Medicaid eligibility status against the Department of Social Services database and re-bill any Medicaid-eligible services that may have been missed.”

Billing and Certification Reviews

To address the issue of “services purchased under Block Grants are provided to individuals in the right scope, amount and duration” the department conducts annual Billing and Safety Reviews annually and Certification Surveys at least every third year.

The SAMHSA Mental Health Block Grant Monitoring Visit Report contained summary of monitoring activities.

“The DMH conducts program monitoring to ensure compliance with administrative rule as well as Medicaid and DMH billing requirements. The Department conducts focused reviews and follow-up reviews when deficiencies are found.

The standards for quality are defined in administrative rule and performance, and outcome measures are linked to the quality standards. The administrative rule applies to both adults and children, although there are specific sections of the rule that address specific differences in the populations, such as eligibility criteria.

The CPS conducts annual reviews of contracted providers. The reviews include a billing and services review only for contracted providers that are nationally accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), and the Commission of Accreditation (COA). Non-accredited, contracted agencies receive an annual review to measure compliance with the Code of State Regulations (CSR), in addition to billing and service review. Certification is on a 3-year cycle and providers receive a comprehensive certification survey the first year and a Safety and Basic Assurance Review the next 2 years. Reviews are also conducted to investigate complaints that have been received.

Survey procedures may include, but are not limited to, interviews with organization staff, individuals being served, and other interested parties; a tour and inspection of treatment sites; review of the organization's administrative records necessary to verify compliance with requirements; review of personnel records and service documentation; and observation of program activities.

Employees of DMH conduct both certification and billing reviews. Consumers and family members are included as members of the survey team on the certification survey. An onsite exit conference is conducted with the agency at the conclusion of a review. Reports then developed are sent to the agency's Chief Executive Officer (CEO), the President of the agency's Board of Directors, and any pertinent staff within CPS."

In order to ensure appropriate use and management of funds, CPS engages in the following monitoring activities:

- Conducts regular onsite certification visits, including a review of financial performance.
- Randomly selects and audits client files and billing records for the appropriateness and accuracy of billing information.
- Requires the submission of a budget for new grant projects and new programs.
- Monitors monthly billings by CMHCs against the available contract funds.
- Requires an A-133 audit for nonprofits subject to the award requirements.
- Conducts a desk review of audit documents.
- Requires a corrective action plan for deficiencies noted in audit reports.

IV: Narrative Plan

I. State Dashboards (Table 10)

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Narrative Question:

An important change to the administration of the MHBG and SABG is the creation of State dashboards on key performance indicators. SAMHSA is considering developing an incentive program for States/Territories based on a set of state-specific and national dashboard indicators. National dashboard indicators will be based on outcome and performance measures that will be developed by SAMHSA in FY 2011. For FY 2012, States should identify a set of state-specific performance measures for this incentive program. These state-specific performance indicators proposed by a State for their dashboard must be from the planning section on page 26. These performance indicators were developed by the State to determine if the goals for each priority area. For instance, a state may propose to increase the number of youth that receive addiction treatment in 2013 by X%. The state could use this indicator for their dashboard.

In addition, SAMHSA will identify several national indicators to supplement the state specific measures for the incentive program. The State, in consultation with SAMHSA, will establish a baseline in the first year of the planning cycle and identify the thresholds for performance in the subsequent year. The State will also propose the instrument used to measure the change in performance for the subsequent year. The State dashboards will be used to determine if States receive an incentive based on performance. SAMHSA is considering a variety of incentive options for this dashboard program.

Plan Year:

Priority	Performance Indicator	Selected
Evidence Based Practices	Number of agencies implementing EBP	<input type="checkbox"/>
Healthcare Homes	Implementation of Health Care Homes	<input type="checkbox"/>
Recovery Oriented Services	Certified Missouri Peer Specialists; Consumer Operated Services Programs; RESPECT Institute	<input type="checkbox"/>

Footnotes:

Missouri DMH will continue to measure the National Outcome Measures. DMH is exploring other dashboard measures and will collaborate with SAMHSA per future instructions.

IV: Narrative Plan

J. Suicide Prevention

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Narrative Question:

In September of 2010, U.S. Health and Human Services Secretary Kathleen Sebelius and Defense Secretary Robert Gates launched the National Action Alliance for Suicide Prevention. Among the initial priority considerations for the newly formed Action Alliance is updating and advancing the National Strategy for Suicide Prevention, developing approaches to constructively engage and educate the public, and examining ways to target high-risk populations. SAMHSA is encouraged by the number of States that have developed and implemented plans and strategies that address suicide. However, many States have either not developed this plan or have not updated their plan to reflect populations that may be most at risk of suicide including America's service men and women -- Active Duty, National Guard, Reserve, Veterans -- and their families. As an attachment to the Block Grant application(s), please provide the most recent copy of your State's suicide prevention plan. If your State does not have a suicide prevention plan or if it has not been updated in the past three years please describe when your State will create or update your plan.

Footnotes:

Suicide Prevention

Since the federal declaration that suicide is a serious public health concern and the accompanying call to action for individual states, Missouri DMH has accepted the responsibility to provide both leadership and technical assistance on mental health promotion within Missouri communities, and has recognized suicide as a leading public health concern. The award of three consecutive three-year federal grants to prevent suicide in youth up to age 24 has enabled this high risk group to receive targeted services. DMH utilizes this SAMSHA funding in conjunction with block grant funding to provide state-wide suicide prevention services tailored to local needs and supplemented with local support. Strategies include gatekeeper training, policy change, a focused initiative on college campuses, regional Resource Centers, survivor support groups, promotion of the National Suicide Prevention Lifeline, incentive awards geared to meet local needs, incorporating suicide prevention information in distance learning courses, raising public awareness through print and electronic media, and conferences.

The sixth annual *Show-Me You Care About Suicide Prevention* conference occurred on July 28-29, 2011, with approximately 155 individuals participating. The conference, which was cosponsored by the Department of Mental Health, Lincoln University and the Missouri Institute of Mental Health helped to increase awareness and education. Attendees included educators, health-care providers, mental health care providers, military personnel, survivors and others. For more information on the suicide prevention activities in Missouri go to <http://dmh.mo.gov/mentalillness/suicide/prevention.htm>

The DMH continues to implement suicide prevention services according to the legislative mandates and grant guidelines. The Suicide Prevention Advisory Committee, which met regularly between late 2006 and early 2010, is currently being transformed into a new state planning group along with the revision of the state plan. During this four year period the committee supported efforts on college campuses as well as directing the Department to work collaboratively with federal initiatives to prevent suicides among veterans. The committee had developed and was implementing a statewide Suicide Prevention Plan. Legislative changes this year eliminated the Suicide Prevention Advisory Committee and transferred the oversight role to the State Advisory Council for CPS. The SAC has formed a subcommittee on Suicide Prevention that is actively meeting and revising the Suicide Prevention Plan.

The Missouri Suicide Prevention Project continues to combine funding from the Federal Block Grant with that of the State Youth Suicide Prevention Grant from SAMHSA to operate the 14 Regional Resource Centers around the state. These Regional sites continue to experience increasing numbers of inquiries and requests for services. In addition to providing gatekeeper training the sites continued to offer a wide range of other services, including survivor support groups, depression screenings, facilitating local coalitions, etc.

Since May 2010 the Project has been using Facebook to reach out to those that might not otherwise be aware of various resources and services. Currently there are approximately 3,700 fans of the page, which can be viewed at: www.facebook.com/MOsuicideprevention

During the grant year over 400 gatekeeper training presentations and other events were conducted to over 9,200 individuals. These sessions ranged from the one-hour QPR (Question,

Persuade & Refer) program to the two-day ASIST (Applied Suicide Intervention Skills Training) workshop. The National Suicide Prevention Lifeline was heavily promoted through the distribution of magnets, stickers, wallet cards and billboards. In the summer of 2010, the Project hosted a QPR Instructor Certification course, establishing over 30 new trainers in the southwest area of the state.

The success of the Youth Suicide Prevention Initiative Community Incentive Award Program inspired the creation of mini-awards geared to the elderly and the youth initiative's format, documents and RFP served as models for the program. Using Block Grant funds, we were able to partner with the Missouri Office of Transformation to award five Older Adult Suicide Prevention Mini-Awards in November 2009. These new older adult-focused projects are progressing successfully.

A partnership with several surrounding states to co-sponsor an "*Assessing and Managing Suicide Risk*" (AMSR) *Training for Trainers Workshop* was held in Omaha, Nebraska in late August 2010. In order to establish trainers on the Western half of the state, DMH sponsored an "Applied Suicide Intervention Skills Training" (ASIST) *Training for Trainers* course in Maryville, Missouri, in early October 2010.

IV: Narrative Plan

K. Technical Assistance Needs

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Narrative Question:

Please describe the data and technical assistance needs identified by the State during the process of developing this plan that will be needed or helpful to implement the proposed plan. The technical assistance needs identified may include the needs of State, providers, other systems, persons receiving services, persons in recovery, or their families. The State should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

Footnotes:

DMH CPS is not requesting any technical assistance at this time.

