

## **A. STATEMENT OF NEED**

In 2014, Congress passed the Excellence in Mental Health Act, allocating \$900 million to the creation of Certified Community Behavioral Health Clinics (CCBHCs). This Act arguably represents the most significant step forward in promoting the behavioral health of the American public since the Community Mental Health Act created the original Community Mental Health Centers (CMHCs) over 50 years earlier. The progression from CMHCs to CCBHCs ushers in a new era in community-based care for persons with mental health and/or substance use disorders. This application from the State of Connecticut seeks funds for a comprehensive planning year to partner with key stakeholders in ensuring that a sufficient number of organizations across the state are prepared to become certified to serve as exemplary prototypes for the Community Behavioral Health Clinics that represent the future of community behavioral health in the U.S.

An early leader in efforts to transform its system of care to a resilience and recovery-orientation that attends to both trauma and health disparities, Connecticut is well positioned to deliver excellent family and person-centered behavioral health care across the life span through a network of well-governed CCBHCs. Much of this preparatory work was based on a combination of the involvement of the recovery and family advocacy communities and the impetus and resources provided by earlier SAMHSA grants, including state incentive grants for system transformation and co-occurring disorders, Access to Recovery funding, and numerous grants targeting more specific areas such as culturally responsive care, consumer and family networks, systems of care, supported housing and employment, screening, brief intervention, and referral to treatment, trauma treatment, and jail diversion. Much work remains to be done, however, in consolidating and expanding on these gains and in expanding Medicaid's reach to cover more evidence-based practices and to include individuals and families who have recently enrolled, or are eligible to enroll, through the provisions of the Affordable Care Act. The following proposal describes the state's current service system and identifies the steps the state will need to take to implement the administrative, programmatic, and workforce development infrastructures needed to transform existing organizations into Certified Community Behavioral Health Clinics.

### **A1. How behavioral health services are organized, funded, and provided in Connecticut**

Public behavioral health services are funded, organized, and provided in Connecticut in part through the Connecticut Behavioral Health Partnership (CTBHP), a collaboration of state agencies that is comprised of the Department of Social Services (DSS), the Department of Mental Health and Addiction Services (DMHAS), and the Department of Children and Families (DCF). DSS is the Medicaid agency for the state, and is the lead applicant for this proposal.

The CTBHP was created to improve quality of and access to a wide range of Medicaid-funded and other state-funded behavioral health services offered by both state-run and private, non-profit providers. ValueOptions serves as the State's behavioral health Administrative Services Organization (ASO), and performs administrative functions including utilization management, clinical oversight, and quality assurance. The Behavioral Health Partnership Oversight Council (BHPOC), an entity created via legislation in 2006, is mandated to assess the development and ongoing implementation of the BHP program and make recommendations to the State agencies and the General Assembly. The BHPOC remains invested in monitoring the progress of the state's on-going system transformation efforts and ensuring on-going improvement throughout the system. Day-to-day leadership and oversight of the CTBHP are provided by the three state partners described below, who welcome the opportunity to expand their close collaboration.

The **Department of Social Services (DSS)** is the single state agency for the administration of Medicaid and the Children’s Health Insurance Program and is responsible for the provision of a wide variety of services to children, families, adults, people with disabilities, and the elderly. These services include health care coverage, child care, child support, long-term care and supports, energy assistance, food and nutrition aid, and program grants. One-third of the Connecticut state budget is allocated to DSS activities. The agency currently serves more than 950,000 individuals in 600,000 households. DSS involvement in the BHP is determined by its Mission, which is: “Guided by shared belief in human potential, we aim to increase the security and well-being of Connecticut individuals, families, and communities.”

DSS utilizes a managed fee-for-service model to pay for Medicaid-covered services. Four Administrative Services Organizations (ASOs) assist the department to manage medical, behavioral health, dental, and non-emergency medical transportation services to individuals eligible for Medicaid-covered services. DSS uses a single vendor to pay all claims associated with Medicaid services. DSS has twelve field offices throughout the state to assist individuals in obtaining Medicaid benefits. DSS staff is out stationed at hospitals and community service providers to expedite Medicaid/HUSKY applications. Additionally, community-based agencies and partner contractors provide many DSS-funded services.

The **Department of Mental Health and Addiction Services (DMHAS)** serves as both the state’s State Mental Health Authority (SMHA) and Single State Agency for addiction services (SSA). It is an independent state agency, having statutory responsibility to promote and administer an integrated system of comprehensive behavioral health preventive, treatment, and rehabilitative services. The DMHAS mission is “to improve the quality of life of the people of Connecticut by providing an integrated network of comprehensive, effective, and efficient mental health and addiction services that foster self-sufficiency, dignity, and respect.” Its primary purpose is to assist persons with mental health and/or substance use disorders to recover and sustain their health through delivery of high quality services that are person-centered, promote hope, attend to trauma, improve overall health, and are anchored to a recovery-oriented system of care that is culturally competent and rooted in evidence-based practices.

To this end, DMHAS operates, funds, and coordinates inpatient and community-based behavioral health services for adults (18 and older) with serious substance use and/or mental health conditions. It also provides programs for individuals with special needs (e.g., AIDS/HIV, gambling) and defined target populations (e.g., young adults, including those transitioning out of the DCF system, those involved with the criminal justice system) including persons with serious mental illness residing in nursing homes, military personnel and their families, and persons who are homeless. DMHAS is responsible for the state’s behavioral health general funds and SAMHSA block grant allocations, and manages the clinical aspects of Medicaid-funded care for adults. DMHAS directly operates three hospitals and contracts with community hospitals and one private psychiatric hospital for inpatient and ambulatory care. State-operated hospitals provide psychiatric care and medically managed detoxification and residential rehabilitation services. DMHAS administers the mental health service system through a network of 13 Local Mental Health Authorities (LMHAs; six state-operated and seven non-profit), along with over 90 non-profit organizations. LMHAs are the sub-state administrative and direct care component for the delivery and coordination of mental health services across the state. They develop, maintain, and manage a comprehensive system of mental health care for designated local service areas and will be one of the primary—but not only—candidates to become CCBHCs (Figure 1).

The **Connecticut Department of Children and Families (DCF)** is one of the nation's few consolidated agencies serving children under the age of eighteen and their families. DCF serves as an umbrella organization for child welfare/protective services, juvenile justice, mental health, substance abuse, early childhood services and prevention. The DCF mission of: “Working together with families and communities for children who are healthy, safe, smart and strong” illustrates the Department’s commitment to addressing the needs of the whole child in an integrated fashion that is inclusive of those persons most important in their lives. DCF is responsible for designing, overseeing, and ensuring access to the mental health system for all youth under the age of eighteen. The broader reach of this mandate requires DCF to provide access to services and programs not only to youth within the child welfare and juvenile justice systems, but also to those not otherwise involved with the Department. Thus, in addition to providing an array of grant funded services that are accessible to all, DCF maintains a Voluntary Services Program that allows parents/guardians to access behavioral health and support services without relinquishing custody of their child to do so (Figure 1).

Connecticut’s behavioral health service system for children and adolescents is based on the core values and principles of the federally endorsed System of Care model, that requires services to be: 1) child-centered, family-focused with the needs of the child and family dictating the types and mix of services provided; 2) community-based, with the focus of services as well as the management and decision-making resting at the community level; and 3) culturally and linguistically competent, with agencies, programs and services that are responsive to the cultural, racial and ethnic differences of the populations they serve.

### **A.2. Population of focus to be served by Certified Community Behavioral Health Clinics**

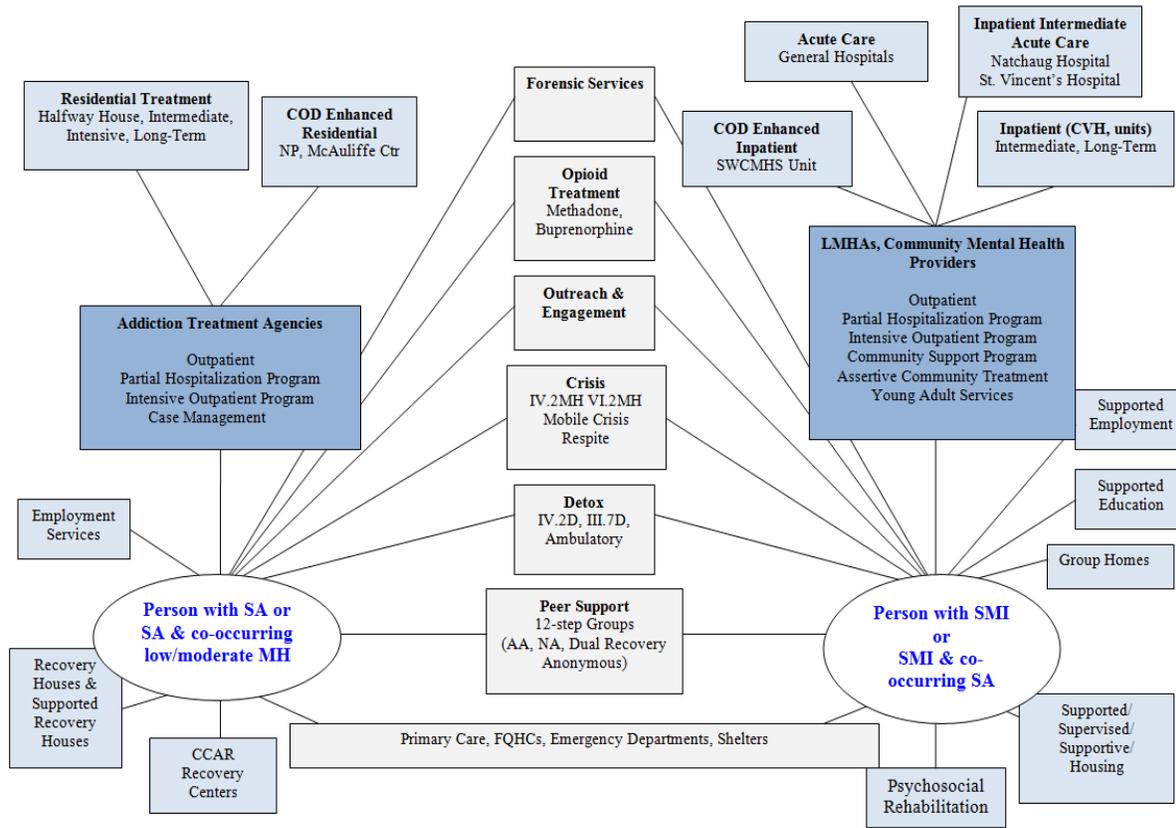
Statewide population data demonstrate a dramatic need for behavioral health services in Connecticut. The rates of mental health and substance use disorders in children, youth, and adults are substantial and similar to the national average (Table 1). Approximately 156,000 of the

Table 1. Percentage of children, adolescents, and adults with mental health and substance use problems in Connecticut	
<b>Children and Adolescents</b>	
Serious Emotional Disturbance (3-17 years)	7.1%
Issue with alcohol or drug use	6.9%
Major depressive episode in past year (12-17 years)	9.4%
Illicit drug use past month (12-17 years)	9.9%
Cigarette use past month (12-17 years)	6.8%
Binge drinking past month (12-20 years)	20.3%
Initiated alcohol years past year (12-17 years)	15%
Initiated marijuana use past year (12-17 years)	8%
<b>Adults</b>	
Serious Mental Illness past year	3.5%
Serious Thoughts of Suicide past year	3.7%
Alcohol dependence or abuse past year	7%
Heavy alcohol use previous month	6.5%
Illicit drug dependence or abuse past year	2.8%
Source: SAMHSA behavioral health barometer, 2014 (1)	

state’s youth have behavioral health symptoms that may benefit from care. 22,000 youth experienced a major depressive episode in the past year, while 88,000 youths and young adults aged 12-20 reported binge drinking, and 29,000 adolescents reported using illicit drugs in the past month. A substantial proportion of the adult population has a mental health condition. 82,000 adults have been diagnosed with a serious mental illness, 93,000 adults had serious thoughts of

suicide, and 243,000 persons 12 or older were dependent on or abused alcohol in the past year. Among persons of color who are Medicaid recipients, 14.7% of adults diagnosed with severe and persistent mental illness are African American and 25.6% are Hispanic.

