



ANNUAL PROGRAMS DESCRIPTION REPORT

FY26

(July 1, 2025-June 30, 2026)

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Presented to Management: 8/18/2026

Table of Contents

Mission Statement.....	3
Core Values.....	3
Quality Assurance	3
Service Description.....	3
Total Client and Community Contacts.....	4
Activity Statistics	5
Turnover Rate	6
Years of Service	6
Student – Volunteer Training	6
Billing and Services Review	6
CARF Accreditation.....	7
Core Competencies.....	7
QUALITY ASSURANCE REPORTS	12
PROCEDURAL PROTOCOL MANUAL	13
INITIAL CLIENT CONTACTS	14
Admissions and Discharges by Program	15
Group Activity	16
Community Mental Health Treatment Project (CMHTP)	17
ITCD (Integrated Treatment for Co-Occurring Disorders).....	17
Healthcare Home (HCH & Disease Management)	18
IPS (Individual Placement and Support) Employment Services.....	18
Zero Suicide	19
Trauma Informed Services.....	20
Grievances.....	20

Mission Statement

North Central Missouri Mental Health Center delivers high quality trauma-informed behavioral health services in a caring and compassionate atmosphere that promotes dignity, builds on natural supports, encourages consumer choice, embraces cultural diversity, and empowers individuals through collaboration to achieve their highest quality of life.

Core Values

NCMMHC will continue developing groundbreaking and accessible services in a timely and responsive way. We value compassion, hope, empathy, encouragement, and respect. We will provide individualized, useful and efficient responses to client needs. We will also provide leadership in the development of cooperative and supportive relationships with other service organizations.

Quality Assurance

NCMMHC provides an Annual Programs Description Report as part of the comprehensive Quality Assurance Plan. Quality assurance data is continually generated throughout the year. The Quality Assurance Coordinator or designee is responsible for compiling all tracking data for the Annual Programs Description report. The Quality Assurance Committee reviews the Annual Programs Description report and submits it to the Management Team for review and final approval. The Annual Programs Description report is then presented to the NCMMHC Board of Directors in November of each year. The Annual Programs Description Report is also presented to the CARF survey team during the certification accreditation survey. The final Annual Programs Description report is kept in electronic format within the COO electronic records and is available upon request.

Service Description

NCMMHC provides comprehensive outpatient mental health services to residents age 5 and above in the north central nine counties of Missouri (Caldwell, Daviess, Grundy, Harrison, Linn, Livingston, Mercer, Putnam and Sullivan). NCMMHC holds current certification through the Missouri Department of Mental Health (DMH), Division of Behavioral Health (DBH) and CARF (Commission on Accreditation of Rehabilitation Facilities).

Outpatient services provided include initial assessment, community outreach/education/referral, case management for children and adults, individual therapy, psychiatric medication services, ASAM (addictive substance use disorders) services for youth and adults, MAT (medication assisted treatment – for opioids), and public speaking engagements.

CPRC (Community Psychiatric Rehabilitation Center) services include community support, healthcare home services for children and adults, IPS (Individual Placement and Support – Employment), crisis intervention and resolution, ITCD (Integrated Treatment for Co-occurring Disorders) for adults, individual and educational groups, SPARCS (Structured Psychotherapy for

Adolescents Responding to Chronic Stress), psychosocial rehabilitation and disease management.

NCMMHC is currently working on three collaborative projects. Two projects are the Community Mental Health Treatment (CMHT/MH-3) program and the Serious Mental Illness (OSMI/MH-4) program. These programs link clients on probation and/or parole to all CPRC (Community Psychiatric Rehabilitation Center) or ITCD (Integrated Treatment for Co-occurring Disorders) services including therapy, medication management, educational programs, and case management. Individual Placement and Support (IPS) is the third collaborative project. We are contracted with Vocational-Rehabilitation to help link clients to jobs in the community.