IV: Narrative Plan

L. Involvement of Individuals and Families

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Narrative Question:

The State must support and help strengthen existing consumer and family networks, recovery organizations and community peer advocacy organizations in expanding self advocacy, self-help programs, support networks, and recovery-oriented services. There are many activities that State SMHAs and SSAs can undertake to engage these individuals and families. In the space below, States should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the State mental health and substance abuse treatment system. In completing this response, State should consider the following questions:

- How are individuals in recovery and family members utilized in the development and implementation of recovery oriented services (including therapeutic mentors, recovery coaches and or peer specialists)?
- Does the State conduct ongoing training and technical assistance for child, adult and family mentors; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and help develop the skills necessary to match goals with services and to advocate for individual and family needs?
- Does the State sponsor meetings that specifically identify individual and family members? issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
- How are individuals and family members presented with opportunities to proactively engage and participate in treatment planning, shared decision making, and the behavioral health service delivery system?
- How does the State support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Footnotes:

Involvement of Individuals and Families

The State Advisory Council (SAC) for the Division of Comprehensive Psychiatric Services is actively involved in many aspects of recommending policy for the Division. The Council is comprised of more than half consumers and family members of consumers. The State Behavioral Health Advisory Council section has more details on their activities. There are details on the peer specialists, consumer/family monitors and the consumer/family/youth conference. Additionally, the SAC was very involved in Mental Health Transformation activities as highlighted in previous Mental Health Block Grant applications.

Certified Missouri Peer Specialists and Family Support Providers are actively engaged throughout the state in implementing recovery oriented services. Training and technical assistance will continue in order to increase the numbers working in the community and hospital settings. Details of these initiatives are noted in other sections of the plan.

Drop-in Centers and Warm Lines will continue to be supported as detailed in the Planning Step 1 section of this plan. CPS supports regular conference calls of the COSPs and will continue to provide technical assistance to improve the quality of services provided.

The Heartland Consumer Network is a program of the Depression Bipolar Support Alliance of Greater St. Louis in conjunction with the Missouri Institute of Mental Health (MIMH). It is funded through a federal grant from the Substance Abuse Mental Health Service Administration (SAMHSA). It is the goal of the Heartland Consumer Network to build recovery based communities to support consumer well-being across the State of Missouri. The Heartland Consumer Network has Facilitators in several communities throughout Missouri. The Facilitators live and work in those communities they represent. The Heartland Consumer Network Facilitators have been evaluating your communities using the Community Fidelity Assessment Common Ingredients Tool (C-FACIT). The purpose of this evaluation is to discover how well each community supports the well-being of consumers in their community. The results of the C-FACIT will be posted on our website and given to the communities at public forums by the Facilitators who live in that area. Communities will use the results to improve upon their strengths in supporting consumer well-being and create grass roots change in their areas.

There are two Statewide Consumer Networks operating in the state that are funded through SAMSHA grants. NAMI Missouri's network trains consumers across the state in self advocacy. The department supports a number of programs with NAMI Missouri.

NAMI Missouri started in St. Louis not long after the establishment of the national organization. Today they have approximately 3000 NAMI members in Missouri and 12 local NAMI affiliates.

“Our mission is to improve the quality of life and recovery for children and adults with mental illness and their families. We accomplish this through support, education, and advocacy. NAMI Missouri and a few affiliates have professional staff. However, we are governed by volunteer boards and nearly all the work of NAMI is carried out by trained, skilled grassroots volunteers. This allows us to offer all our support and education programs free of charge. Two of NAMI’s “signature” volunteer programs, the Family-to-Family Course and In Our Own Voice have earned recognition from the Substance Abuse and Mental Health Services Administration (SAMHSA). Family-to-Family is now considered an “evidence-based practice.”

NAMI Missouri’s funding comes from varied sources such as member dues, contributions, fundraisers, foundation grants, SAMHSA grants and (by competitive bid) state Department of Mental Health contracts. We are a private, public interest not-for-profit organization.”

DMH has five contracts with NAMI Missouri:

1. Information and Education Services
2. Parent Ombudsman Services
3. Training Services for Mental Health Professionals
4. Family to Family Program
5. NAMI Warm Line

DMH has a contract with Mental Health America of Eastern Missouri for the Building Recovery of Individual Dreams & Goals through Education & Support (BRIDGES) program. This peer-to-peer, self-help program provides education and support to people with psychiatric illnesses. It empowers students to take an active role in treatment and recovery. It also provides a framework for social interaction, inclusion and increased self-esteem. The support groups provide a foundation for maintaining a mentally healthy life. Mental Health America has trained BRIDGES trainers state-wide.

The Missouri Code of State Regulations has many requirements for peer support and family involvement in community mental health centers. For example,

9 CSR 10-7.010 Treatment Principles and Outcomes

(9) Essential Treatment Principle—Peer Support and Social Networks.

(A) The organization shall mobilize peer support and social networks among those individuals it serves.

1. The organization shall encourage participation in self-help groups.
2. Opportunities and resources in the community are used by individuals, to the fullest extent possible.

(10) Essential Treatment Principle—Family Involvement.

(A) Efforts shall be made to involve family members, whenever appropriate, in order to promote positive relationships.

1. Family ties and supports shall be encouraged in order to enrich and support recovery goals.
2. Family members shall be routinely informed of available services, and the program shall demonstrate the ability to effectively engage family members in a recovery process.

3. When the family situation has been marked by circumstances that may jeopardize safety (such as domestic violence, child abuse and neglect, separation and divorce, or financial and legal difficulties), family members shall be encouraged to participate in education and counseling sessions to better understand these effects and to reduce the risk of further occurrences.

(B) Particular emphasis on family involvement shall be demonstrated by those programs serving adolescents and children.

IV: Narrative Plan

M. Use of Technology

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Narrative Question:

Interactive Communication Technologies (ICTs) are being more frequently used to deliver various health care services. ICTs are also being used by individuals to report health information and outcomes. ICT include but are not limited to: text messaging, etherapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, case manager support and guidance, telemedicine. In the space below, please describe:

- a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?
- b. What specific applications of ICTs does the State plan to promote over the next two years?
- c. What incentives is the State planning to put in place to encourage their use?
- d. What support systems does the State plan to provide to encourage their use?
- e. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?
- f. How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?
- g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?
- h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?

Footnotes:

Use of Technology

Telemedicine is used in the community mental health centers. Missouri Medicaid does pay for the service. The Psychotherapy Bulletin is below.

PROVIDER BULLETIN

Volume 31 Number 47

<http://www.dss.mo.gov/mhd>

February 6, 2009

PSYCHOTHERAPY BULLETIN

PHYSICIAN (PSYCHIATRISTS), PSYCHOLOGISTS, PSYCHIATRIC CLINICAL NURSE SPECIALISTS (PCNS) AND COMMUNITY MENTAL HEALTH CENTERS (CMHC)

CONTENTS

- **Telehealth Services Background**
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Effective for dates of service on or after August 28, 2008, the MO HealthNet Division (MHD) will reimburse for Telehealth Services. This bulletin focuses specifically on covered psychotherapy services billable under the Psychology Program.

TELEHEALTH SERVICES BACKGROUND

The Missouri Code of State Regulations 13 CSR 70-3.190 Telehealth Services, establishes coverage for Telehealth Services through the MO HealthNet program.

Telehealth Services are medical services provided through advanced telecommunications technology from one location to another. Medical information is exchanged in real-time communication from an Originating Site, where the participant is located, to a Distant Site, where the provider is located, allowing them to interact as if they are having a face-to-face, "hands-on" session.

Telehealth offers participants, particularly those in rural areas of the state, access to health care services without having to travel extensive miles for an appointment.

TELEHEALTH COVERED SERVICES

A Telehealth service requires the use of a two (2)-way interactive video technology. Asynchronous telecommunication systems or store-and-forward systems are not covered technologies. Telehealth is not a telephone conversation, email, or faxed transmission between a healthcare provider and a patient, or a consultation between two healthcare providers. The participant must be able to see and interact with the off-site provider at the time services are provided via Telehealth. Services provided via videophone or webcam are not covered.

Telehealth services are only covered if medically necessary. Coverage of services rendered through Telehealth at the distant site is limited to:

1. Consultations made to confirm a diagnosis; or
2. Evaluation and management services; or
3. A diagnosis, therapeutic, or interpretative service; or
4. Individual psychiatric or substance abuse assessment diagnostic interview examinations; or
5. Individual psychotherapy; or
6. Pharmacologic management.

ELIGIBLE PROVIDERS

Health care providers utilizing Telehealth at either an originating site or a distant site must be enrolled as a MO HealthNet provider. Providers eligible to receive payment for Telehealth services include:

- Physicians
- Advanced Registered Nurse Practitioners, including Nurse Practitioners with a Mental Health specialty
- Community Mental Health Centers
- Psychologists

TELEHEALTH SERVICE REQUIREMENTS

Medically necessary Telehealth services may be arranged for participants by a referring provider. The referring provider evaluates the participant, determines the need for a consultation, and arranges the services of a consulting provider at the distant site for the purpose of diagnosis or treatment.

The originating site is where the MO HealthNet participant receiving the Telehealth service is physically located for the encounter. The originating site must be one of the following locations:

- Office of a physician or health care provider
- Hospital

- Critical Access Hospital
- Rural Health Clinic (RHC)
- Federally Qualified Health Center (FQHC)
- Missouri State Habilitation Center or Regional Center
- Community Mental Health Center
- Missouri State Mental Health Facility
- Missouri State Facility

A referring provider may introduce a participant to the consulting provider at the distant site, for examination, observation, or consideration of medical information. The referring provider may assist with the Telehealth service if requested by the consulting provider.