DMHAS Healthcare System Schematic



CT Children's Behavioral Health System of Care

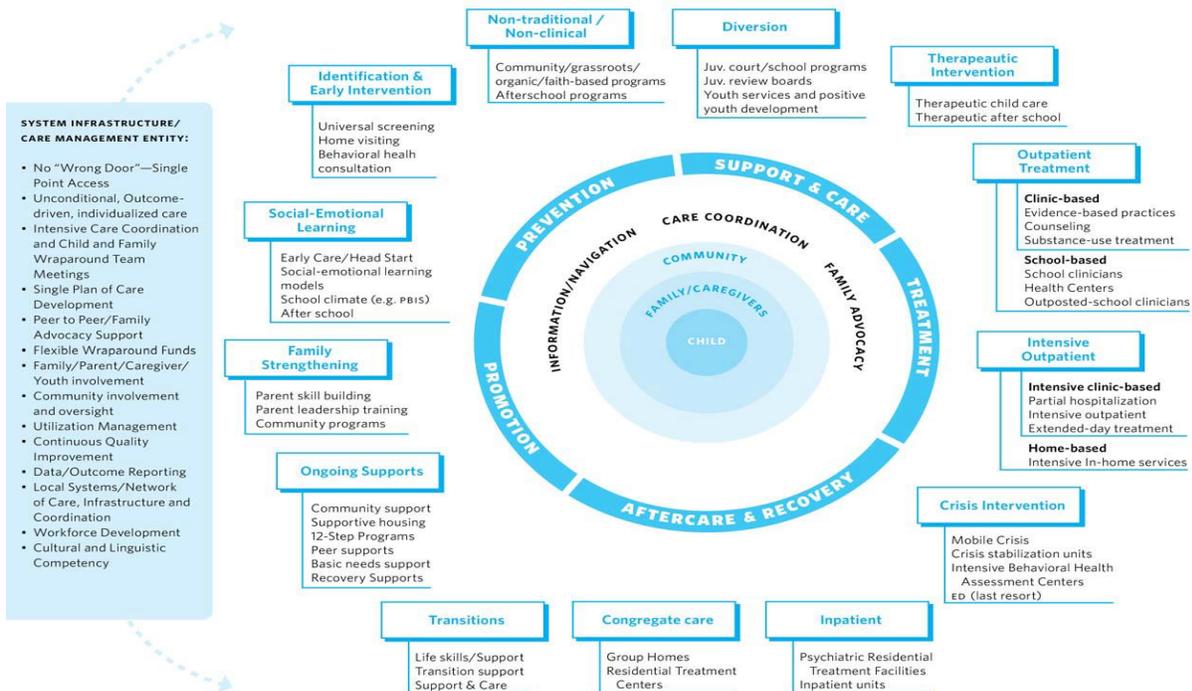


Figure 1. Connecticut Adult's and Children's Systems of Care

### A3. Capacity of current Medicaid State Plan to provide needed services

Connecticut's Medicaid State Plan already covers a number of outpatient services for the behavioral health population in a variety of treatment settings including hospitals, FQHCs, and behavioral health clinics. The following services are covered under Medicaid as of 7/1/2015: assessment/evaluation, evaluation and management services with patient/family, family counseling, individual and group psychotherapy, consultation, psychological and neuro-behavioral testing, smoking cessation, preventive groups, substance use services, partial hospitalization, intensive outpatient, injections, crisis intervention stabilization, targeted case management (TCM), and a comprehensive pharmacy benefit. TCM services include activities and interventions related to assessment, planning, linking, support, and advocacy. To date, these services have been provided to adults with "severe and persistent psychiatric and substance dependence disorders" and children with similarly severe behavioral health disorders. Under the demonstration project we will expand these services to additional adults and children and their families. Families in poverty who have children with behavioral health conditions are known to struggle with the multiple systems involved in their lives, and can benefit from assistance in coordinating those multiple systems. Care coordination will be provided for anyone in need.

We understand also, however, that there are additional services required for the CCBHCs that are not currently part of the Medicaid rate schedule. Connecticut welcomes the opportunity provided under this Cooperative Agreement to make enhancements to assure that the rate includes any and all services that might assist an individual and/or family in their recovery. We anticipate that much of the work of the Steering Committee and associated subcommittees will help inform these choices, but a few evidence-based practices that are already under consideration for inclusion are described in Section B.5.

### A4. Statement of need for Certified Community Behavioral Health Clinics

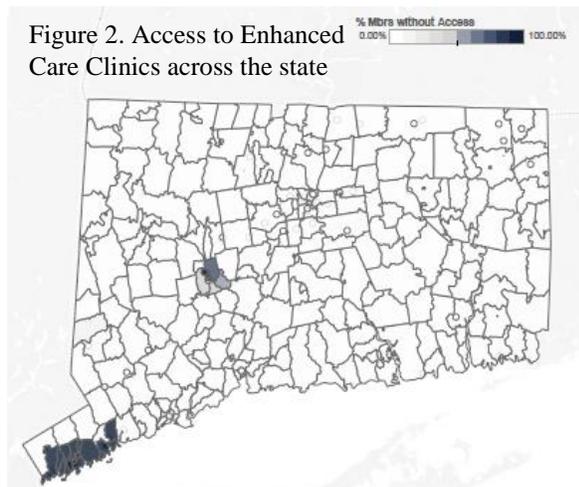
Connecticut has a substantial unmet need among both youth and adults who have diagnosable mental health and substance use conditions who do not yet receive behavioral health care.

Percent of adolescents with MDE receiving treatment	52.3%
Percentage diagnosed with any mental disorder who received services past year for any mental illness	45%
Percentage receiving treatment for alcohol use with alcohol dependence or abuse diagnosis	6%
Percentage receiving substance use treatment with illicit drug dependence or abuse diagnosis	20.5%
Source: SAMHSA Behavioral Health Barometer, 2014 (1)	

Specifically, in comparing prevalence rates of various behavioral health conditions to percentage of children and adults receiving care, we find a significant proportion of both children and adults with behavioral health disorders are not

receiving services. For example, 47.7% of CT youth who have experienced a major depressive episode in the last year have not received treatment. More than half of adults (55%) who have been diagnosed with any mental illness in the past year do not receive services. Most dramatically, 94% of CT people with an alcohol use disorder and 80% of people with a drug use disorder do not receive care. Data also suggest that disparities continue to exist in Connecticut in relation to race, ethnicity, culture, and gender. Residents of Hispanic and/or African American origin are significantly more likely to be uninsured and under-served, adolescent males are less likely to receive treatment for depression than females (2), and Medicaid data suggest that African American youth are less likely to receive inpatient care while African American adults

were more likely to be hospitalized. Caucasian adults, across almost all levels of care, were slightly overrepresented compared to their proportions in the Adult Medicaid Population.



As Connecticut is a relatively small state, the data reported above have been for the overall population. Unmet needs for behavioral health care among the state's Medicaid population also have been analyzed by region by the state's ASO partner, ValueOptions. In particular, two areas of the state have been designated as having a significant population of adults that do not have access to Enhanced Care Clinics, which is a primary mode for the provision of community behavioral health care to Medicaid populations (Figure 2). These are the Waterbury and Stamford areas, which have been found to serve a smaller percentage of the youth substance use population

as well. These two areas will be given priority in selection for the initial cohort of organizations to prepare to become CCBHCs. As these are both urban areas, though, we will also be giving priority to preparing and certifying CCBHCs that serve rural areas.

Connecticut has made much progress over the last decade in transforming its systems of care to a resilience and recovery orientation, improving the quality of care it provides to its citizens through numerous SAMHSA and CMS-funded initiatives to ensure that the care provided is family and person-centered, trauma-informed, strength-based, culturally competent, and inclusive of peer and family-delivered supports (as will be described below). As this Section makes clear, though, much work remains to be done in increasing the capacity, access, and availability of needed care (especially in the two areas identified above), in expanding the array of services offered to include additional evidence-based practices, and in eliminating the remaining disparities that persist based on race, ethnicity, and gender. The following Sections describes concrete plans for how the state will build and expand on this solid foundation to ensure that newly certified CCBHCs achieve a degree of excellence in their provision of care for local communities that is population-based, timely, responsive, and promotes overall wellness.

## **B. PROPOSED APPROACH**

### **B1. Expansion of capacity, access, and availability of needed services**

Connecticut views the introduction of the CCBHC model into its service system as an excellent and timely opportunity to build upon existing infrastructure to expand capacity, access, and availability of services for individuals and families who will be eligible for Medicaid-funded care. We also see this as an opportunity to consolidate and further build on the gains we have made in the last 15 years in introducing family and person-centered care that is resilience and recovery-oriented, culturally responsive, and attentive to trauma, with the ultimate aim of improving behavioral health and overall health outcomes. We have an established track record of developing innovative solutions to assuring and expanding timely access to appropriate services, connections to care, and quality of care provided by a range of competent professionals. This section describes how these approaches will be brought to bear in the creation of CCBHCs.