Total Client and Community Contacts

Total special services contacts for FY26 = 174 outreach activities

Total Initial contacts for FY26 = 1105 (92 contacts per month)

Best estimate of Total Unduplicated count of clients for FY26: 2815 (as of June 30, 2026)

Total charts closed FY26: 1209 (101 closed charts per month)

Total Crisis calls (CommCare) for FY26 = 76 (6 contacts per month)

Total Crisis calls (NCMMHC) for FY26 = 125 (10 contacts per month)

Total 988 calls for FY26 = 93 (8 contacts per month)

Total clients served FY26 = 3,393

Total Charts Open

	July-Dec	Jan-June		July-Dec	Jan-June
Youth	176	185	In case management	129	132
Adult	454	412	In case management	264	209

Census by Program

Program	12/31/25	06/30/26	Program	12/31/25	6/30/26
<i>Adult Clients 590</i>	542	510	<i>Youth Clients 590</i>	393	430
<i>Adult Clients 573</i>	481	524	<i>Youth Clients 573</i>	93	84
<i>Adult EAP</i>	0	0	<i>Youth ASAM</i>	13	8
<i>DOC</i>	0	0	<i>DM3700</i>	57	64
<i>Adult ITCD</i>	176	178	<i>Adult ASAM</i>	6	5

Tracking Only (the following program numbers as of June 30, 2026)

Program	# of Clients	Type of Clients	Program	# of Clients	Type of Clients
<i>Intensive CPRC 597</i>	0	Youth	<i>Wellness Coaching</i>	2	Y & A
<i>CBHL (tracking)</i>	37	Adult	<i>HCH (tracking)</i>	811	Y & A
<i>DOC (tracking)</i>	75	Adult	<i>IPS</i>	50	Adult
<i>DM3700</i>	118	Adult	<i>Zero Suicide</i>	2	Y & A
<i>ERE</i>	24	Y & A	<i>MAT</i>	7	Adult
<i>YBHL</i>	88	Youth			

Activity Statistics

Gender	#	%
Female	1571	55.81%
Male	1239	44.01%
Unknown	1	0.04%
Age	#	%
Under 5	2	0.07%
Between 5 and 12	355	12.61%
Between 13 and 17	342	12.15%
Between 18 and 29	533	18.93%
Between 30 and 64	1362	48.38%
Over 64	221	7.85%
Unknown	0	0.00%
Marital Status	#	%
Divorced	357	12.68%
Married	472	16.77%
Separated	158	5.61%
Single	1630	57.90%
Unknown	111	3.94%
Widowed	83	2.95%
Race	#	%
American Indian or Alaska Native	11	0.39%
Asian	1	0.04%
Biracial	47	1.67%
Black or African American	46	1.63%
Native Hawaiian or Other Pacific Islander	5	0.18%
Other	5	0.18%
Spanish American	14	0.50%
Two or More Races	4	0.14%
Unknown	17	0.60%
White	2661	94.53%

County	Count	%
Adair	1	0.04%
Boone	2	0.07%
Buchanan	1	0.04%
Caldwell	165	5.86%
Carroll	8	0.28%
Chariton	5	0.18%
Clinton	6	0.21%
Cooper	1	0.04%
Daviess	201	7.14%
DeKalb	6	0.21%
Gentry	3	0.11%
Grundy	489	17.37%
Harrison	193	6.86%
Jackson	2	0.07%
Linn	546	19.40%
Livingston	874	31.05%
Macon	4	0.14%
Mercer	71	2.52%
Nodaway	3	0.11%
Osage	1	0.04%
Phelps	2	0.07%
Putnam	70	2.49%
Randolph	1	0.04%
Ray	1	0.04%
Saint Louis City	1	0.04%
Schuyler	1	0.04%
Story	1	0.04%
Sullivan	139	4.94%
Unknown	13	0.46%

Turnover Rate

NCMMHC has set a goal to keep the annual turnover rate for full-time employees under 20%. In FY26 there were 120 full-time employees. Current turnover rate is 17.1%, which continues to meet our agency goal. Twenty-one employees left the agency during FY26. However, 24 employees were hired in FY26 which makes agency employee net growth 1.14 percent.

Years of Service

The following chart reflects employment longevity for full-time, part-time and contract employees according to the employee anniversary dates. Thirty (30) or 23% of NCMMHC employees have remained employed at the agency for over 10 years.