The consulting provider may request a Telepresenter to be present with the participant to assist with the service. A Telepresenter will aid in the examination by following the orders of the consulting provider, including the manipulation of cameras and appropriate placement of other peripheral devices used to conduct the patient examination.

It is not required for a referring provider or a Telepresenter to be present with the participant during the service; however, the originating site must ensure the immediate availability of clinical staff during the Telehealth encounter in the event a participant requires assistance.

REIMBURSEMENT

Reimbursement to the health care provider delivering the medical service at the distant site is equal to the current fee schedule amount for the service provided. Use the appropriate CPT code for the service along with the "GT" modifier (via interactive audio and video telecommunications system) indicating interactive communication was used.

The following psychotherapy services are billable by the distant site provider using the "GT" modifier:

Proc Code	Mod	Mod	Description
90801	AH	GT	Psychiatric diagnostic interview examination
90801	GT		Psychiatric diagnostic interview examination
90804	AH	GT	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient
90804	GT		Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient
90805	GT		Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services
90806	AH	GT	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient
90806	GT		Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility,

			approximately 45 to 50 minutes face-to-face with the patient
90807	GT		Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services
90862	GT		Medication Management

The originating site is only eligible to receive a facility fee for the Telehealth service. Claims should be submitted with HCPCS code **Q3014** (Telehealth originating site facility fee). Reimbursement will be made at the lesser of the actual charge or \$14.60.

PRIOR AUTHORIZATION AND UTILIZATION REVIEW

All services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, before payment is made, or after payment is made.

Certain procedures or services can require prior authorization from the MO HealthNet Division or its authorized agents. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process. A service provided through Telehealth is subject to the same prior authorization and utilization review requirement which exist for the service when not provided through Telehealth.

DOCUMENTATION FOR THE ENCOUNTER

Participant records at the originating and distant sites are to document the Telehealth encounter. A request for a Telehealth service from a referring provider and the medical necessity for the Telehealth service shall be documented in the participant's medical record. A health care provider shall keep a complete medical record of a Telehealth service provided to a participant and follow applicable state and federal statutes and regulations for medical record keeping and confidentiality in accordance with 13 CSR 70-3.020 and 13 CSR 70-98.015.

Documentation of a Telehealth service by the health care provider shall be included in the participant's medical record maintained at the participant's location and shall include:

1. The diagnosis and treatment plan resulting from the Telehealth service and progress note by the health care provider;
2. The location of the distant site and originating site;
3. A copy of the signed informed consent form; and
4. Documentation supporting the medical necessity of the Telehealth service.

CONFIDENTIALITY AND DATA INTEGRITY/APPROVED MISSOURI TELEHEALTH NETWORK (MTN)

All Telehealth activities must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 and all other applicable state and federal laws and regulations.

A Telehealth service shall be performed on a private, dedicated telecommunications line approved through the Missouri Telehealth Network (MTN). The telecommunications line must be secure and utilize a method of encryption adequate to protect the confidentiality and integrity of the Telehealth service information. The Missouri Telehealth Network must also approve the equipment that will be used in Telehealth service. Both a distant site and an originating site shall use authentication and identification to ensure the confidentiality of a Telehealth service.

Providers of Telehealth services shall implement confidentiality protocols that include identifying personnel who have access to a Telehealth transmission and preventing unauthorized access to a Telehealth transmission.

A provider's protocols and guidelines shall be available for inspection by the department upon request.

INFORMED CONSENT

Before providing a Telehealth service to a participant, a health care provider shall document written informed consent from the participant and shall ensure that the following written information is provided to the participant in a format and manner that the participant is able to understand:

1. The participant shall have the option to refuse the Telehealth service at anytime without affecting the right to future care and treatment and without risking the loss or withdrawal of a MO HealthNet benefit to which the participant is entitled;
2. The participant shall be informed of alternatives to the Telehealth service that are available to the participant;
3. The participant shall have access to medical information resulting from the Telehealth service as provided by law;
4. The dissemination, storage, or retention of an identifiable participant image or other information from the Telehealth service shall not occur without the written informed consent of the participant or the participant's legally authorized representative;
5. The participant shall have the right to be informed of the parties who will be present at the originating site and the distant site during the Telehealth service and shall have the right to exclude anyone from either site; and
6. The participant shall have the right to object to the videotaping or other recording of a Telehealth service.

A copy of the signed informed consent shall be retained in the participant's medical record and provided to the participant or the participant's legally authorized representative upon request.

The requirement to obtain informed consent before providing a service shall not apply to an emergency situation if the participant is unable to provide informed consent and the participant's legally authorized representative is unavailable.

MISSOURI TELEHEALTH NETWORK

Providers interested in obtaining information on an approved Missouri Telehealth Network (MTN) and services in your area may contact:

Missouri Telehealth Network
2401 Lemone Industrial Boulevard
DC345.00
Columbia, Missouri 65212
Phone: 573.884.7958
Email: mtn@health.missouri.edu

Or may go to their website: <http://www.telehealth.muhealth.org>

Provider Bulletins are available on the MO HealthNet Division (MHD) (Formerly the Division of Medical Services) Web site at <http://dss.mo.gov/mhd/providers/pages/bulletins.htm>. Bulletins will remain on the Provider Bulletins page only until incorporated into the [provider manuals](#) as appropriate, then moved to the Archived Bulletin page.

MO HealthNet News: Providers and other interested parties are urged to go to the MHD Web site at <http://dss.missouri.gov/mhd/global/pages/mednewssubscribe.htm> to subscribe to the electronic mailing list to receive automatic notifications of provider bulletins, provider manual updates, and other official MO HealthNet communications via E-mail.

MO HealthNet Managed Care: The information contained in this bulletin applies to coverage for:

- MO HealthNet Fee-for-Service
- Services not included in MO HealthNet Managed Care

Questions regarding MO HealthNet Managed Care benefits should be directed to the patient's MO HealthNet Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the red MO HealthNet card or by calling the Interactive Voice Response (IVR) System at 573-635-8908 and using Option One for the red or white card.

Provider Communications Hotline
573-751-2896

IV: Narrative Plan

N. Support of State Partners

Page 48 of the Application Guidance

Narrative Question:

The success of a State's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, education and other State and local governmental entities. States should identify these partners in the space below and describe the roles they will play in assisting the State to implement the priorities identified in the plan. In addition, the State should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the State education authority(ies); the State Medicaid agency; the State entity(ies) responsible for health insurance and health information exchanges (if applicable); the State adult and juvenile correctional authority(ies); the State public health authority, (including the maternal and child health agency); and the State child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan. This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The State Department of Justice that will work with the State and local judicial system to develop policies and programs that address the needs of individuals with mental and substance use disorders that come into contact with the criminal and juvenile justice systems; promote strategies for appropriate diversion and alternatives to incarceration; provide screening and treatment; and implement transition services for those individuals reentering the community.
- The State Education Agency examining current regulations, policies, programs, and key data-points in local school districts to ensure that children are safe; supported in their social-emotional development; exposed to initiatives that target risk and protective actors for mental and substance use disorders; and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The State Child Welfare/Human Services Department, in response to State Child and Family Services Reviews, working with local child welfare agencies to address the trauma, and mental and substance use disorders in these families that often put their children at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system.

Footnotes:

Support of State Partners

The Missouri Department of Mental Health (DMH) has strategic partnerships with its sister agencies. As the State Mental Health Authority, we have historically worked collaboratively with the Department of Social Services, Department of Health and Senior Services, Department of Elementary and Secondary Education, Department of Corrections, Department of Public Safety, Office of State Court Administrators, Department of Justice, Department of Insurance, Financial Institutions and Professional Registration, Department of Economic Development and the Governor's Office of Administration.

DMH has formal written memorandums of understanding with many of the above partner departments. Some of the MOUs are quite large and overly cumbersome to include in full in this document. Summaries of some of the current projects and agreements are listed in this section. The letter of approval for the block grant from the Mental Health Planning Council is in the attachment section. All required departments have representation on the council.

Health Homes

DMH is working very closely with the Department of Social Services (DSS), MO HealthNet (Medicaid) to develop the Health Home State Plan Amendment for Community Mental Health Centers. There is weekly and sometimes daily contact as we work through the planning and implementation of Health Reform. Details about the Health Homes and documents already developed including the State Plan Amendment are on the DMH website at

<http://dmh.mo.gov/about/chiefclinicalofficer/healthcarehome.htm> Partners in developing Missouri Health Homes are:

- Michael Bailit of Bailit Health Purchasing
- Alicia Smith of Health Management Associates
- Missouri Coalition of Community Mental Health Centers
- Missouri Primary Care Association
- ACS Heritage
- Care Management Technologies "CMT"
- Missouri Foundation for Health

Missouri Coalition of Community Mental Health Centers, Missouri Institute of Mental Health, Missouri Foundation for Health, and Missouri Primary Care Association are consistent partners with DMH in improving healthcare for Missourians.

DMH continues to work closely with DSS on oversight of Medicaid billings. DSS has expanded its Medicaid fraud and abuse unit to monitor contracted agencies including community mental health centers. DMH and the Missouri Medicaid Audit and Compliance Unit are currently working on a MOU for Medicaid billing reviews.