In 2007, Connecticut established Enhanced Care Clinics (ECCs), which are specially designated mental health and substance use clinics that serve adults and/or children. There are currently 30 ECCs operating at this time, with 124 sites throughout the state. The model under this initiative provides an existing baseline from which to elevate standards in order to assure adherence to the new CCBHC criteria. The overall goal of the ECC initiative is to provide adults and children who are seeking behavioral health services and supports with improved timeliness of access to behavioral health care as well as improved quality of care. Currently under this model, ECCs must adhere to the following access standards: the capability to 1) see clients with emergent needs within two hours of arrival at the clinic; 2) see clients with urgent needs within two days of initial contact; and 3) see clients with routine needs within two weeks of initial contact. Following an initial face-to-face clinical evaluation those clients who are determined to need outpatient services must be offered a follow-up appointment within 2 weeks of the initial evaluation. ECCs must also provide extended coverage outside of normal business hours. Evidence of collaboration and coordination with primary care providers as well as screening, evaluation, and treatment of co-occurring mental health and substance use conditions are additional requirements for all ECCs. This initiative offers a recent example of the state's success with certification, separate payment methodologies, and enhanced oversight of performance measures such as access and coordination, serving as a platform from which to develop similar structures for CCBHCs; a model to which we expect many EECs to aspire.

CCBHCs will be required to participate in the new local Community Care Teams (CCTs) that have been created to bring hospital staff, local community providers, and other stakeholders together to better serve individuals who are currently frequent visitors to Emergency Departments (EDs) and/or high utilizers of other behavioral health services. The purpose of the CCTs is to organize a coordinated response to meeting the often multiple and complex needs of persons who are not benefitting from existing outpatient care in a more immediate and effective way that will enable them to decrease their repetitive use of more costly, acute care services. Presently, there are CCTs scattered across the state. Recent legislation authorizes Connecticut to create CCTs where none exist and strengthen those that do by paying for the staffing to coordinate local efforts in areas where ED usage is high among frequent visitors. CCBHCs will be required to be an integral part of the CCTs, especially as related to coordination of care. Based on the effectiveness of this strategy of partnering with our ASO and community providers to better address the needs of this population, Connecticut was recently selected to participate in the National Governors Association Center for Best Practices in the development of state-level capacity to improve health and reduce cost of populations with complex care needs. This initiative is focused on high need and high cost users of Medicaid services.

In response to the Affordable Care Act's authorization to create health homes, Connecticut is currently pending a State Plan Amendment submission (projected October 2015) to commence provision of Behavioral Health Home (BHH) services to a population of individuals (children and adults) with mental illnesses. There will be considerable overlap between the LMHAs and ECCs referenced above with BHH providers. The BHH designated provider network mirrors the LMHA network with the addition of 2 affiliated providers (15 providers to assure statewide coverage). Under this model, providers offer care management, care coordination, health promotion, referral to community support services, transitional care, and individual/family support. Another key requirement of the BHH providers are collaborative agreements in the form of Memorandums of Understanding between themselves and regional hospitals or provider systems to ensure a formalized relationship for transitional care planning, to include

communication of inpatient admissions as well as identification of individuals seeking ED services (for children, these MOUs must build upon those executed between EDs and emergency mobile psychiatric service providers). Additionally, they must develop and maintain written referral agreements with regional primary care practices or federally qualified health centers. These requirements, plus the existing framework under the ECC model, demonstrate Connecticut's readiness to implement and achieve similar requirements for certifying CCBHCs.

In addition to building on these advances, Connecticut is in the process of, or planning to, implement the following strategies to enhance capacity, access, and availability of services. First, the state is currently expanding its peer workforce and establishing the roles of community health worker and peer health navigator as essential, reimbursable, components of the behavioral health home model described above. In addition to instilling hope, role modeling self-care and recovery, and assisting their clients to access and navigate needed behavioral health and medical services, peer staff have been found to be uniquely well-qualified to, and effective in, conducting outreach to engage into care persons who have been underserved, poorly served, or simply not served at all previously (3). Second, DCF and DMHAS have exerted considerable efforts over the previous decade to expand the diversity of the state's workforce and to ensure that services provided are culturally responsive and trauma informed. These efforts will continue in preparing existing agencies to become CCBHCs, with consultation, technical assistance, and workforce development support to be provided both by DCF/DMHAS staff and by local academic partners contracted through grant funds as described.

## **B2. Stakeholder involvement in the development of the demonstration program**

Connecticut has long recognized the importance of stakeholder involvement and feedback in the design and ongoing operations of its systems of care and programs. In order to best ensure stakeholder involvement during the preparation of this application, we held focus groups with six state advocacy organizations for persons in recovery and families, including the Connecticut Community for Addiction Recovery, Connecticut FAVOR, African Caribbean American Parents of Children with Disabilities, Advocacy Unlimited, the Connecticut chapter of the National Alliance on Mental Illness, and Focus on Recovery United. In addition, we conducted forums with the Children's Behavioral Health Advisory Council, that has majority family membership, and with the statewide trade organization for behavioral health organizations in the state, the Connecticut Community Providers Association. In total, we met with 33 community agency staff, 21 advocacy organization representatives, and 51 persons in recovery and family members.

Feedback from these groups was instrumental in designing our planning structure and process. The conversations reflected interest in representation on a Steering Committee, but also concern that highly technical discussions are seldom conducted using plain language. They noted that past efforts to include stakeholders had not always allowed the time needed for adequate discussion between their members or for thoughtfulness about the differences between regional and subgroup interests. They recommended a dual feedback system, including representation on a central planning group as well as regular and diverse opportunities to receive information and provide input on an on-going basis, utilizing a regional structure to be described below. They also were enthusiastic about having a dedicated website that would be updated regularly with the latest meeting minutes prepared in simple-to-understand terms, and being offered the opportunity to submit comments and questions moving forward.

Ongoing involvement of stakeholders will be ensured through this dual feedback system, as well as through majority representation on the Steering Committee to be established during the planning grant year. The Steering Committee will be comprised of a minimum of 50% representation from persons in recovery and families, demonstrating our ongoing commitment to shared governance. In addition to persons in recovery and family members, the Steering Committee will include veterans, tribal representatives, providers, and state agency representatives. We anticipate that subcommittees tasked with various planning activities will be formed during the planning year to assure a wide range of voices are heard and assimilated in this process. Meeting minutes and output from the various subcommittees will be available to the public via an outward facing website managed by one of the three State Departments, with alerts being issued by our advocate partners and regional planning boards to ensure that citizens know when to refer to the website. Where broad-based input is especially needed, we will request comments from those viewing the website. Connecticut has substantial experience with this approach, as demonstrated through various oversight entities and project. The Behavioral Health Partnership Oversight Council (BHPOC) is one such entity that has a significant role in the oversight of behavioral health services provided to Medicaid members. The BHPOC is comprised of individuals in recovery, families, advocates, providers, and legislators. The Steering Committee will collaborate closely with this entity (see letter of support attached).

As noted above, in addition to representation on the Steering Committee and an interactive website with alerts, the stakeholders urged us to conduct regional forums (also described as “community conversations”) with people in recovery and family members. This structure was employed in the state’s recent development of the Children’s Behavioral Health Plan, following the tragedy at Sandy Hook, and was reported to have given people confidence that the final report would reflect their concerns. These meetings would be held at least every other month, and would be attended by the representatives serving on the Steering Committee and staff who are trained to explain recent Steering Committee discussions and up-coming decisions in understandable language, and to return feedback from the forums to the Steering Committee prior to final decision-making on any issue. We plan to collaborate with the existing DMHAS-funded Regional Mental Health Boards to organize and host these forums. Finally, DCF staff work in partnership with and solicit input from local Youth Advisory Boards around the state and the statewide Youth Advisory Board. The boards empower children and youth to directly participate in and advocate for mental health and related system changes and development. Approximately 50 children and youth in “out-of-home care” participate on the boards. This existing infrastructure will allow for additional input by youth receiving behavioral health services either on the Steering Committee or as a consulting body to the Steering Committee.

### **B3. Selection process of community behavioral health clinics to become certified**

During the planning year, Connecticut commits to certifying at least two providers to become CCBHCs, one of which will be an urban provider (with priority given to either the Waterbury or Stamford areas identified in Section A.4) and one of which will be a provider that serves a rural community.

To elicit participation, DSS will issue an RFA at the beginning of the planning year to all eligible organizations, inviting them to apply for inclusion in the CCBHC Learning Community that will be described below. A maximum of up to six of these organizations will be chosen to participate in the learning community based on their applications, which will include the scores from their

self-administration of the CCBHC Certification Readiness Tool (CCRT), a tool uniquely developed for this purpose by MTM Services, the National Council for Behavioral Health's consulting division. Selection will also be informed by additional data on service gaps and under-served populations provided by Value Options. This information will enhance our ability to identify additional critical areas of the state where CCBHCs could have the most beneficial impact. We envision that having a large and diverse group of agencies to work with during this planning year will be crucial to identifying the challenges that will have to be addressed and the lessons that will need to be learned for the state to be successful during the demonstration period.

To commence preparation efforts, the state will contract with MTM Services to develop a CCBHC Learning Community and to provide additional project management services to support the state's planning process. MTM will analyze the results of the assessment of provider readiness to achieve certification standards for CCBHCs (the scores from the CCBHC Certification Readiness Tool) and aggregate these scores across the system to inform the creation of the Learning Community. This Community will be convened during the course of the planning year, through a mixed delivery approach that includes both onsite and web-based support, and will address areas of improvement for providers to achieve readiness in each of the CCBHC criteria areas. *As noted above, we will make this opportunity available to a larger group of providers than will ultimately become certified, as we see this as an opportunity for widespread practice improvement.*

During the planning year we also anticipate enhancing the training and technical assistance offered through the Learning Community with content specific to Connecticut highlights themes critical to the Departments, and provides context for implementing CCBHCs within existing systems of care. This will include utilizing existing partnerships for the implementation of Evidence-Based Practices (dependent on the selection of EBPs for inclusion), as well as for workforce development in the area of cultural competence. We also will link CCBHCs to existing resources, including the Connecticut Suicide Advisory Board, which is planning to initiate its own learning community in October 2015 that will provide practitioners with state and national resources, workforce peer to peer support, and encouragement to promote the aspirational goal and philosophy of Zero Suicide to their communities, ultimately reducing suicide death and attempts.

Another existing resource to be leveraged in this regard is the Office of Veterans Services at DMHAS. With this resource, as well as our partnership with the VA CT Healthcare System, we propose to facilitate CCBHC staff training in the following relevant areas: military organizational structure and culture, the prevalent psychological and behavioral challenges and unique health problems among returning veterans and their families, VA eligibility, enrollment, and referral protocols in order to de-mystify the VA and Veterans Center systems and to encourage greater inter-system communication and collaboration. These partners can also serve as a resource for CCBHCs in treatment/discharge planning efforts for individuals and assist veterans and families in accessing state and federal benefits.