Years employed	# of staff in year category	Percentage of staff in category
0-4 years	74	56%
4.1 – 10 years	28	21%
10.1 - 15 years	14	11%
15.1 - 20 years	7	5%
20.1 - 25 years	2	2%
25.1 years and over	7	5%

Student – Volunteer Training

NCMMHC is dedicated to civic improvements. We feel it is our responsibility as mental health professionals to assist community members, area schools, colleges and universities in training the next generation of service providers for our communities. During FY26 NCMMHC hosted 39 students from five different institutions – Chillicothe R-2 High School, North Central Missouri College, Truman University, Western Governors University, and Wichita State University. Two of the 39 students were PMHNP students and one was a MA Counseling student.

Billing and Services Review

The DMH conducts a Billing and Services Review (BSR) for NCMMHC each year. The BSR review was conducted September 8-12, 2025. There were 33 records reviewed. There were 8 claims reviewed with Adult CMHC SCL. In this category there were 0 disallowances. There were 5 claims reviewed in CPS Adult POS and no disallowances in this category. There were 36 claims reviewed in Adult Community Psychiatric Rehabilitation and no disallowances in this category. There were 10 claims in CCBHC SUD and no disallowances in this category. There were 52 claims reviewed in CPS Youth Community Psychiatric Rehabilitation with no disallowances in this category. Zero disallowances were found during the review. One service was billed with the incorrect units. It was voided and rebilled with the correct number of units. No action plan was required.

CARF Accreditation

(Commission on Accreditation of Rehabilitation Facilities)

In May of 2011 NCMMHC was surveyed for the first time by CARF and was awarded a three-year accreditation. The most recent CARF survey was conducted March 29, 2023-March 31, 2023. The next CARF survey is scheduled for September 23, 2026 through September 25, 2026.

During each CARF survey, NCMMHC receives additional recommendations and suggestions on how to continue improving NCMMHC services. After each survey, CARF requests a Quality Improvement Plan to be written that delineates how NCMMHC will conduct continuous improvements in service delivery. The 2023 CARF survey resulted in 74 recommendations for improvement, and the agency has made significant progress toward completing them. During the last CARF survey, the CARF surveyors were very complimentary regarding the services offered through NCMMHC.

Core Competencies

NCMMHC supports continuous improvement through regular core competency reviews. These reviews measure compliance with key NCMMHC, CARF, and DMH requirements and help identify opportunities to improve clinical service delivery. Completed reports are provided to the responsible staff and supervisors for review, correction, and training.

Every six months, the Quality Assurance Coordinator compiles a Core Competency Training Needs Report showing competency percentage rates across all reviewed areas. Areas with the lowest performance are identified for individual or group training. Assigned reviews are tracked through the quality assurance process to ensure they are completed, corrected, and addressed through training when needed. Scores are averaged to provide enough detail to support individual service improvement while also identifying broader system needs.

Annually, NCMMHC and the Board of Directors review the Quality Assurance (QA) Plan as needed to strengthen the process for measuring, monitoring, and reporting competency scores. The purpose of the core competency QA plan is to support high-quality client care and evaluate staff performance. The Quality Assurance Committee has identified 23 competency areas with written procedures for measuring staff performance. During this past year, 17 of the 23 competencies were evaluated by years. The FY27 target is 100 percent of the core competencies being evaluated.

Core competencies are reviewed by trained staff and reflect essential duties performed during employment at NCMMHC. The agency monitors staff performance by setting measurable goals, tracking results, and reviewing findings to identify areas for improvement. Results are compiled by the Quality Assurance Coordinator or designee and included in this report, including agency scores and competencies targeted for training. Individual scores are maintained in the Wufoo link where the review was completed and are reflected in job descriptions, supervision, and annual performance evaluations as applicable.

Supervisors review competency results with staff during scheduled individual supervision. For new hires, supervisors review 100% of progress notes for six weeks following orientation or until competency is demonstrated. Clinicians may challenge or discuss scores with their supervisors, and any score changes with explanations are copied to the Chief Operating Officer. If a competency is not completed within the year, the supervisor may schedule a review before the next performance evaluation. When scores consistently fall below acceptable standards, supervisors may review up to 100% of identified tasks until competency is demonstrated. Supervisors may also conduct a competency review at any time during the year.