Mental Health Transformation

The state of Missouri was awarded a Mental Health Transformation Grant by the Substance Abuse and Mental Health Services Administration for five years, effective October 1, 2006. The five year grant has helped support building an infrastructure required for transformation, such as planning, workforce development, evidence-based practice implementation, and technology

enhancements. The common goals are to foster communities of hope through cooperation and collaboration of effort, and to employ a public health approach to mental health service delivery.

Missouri is one of nine states to receive a five-year federal grant for the transformation of its mental health service system. Though based in the state Department of Mental Health, this system involves all human service agencies whose objective is improved quality of life for the citizens of this state. Transformation of the state's mental health system is a high priority. A Human Services Cabinet Council (the "Council") was established; composed of cabinet-level directors of the Departments of Mental Health, Health and Senior Services, Social Services, Elementary and Secondary Education, Corrections and Public Safety. State information technology director also participates on the Council to support the work of the grant as does a designee from the Governor's office. The purpose of the Council was to review cross-department policy and operations related to human services and to develop and implement a comprehensive state mental health plan. This has been accomplished and details can be found on the DMH website at <http://missouridmh.typepad.com/transformation/>

Children's Services

The Department of Mental Health, Division of Comprehensive Psychiatric Services has the responsibility of overseeing the operations, and continuous quality improvement of a system of care for youth with serious emotional disorders and their families. In this role, the Division of CPS works with the Office of Comprehensive Child Mental Health that addresses cross-divisional and cross-departmental policy issues as well as supports the Comprehensive System Management Team.

The Comprehensive Children's Mental Health State Management Team continues to function as oversight, coordination, and technical assistance to ensure implementation of a comprehensive children's mental health system. This committee consists of representatives from: The Department of Social Services: Children's Division, Division of Youth Services and Division of Medical Services; The Department of Elementary and Secondary Education: Division of Vocational Rehabilitation and Division of Special Education; The Department of Public Safety; The Department of Mental Health: Divisions of Alcohol and Drug Abuse, Comprehensive Psychiatric Services, and Mental Retardation and Developmental Disabilities; The Department of Health and Senior Services; Office of State Court Administrators; juvenile offices; parents; parent advocacy groups; and representatives from each of the geographic local systems of care. This group meets at least once a month.

Department of Corrections

CPS has a joint project with Department of Corrections to provide services to mentally ill persons recently released from correctional facilities through the CMHCs. The Department of Mental Health has added a service code for "Intake Screening-Corrections" to allow for the pre-release planning and intake screening of persons with serious mental illness being discharged from correctional facilities in the DMH/DOC Mental Health 4 project.

Intake Screening-Corrections MH4 occurs prior to discharge from the correctional facility and all face-to face, indirect, and travel costs are built into the cost of the service unit. Service activities include the following:

1. Orientation of the inmate and solicitation of enrollment in the project.
2. Conducting an intake session, reviewing inmate history of mental health services and medications prior to and during incarceration, and providing clinical information to CMHC psychiatrists and other clinicians who will serve the transitioning inmate upon release.
3. Participation in the development of transition plans with the inmate and correctional treatment staff.
4. Scheduling immediate services for the offender to receive from CMHC staff during the first week following release.

The DMH has a recent collaboration with DOC involving women released from prison.

Other Department of Social Services Collaborations

Missouri's efforts continue on the development of a comprehensive system of care for children and youth. A system of care is a comprehensive array of mental health and support services which are organized in a coordinated way to meet the multiple and changing needs of children, youth and their families. However, a system of care is more than an array of services, it is a philosophy about the way in which children, youth and families receive services. The common philosophy of child-centered, family-focused and community-based services permeates the entire process. Partnerships between families, providers, communities, regions and the State are fundamental to an effective system of care.

CPS works closely with three divisions of the Department of Social Services: Children's Division (child welfare); Division of Youth Services (youth adjudicated as delinquent and committed to state custody); and MO HealthNet (Medicaid agency).

- Cross-departmental initiative to promote the use of best practices in the prescribing of psychiatric medications and insure better care coordination for children in state custody placed in residential treatment centers.
- The Division has developed a working partnership with the state Medicaid authority, Missouri HealthNet, to improve the quality of services provided to recipients. This has included active participation in the standing Non-Pharmaceutical Prior Authorization Group and participation in clinical audits of Medicaid managed care behavioral health services. Through this partnership providers now have access electronically to services provided to individual consumers to help in the coordination of care.
- CPS continues to partner with Children's Division (child welfare) to improve the Custody Diversion Protocol so that families do not have to voluntarily relinquish custody solely to access mental health services. To date 991 or 96% of the children referred have been diverted from state custody.
- CPS Children's Services is leading the trauma initiative that involves the Division of Youth Service and Children's Division.
- CPS Children's Services received a Healthy Transitions Initiative cooperative agreement and has engaged Children's Division, one of their statewide intensive services contract providers, and the Division of Vocational Rehabilitation in this effort (along with the adult services in CPS).

CPS along with MO HealthNet worked with the Children's Division to devise a quality improvement initiative that holds treatment providers more accountable for planning, providing and documenting effective clinical services. An additional area of clinical concern for the Children's Division was the number and types of medications children in residential treatment centers were prescribed. Modeled after a similar initiative for adults that helped in changing prescribing practices, CPS contracted for creation of an Integrated Health Profile for each child in Children's Division Custody in a residential placement based on Medicaid billing information. This profile includes information in regards to clinical guidelines related to type and dose of medications for a specific child, medication adherence and red flags related to co-occurring health issues. Some examples of quality indicators are more than three concurrent psychotropic medications for those under age 12, more than two antipsychotic medications concurrently prescribed, and timeframes for required labs and follow ups for health conditions. The Integrated Health Profile also contains information regarding primary care physician, treating psychiatrist, and case worker to aid in coordination of care. CPS continues to lead the Department of Mental Health in collaboration with Children's Division to implement, monitor and as necessary revise the Custody Diversion Protocol to prevent parents from having to voluntarily relinquish custody solely to access mental health services and transferring custody back to the parent if custody was based on mental health needs only. Children's Division has been an active partner in the Healthy Transition Initiative Cooperative Agreement. Through the initiative, in addition to examining a model for young adults, specialized consultation related to the special needs and system's issues of child welfare has been identified.

The Missouri Division of Youth Services (DYS) has been touted as an exemplary model for working with youth adjudicated as delinquent. Many states have come to Missouri to learn and attempt to learn from this Division. CPS has continued to work with DYS in identification of evidence based practices, including provision of training to staff on Dialectical Behavior Therapy which may be incorporated into their existing programs. DYS is a participant in the CPS Children's Trauma Initiative in examining how agencies/systems can enhance trauma-informed care. CPS has arranged for targeted consultation with DYS to address their population and agency's need. Additionally, DYS is engaged with CPS around the expansion of wraparound to enhance transitions to the community and aftercare services.

CPS has multiple joint initiatives with the Medicaid agency for Missouri. The majority address quality of care both for managed care and fee-for-service. MO HealthNet started a case management review of the behavioral health managed care providers. CPS serves on the review teams to provide clinical expertise. Additionally CPS staff several MO HealthNet workgroups related to creation of Dashboard indicators, case management, etc. MO HealthNet also is gradually bringing in a quality initiative for fee-for-service care. In this initiative, prior authorization is required to guide care towards best practices related to diagnostic or age groups, and to insure appropriate documentation and coordination with other stakeholders. CPS staff serves on these standing committees. CPS staff partner with MO HealthNet staff in the review of the managed care contracts related to system and service best practices.

Department of Elementary and Secondary Education

DMH embraces the importance of employment as critical to recovery of mental health consumers. DMH and DESE's Division of Vocational Rehabilitation (DVR) have a long history

of working collaboratively to assure individuals with psychiatric disorders have access to employment. Over the past fifteen years, DMH and DVR have collaborated on training, joint programming, and promoting of EBP. DMH and DVR received a Johnson & Johnson grant for Supported Employment. Six supported employment sites were chosen and technical assistance from Dartmouth University has been provided. A manager for the supported employment project was hired and ongoing technical assistance and fidelity monitoring has been conducted. Especially notable is the Benefits Planning training provided to community support workers in the community mental health centers.

Coordinating Board for Early Childhood which is charged with developing a comprehensive statewide long-range strategic plan for a cohesive early childhood system; identify legislative recommendations to improve services for children from birth through age five; promote coordination of existing services and programs across public and private entities; promote research-based approaches to services and ongoing program evaluation; and to identify service gaps and advise public and private entities on methods to close such gaps. Additionally, Division staff chair the workgroup on the Social and Emotional Development for the Early Childhood Comprehensive System Maternal/Child Health Grant.

CPS has been exploring the implementation of a school mental health model. The Show Me Bright Futures, although not a school program, encourages communities to interact with their community schools to support healthy social and emotional development. A dialogue has occurred with the Department of Elementary and Secondary Education (DESE) to learn more of their plans, goals and outcomes for students. DESE has worked for the past year to create the Missouri Integrated Model which merges components of three-tiered models in enhancing school responsiveness, academic performance as well as development of students. DESE has long supported the implementation of School Wide Positive Behavioral Supports (SWPBS) and is well on its way across the state in schools having Universal Tier 1 environments in place. CPS, in planning with DESE, has developed a model with leveraged Medicaid funding to help those schools/districts that have implemented Tier 1 to move on to implementation of Tier 2 and 3 for those youth who are at risk or already displaying social and emotional impairments. The model proposed allows for local development and governance with an effective partnership between the school or district, community mental health center and families. This allows for a model that serves all youth at their level of need, independent of their special education status. Several partnerships are forming around this initiative. CPS is participating in the interagency planning to create and sustain a training initiative to support the implementation of SWPBS including components on wraparound and functional assessments.