Finally, Connecticut's behavioral health system recognizes that children and adolescents are individuals embedded within family systems who have behavioral health needs that are separate and distinct from adults. As described above, the children's behavioral health system sits within a larger children's services agency and has evolved over the years into a robust system with providers and services that may, or may not overlap with the adult provider network. While a positive feature in terms of creating a developmentally appropriate service system, challenges

obviously exist when addressing the life span requirement of the CCBHC model. As such, Connecticut will need to consider designing a common management structure that will allow those providers, exclusive to the children's system, an opportunity to work collaboratively with adult providers while maintaining their child and family-centric focus. Including a larger number of agencies in the Learning Community will allow us to experiment with different approaches to addressing the governance and organizational challenges involved in bringing agencies together.

#### **B4. Provision of needed services through Certified Community Behavioral Health Clinics**

Services to be provided by the CCBHCs are as follows: crisis services; screening, assessment, and diagnosis; person and family-centered care planning; risk assessment and management; outpatient mental health and substance use services; primary care screening; targeted case management; psychiatric rehabilitation services; peer and family support; and intensive community-based mental health care for members of the armed forces and veterans. How we propose to offer each of these services is described in greater detail below.

**Crisis Services.** Mental health crisis services offered under the CCBHC model will be age-specific. For *adults* experiencing a mental health crisis, responsive services will be available in all communities, delivered by a statewide network of contracted or state-operated staff. These services are defined as mobile, readily accessible, rapid response, short-term services for individuals and families experiencing acute behavioral health crises and are delivered with appropriate safety measures in settings such as at the Local Mental Health Authority (LMHA), at walk-in clinics, or in other community settings. These services include concentrated interventions to establish safety, treat a rapidly deteriorating behavioral health condition, reduce risk of harm to self or others, stabilize psychiatric symptoms, address behavioral and situational problems, and whenever possible, avert the need for hospitalization. Mobile emergency crisis services focus on evaluation and stabilization activities which may include: assessment and evaluation, diagnosis, hospital pre-screening, medication evaluation and prescribing, targeted interventions, and arrangement for further care and assistance as required. Often, mobile emergency crisis clinicians collaborate with and assist local police officers to de-escalate crises. They may also issue a Physician's Emergency Certificate (PEC) if needed.

Mobile crisis teams also maintain community partnerships with provider organizations that serve the community and have a stake in establishing and maintaining a seamless system of care. These organizations include hospitals, EDs and inpatient psychiatric units; local law enforcement; state-operated and private non-profit local mental health agencies; community mental health and substance abuse treatment service providers; primary health care providers; and other community organizations such as housing providers and recovery support service providers. In addition, in CT, as of July 1, 2014 over 1,875 police officers in 97 state, federal and local public safety agencies and their community mental health partners have received Crisis Intervention Team (CIT) training. These programs are specifically designed to improve the way law enforcement and the community responds to people experiencing mental health crises. They are built on strong partnerships between law enforcement, mental health provider agencies, and individuals and families affected by mental illness.

For *children*, Emergency Mobile Psychiatric Services (EMPS), a statewide mobile crisis intervention network for children experiencing behavioral health or psychiatric emergencies, will be deployed. The service is delivered through a face-to-face mobile response to the child's home, school, or other location preferred by the family. Clinicians assess and intervene during the

immediate crisis and follow up with referrals to appropriate services following the crisis. In rare situations, services can be delivered through a telephonic intervention, if appropriate.

**Screening, Assessment, and Diagnosis.** In 2006, DMHAS implemented a year long pilot of four standardized screening measures as part of the state's SAMHSA-funded Co-Occurring State Incentive Grant, including two substance use screens and two mental health screens (i.e., CAGE-AID, Simple Screening Instrument for Alcohol and Other Drugs, Modified Mini, and Mental Health Screening Form-III). After a pilot with 30 providers, DMHAS moved to statewide implementation of these measures in 2007. Since that time, all DMHAS-funded providers administer one of the substance use screens and one of the mental health screens for all admissions. This practice of integrated screening leads to early identification and early intervention for co-occurring disorders and have been included in the Enhanced Care Clinic requirements. An additional screening tool (Global Appraisal of Individual Needs) also has been included in the requirements for ECCs that serve youth. Regarding assessment, the state has not mandated a particular biopsychosocial assessment instrument and instead developed a core set of integrated assessment guidelines that providers were asked to use in assessing the adequacy of their assessment tool. These guidelines are described in detail in the state's 2008 *Practice Guidelines for Recovery-Oriented Care for Mental Health and Substance Use Conditions*. As part of the CCBHC efforts, we will consider adding to this an evidence-based suicide assessment tool like the Columbia Suicide Severity Rating Scale or SAFE-T. Biopsychosocial assessments, medical reviews, and the development of a person-centered recovery plan in collaboration with each client and his or her natural supports are to be completed every six months. Diagnostic formulations are developed by licensed and credentialed professionals utilizing the DSM 5.

**Family and Person-Centered Recovery Planning.** The state has partnered with the Yale Program for Recovery and Community Health (PRCH) over the last decade to develop, evaluate, and implement an innovative approach to family and person-centered recovery planning (PCRP) that is also described in detail in the 2008 *Practice Guidelines for Recovery-Oriented Care for Mental Health and Substance Use Conditions*. Dr. Janis Tondora, the faculty member at PRCH who is the lead developer of PCRP, has done the majority of training, technical assistance, and coaching with behavioral health providers in the state on this best practice. In addition to the NIMH funds used to develop and evaluate PCRP, DMHAS secured a multi-year CMS grant to implement this approach with the six state-operated LMHAs and more recently PRCH secured an NIMH grant to do further implementation and evaluation work on PCRP with the seven private non-profit LMHAs. Together, these collaborators and additional funding have achieved a solid foundation of delivering PCRP across the state. Should there be organizations aspiring to be CCBHCs who have yet to receive this training, however, Dr. Tondora can provide the training and technical assistance within the context of the Learning Community during the planning year. In addition, the state already has a contract with Patricia Deegan, Ph.D., to provide more focused training and technical assistance on shared decision making within this context; this contract could be expanded for inclusion in the CCBHC Learning Community as noted above as well.

Connecticut adopted the federally endorsed System of Care model as the basis for the state mental health plan in 1997 and established a coordinated network of community services and supports to meet the needs of emotionally disturbed children, youth and their families. The system of care is not a program; it is a philosophy of how care should be delivered. The hallmarks of the system of care approach include the following.

- The mental health service system is driven by the needs and preferences of the child and family, using a strengths-based perspective.
- Family involvement is integrated into all aspects of service planning and delivery.
- Services are built on multi-agency collaboration and grounded in a strong community base.
- A broad array of services and supports are provided in an individualized, flexible, coordinated manner and emphasize treatment in the least restrictive, most appropriate setting.

Core values include:

- Child-centered, family focused, and family-driven;
- Community-based; and\
- Culturally competent and responsive.

The Department's grant-funded child/adolescent provider contracts as well as the practice standards for each service/program type require that services are delivered in accordance with these principles and core values.

***Outpatient Mental Health and Substance Use Services.*** Under Connecticut Medicaid, outpatient psychotherapy is provided by a number of different clinic types (e.g., Enhanced Care Clinics, Hospital Clinics, School Based Clinics, Free Standing Clinics, etc.). The CT Healthcare Advocate reported in 2013 that the Department of Public Health licensed 205 psychiatric outpatient clinics for adults, and the Department of Children and Families licensed 63 outpatient clinics for children. A recent report of the Connecticut Behavioral Health Partnership regarding network adequacy identified a total of 227 outpatient mental health and 121 substance abuse clinic sites for adults and 188 outpatient mental health and 36 substance abuse sites for children and adolescents. Of these facilities, a total of 124 sites are designated as Enhanced Care Clinics (this number includes satellite sites), with 63 youth and 22 adult mental health clinics and 19 youth and 20 adult substance abuse clinics. It is anticipated that the development of ECC requirements for timely access and collaboration with primary care will provide a platform for developing the process for certification of CCBHCs in Connecticut, ensuring that timely, coordinated, and high quality services are provided to clients under the state Medicaid plan.

With respect to evidence-based approaches, the state also offers Adolescent Community Reinforcement Approach/Assertive Continuing Care (ACRA-ACC) and Screening, Brief Intervention, and Referral to Treatment (SBIRT). ACRA-ACC is an evidence-based substance use outpatient treatment program for adolescents ages 12 through 17 years and their caregivers. The model provides a combination of clinic-, community- and home-based services, based on the individualized need of the youth and family served. ACRA-ACC is available to adolescents who meet the admission criteria of an identified substance use issue and the American Society of Addiction Medicine criteria for an Outpatient level of care. This evidence-based model of care is one of four models from which CCBHCs can chose to train staff and provide.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) was originally introduced to Connecticut through a SAMHSA grant to DMHAS. More recently, DMHAS has provided DCF with the funds to train the workforce on adolescent SBIRT and dissemination of this model throughout Connecticut by using a “train the trainer” model for sustainability. This project has just begun and will be complete in August 2016 and will include the training of emergency psychiatric service responders to children, DCF staff, parole and probation officers, behavioral health service providers, and medical providers. For CCBHCs, SBIRT will provide the tools needed for screening for substance use disorders among adolescents and adults in Connecticut.

***Outpatient Clinic Primary Care Screening.*** In Connecticut, the movement toward integrated care is diffuse and represented across a number of initiatives and programs. ECCs are required to develop formal relationships with primary care practices to support mutual referral practices and to facilitate collaborative care and the efficient exchange of information to support patient care. ECCs follow communication guidelines to support ECC and primary care co-management of patients with behavioral health and physical health disorders. The BHH model also includes integrated health care service delivery including age-appropriate screening and preventive interventions for adults, children, and older adults that is recovery-oriented and person and family-centered. CCBHC providers who are also BHH providers would assess an individual and formulate a Plan of Care with goals, objectives, and interventions that addresses the whole person: mental health, substance use, and physical health needs in addition to other recovery goals (e.g., employment, education). The purpose of the plan of care is to: identify strengths and needs and link the individual to medical, dental, and other physical health professionals and wellness services and supports; teaching/coaching the individual to maximize independence in the community; promoting health education specific to the individual's chronic condition(s), and assisting the individual with accessing self-help, peer support, technology such as smart phones, support groups, wellness centers, and other self-management programs. For the BHH initiative, required reporting for providers includes not just behavioral health outcomes, but many of the same key indicators represented in the CCBHC required quality outcomes dataset, including: tobacco use screening and cessation and adult body mass index screening and follow-up.