In FY26, the URT and QA committees have started reviewing all core competency QA procedures and forms for relevance and accuracy. Several core competency QA forms have been updated to identify current training needs of the staff. The committees hope to finish this process in FY27.

Every six months, average agency competency findings are reported to the Management Team and program directors, including the weakest items in each category that may require additional training. Scores below 90% are included in the full report. Scores below 80% require individual staff training and review during scheduled first-Monday group training days.

Competency scores are based on the following legend:

90% – 100% = Exceeds Requirements/Expectations

80% – 89% = Meets Job Requirements

70% - 79% = Needs Improvement

0% - 69% = Unacceptable

Competency data for this report covers the fiscal year of July 1, 2025 through June 30, 2026. There were 1,107 peer reviews completed in FY26.

QA falling below 90%

Annual Psychosocial Assessment (41 reviewed)

- Q1: NARRATIVE UPDATE appears to be from the client's perspective. Explains if the problems that brought them into services have or have not been resolved. **85%**
- Q6: NEED FOR AND AVAILABILITY OF SOCIAL, COMMUNITY AND NATURAL SUPPORTS/RESOURCES section clearly identifies the client's current needs. **76%**
- Q8: SNAP is filled out using client's own words/quotes. **78%**
- Q10: TREATMENT PLAN GOALS/WHY CONTINUE LEVEL OF CARE section includes the treatment goal summary in client's quotes. **68%**

Clinic Nurse Progress Note (36 reviewed)

- Q9: Medications match ECR med list. **89%**
- Q14: Is the note free from obvious grammatical errors? **72%**
- Q15: Includes details regarding client's demeanor/appearance. **72%**
- Q16: Follow-up date with physician noted. **89%**

Comprehensive PSI (52 reviewed)

- Q2: PRESENTING CONCERNS in the client's own words. **88%**
- Q4: MEDICATION INFORMATION includes efficacy of meds. **88%**
- Q10: ASSESSED NEEDS/TREATMENT RECOMMENDATIONS section includes the treatment goal summary in client's quotes. **63%**
- Q12: QMHP signed the assessment prior to the master treatment plan. **83%**
- Q15: Signed within 3 business days. **88%**

Crisis Review After Call Debrief (0 reviewed)

This core competency was revised during the last year. Results will be included next year.

CSS Progress Note (264 reviewed)

- Q2: Is there documentation in the comments section of the "Symptoms of Risk" page in the client's own words addressing the "Symptoms of Risk?" **79%**
- Q3: Was the plan in the previous progress note addressed in the client's own words on what they did or didn't do to address the plan of their last progress note? **67%**
- Q8: Does the plan section of the progress note describe in measurable terms what the client will do until the next visit in order to make progress on their treatment objective(s) that they worked on during the visit. **52%**
- Q11: Is the next scheduled appointment time identified? **88%**
- Q12: Is the next scheduled appointment date and time on the clinician's schedule? **83%**
- Q14: Is the note free from obvious grammatical errors? **89%**

Incident Reporting (58 reviewed)

- Q7: Does the report describe the disposition? **84%**
- Does the report describe the follow up? (What will you do next) **53%**
- Was it reported in writing to the COO or CEO within 24 hours of discovery? **86%**

Initial Intake Assessment (41 reviewed)

- Q1: PRESENTING PROBLEM appears to be from the client's perspective. **83%**
- Q2: PRESENTING PROBLEM explains how daily life is affected. **78%**
- Q3: PRESENTING PROBLEM states how long this has been going on. **44%**
- Q5: CURRENT MEDICATIONS section includes the efficacy of the current/previously used medications. **73%**
- Q8: CLIENT'S PREFERENCES in the client's own words. **61%**
- Q10: ASSESSED NEEDS/TREATMENT RECOMMENDATIONS section includes the treatment goal summary in client's quotes. **63%**

IPS ES Progress Note – Client (21 reviewed)