Department of Public Safety

The Department of Mental Health as the public mental health authority leads the mental health response to disasters within Missouri. The Department continues to plan for its own facilities and for a statewide response. In addition, DMH is working cooperatively with other state agencies to plan for disasters and public health emergencies as well as to develop and provide training. Collaboration occurs with DHSS, Department of Public Safety, Department of Agriculture, universities, school personnel, clergy, public health nurses, and mental health centers.

Juvenile Justice Services

The Division continues to lead a state level mental health/juvenile justice policy team to identify and address issues related to the mental health needs of youth at risk of or currently in the juvenile justice system. Individuals representing child welfare, juvenile justice and mental health have been trained on the Assessment Guidelines. A survey sent out six months later, showed that the majority of respondents felt they had gained knowledge about when to refer, what can be learned from mental health assessments, were better able to use the information provided by the assessment, and how to use the assessment to guide service provision. CPS continues to provide training to circuits upon request. One hundred and thirty-nine therapists in two communities were trained and certified on Trauma-Focused Cognitive Behavioral Therapy. Another community provided training to 181 staff on Dialectical Behavior Therapy, with a core adolescent team receiving targeted training to provide therapy. Forty-eight juvenile officers and therapists received training in motivational interviewing and Strengthening Families and a final community provided training to 22 school and mental health staff on Too Good for Drugs and/or Reconnecting Youth.

The Mental Health/Juvenile Justice Policy Group is now focusing on creating a continuum of services for youth with problem sexual behaviors. The first step was developing guiding principles, values and practices to insure a common vision. As this step is being completed, the group has begun the process of examining different best practices that can be developed and accessed by juvenile justice, child welfare, mental health, schools and families. MO HealthNet serves on this group to aid in leveraging Medicaid dollars in support of best practices. The MHJG applied for a grant through BJA to expand access to evidence based practices for youth with problem sexual behaviors. Although the success of this application is currently unknown, the MHJG continues to focus on improving access to evidence based practice.

Missouri Juvenile Justice Information System (MOJJIS) is the response to statute which directs circuit courts and the departments of social services, mental health, elementary and secondary education and health to share information regarding individual children who have come into contact with or been provided service by the courts and cited departments. The Department of Mental Health participates in this effort while maintaining compliance with HIPAA and Federal Drug and Alcohol Confidentiality Laws.

Substance Abuse Services

The CPR program has developed strategies to help youth with substance abuse/addiction. Youth identified as having a co-occurring disorder are referred to CSTAR programs in their community or service area. CSTAR programs use research based treatment modalities to address problems with substance abuse and addiction. CPR and CSTAR programs cooperate to develop a treatment plan to meet each individual's needs. CSTAR Adolescent Treatment Programs are specialized for youth needs. Early intervention, comprehensive treatment, academic education, and levels of care are important in averting chronic substance abuse and resulting problems that might otherwise follow a young person for a lifetime. The specially trained staff of adolescent CSTAR programs utilizes individual, group and family interventions.

Department of Health and Senior Services

Over the last few years, CPS has been building a collaborative relationship with the Department of Health and Senior Services around several different initiatives, many of which have already been mentioned in other sections and include Show Me Bright Futures which provides support for communities to apply the public health approach to children's mental health in teaching how to do surveillance to identify needs, institute policies/interventions to address these needs, and to provide monitoring and assurances that these policies/interventions have the intended impact. This model has been presented at national conferences both in the mental health and public health field. Another strong partnership is around the Early Childhood Comprehensive System which identifies social and emotional development as a major goal and is devising ways to enhance knowledge regarding social and emotional wellness as well as identifying young children in their natural environments (early learning centers, pediatricians, families) who may need targeted assistance. Current initiatives include development and inclusion of training modules on social and emotional development and identification of risk factors in the Child Care Orientation Training that is required for licensed early learning providers. CPS is providing dollars for DHSS to provide training to inclusion specialists on social and emotional development based on the Pyramid Model of the Center for Social and Emotional Foundations of Early Learning. Dialogues have now begun to develop a training series for mental health providers on early childhood development.

DMH has collaborated with DHSS of services to older adults. A Mental Health and Aging Workgroup was initiated by the Transformation Working Group (TWG) and continues to meet. Membership in the group includes each of the three divisions in the Department of Mental Health (Comprehensive Psychiatric Services, Alcohol and Drug Abuse, and Developmental Disabilities); the Department of Health and Senior Services (DHSS), which includes the State Unit on Aging; the Missouri Association of Area Agencies on Aging (MAA); the Missouri Centers for Independent Living (CILs); the MO HealthNet Division (the state Medicaid agency) in the Department of Social Services (DSS); the Department of Corrections (DOC), and others, including consumer representation.

In response to these debilitating effects of depression in older adults, the Mental Health and Aging Workgroup voted to encourage the development of Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors), an evidence-based intervention effective with both major and subclinical depression. To this end, the Workgroup, with assistance from Washington University, sponsored a statewide informational summit in September 2009. Nancy Wilson (Baylor School of Medicine) and Alixe McNeill (VP, National Council on Aging), both leading lights in the development and dissemination of Healthy IDEAS, explained the program. More than 36 agencies were in attendance. Six senior service agencies (including four area agencies on aging) serving more than 38 counties applied and were approved for training and startup funds to implement Healthy IDEAS in collaboration with local CMHCs whose staff will serve as clinical coaches.

A Sample MOU between the DMH and DOC is included below.

Amendment 002
Memorandum of Understanding
Between
The Missouri Department of Corrections
and
The Missouri Department of Mental Health
for
Comprehensive Psychiatric Services for Department of Corrections Offenders

The parties herein agree to extend the previously signed Memorandum of Understanding between the Missouri Department of Corrections (DOC) and the Missouri Department of Mental Health (DMH) for the period of July 1, 2010 through June 30, 2011.

All other terms, conditions, and requirements of the original agreement and amendment(s) thereto shall remain the same.

Therefore, in consideration of the mutual agreements outlined herein it is understood that effective upon the signature of both parties, and countersigned by an authorized official of the Missouri Department of Corrections, as stipulated herein, a binding agreement shall exist.

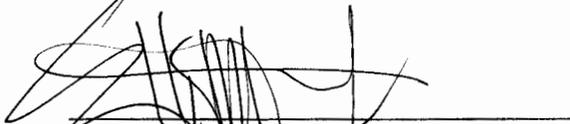
Signed and agreed to herein



Keith Schafer, Ed.D, Director
Missouri Department of Mental Health



Mark Stringer, Acting Director
Comprehensive Psychiatric Services
Missouri Department of Mental Health



Ellis McSwain, Jr, Chairman
Board of Probation and Parole
Missouri Department of Corrections

**MEMORANDUM OF UNDERSTANDING FOR COORDINATION OF ACTIVITIES RELATED
TO THE FY2009 FUNDS TRANSFER
BETWEEN
THE DEPARTMENT OF CORRECTIONS
AND
THE DEPARTMENT OF MENTAL HEALTH**

This memorandum of understanding establishes an agreement between the Department of Corrections (DOC) and the Department of Mental Health (DMH) to efficiently provide, through existing community service contracts, comprehensive psychiatric services for DOC offenders who are under the supervision of DOC.

1. PURPOSE AND SCOPE

DMH has been providing comprehensive psychiatric services to eligible offenders designated as moderate to serious mental health conditions. This agreement allows for the delivery of and any required modification of those services.

Nothing in this Memorandum of Understanding (MOU) is intended to give a protected interest to any offender. This MOU is intended to guide the actions of state agency staff.

2. RESPONSIBILITIES

The Department of Corrections will:

- A. Monitor pre-release transitional and community mental health services through billing reviews. Probation and Parole (P&P) contract managers will review invoices for accuracy and provide signatures certifying their review.
- B. Community based offender will be referred to DMH contractors utilizing a specified referral form.
- C. Refer pre-release transitional offenders to the Coalition of Missouri Community Mental Health Centers Office via e-mail six weeks prior to release.
- D. Include in their referral specific contract identification for all referrals to contracts.
- E. Allocate funding to DOC regions and notify DMH of allocations and changes as they occur.
- F. Maintain copies of invoices.
- G. Reimburse DMH up to \$1,272,400.00 for Fiscal Year 2009 from the DOC Inmate Revolving Fund for authorized services provided to DOC offenders.
- H. Participate in contract oversight meetings as established by contract managers and DMH.

The Department of Mental Health will:

- A. Provide comprehensive psychiatric services, through the CPS service delivery system, to eligible probationers and parolees in the community. Services will include evaluation, treatment planning, medication, medication management, case management, community support and other mental health services indicated in the offender's individual treatment plan and approved by DOC. Reimbursement rates will be based on the existing contract between DMH and the contractor.
- B. Provide comprehensive psychiatric services, through the CPS service delivery system to eligible pre-release transitional offenders. Services will include pre-release engagement and planning, evaluation, treatment planning, medication, medication management, case management, community support, wrap-around services and other mental health services indicated in the offender's individual treatment plan and approved by DOC. Reimbursement rates will be based on the existing contract between DMH and the contractor.