In addition to providers operating as ECCs and BHHs, several LMHAs have also been or are currently SAMHSA Primary Care and Behavioral Health Integration grantees. Connecticut has 4 grantees: 2 are active grantees and 2 are from previous award cohorts. Sustainability for this model of integrating primary care on-site at a behavioral health clinic has been achieved; both providers from early award cohorts have sustained their models through ongoing relationships with hospitals and health centers. DMHAS has supported the applications for these grantees and anticipates that additional providers will apply for this opportunity during future grant cycles.

For children, Connecticut ACCESS Mental Health (ACCESS-MH) is a program designed to increase the competencies of primary care providers to identify and treat behavioral health disorders in children and adolescents and to increase their knowledge/awareness of local resources designed to serve the needs of children and youth with these disorders. ACCESS-MH is a phone consultation model staffed by child psychiatrists, clinicians, and peer advocates through three hubs that provide state-wide coverage to all interested pediatric and primary care practices serving children and adolescents.

***Targeted Case Management.*** In Connecticut, Targeted Case Management is provided to adults with serious mental illnesses by agencies approved as TCM providers by DMHAS. These services, as defined in our State Plan Amendment, are services furnished to assist eligible individuals in gaining access to needed medical, social, educational, and other services. TCM includes the following services: comprehensive and periodic assessment and reassessment; development of specific care plans with active individual participation; referral and linkages to providers, programs, and services; monitoring and follow-up to assure care plan implementation; and collateral contacts with other sources of information and support for the individual. It is anticipated that most, if not all, of the prospective CCBHCs are also credentialed providers of TCM to adults and as such have extensive experience in provision and documentation of these services. The CCBHCs will be expected to provide Targeted Case Management (TCM) services

to children with SED and their families as part of the overall treatment services array, which is an expansion of this service for this population. TCM can be provided in addition to traditional outpatient psychotherapy services as a means to linking and coordinating the multiple systems in a child's life such as school, primary care, child welfare, if involved, and juvenile justice, if involved. Also, TCM can provide support and linkage around housing and food insecurity issues and will be a key mechanism, in addition to others, for ensuring care coordination.

***Psychiatric Rehabilitation Services.*** DMHAS and DCF provide a number of evidence-based psychiatric rehabilitation services including supported housing, supported employment, supported education, and assertive community treatment. In addition, there is a network of over 20 social club/club house model programs that offer supported socialization, transitional employment, volunteer opportunities, and support for other social and recreational activities. To this array, we plan to add the evidence-based practices of Family Psychoeducation and Illness Management and Recovery to be described in the following Section on evidence-based practices.

***Peer Support/Family Support.*** The State of Connecticut has been a pioneer in both peer and family support approaches and continues to expand on these innovative and effective models. The state's Department of Administrative Services implemented a state job specification for Recovery Support Specialist (RSS) in 2009. DMHAS now requires various different levels of care (e.g., assertive community treatment, community support programs) to include RSSs, both in state-operated and private non-profit agencies. These peer specialists are certified by a peer-run agency, Advocacy Unlimited (AU) through a contract with DMHAS. AU facilitates a quarterly Peer Forum for peers working across agencies and programs to hear speakers, network, gain support, and share lessons learned. This experience serves as a model for including peers in outpatient services more broadly.

DCF funds FAVOR (not an acronym), an umbrella statewide family-run advocacy organization that has been created to educate, support, and empower families. FAVOR's mission is to provide family-focused, advocacy-based, and culturally sensitive community services that improve outcomes and family wellbeing. One component of their work is the delivery of advocacy services to selected families, the primary goal of which is to empower these families to advocate for their own needs and services. The FAVOR Family Peer Support Program provides direct family advocacy services to families with children who have medical, mental, or behavioral health challenges. Family peer support providers furnish assistance to families who need to navigate the special education, juvenile justice, and mental health care service systems. Services can include education on caregiver and child rights and responsibilities, and attending school and child and family teaming meetings. Working collaboratively with families, children and youth, schools and other service providers, family peer support providers empower families and help them participate fully in the development of their child's treatment and service plans.

In addition, the CTBHP has implemented a system of family peer specialists through the ASO contract with ValueOptions. These specialists have experience in negotiating the behavioral health services system themselves or for someone in their lives. It is because of this understanding that they are able to relate to the experiences and support the needs of individuals with service needs. The specialists work with families, children and youth to provide support and information when needed and to help them navigate through difficult times, as they work toward recovery and wellness. Also, DCF has joined with DMHAS to develop a substance use and recovery support plan to provide peer support services to adolescents and young adults

throughout the state. The plan will include methods to increase community support and methods to alert youth that such support is available.

***Mental health care for members of the armed forces and veterans.*** DMHAS demonstrates an ongoing commitment to serving veterans and service members through a variety of programs designed to best meet their unique needs, while honoring these individuals as citizens with freedom of choice first and foremost. To our knowledge, Connecticut is the only state that has an established Veterans Services Unit within the DMHAS Office of the Commissioner. Connecticut is also the only state that provides free, confidential, statewide outpatient counseling services to veterans, service members, and their families. The Military Support Program (MSP), established in 2007, provides free, confidential, locally available outpatient behavioral health services to veterans and service members. MSP staff work with the CT Army-Air National Guard, receiving referrals for care and assisting veterans with complex, long-term care needs in connecting to the VA, while honoring their freedom of choice. Additionally, MSP operates an Embedded Clinician Program under which 31 licensed MSP clinicians actively participate during drill weekends of the CT National Guard to serve as key points of contact for behavioral health.

Another critical program for service to veterans in Connecticut is the Veteran's Jail Diversion and Trauma Recovery program, funded by SAMHSA in 2008 as the first cohort of its kind. This model works to identify, engage, and divert/refer justice-involved Veterans to a seamless system of treatment and recovery support services. The state recognized the investment in this program beyond the grant funding cycle and has sustained the program, which is now present in four court systems statewide. Between the services and connections offered via these two programs, as well as staff training efforts as articulated above, we see opportunity for a comprehensive approach to CCBHCs serving veterans and service members with the appropriate levels of support and education about their unique needs.

#### **B5. Evidence-Based Practices (EBPs) to be provided by CCBHCs**

Connecticut has considerable experience with the implementation and ongoing support of EBPs and has identified several evidenced-based practices to be considered for expansion or adoption by the Steering Committee during the planning year. Some of the programs listed are already implemented in parts of the state, while others represent new initiatives put forward for consideration. Given that the focus of the planning is the outpatient level of care to be offered by CCBHCs, these practices were chosen because they are considered foundational for working across diverse groups of people within the overall behavioral health population we expect to see coming to outpatient clinics. In combination, they also focus on increasing access, engagement, and retention; skill development for self-care and recovery; medication-assisted treatment; and addressing the near-universal experience of trauma, across both mental health and substance use conditions. As noted above (and included in the budget) significant funds have been requested for training and technical assistance to integrate implementation and support of whichever evidence-based approaches are selected as part of the CCBHC Learning Community.

*Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC)* is an evidence-based treatment designed for children ages 7-15. Unlike most approaches that focus on single disorders, MATCH is designed for children experiencing multiple difficulties, including anxiety, depression, and posttraumatic stress, as well as the disruptive conduct often associated with attention deficit hyperactivity disorder. This

broad-based model is an ideal fit for CCBHCs as it serves a broader population of families who seek care. The intervention model, co-developed by Dr. John Weisz at Harvard University, combines clinical training and supervision in 33 well-documented evidence-based interventions that address 75% of the most common presenting problems in community-based clinics for children, including anxiety, depression, post-traumatic stress, and conduct problems (5).

*Adolescent Community Reinforcement Approach/Assertive Continuing Care (ACRA-ACC)* is an evidence-based adolescent substance use treatment model which is delivered in a clinic, community, or home-based setting to treat the unique needs of the substance using adolescent (6). ACRA's behavioral therapy uses social, recreational, familial, school, or vocational reinforcers, and skill training so that non-substance using behaviors are rewarded and can replace substance use behavior. In ACC, additional emphasis is placed on helping the adolescent follow-through with needed education/GED services, juvenile justice compliance, accessing healthcare, and other programs-social activities. ACC includes case management services and is delivered in the home and community setting, and will be a welcome support for Connecticut families.

*Family Based Recovery (FBR)* is an intensive, in-home evidence-based clinical program for families with infants or toddlers (birth to 36 months) who are at risk for abuse and/or neglect, poor developmental outcomes, and removal from their home due to parental substance abuse. The overarching goal of the intervention is to promote stability, safety, and permanence for these families. Treatment and support services are family-focused, strength-based, trauma-informed, culturally competent, and responsive to the individual needs of each child and family. The clinical team provides intensive psychotherapy and substance abuse treatment for the parent(s) and attachment-based parent-child therapy and helps to prevent longer-term difficulties (7,8).

*High Fidelity "Wraparound (WRAPCT)* is an intensive, individualized care planning and management process for youths with serious or complex needs. Wraparound is a team-based planning process intended to provide individualized, coordinated, family-driven care to meet the complex needs of children who are involved with various child and family serving systems (e.g. mental health, child welfare, juvenile justice, special education), who are at risk of placement in institutional settings, and who experience emotional, behavioral, or mental health difficulties. The Wraparound process and the written Plan of Care it develops are designed to be culturally competent, strengths based and organized around family members' own perceptions of their needs, goals, and vision.

*Family Psychoeducation* is an evidence-based psychiatric rehabilitation service that is primed for inclusion in the CCBHC model to address the needs of adults with serious mental illnesses and their families. SAMHSA published a Family Psychoeducation Evidence-Based Practice Toolkit in 2010 (9). Family Psychoeducation has been shown to reduce relapse rates and facilitate recovery. A core set of characteristics of effective family psychoeducation programs has been developed, including the provision of emotional support, education, and resources during periods of crisis, and problem-solving skills. Unfortunately, the use of family psychoeducation in routine practice has been limited in Connecticut as it has been across the country (10).

*Illness Management and Recovery (IMR)* is an evidence-based practice, included in the SAMSHA toolkit series (11), that uses a broad set of strategies designed to help individuals with serious mental illness identify their goals, collaborate with professionals, reduce their susceptibility to the illness, and cope effectively with their symptoms. Research on illness management for persons with severe mental illness, including 40 randomized controlled studies,

indicates that psychoeducation improves people's knowledge of mental illness; that behavioral tailoring helps people take medication as prescribed; that relapse prevention programs reduce symptom relapses and re-hospitalizations; and that coping skills training using cognitive-behavioral techniques reduces the severity and distress of persistent symptoms (12). Other places (e.g., New York) have modified IMR, at least in name, to Wellness Management and Recovery (WMR), including a Spanish version that could be a key resource for Connecticut as well.