- Q1: Are the travel origin and destination identified both before and after the client visit? **71%**
- Q3: Was the plan in the previous progress note addressed in the client's own words on what they did or didn't do to address the plan of their last progress note? **38%**
- Q4: Is there an employment goal on the client's current master treatment plan? **81%**

- Q5: Is the employment treatment plan intervention activity addressed in the intervention portion of the progress note? **43%**
- Q6: If the progress note mentions coping skills or stressors, did the ES explain what coping skills or stressors are? **62%**
- Q7: Does the progress note documentation describe what the ES is doing to help the client learn from and/or analyze each job experience, job loss, job problems and/or job successes? **57%**
- Q8: Does the progress note documentation describe client preferences, experiences, skills, current adjustment, strengths, and/or personal contacts? **48%**
- Q9: Does the progress note documentation describe barriers/problems and specific problem-solving suggestions using environmental assessments and consideration of reasonable accommodations? **38%**
- Q12: Does the plan section of the progress note describe in measurable terms what the client will do until next visit to make progress on their treatment objective that they worked on during the visit? **62%**
- Q13: Is the next scheduled appointment date/time identified on the progress note? **67%**
- Q14: the next scheduled appointment date and time on the ES's ECR schedule? **62%**

IPS ES Progress Note—Employer (22 reviewed)

- Q1: Are there 6+ employer contacts in the week of the reviewed progress note? **41%**
- Q2: If the employer contact was client specific, was the client identified and the reason the client would be a good fit for the job, on the weekly job development tracking progress note? **55%**
- Q3: Is there documentation regarding what the ES learned about the employer, their type of business, and their current needs? **27%**
- Q4: Is there documentation that the ES explained how the IPS program could benefit the employer? **59%**
- Q5: Is there documentation regarding how the ES advocated how an IPS client would be a good fit for employment? **23%**
- Q6: Is there clear documentation whether the ES is sitting in on an interview or making a follow-up contact for a specific client? **59%**
- Q8: Does the progress note documentation describe discussion with the employer pertaining to the client's preferences, skills, and/or current adjustment? **41%**
- Q9: Does the progress note documentation describe the employer's perception to client barriers/problems and/or specific problem solving weaknesses? **14%**
- Q10: Is there documentation regarding the ES offering suggestions using environmental assessments and considerations of reasonable accommodations? **32%**
- Q11: Does the progress note describe the employer's response to the information provided that day? **77%**
- Q15: Is the content of the progress note different across visits? **82%**
- Q16: Is the content of the progress note different across clients? **82%**

ITCD Progress Note (79 reviewed)

- Q1: Is there documentation in the comments section of the “Symptoms of Risk” page in the client’s own words addressing the “Symptoms of Risk?” **85%**
- Q2: Was the plan in the previous progress note addressed in the client’s own words on what they did or didn’t do to address the plan of their last progress note? **84%**
- Q7: Does the plan section of the progress note describe in measurable terms, what the client will do until the next visit in order to make progress on their treatment objective(s) that they worked on during the visit? **59%**
- Q11: Is the next scheduled appointment date and time on the clinician’s schedule? **87%**

NCM Health Screening (82 reviewed)

- Q5: Is there a current release of information for client PCP? **88%**
- Q7: If the client uses tobacco, is there a related health goal listed? **88%**
- Q13: If blood glucose is over 100 or Hg1A1C over 6.0, is there a recommendation for follow-up.? **84%**
- Q14: If total cholesterol is over 200, LDL over 140, HDL less than 40 or Triglycerides over 150, is a recommendation for follow-up? **85%**

New Hire CSS Progress Note (59 reviewed)

- Q1: Are the travel origin and destination identified both before and after the client visit? **86%**
- Q2: Is there documentation in the comments section of the “Symptoms of Risk” page in the client’s own words addressing the “Symptoms of Risk?” **62%**
- Q3: Was the plan in the previous progress note addressed in the client’s own words on what they did or didn’t do to address the plan of their last progress note? **69%**
- Q4: Is each chosen treatment plan problem/goal/objective activity explained in the intervention portion of the progress note? **78%**
- Q5: If the progress note mentions coping skills or stressors, did the CSS explain what the coping skills or stressors are? **85%**
- Q6: Does the plan section of the progress note describe in measurable terms what the client will do until the next visit to make progress on their treatment objectives? **78%**