- C. Provide invoice data to DOC to properly identify offenders receiving services. The copies must be submitted to Probation & Parole, 1511 Christy, Jefferson City, MO 65101.
- D. Maintain original invoices.
- E. DMH must provide copies of these contracts to DOC, including contract identification numbers that will be used by DOC in referrals.

Joint Responsibilities Include:

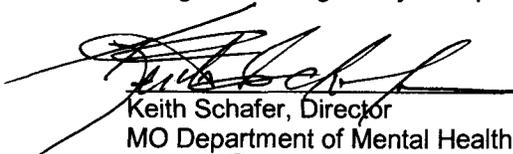
- A. DOC and DMH will work together to provide input for contract amendments to the pertinent contracts and reach consensus on the amendment prior to issuance.
- B. Provide monitoring and technical assistance activities of community providers/contractors.
- C. Sharing of client/offender data for research outcomes measurements analysis and reporting.
- D. Participation in oversight committee, which will include the designated management staff of contractor, P&P Contract Manager, and DMH staff members.
- E. Contract implementation meetings with agency staff and vendors to discuss implementation, implementation plan timelines, and to resolve any initial differences in contract interpretation.
- F. DOC and DMH will coordinate any adjustments to allocations.

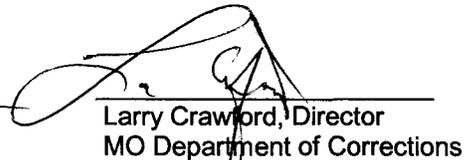
3. CONFIDENTIALITY AGREEMENT

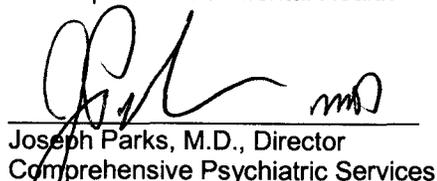
- A. The privacy and confidentiality offender records will be maintained in accordance with the requirements of all applicable state and federal laws.
- B. Both parties agree to work together to develop a plan to assure compliance with 42 CFR subpart 2, HIPAA and applicable State and Federal law.

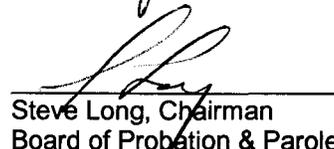
4. TERMS OF UNDERSTANDING

The terms of this MOU is the period beginning the date of final signature and ending June 30, 2009. The MOU may be renewed for up to five (5) additional one-year periods or any portion thereof as mutually agreed to in writing by both parties. The MOU may be revised at any time upon mutual agreement with written notice provided to each party prior to the effective date of the revision. At a minimum, the MOU should be reviewed and revised annually between the dates of June 1st and July 30th. The MOU may be amended, terminated, and/or extended by written agreement signed by both parties.


 Keith Schafer, Director
 MO Department of Mental Health


 Larry Crawford, Director
 MO Department of Corrections


 Joseph Parks, M.D., Director
 Comprehensive Psychiatric Services


 Steve Long, Chairman
 Board of Probation & Parole

IV: Narrative Plan

O. State Behavioral Health Advisory Council

Page 49 of the Application Guidance

Narrative Question:

Each State is required to establish and maintain a State advisory council for services for individuals with a mental disorder. SAMHSA strongly encourages States to expand and use the same council to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders as well. In addition to the duties specified under the MHBG, a primary duty of this newly formed behavioral health advisory council would be to advise, consult with and make recommendations to SMHAs and SSAs regarding their activities. The council must participate in the development of the Mental Health Block Grant State plan and is encouraged to participate in monitoring, reviewing and evaluating the adequacy of services for individuals with substance abuse disorders as well as individuals with mental disorders within the State.

Please complete the following forms regarding the membership of your State's advisory council. The first form is a list of the Advisory Council for your State. The second form is a description of each member of the behavioral health advisory council.

Footnotes:

State Behavioral Health Advisory Council



The role of the Missouri Behavioral Health Advisory Council is to improve mental health services within the State. The mission of the planning council known as the Division of Comprehensive Psychiatric Services State Advisory Council (CPS/SAC) is to advise the division in the development and coordination of a statewide inter-agency and inter-departmental system of care for children and youth with serious emotional disorders and adults with mental illness and their families. Council members are primary consumers, family members, providers and State agency representatives. The CPS/SAC serves as the block grant planning council for Missouri and was first established in 1977 by a Governor's Executive Order. Missouri Revised Statutes, Chapter 632 Comprehensive Psychiatric Services, Section 632.020 currently stipulates the requirements for the advisory council.

By Federal law, State Planning Councils have the following duties:

1. Review State plans and submit any recommended modifications to the State.
2. Serve as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems.
3. Monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

The Divisions of CPS and ADA are currently in the process of merging. The Division of ADA has its own State Advisory Council. The role of the ADA SAC as prescribed in Missouri State Statute 631.020 is:

“The council shall collaborate with the department in developing and administering a state plan on alcohol or drug abuse. The council shall be advisory and shall do the following:

- (1) Promote meetings and programs for the discussion of reducing the debilitating effects of alcohol or drug abuse and disseminate information in cooperation with any other department, agency or entity on the prevention, evaluation, care, treatment and rehabilitation for persons affected by alcohol or drug abuse;
- (2) Study and review current prevention, evaluation, care, treatment and rehabilitation technologies and recommend appropriate preparation, training, retraining and distribution of manpower and its resources in the provision of services to persons affected by alcohol or drug abuse through private and public residential facilities, day programs and other specialized services;
- (3) Recommend what specific methods, means and procedures should be adopted to improve and upgrade the alcohol and drug abuse service delivery system for citizens of this state;
- (4) Participate in developing and disseminating criteria and standards to qualify alcohol and drug abuse residential facilities, day programs and other specialized services in this state for funding by the department.”

The CPS and ADA SAC's conducted joint subcommittee meetings this past year to develop recommendations for the Division Director regarding integration of the SAC's. To integrate the two councils will take legislative changes to state statutes making integration a longer term

process. Additionally, changes to SAC structure must consider federal requirements for Behavioral Health Advisory Councils. The Division Director decided the first step is to merge the division's internal staff structure then tackle the necessary legislative changes to merge the SACs.

The CPS SAC is meeting its obligations as required by federal law.

Reviewing Plans and Submitting Recommendations

The State of Missouri is committed to ensuring the voice and perspective of mental health consumers and family members inform the provision of mental health services throughout the state. The CPS/SAC has played an active role in developing and fulfilling this commitment by convening on a monthly basis to review plans and discuss mental health services. The division director or his designee routinely reported on the department budget to maintain an informed council and solicit input from council members on spending the limited dollars available. The letter from the CPS/SAC Chair outlines the review of the Mental Health Block Grant State Plan with no recommendations for modifications.

To ensure excellent mental health care is delivered and research is accelerated, CPS/SAC has had discussions on evidenced based practices including Integrated Dual Disorders Treatment, Assertive Community Treatment, Dialectical Behavior Therapy, Supported Employment and Consumer Operated Services Programs for adults and Comprehensive System of Care for children.

The CPS/SAC has recently taken responsibility for oversight of the Suicide Prevention Plan due to legislation that was passed this past year eliminating the Suicide Prevention Advisory Council. A subcommittee has been formed and the members are familiarizing themselves with the past activities and current requirements.

Advocacy

The CPS/SAC serves as an advocate for adults with serious mental illness, children with severe emotional disturbance, and other individuals with mental illness or emotional problems. CPS/SAC advocacy activities include promoting the Consumer/Family/Youth Conference, Peer Specialist training and certification, planning and implementing Hands Across Missouri, and Mental Health Transformation activities to name a few.

Several members of the CPS/SAC were involved in planning the first statewide consumer/family/youth conference with the Office of Consumer Affairs that occurred in November 2008. The fourth annual Consumer/Family/Youth Conference occurred on August 21-23, 2011, with 460 individuals participating. CPS SAC members played a major role in planning and implementing the conference. CPS/SAC members will continue their involvement in this annual event to train consumer/family/youth leaders.





CPS/SAC members researched and chose a Peer Specialist training and certification model. Based on the CPS/SAC recommendations CPS has adopted the Appalachian Consulting Group “Georgia Model” for Peer Specialist training. The Division is moving the mental health system to a wellness model that empowers service participants to establish their personal mental health goals and manage both their mental health and plan of care through education and supports. One primary strategy in transforming the system is to recognize the power of consumer as providers. Recognizing consumers as providers is taking root in the mental health system. Emerging evidence strongly supports the need for peer support services as a cost-effective and complementary adjunct to professional mental health services and supports. Peer support services can move the system to focus less on illness and disability and more on wellness. To accomplish this goal, Missouri has provided equal weight to expertise gained through the “lived experience” as is done with any other credential or knowledge base. A Peer Specialist can share lived experiences of recovery, share and support the use of recovery tools and model successful recovery behaviors. Through this process, consumers can learn to identify their strengths and personal resources, learn to make independent choices, and take a proactive role in their treatment. Additionally, Peer Specialists can help consumers connect with other consumers and with their community at large.