*Motivational Interviewing* (MI) is an evidence-based clinical approach that helps people with mental health and substance use disorders and other chronic conditions, such as diabetes, cardiovascular conditions, and asthma, make positive behavioral changes to support better health. The approach upholds four main principles: expressing empathy and avoiding arguing, developing discrepancy, rolling with resistance, and supporting self-efficacy. MI encourages staff to offer non-judgmental support in such a way that develops the client's own motivation to follow through on pragmatic goals. As of 2013, MI has been implemented at more than 30,000 sites in all 50 States and around the world, with an estimated 3 million clients. More than 70 reports have been published on MI implementation efforts (13).

*Cognitive Behavioral Therapy* (CBT) is arguably the evidence-based practice with the highest levels of empirical support across a range of both substance use and mental health conditions (14). It is listed on SAMHSA's National Registry of Evidence Based Programs and Practices in its application to a very wide list of conditions (e.g., PTSD, depression). CBT also has been shown to be effective across a wide range of substance use disorders, including alcohol, marijuana, cocaine, and opiate dependence (15-18), is compatible with a number of other approaches, including pharmacotherapy (19,20), medication-assisted treatment (21,22), and traditional counseling approaches (23), and thus can be implemented in a wide range of settings. A key distinguishing feature of CBT for addiction includes its relative durability of effects. Several groups have demonstrated that the effects of CBT tend to be longer lasting than most therapies, in some cases with clients continuing to improve even after treatment ends (24-26).

*CBT4CBT* is an evidence-based internet-based program that provides a form of CBT that could be delivered much more broadly than traditional clinician-delivered CBT. Although clients will all be offered CBT in the clinic setting, we will also offer them the chance to use CBT4CBT at home or through other internet locations. People can also use CBT4CBT when they have difficulty getting to a clinic. Dr. Kathy Carroll, nationally recognized addiction researcher at Yale, developed this computer-assisted version of CBT with support from NIDA and NIAAA, to capitalize on the multimedia features and wide availability of the internet to increase access to CBT. Two randomized trials of CBT4CBT have been completed in community-based settings and have established the effectiveness, safety and feasibility of computerized CBT (27-30).

*Medication-Assisted Treatment* (MAT) is an evidence-based approach to addiction treatment that has primarily been implemented in Connecticut through a strong statewide network of methadone clinics. Through the CCBHC planning and demonstration, we would like to expand access to FDA-approved medications for opiate use disorders (e.g., naltrexone, buprenorphine) and alcohol use disorders (i.e., naltrexone, disulfiram, acamprosate) through the CCBHCs.

*Trauma-Specific Interventions.* DMHAS has a strong trauma-informed and trauma-specific initiative that started more than a decade ago. DMHAS, in collaboration with its contractor, the CT Women's Consortium, recently published the first statewide Trauma Services Directory for adults (31). All CCBHCs will offer at least one evidence-based trauma specific intervention. The

most common trauma-specific interventions in use by adult behavioral health providers are Seeking Safety, Trauma Recovery and Empowerment Model (TREM), Beyond Trauma, and Eye Movement Desensitization and Reprocessing (EMDR). Training and implementation support is available on all of these models through the Women's Consortium.

*Partners for Change Outcome Management System (PCOMS)*. Related to the ongoing work of the state partners and the Behavioral Health Partnership relative to adult and child outpatient care, we have been exploring the potential use of measures like the PCOMS as a way to collect real-time outcome-based self-report data to inform practice. If funded for the CCBHC planning year, we would continue this exploration work with stakeholders. The PCOMS include two scales: 1) 4-item Outcome Rating Scale at the beginning of each session and 2) 4-item Session Rating Scale at the end of each session. Information from the measures are integrated into clinical practice to improve therapeutic alliance and outcomes of care. PCOMS is included in SAMHSA's National Registry of Evidence-based Programs and Practices.

#### **B6. Certification process for CCBHCs in both urban and rural communities**

The certification process for CCBHCs will be administered by DSS. As noted above, priority will be given during the selection process for inclusion into the CCBHC Learning Community for agencies that serve rural areas and those that serve underserved communities as described in Section A.4. In order to be certified, agencies will have to meet all six of the program requirements outlined in the SAMHSA *Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics*. In addition to determining that these program requirements are met, DSS staff will ensure that the services provided are family and person-centered, strength-based, trauma-informed, culturally and linguistically competent, and *coordinated* across providers, agencies, levels of care, and behavioral health and primary care, as preferred by the person or family.

#### **B7. Finalization of planning activities and implementation of demonstration program**

No later than October 1, 2016, Connecticut will submit a proposal for the demonstration program. This proposal will include: target Medicaid population to be served, including any special populations of focus; descriptions of the initial cohort of certified CCBHCs with detail about their service array; a list and description of the included behavioral health services available under the state Medicaid program that will be paid for under the PPS tested in the demonstration program contrasted against the current provider fee schedule for Medicaid, and any other information requested by SAMHSA. It will also include verification that the state has agreed to pay for services funded under the demonstration program at the rate established under the PPS. If selected for implementation of the demonstration program, Connecticut stands prepared to transition the new CCBHCs to a PPS payment structure and to begin providing services consistent with all required program criteria. Given that we plan to include roughly twice as many agencies in our CCBHC Learning Community as we anticipate being able to certify by the end of the planning year, we recognize that providers other than those selected may also demonstrate readiness after the conclusion of the planning grant year, and those providers will be considered for inclusion as a CCBHC during the demonstration period.

#### **B8. Selection of PPS rate-setting methodology based on supporting data**

DSS will contract with an actuary firm in partnership with DMHAS and DCF to develop and certify a PPS-2 cost based, per clinic monthly rate. Connecticut considered both PPS payment models and is inclined to pursue a monthly rate instead of an encounter rate to incentivize value instead of volume in the purchase of services/service delivery. The state will utilize an actuary firm to assist the Departments in developing the PPS-2 rate structure and all of the associated tasks for the development of an actuarially sound reimbursement methodology, including certification of the rate in compliance with 42 CFR 438.6(c), provider education, and provider stakeholder support. Rate adjustment factors for establishing clinic-specific monthly capitation rates will include such considerations as acuity, age, and region/geography. In addition to a monthly capitated rate and rate adjustment factors, the state will develop an outlier payment methodology to reimburse clinics for services provided to members that exceed an established threshold. Finally, as part of the PPS-2 payment methodology, the state will establish performance payments for those clinics that meet or exceed established thresholds on the quality measures. DSS will utilize the CMS guidance due to states no later than September 1, 2015.

In order to develop a PPS-2 for clinics, DSS will issue a cost report that clinics must complete to meet certification requirements. DSS is prepared to use a CMS Medicare cost report (e.g. CMS 2088-92 or CMS 222-92) with state specific schedule pages or a customized cost report developed by CMS for the purposes of CCBHCs. DSS recently issued state specific cost reports to Federally Qualified Health Centers and Chemical Maintenance Facilities and is familiar with CMS approved state specific and Medicare cost reports. DSS will also use the Medicare Economic Index (MEI) to inflate the PPS-2 in the second year of the demonstration.

The state will develop a monthly base rate for each clinic. Payment will be triggered by a claim submitted to the Medicaid Management Information System (MMIS). The claim must include a CPT code that represents one of the core services outlined in the scope of services section. No payment will be made to the clinic if a claim is not submitted or if a claim is submitted without an applicable CPT code. As Connecticut is not a managed care state, managed care considerations are not applicable. Instead, the state uses a single entity to adjudicate and pay claims. As a result, Connecticut Medicaid is fortunate to have a single repository of all Medicaid claims within the MMIS. This single repository of Medicaid claims is invaluable in the process of claims analysis and will greatly benefit the actuary process when analyzing claims history.

Mercer Health & Benefits, LLC will be contracted to support the development of the PPS-2 and all of the ancillary services. Ancillary services include, but are not limited to, stakeholder engagement and education (on-site), desk reviews of costs reports with the applicable review of claims data, development of clinic specific PPS-2 rates and rate adjustment factors, development of an outlier payment methodology, design of a performance payment methodology, and the final certification of PPS rates for certified clinics.

#### **B9. Establishment of a PPS for behavioral health services to be provided by CCBHCs**

The state will establish an actuarially sound monthly rate for each clinic using the following process:

- All clinics pursuing certification must submit a cost report to the state
- All services provided by the clinic, as outlined in the scope of services, will be priced using existing fee schedules
- New services will be priced using existing fee schedules through government approved sources such as Medicare and/or Tricare or, if rates are not available

through those sources, the state will develop the fee schedule rate through an analysis of cost details from the submitted cost reports, Department of Labor statistics, and other available data on cost items

- Service utilization data will be analyzed to determine the frequency and type of service or services used by Medicaid members
- A base rate for each clinic will be established using frequency and expected service utilization
- Rate adjustment factors will be calculated for those members with higher acuity and in need of more intense services or longer duration services. Rate adjustment factors may also include age and region/geography.
- Cost updates will be collected throughout Year 1 of the demonstration to inform the rebasing methodology for Year 2
- An outlier payment methodology will be established for costs incurred by clinics in excess of an established threshold

Finally, a methodology for performance payments will be established based on a minimum utilization threshold, a minimum threshold of performance on the quality measure set, and a minimum improvement threshold on the quality measure set. The existing Person Centered Medical Home (PCMH) initiative within the Connecticut Medicaid Program is an excellent example of program that has a certification process for providers based on established criteria (NCQA PCMH certification), enhanced payments based on care coordination services, and performance payments for improvement on quality measures and performance payments for meeting or exceeding established standards on a core quality measure set. The PCMH Program started in January 2012. There are now a total of 1,383 PCMH providers in the Medicaid network. Every PCMH practice had to participate in a readiness review process and underwent an on-site review prior to becoming a PCMH practice. DSS is awaiting outcome data for CY 2014, but preliminary data indicates that those providers who are working toward certification as a PCMH practice and those who are certified PCMH practices have better health outcomes compared to non-PCMH providers. We expect to find the same improvements with CCBHCs.

#### **B10. Organizations that will participate in the project**

**The Behavioral Health Partnership Oversight Council (BHPOC)** has existed in Connecticut for almost ten years and was created to advise DSS, DMHAS, and DCF on the planning and implementation of the Connecticut Behavioral Health Partnership. The BHPOC is comprised of legislators and their designees, behavioral health consumers, family member, and advocates, medical and mental health practitioners, and state agencies. They work closely to monitor and assist the Departments in achieving their goal of improving care for Connecticut's citizens with behavioral health concerns. The Council is prepared to bring its collective resources to the CCBHC planning process, thereby ensuring that all stakeholders' voices are represented.