Certified Peer Specialist / Family Support Provider Progress Note (35 reviewed)

- Q1: Are the travel origin and destination identified both before and after the client visit? **80%**
- Q7: Is there documentation in the comments section, in the client’s own words, that is related to the “Symptoms of Risk”? **54%**
- Q10: Does the plan section of the progress note describe in measurable terms what the client will do until next visit to make progress on their treatment objectives? **69%**
- Q14: Is the next scheduled appointment date and time on the clinician’s schedule? **83%**

Quarterly Review (60 reviewed)

All competencies exceeded job expectations.

Therapy Progress Note (98 reviewed)

- Q4: In the comments section of the “Symptoms of Risk” assessment, is there documentation in the client’s own words that describes the client’s response to the risk assessment? **76%**
- Q7: Was the plan in the previous progress note addressed in the intervention section, describing the progress or lack of progress? **84%**
- Q10: Does the response section of the progress note use the client’s own words to describe the client’s response respective to the symptoms of their diagnosis? **69%**
- Q14: Does the plan section of the progress note describe in measurable terms what the client will do until the next visit to make progress on their treatment objectives? **43%**
- Q15: Does the plan section of the progress note state that the client agreed and/or negotiated the plan with the therapist? **74%**

Transition Summary (65 reviewed)

All competencies exceeded job expectations.

Treatment Planning (78 reviewed)

- Q1: GOAL SUMMARY includes the client’s quoted statement(s) (“I...”). **86%**
- Q2: GOAL SUMMARY includes all the treatment objectives. **87%**
- Q8: INTERVENTIONS are written in simple specific language. **87%**
- Q10: OBJECTIVES are different from the previous treatment plan. If not, start dates were left the same or documented in assessment/treatment plan client wants the same objectives. **88%**
- Q14: Signed within 3 business days. **86%**

Zero Suicide Tracking (16 reviewed)

- Q9: Were they seen throughout the duration of being on zero suicide? Duration of ten days, as opposed to three times per month. **69%**
- Q10: Was a CSSRS done at each visit for the length of time the client is on the Zero Suicide tracking list? **63%**
- Q12: Is there documentation that the CSS attempted to call/visit the client assigned to the Zero Suicide program within 24 hours after the DNS/CBC? **88%**

Overall, the agency competency scores are broken down by categories of clinical skill. NCMMHC strives for improvement in all areas that are scored. Performance improvement is scheduled at all levels of service delivery. The measurement of core activities continues to allow the agency to see how well clinicians are responding to agency and client goals. The full Core Competency Training Needs Report along with all core competency questions and scores are kept with the Chief Operating Officer and are available upon request.

Quality Assurance Reports

There are many detailed quality assurance (QA) activities carried out by a variety of trained NCMMHC staff. All QA reports are kept on the Chief Operating Officer’s Microsoft 365 Drive and are available upon request. Some of those QA reports include:

Core Competency Annual PSA	Core Competency Quarterly Review
Core Competency Clinic Nurse Progress Note	Core Competency Support Staff *
Core Competency Comprehensive PSI	Core Competency Therapy Progress Note
Core Competency CPS/FSP Progress Note	Core Competency Transition Summary
Core Competency CPS/FSP Visit *	Core Competency Treatment Planning
Core Competency Crisis Intervention Review *	Core Competency Zero Suicide Tracking
Core Competency CSS Progress Note	
Core Competency CSS Visit *	Children & Youth Plan of Service and Program Review
Core Competency Doctor Peer Review	CMHTP/Department of Corrections Program Review
Core Competency Incident Report	Consumer Satisfaction Surveys for all departments
Core Competency Initial Intake Assessment	Crisis Department Plan of Service & Program Review
Core Competency Injections *	Crisis Department Quarterly Report*
Core Competency IPS ES Progress Note – Client	CMHTP/Department of Corrections Program Review
Core Competency IPS ES PN - Employer	CPRC Plan of Service and Program Review
Core Competency ITCD Progress Note	Critical Incident Sentinel Event Report
Core Competency MAT*	Healthcare Home Plan of Service & Program Review
Core Competency NCM Health Screening	Initial Contact Intake Report
Core Competency New Hire CSS Progress Note	Individual Placement Support (IPS) Program Review
Core Competency New Hire Health Screening *	ITCD Plan of Service and Program Review
Core Competency CPS/FSP Progress Note	Training Needs Report