With the oversight of the CPS/SAC, Peer Specialist Basic Trainings have been conducted since 2008. The week-long training has been conducted by Mental Health America of the Heartland staff and trained CPS/SAC members. To date 213 individuals have been trained and 130 have reached the goal of Certified Missouri Peer Specialist status. Twenty community mental health centers have sent individuals to the training and 12 have certified peer specialists working in their agencies. Ten Consumer Operated Services Program Drop-In Centers and Warm Lines sent individuals to the training. Additionally, the Veteran’s Administration, residential providers, Services for Independent Living, and substance abuse treatment agencies have sent individuals to the training. Three of the state operated inpatient facilities have active Certified Missouri Peer Specialists on staff.

With regular conference calls a more cohesive network is being formed of the trained individuals to provide ongoing support and consultation. The plan for October 2011 through June 2013 is to continue to provide the Peer Specialist Basic Training, Supervisors Training and continuing education training.

Wellness Coaching Training was provided to 20 selected CMPS by Peggy Swarbrick, PhD, OTR, CPRP, Assistant Professor, Department of Psychiatric Rehabilitation and Counseling Professions, UMDNJ-School of Health Related Professions, & Director, The Institute for Wellness and Recovery Initiatives, Collaborative Support Programs of New Jersey; Amy Spagnolo, PhD, CPRP, Associate Professor and Director of Graduate Programs; and Ann Murphy, MA, CPRP, Assistant Professor, Department of Psychiatric Rehabilitation and Counseling Professions, UMDNJ-School of Health Related Professions. The training was highly successful and the department is exploring expanding the training to all peer specialists and community support workers.



CPS/SAC and the Missouri Mental Health Foundation requested proposals for locally hosted, consumer-led celebrations of Hands Across Missouri Mental Health Day. The five public events were picnics, walks, etc. held across the state. Each community event was expected to include a brief ceremony consisting of a moment of silence and a joining of hands at 11 a.m. (CDT) to honor individuals with mental health problems across the state. The activities were open to the community and held in parks or other public spaces and included information booths as well as the formal ceremony. The purpose this symbolic gesture was to show unity among Missourians, to combat prejudice and discrimination.

The DMH provides services to about 170,000 Missourians each year, many of whom are making major progress in overcoming the challenges of mental illnesses, substance abuse, and developmental disabilities. Unfortunately, few of their personal stories are known. To address this, the department recognized the accomplishments of three of these individuals with the fourth annual Mental Health Champions recognition. Three persons were selected from statewide nominations as Mental Health Champions. A member of CPS/SAC was nominated for the Champions award. The nominees were representative of individuals with mental illnesses, developmental disabilities, and persons in recovery from substance or gambling addictions. They were persons who have overcome their personal challenges to make life better for others and for their communities. The fourth Mental Health Champions Banquet was held April 6, 2011, at the Capitol Plaza Hotel in Jefferson City. Videos of the Mental Health Champion awardees can be viewed at <http://www.dmh.mo.gov/news/MHChampions.htm>



"They are persons who inspire others. For years I have seen firsthand many inspiring stories of people doing exceptional things while overcoming their illnesses, developmental disabilities or substance abuse problems. This recognition is long overdue. One major way to break down the stigma that affects the people we serve is to bring their strengths and contributions to the forefront." - *Mental Health Director, Keith Schafer.*

Monitoring, Reviewing and Evaluating

The CPS/SAC monitors, reviews and evaluates State services through several means.

1. CPS/SAC members review the Block Grant and on a continuous basis review the data gathered by the DMH. The July and August 2011 meetings focused on discussion and review of the Block Grant proposal.
2. CPS/SAC meetings often include presentations on the budget, current programming, grants, and initiatives for the purpose of allowing input and feedback on the adequacy of mental health services within the State.
3. CPS/SAC meetings include monthly conversations with the Department and Division Directors or designees allowing feedback and ideas to be presented directly to decision makers.
4. CPS/SAC members have been full team members for certification surveys of the community mental health centers for the past three years. These reviews evaluate the quality of care from a consumer/family perspective. Twenty-four organizations have been reviewed with the Consumer/Family Monitors as team members since 2008.

The CPS/SAC members are individually and collectively committed to improving the outcomes of individuals served in the mental health system. It is characteristic of membership to be involved locally in their communities as well as on the State level.



BYLAWS OF THE STATE ADVISORY COUNCIL FOR COMPREHENSIVE PSYCHIATRIC SERVICES

Article I – Mission

The State Advisory Council (SAC) shall be responsible for advising the Division of CPS in the development and coordination of a statewide inter-agency/inter-departmental system of care for persons with mental illness, their families and children/youth with serious emotional disturbances.

Article II – Responsibilities

In order to accomplish this mission the SAC shall:

Advise CPS in the development of models of services and long range planning and budgeting priorities.

Identify statewide needs, gaps in services, and movement toward filling gaps.

Provide education and information about mental health issues.

Monitor, evaluate, and review the allocation and adequacy of mental health services within the state.

Article III – Organization

- A. The Director of the Division of Comprehensive Psychiatric Services shall appoint up to 25 members to the State Advisory Council for Comprehensive Psychiatric Services.
- B. The terms of office for members shall be overlapping terms of a full three (3) years. A member of the State Advisory Council for Comprehensive Psychiatric Services may serve an additional three-year term if properly nominated and approved by the State Advisory Council and the Division Director. Exceptions to terms of office can be made at the discretion of the State Advisory Council with approval by the Division Director.
- C. Members shall have a professional, research, or personal interest in the prevention, recovery, evaluation, treatment, rehabilitation, and system of care for children/youth with serious emotional disturbance and persons affected by mental disorders and mental illness and their families. The Council shall include representatives from the following:

1. Non-government organizations or groups and state agencies concerned with the planning, operation or use of comprehensive psychiatric services.
 2. Representatives of primary and secondary consumers and providers of comprehensive psychiatric services, who are familiar with the need for such services.
- D. The membership composition of the State Advisory Council shall follow the guidelines set forth in P.L. 102-321 as follows:
1. At least 13 of the members of SAC shall be self-identified consumers defined as follows:
 - a. Primary Consumer: A person who is an active or former recipient of mental health, substance abuse and/or developmental disabilities services, regardless of source of payment. Parents, family members, and/or legal custodians/guardians of children and youth are primary consumers if they are actively engaged in the treatment planning and/or delivering services and supports for the child or youth.
 - b. With respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council.
 - c. With respect to the membership of the Council, the ratio of individuals with Serious Mental Illness to other members of the Council is sufficient to provide adequate representation of such individuals in the deliberations of the council.
 2. At least 12 of the members of SAC shall be providers defined as follows:
 - a. System Customer: An entity/service delivery system, which uses, purchases and/or coordinates with mental health, substance abuse and developmental disabilities services provided by the Department of Mental Health. Representatives of the following state agencies are mandated: mental health, education, vocational rehabilitation, criminal justice, housing, social services, and Medicaid. The remainder could be representatives of mil tax boards, community agencies, faith sector, family members, and advocates.
- E. The Council shall be representative of the state's population, taking into consideration their employment, age, sex, race, and place of residence and other demographic characteristics of the state, determined essential by the Council and Director.

Article IV – Membership Nominations

- A. Nominations for vacant council positions shall be accepted from any individual or organization.
- B. Vacancies, when they occur, shall be announced and publicized.

Article V – Officers

- A. The Council shall elect the chairperson and vice-chairperson every two years. The chairperson shall mentor the chair elect for 6 months or the first three meetings of the State Advisory Council. Nominations shall occur in November and elections in January, except in cases of extraordinary circumstances.
- B. The chairperson shall preside at all meetings of the Council and appoint all committees and task forces. The vice-chairperson shall preside at meetings in the chairperson's absence, and act for the chairperson when he/she cannot attend.

Article VI – Committees

A. Project Committees:

- 1. Project Committees shall be formed as they are needed. These Committees shall address block grant planning and special issues identified by the State Advisory Council or the Division as topics relevant to the Mental Health Service Delivery System.
- 2. Project Committee members will report to the full council at each council meeting.
- 3. A Committee will disband when work is done on its particular issue.

B. Executive Committee:

- 1. The membership of the Executive Committee shall consist of the chairperson of the Council, the vice-chairperson of the Council, immediate past chairperson, and chairpersons of any project committees.
- 2. The Executive Committee shall meet at the call of the chairperson, upon request of three or more of the committee members, or a call of the Division Director. A quorum shall consist of a majority of Executive Committee members.

C. The Committee chairpersons shall preside at all committee meetings and shall be appointed by the Council chairperson or, in his/her absence, the vice-chairperson.

D. The Chairperson shall be an ex-officio member of all committees and task forces.

Article VII – Meetings

- A. The Council shall meet at least every ninety days at the call of the Division Director or the Council chairperson.
- B. A quorum requires the attendance of at least 50% of the members of the Council.
- C. When necessary, a telephone poll may be conducted to complete the quorum necessary for action and to conduct other Council matters in a timely manner, and such action shall be included in the minutes of the next regularly scheduled meeting.
- D. All Council sessions are public meetings as defined by the Sunshine Law, “Any meeting, formal or informal, regular or special, of any governmental body at which any public business is discussed, decided, or public policy formulated.”

Article VIII – Meeting Attendance

Absence from three (3) consecutive meetings in any calendar year without prior notification shall be considered as a resignation from the Council.