**The Connecticut Department of Public Health (DPH)** was established in 1878 and is the lead agency in protection of the public's health, and in providing health information, policy, and advocacy. DPH is a central part of a comprehensive network of public health services, and is a partner to local health departments for which it provides advocacy, training and certification, technical assistance and consultation, and specialty services that are not available at the local level. The mission of the DPH is to protect and improve the health and safety of the people of Connecticut by assuring the conditions in which people can be healthy; preventing disease,

injury, and disability, and promoting the equal enjoyment of the highest attainable standard of health, which is a human right and a priority of the state.

**ValueOptions, Inc.** is the Administrative Service Organization for the Connecticut Behavioral Health Partnership and works collaboratively with DSS, DCF, and DMHAS to create a quality service delivery system in Connecticut. Under the CCBHC planning grant and demonstration, ValueOptions would provide the clinical and analytical support to the statewide Medicaid behavioral health network.

**The Statewide Council of Community Collaboratives** is a subcommittee of the Children's Behavioral Advisory Council and is responsible for: monitoring and reviewing statewide local systems of care including the handling of grievances; linking children and families to their community collaborative; supporting local collaborative efforts; addressing issues related to the long-term direction, focus, and priorities of the state's system for children's mental health, including drafting recommendations regarding these services to be submitted to DCF.

**Connecticut Community Providers Association (CCPA)** is the premier state trade association representing organizations that provide health and human services and supports for children, adults, and families in the areas of mental health, substance use disorders, developmental disabilities, child and family health and well-being, and other related issue areas. CCPA works closely with member organizations, and advocates on their behalf at the Connecticut state legislature, with Connecticut state agencies, and at the federal level. CCPA provides information to its members on all relevant state and federal policies, funding, and innovations. CCPA also provides quality education and training on timely and significant health and human service issues, including implementation of health care reform.

**MTM Services (MTM)** is the premiere firm for organizations who want to accomplish substantial changes in their behavioral health service delivery system that improve the quality of care being delivered and the quality of life for those delivering it. The National Council for Behavioral Health has been MTM Services' exclusive contract agent nationally since 1997 and manages all of their contracts for services and invoicing. Together they provide a full suite of consulting services to prepare behavioral health for the dynamic new healthcare marketplace.

### **B11. Establishment of Boards of Governance for CCBHCs**

Connecticut is proposing to create an infrastructure to provide training and technical assistance support to agencies striving for CCBHC status. As part of that process, we anticipate governance and input from relevant stakeholders to be an area of ongoing planning and support. Fortunately, Connecticut has robust recovery and advocacy communities and a long history of stakeholder involvement in governance. As part of the self-assessment CCBHC tool that agencies will complete and submit, they will rate their own governance structure as it currently stands. Agencies that note compliance with CCBHC governance standards as a "concern" will be offered support in this area through a Learning Community offered by Connecticut's contractor, MTM. CCBHCs may need to recruit new board members, considering demographic criteria consistent with the standards, and to find additional ways for stakeholders to be involved in quality improvement initiatives and other ways for securing meaningful input from persons in recovery and family members. Agencies who do not meet the required governance structure may propose an alternative arrangement that accounts for CCBHC responsiveness to the population served; acceptance of this arrangement will be at the state's discretion.

## **C. STAFF, MANAGEMENT, and RELEVANT EXPERIENCE**

### **C1. Experience and capability of Connecticut to establish CCBHCs**

Based on the groundwork laid over the last 15 years, Connecticut is especially well-poised to make the most of this opportunity to establish the infrastructure needed to be able to prepare, equip, certify, and govern a network of CCBHCs across the state. There is, for example, a long-standing and highly successful cross-agency partnership among DSS, DMHAS, and DCF and with the Connecticut Behavioral Health Partnership (CTBHP) that enables a family and person-centered lifespan approach to behavioral health services that encompasses both Medicaid and grant-funded services and supports to individuals with behavioral health needs. Connecticut has been a national leader in the adoption of a resilience and recovery-oriented approach to care and has worked diligently to identify and rectify behavioral health disparities. The partner agencies of the CTBHP have shown that they can identify and respond to unmet needs by implementing such strategies as mental health and substance abuse screens, Crisis Intervention Training for police and other first responders, Enhanced Care Clinics, Emergency Mobile Crisis Teams, Person-Centered Medical Homes, and Behavioral Health Homes. It was for this reason, for example, that in July 2013, Connecticut was one of only six jurisdictions selected to participate in the Three Branch Institute on Child Social and Emotional Well-Being sponsored by the National Governors Association's (NGA) Center for Best Practices, the National Conference of State Legislatures, Casey Family Programs, the National Council of Juvenile and Family Court Judges, and the National Center for State Courts.

Connecticut Medicaid built on its already broad eligibility standards to become both an early expansion and full eligibility expansion state, and has worked with a fully constituted state-based health insurance exchange to establish an integrated eligibility process through which new Modified Adjusted Gross Income (MAGI) applicants and individuals being re-determined for eligibility use a single, consumer-friendly portal. Eligibility expansion has enabled Connecticut to serve nearly 192,000 single adults between the ages of 19 and 64, many of whom were previously uninsured or underinsured. Finally, Connecticut Medicaid is a self-insured, managed fee-for-service model that 1) utilizes four, statewide Administrative Services Organizations to streamline and optimize holistic use of Medicaid-funded services; 2) uses a rich and comprehensive set of claims data to risk stratify Medicaid beneficiaries; and 3) supports high cost, high need beneficiaries with Intensive Care Management services, in collaboration with hospitals and other community partners.

### **C2. Key Personnel**

The following people will direct and manage the planning process:

Project Director, DSS: William Halsey, LCSW, MBA, Director of Integrated Care. Mr. Halsey will serve as the lead staff person from Connecticut (25%)

Project Manager, DSS: Roderick Winstead, MS, MAEd, Manager (25%)

Project Manager, DMHAS: Jessica DeFlumer-Trapp, MA, LPC, Clinical Manager (50%)

Project Manager, DCF: Lois Berkowitz, PsyD, Director of Special Projects (25%)

Project Accountant, DSS: Krista Pender, MBA, Assistant Director (25%)

### **C3. Experience and qualifications of key personnel to develop project infrastructure**

*William Halsey, LCSW, MBA*, will provide overall oversight for this project. Mr. Halsey is currently the Director of Integrated Care for DSS, where he oversees the services and Administrative Services Organizations' contracts for medical, behavioral health, dental, and non-emergency medical transportation services for the Connecticut Medicaid Program. Prior to his current position, Mr. Halsey served as the Director of Behavioral Health for the Medicaid Program and still services in that capacity today. Mr. Halsey is also the Principal Investigator for the Medicaid Incentives Program to Prevent Chronic Diseases and the Project Director for the CMS Medicaid Emergency Psychiatric Demonstration Program. Mr. Halsey also implemented and managed the SAMHSA Access To Recovery grant from 2004-2010. He is well-positioned and highly capable of ensuring a successful planning year.

*Roderick Winstead, MS, MAEd*, will supervise the DSS Project Coordinator and directly oversee all DSS activities related to this project. Mr. Winstead is a manager in the Integrated Care Unit, Division of Health Services at DSS. In that position, he supervises the process of developing, modifying, and amending ASO deliverables. He manages these contracts to ensure that utilization management processes are aligned and conform to the Mental Health Parity law, and lead staff on promoting integration and excellent communication between ASOs, state departments, and providers. His close working relationships will be leveraged in this project.

*Jessica DeFlumer-Trapp, MA, LPC*, will supervise the DMHAS Project Coordinator and directly oversee all DMHAS activities related to this project. Ms. DeFlumer-Trapp is currently a Clinical Manager with the Managed Services Division of DMHAS, where she oversees projects related to healthcare reform initiatives, financing, and health information technology. At DMHAS, Ms. DeFlumer-Trapp serves as part of the implementation team for Connecticut's Behavioral Health Home Initiative, supports efforts toward strategic system re-design, and develops Departmental initiatives related to Health Information Technology research and implementation, an array of responsibilities that will be crucial to the success of the planning year activities.

*Lois Berkowitz, PsyD*, will supervise the DCF Project Coordinator and directly oversee all DCF activities related to this project. Dr. Berkowitz has been Director of Special Projects with the Clinical and Community Consultation and Support Team of DCF since 2006. She oversees multiple projects including the Enhanced Care Clinic initiative and quality of treatment at Psychiatric Residential Treatment Facilities. In addition, Dr. Berkowitz serves on the team that manages the contract with ValueOptions as part of the Connecticut Behavioral Health Partnership and will continue in this expanded capacity for the planning year.

*Krista Pender, MBA*, will lead all of the fiscal and accounting activities involved in establishing the PPS for the project. Ms. Pender has been the Assistant Director in Reimbursement and Certificate of Need for DSS since 2013. She has a bachelor's degree in Accounting and a master's degree in Professional Accounting. Prior to her work at DSS, she was with the Department of Developmental Services for 15 years in various levels of audit functions, rate setting, and revenue enhancement and brings a wealth of accounting experience to this project.

## **D. DATA COLLECTION and PERFORMANCE MEASUREMENT**

### **D1. Ability of Connecticut to collect and report on required performance measures**

Connecticut has received over \$220 million dollars in SAMHSA funding over the last 15 years and has successfully conducted evaluations of each of these projects as well as successfully participated in multiple national evaluations.

***Plan for process evaluation data collection, management, analysis, and reporting.*** We will collect the required performance measures as specified in Section I-2.2 of the application. Specifically, we will collect the number of organizations implementing training programs, the number of people newly credentialed/certified, the number of financing policy changes, the number of information technology links across multiple agencies, the number of workgroup/advisory group/council members who are consumer/family members, the number of policy changes, the number of organizational changes, and the number organizations that are collaborating/coordinating/sharing resources during the planning year. We have available multiple strategies for collecting these performance measures including through quarterly survey-monkey surveys to the organizations involved in the grant asking about recent changes, discussions at project management and steering committee meetings about changes in these performance measures during the last quarter, and ongoing data collection from conversations with project management team and key staff.

Management of the data will be accomplished through an access database that is maintained by study staff. This database will store the specific numbers required for performance evaluations as well as qualitative information detailing specific information about the number including details describing the performance, implementation details, and effects of the number. Analysis of the numerical data will be accomplished through queries in the access database and also through excel exports of the access database.

Reports on the numbers and process of the performance measures will be given to project management on an ongoing basis in order to document their progress on achieving the goals and inform their planning for future months. Ongoing reports will also be given to the CCBHC Steering Committee in order to help them track progress as well as give them information from which to advise the project management and evaluation team about progress on meeting the goals of the CCBHC planning year. Quarterly reports will be submitted to SAMHSA project management and the numerical information will be entered into CDP (Common Data Platform).