Article IX - Miscellaneous

- A. Compensation: Each member shall be reimbursed for reasonable and necessary expenses including travel expenses pursuant to the travel regulations for employees of the Department, actually incurred in the performance of his/her official duties.
- B. Amendments: Any Council member may present amendments for consideration at any meeting. Such amendment will be voted on at the next regular meeting and requires a 2/3 majority to amend the bylaws. In circumstances where amendments to the bylaws are time sensitive, a vote may be taken by telephonic or electronic means.
- C. The Division Director shall:
 - 1. Serve as the primary Departmental consultant to the State Advisory Council.
 - 2. Provide the Council and committees with Division staff for technical assistance and secretarial support.

Approved 9/24/09

IV: Narrative Plan

Table 11 List of Advisory Council Members

Pages 51 and 52 of the Application Guidance

Start Year:

End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Barbara Anderson	Individuals in Recovery (from Mental Illness and Addictions)		5577 Connecticut St. Louis, MO 63139 PH: 314-781-5492	BKanderson2@att.net
Mary Louise Bussabarger	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		1914 Princeton Drive Columbia, MO 65203 PH: 573-445-4147	
Bruce Charles	Individuals in Recovery (from Mental Illness and Addictions)		2715 Chestnut Hannibal, MO 63401 PH: 573-541-2715	Bruce.Charles28@yahoo.com
Stewart Chase	Providers		ReDiscover, 901 NE Independence Avenue Lee's Summit, MO 64086 PH: 816-246-8000 FAX: 816-246-8207	sachase@rediscovermh.org
Lisa Clements	State Employees	Department of Social Services/Medicaid	Department of Social Services/Medicaid, P.O. Box 6500 Jefferson City, MO 65102 PH: 573-522-8336	Lisa.M.Clements@dss.mo.gov
Heather Cushing	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		114 Distinction Lake St. Louis, MO 63367 PH: 314-608-1206	hjcushing@gmail.com

Sarah Earll	Individuals in Recovery (from Mental Illness and Addictions)		St. Louis Empowerment Center/Heartland Consumer Network, 1908 Olive St. Louis, MO 63103 PH: 314-652-6100 FAX: 314-652-6103	ssearll@sbcglobal.net
Betty Farley	Providers		Missouri Protection and Advocacy Services, 925 South Country Club Drive Jefferson City, MO 65109 PH: 573-659-0678 FAX: 573-893-4231	Betty.Farley@mo-pa.org
Scott Giovanetti	State Employees		Department of Mental Health, 5400 Arsenal Street St. Louis, MO 63139 PH: 314-877-0372 FAX: 314-877-0392	scott.giovanetti@dmh.mo.gov
Andrew Greening	Providers		Preferred Family Healthcare, 4355 Paris Gravel Road Hannibal, MO 63401 PH: 573-248-3811 FAX: 573-248-3080	agreening@pfh.org
Liz Hagar-Mace	State Employees	State Housing Authority	State Housing Agency, 1706 East Elm Street Jefferson City, MO 65102 PH: 573-522-6519 FAX: 573-526-7797	liz.hagar-mace@dmh.mo.gov
John Harper	State Employees	Dept. of Elementary & Sec. Educ./Div. of Voc. Rehab.	3024 Dupont Circle Jefferson City, MO 65101 PH: 573-526-7049 FAX: 573-751-1441	john.harper@vr.dese.mo.gov
Robert Hawkins	Individuals in Recovery (from Mental Illness and Addictions)		43 Catamaran Drive Lake St. Louis, MO 63367 PH: 636-575-1913	bobhawkins08@yahoo.com
Jessica Johnson	Individuals in Recovery (from Mental Illness and Addictions)		4000 Hyde Park Avenue, Apt. 29 Columbia, MO 65201 PH: 417-343-1634	jessicajohnson22@gmail.com
Toni Jordan	Individuals in Recovery (from Mental Illness and Addictions)		3640 Garfield Avenue St. Louis, MO 63113	Jordan.toni@ymail.com

Addictions)

PH: 314-531-0511

Gregory
Markway

State Employees

State Criminal Justice
Agency

2729 Plaza Drive
Jefferson City, MO 65102
PH: 573-526-6523 FAX: 573-526-
8156

greg.markway@doc.mo.gov

Glenda
Meachum-Cain

State Employees

Missouri Dept. of Health and
Senior Services, 912 Wildwood
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Glenda.Meachum-
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Mickie
McDowell

Individuals in Recovery (from
Mental Illness and
Addictions)

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mickie.mcdowell@gmail.com

Rene Murph

Family Members of
Individuals in Recovery (from
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Jennifer
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Jerome Riley

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1234 W. Cape Rock Dr. Apt. 31
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jriley@cccntr.com

John Robbins

State Employees

State Education Authority

205 Jefferson
Jefferson City, MO 65102
PH: 573-522-1488 FAX: 573-526-
4261

john.robbins@dese.mo.gov

Tish Thomas

Leading State Experts

University of Missouri, 1706
East Elm
Jefferson City, MO 65102
PH: 573-751-8076 FAX: 573-751-
7815

tish.thomas@dmh.mo.gov

Footnotes:

The Mental Health Planning Council is exploring who to add from the State Exchange Agency to comply with this recommendation. The Department of Social Services is also the State Child Serving Agency.

IV: Narrative Plan

Table 12 Behavioral Health Advisory Council Composition by Type of Member

Pages 52 and 52 of the Application Guidance

Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	25	
Individuals in Recovery (from Mental Illness and Addictions)	10	
Family Members of Individuals in Recovery (from Mental Illness and Addictions)	3	
Vacancies (Individuals and Family Members)	<input type="text" value="0"/>	
Others (Not State employees or providers)	0	
Total Individuals in Recovery, Family Members & Others	13	52%
State Employees	7	
Providers	3	
Leading State Experts	1	
Federally Recognized Tribe Representatives	0	
Vacancies	<input type="text" value="1"/>	
Total State Employees & Providers	12	48%

Footnotes:

IV: Narrative Plan

P. Comment On The State Plan

Page 50 of the Application Guidance

Narrative Question:

SAMHSA statute requires that, as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State plan. States should make the plan public in such a manner as to facilitate comment from any person (including Federal or other public agencies) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary. In the section below, States should describe their efforts and procedures to obtain public comment on the plan in this section.

Footnotes:

Public Comments on the State Plan

In accordance with Section 1941 of the Block Grant legislation, the State of Missouri has provided ample opportunity on an ongoing basis for public comments on the State Plan. The fiscal year 2005, 2006, 2007, 2008, 2009, 2010 and 2011 State Plans are posted on the DMH website at <http://www.dmh.mo.gov/cps/rpts/blockgrant/blockgrant.htm> with instructions to send comments to the department. The 2006, 2007, 2008, 2009 and 2010 Implementation Reports are also posted on the DMH website for comment.

The Mental Health Planning Council for Missouri has instituted a regular review of the Block Grant at their monthly open meetings. Meeting agendas are posted to the DMH website at least 24 hours before the open public meetings. Block Grant Discussion is clearly labeled on the agendas, thus giving the general public opportunity to attend the meeting and make comment. The Planning Council regularly engaged in discussion about evidence-based practices, mental health transformation, budget and data analysis throughout the fiscal year 2011 relevant to the Block Grant state plan. The Planning Council has direct access to the Department and Division Directors, at meetings and by phone/email, to offer opinions and comments on the adequacy of mental health services within the State.

The Planning Council was emailed copies of the draft State Plan for comment. The July and August 2011 meetings provided specific time for discussion of the draft State Plan. All comments have been considered and incorporated where applicable.

**State Advisory Council
For
Comprehensive Psychiatric Services**



Missouri Department of Mental Health
1706 E. Elm St., P.O. Box 687
Jefferson City, MO 65102
Telephone: 573-751-8017
Fax: 573-751-7815
www.dmh.mo.gov

August 25, 2011

Christine Chen, Director
Substance Abuse and Mental Health Services Administration
Division of Grants Management
1 Choke Cherry Road, Room 7-1091
Rockville, MD 20857

Dear Ms. Chen:

The State Advisory Council for the Missouri Department of Mental Health, Division of Comprehensive Psychiatric Services, has reviewed the State Plan for the FY 2012 Community Mental Health Services Block Grant Application. The State Advisory Council is committed to working with the department to create a recovery oriented system of care. We approve of the state plan written under our guidance.

The State Advisory Council has been very involved in transforming the mental health system in Missouri to be more consumer and family driven. Council members have promoted and achieved the inclusion of consumers and family members in surveying the quality of care during certification visits of the community mental health centers in order to offer a consumer/family perspective. We are involved in the Peer Specialist training and certification process being implemented statewide. We support the continued services of consumer operated Drop-In Centers and Warm Lines. We are involved in planning and implementing the Consumer/Family/Youth Annual Conference, Real Voices Real Choices, which provides leadership training for consumers of all three divisions. We are excited by changes in the system that we have endorsed.

We will continue to work with Comprehensive Psychiatric Services staff in monitoring the implementation of the State Plan. We appreciate our involvement in the Block Grant development and would like to express appreciation to SAMHSA and the Center for Mental Health Services for making these funds available.

Sincerely,

Mickie McDowell, Chair
CPS State Advisory Council

The Department of Mental Health does not deny employment or services because of race, sex, creed, marital status, national origin, disability or age of applicants or employees.