## **D2. Establish performance measurement infrastructure and implement CQI processes**

Connecticut will support the CCBHCs as they build performance management infrastructure and implement continuous quality improvement processes. Specifically, the state will consult about the performance targets indicated in the RFA as well as additional performance targets the CCBHCs would like to address. We, along with our ASO, ValueOptions, will help the CCBHCs design or modify and implement data collection systems—including registries or electronic health record functionality that report on access, quality, and scope of services using various types of data, including CCBHC administrative data and personnel records, claims, encounter data, patient records, and patient experience of care data. We will also assist the CCBHCs with preparing to use data to inform and support continuous quality improvement processes. This work will benefit from the state's extremely positive experience with a Consumer, Youth, and Family Quality Improvement Collaborative that was developed as part of our SAMHSA Mental Health Transformation State Incentive Grant. This consumer, youth, and family collaborative led to the development of standards for the involvement of stakeholders in quality improvement

activities and a new quality of care tool (*Elements of a Recovery Facilitating System*; 32) that was then administered by 45 consumers, youth, and family members to over 1,200 of their peers across the state. Agencies will thus be able to draw on consumers, youth, and family members who have experience in quality assessment and improvement to assist them in implementing this component of the CCBHC model. Finally, quality improvement will also include the use of fidelity measures already developed and used widely in Connecticut for EBPs including family and person-centered care, recovery orientation, and cultural competence/CLAS standards implementation.

### **D3. Plan for conduct of required performance assessment**

At least quarterly, we will review the performance data we are collecting and will report our analysis to SAMHSA as well as the project management team and the Steering Committee. This review of performance data will assess our progress towards meeting performance goals and we will use our review to improve management of this project. In particular, our review will help us determine whether the goals, objectives, and intended outcomes have been achieved and whether adjustments are needed in order to achieve those goals, objectives, and outcomes.

Our performance assessments will also be used to determine whether the project is currently having and will have in the future the intended impact on behavioral health disparities. We will submit written quarterly reports within 15 days from the end of the reporting quarter to SAMHSA documenting our performance evaluation, starting with January 2016. The report will describe progress on each of the required and allowable activities for which funding is provided.

### **D4. Address challenges encountered in collecting data for national evaluation**

One potential challenge related to data collection is that each of the three agencies involved in the planning period and demonstration project (DSS, DMHAS, and DCF) have separate data systems (see Attachment 2 for a table that lists which data elements are collected by which agency's systems). In addition, the data elements, frequency of collection, and streamlined approach to indexing individuals and other clinical data are diverse across all systems. This challenge has been addressed thus far through the contract the state has with ValueOptions, its ASO. ValueOptions performs various utilization management, quality management, and provider relations activities in support of the service system. Data serves a critical role in carrying out the functions of the ASO and therefore ValueOptions has had to find ways to integrate a number of data streams to inform and improve the service system. These data streams include DSS Medicaid Eligibility Information; DSS Medicaid Provider Data; DSS Medicaid behavioral health, medical, and pharmacy member level claims data; DMHAS behavioral health funded services encounter data; DCF flexible funding client level service data; Service utilization and clinical information obtained via the Medicaid service authorization and registration process. ValueOptions information technology, data reporting, data analytic, utilization, and quality management professionals produce thousands of reports each year that are used to enhance access to care, member experience, and quality. The ValueOptions quality department is experienced in developing quality measures using HEDIS, NCQA, and NQF specifications and has many of the CCBHC required reports already in use or in production.

In addition to these challenges in merging existing data, we expect to encounter challenges in assisting the CCBHCs in collecting new data elements needed for the national evaluation.

Although it is likely that the CCBHCs that will be certified will have electronic health records and will already collect and store many of the indicators needed through participation in the statewide data collection (e.g., patient registration/records, encounter data, MHSIP) effort will be devoted in the planning year to building the necessary infrastructure and programming needed to collect all of the measures in Appendix A, Table 1. Value Options will be contracted to develop the infrastructure needed, replicating the process used for the Medicaid Behavioral Health Homes project. ValueOptions will establish a new workflow mirroring existing structure to effectively and efficiently match individuals, claims, and clinical encounter data across data systems and store it for report output. This infrastructure will be available for use for CCBHCs to collect and merge the data necessary for the national evaluation.

#### **D5. Selection of comparison group of Medicaid enrollees not served by CCBHCs**

As part of our preparation for participation in the national evaluation, we will select comparable sites without CCBHC designation as a comparison group for an assessment of access, quality, and scope of services available to Medicaid enrollees served by CCBHCs compared with Medicaid enrollees who access community-based mental health services from other providers. Given that the state funds and operates multiple sites and administrative data are collected from all agencies, we will have no trouble finding numerous sites from which to compare our CCBHC clients.

Since many of the indicators specified in the RFA (e.g., Appendix II, Section 5; Appendix A; Appendix III) are collected on all DMHAS and DCF clients and many of these clients are Medicaid enrollees, we will have an ample population from which to select a comparison group of Medicaid enrollees who access community-based mental health services from non-CCBHC providers. Our ASO, ValueOptions, has also developed algorithms for finding the comparable providers based on size, location, and services rendered. This approach can be leveraged for appropriate inclusion in this model. The comparison group can take a variety of forms including comparing certified CCBHCs to non-certified CCBHCs or to general community care, depending on what the algorithm used by ValueOptions returns and what SAMHSA suggests.

#### **D6. Capacity to collect data for national evaluation of demonstration program**

We will participate fully in the national evaluation, led by HHS, to compare accessibility to community-based behavioral health services in participating clinics with accessibility for patients who are not served by CCBHCs in addition to evaluating the cost, quality, and scope of services provided by CCBHCs and the impact of the demonstration programs on the federal and state costs for a full range of mental health and substance use services (including inpatient, emergency, and ambulatory services paid for through sources other than the demonstration program funding). In particular, we will 1) collaborate with the national evaluation planning team and provide input on the evaluation design, data sources, and performance measures, 2) work with HHS and the evaluation planning team to construct a comparison group for an assessment of access, quality, and scope of services available to Medicaid enrollees served by CCBHCs compared with Medicaid enrollees who access services from other community-based mental health services providers, and 3) prepare requests for an Institutional Review Board's approval to collect and report on process and outcome data (as necessary, for the multiple agencies and research institutions involved in this grant).

Through various initiatives in Connecticut that require combining clinical records with claims data mentioned above, we feel that we are poised to continue this effort by collecting and reporting on the required Quality Outcomes of this RFA. Under the CTBHP, ValueOptions with the assistance of the Departments has established a method for matching DMHAS and DCF service use data with DSS Medicaid claims data. Proven success at integrating data across systems at the member level allows for a fuller and more complete dataset that improves reporting and analytics. For example, by including records of state-funded services that are not Medicaid reimbursed in our measures of the rate at which Medicaid members connect to care following an inpatient admission, the accuracy of the measure is improved. For an upcoming project, Behavioral Health Home (BHH) implementation in Connecticut (State Plan Amendment pending), DMHAS and DCF will expand data capacity by collecting validated quality measures related to health, many of which overlap with the required quality outcomes for the CCBHCs.

Both DMHAS and DCF utilize platforms for collecting and reporting on service and demographic data. The DMHAS Data Performance System (DDaP) is a web-based system that allows providers the ability to submit and manage data through direct interface or batch file submission. The DMHAS Data Performance System includes client management, reporting, and auditing functions in a HIPAA-compliant, 24/7 secure online platform. Behavioral health providers contracted by DCF report client-level data into an internet-based system known as the DCF Provider Information Exchange. Each contracted service (referred to as a Program) has its own customized data collection model, though many data elements are shared across Programs. Client-level data are also reported at the level of behavioral health clinic, and these reports can be used to assist CCBHC's with their reporting requirements in the demonstration years.

In addition, patient experience data is also collected routinely in the form of client satisfaction surveys from state agencies serving individuals and families using the MHSIP, which is also one of the required measures of the CCBHCs in Appendix A of the RFA. DCF requires outpatient providers to administer the Youth Services Survey for Families (YSS-F) during the course of treatment or no later than at the conclusion of a treatment episode to assess perceptions of behavioral health services. A modification of the MHSIP (Mental Health Statistics Improvement Plan) survey for adults, the YSS-F assesses caregivers' perceptions of behavioral health services for their children aged 17 and under. Both surveys consist of 26 questions, which create seven domains that are used to measure different aspects of customer satisfaction with public behavioral health services. Results are uploaded into DCF's PIE system. Thus, CCBHCs certified in the planning year could use this existing infrastructure to meeting this reporting requirement.

Finally, the Health Information Technology for Economic and Clinical Health Act (HITECH) has provided federal funding through the Centers for Medicare and Medicaid (CMS) for state-based Health IT initiatives. The goal of HITECH is to increase the use of Health IT to improve quality, safety, and efficiency of health care while reducing disparities, engaging patients and families, improving care coordination, ensuring adequate privacy and security protections for personal health information, and improving population and public health. As of June 2015, the State of Connecticut had received a little over \$325 million through the EHR incentive program. Public Act 14-217 has designated the DSS as the lead state agency for the Health Information Exchange (HIE) and Health Information Technology (HIT). The Commissioner of DSS serves as the chair of the HIT Advisory Council for the state, and both DMHAS and DCF have representatives on this Council.

The following enterprise solutions have been procured by the state and are being deployed at the Bureau of Enterprise Systems and Technology (BEST) and are fundamental to supporting a quality data infrastructure that is essential for enhanced care delivery and payment reform: 1) a standards based Health Provider Directory; 2) Enterprise Master Patient Index; and 3) a Health Information Service Provider service for Direct Messaging (DM). These will serve as building blocks for operating a statewide health information exchange. We are promoting the use of DM protocol to send messages between providers and/or systems to enhance care-coordination for an array of program services (e.g., long term post-acute care provider network, durable medical equipment) by ensuring exchange of documents (e.g. discharge summary, assessments, orders, and continuity of care documents).

Currently, DSS is working with CMS to provide a Personal Health Record (PHR) to Medicaid beneficiaries through a demonstration grant. DSS plans to use Quality Reporting Document Architecture (QRDA) Category III and Category I standards for receiving eClinical Quality Measures as one option in their EHR Incentive program. Lastly, the state will use a federated approach to review/produce provider/organization/state-level data quality enabled by edge-server based indexing technology. This helps mediate differences between small and large provider groups. All HIT assets will be available to other interested parties for re-use through a shared cost arrangement. The technologies and systems are designed for scaling to enterprise requirements. As Connecticut evolves its HIT capacity, the CCBHC data will be indexed and available for measurement and quality improvement purposes.