Procedural Protocol Manual

The Management Team, Utilization and Review Team (URT) and Quality Assurance (QA) committee continue to update the Procedural Protocol manual that is located on the agency “S” (shared) drive for employee use. This is a dynamic record of procedures used to examine, refine and implement agency activities. In this manual, agency procedures are spelled out in a detailed sequential format. The Procedural Protocol manual is used to clarify and lessen any systemic difficulties. The master copy of the Procedural Protocol manual is maintained by the Quality Assurance Coordinator, kept on the Chief Operating Officer’s Microsoft 365 Drive and may be reviewed upon request.

The following table shows the number of procedures reviewed and updated in the fiscal years from FY22 through FY26. Between July 1, 2025 and June 30, 2026 the URT and the management team reviewed and clarified 38 procedures.

Year	# procedures updated
FY22	56
FY23	68
FY24	76
FY25	41
FY26	38

Procedures also impact agency forms, handbooks, job descriptions, and letter templates. In FY26, URT and Management Teams created, reviewed, or revised 24 agency forms, 3 client handbooks, 3 job descriptions, and 1 letter template.

Initial Client Contacts

(Compiled by Loretta Ray, Intake Specialist)

As a CCBHO (Certified Community Behavioral Health Organization), NCMMHC is required to meet pre-determined access goals which are provided by DMH.

CCBHOs are required to conduct a preliminary screening and risk assessment at the time of first contact (by phone or in person) to determine whether the individual seeking services is in crisis or has an urgent or routine need for services. For those with urgent needs, CCBHOs are expected to complete an eligibility determination and provide or arrange for services within 1 business day. For those with routine needs, CCBHOs are expected to complete an eligibility determination and provide or arrange for services within 10 business days.

The following are the numbers for July 1, 2025-June 30, 2026.

The number of new individuals seeking service

An emergency/crisis need for service (Same Day): **150**

Urgent need for service (Next Day): **69**

Routine need for service (within 10 days): **665**

For individuals with an urgent need for service, the number and percentage with an eligibility determination completed within 1 business day: 150; 100%

The mean number of days from first contact to completion of initial intake assessment (should be within 10 days): 6.7 days

The mean number of days from first contact to completion of a comprehensive evaluation (should be within 60 days): 41 days

NCMMHC recognizes that complying with these criteria is challenging. Even when a CCBHO offers same day appointments to all individuals seeking service, not all individuals will access services within the expected timeframes.

One hundred percent (100%) of “Initial Contacts” to NCMMHC are tracked throughout the year. The time it takes from the initial contact screening to having an initial intake scheduled is 0 days. NCMMHC recognizes an average of 10 waiting days as an acceptable goal for an initial eligibility assessment.

From July 1, 2024 through June 30, 2025 the average number of days a client had to wait from the initial contact to the initial eligibility assessment was 6 days. For FY26, the average wait increased to 7 days. However, there were also 122 more intakes assigned and 84 additional charts opened than in FY25. The data from both years are below:

Initial Contacts FY26 (July 1, 2025 – June 30, 2026)

Office	Intakes Assigned	Charts Opened	Percent Opened	Avg # business days from initial contact to intake
Bethany	71	54	76%	9.4
Brookfield	116	97	84%	5.5
Chillicothe	498	377	76%	6.1
Trenton	378	289	76%	5.8
BWI	4	4	100%	N/A
CWI	31	31	100%	N/A
TWI	32	32	100%	N/A
Total	1130	884	78%	6.7

Initial Contacts FY25 (July 1, 2024 – June 30, 2025)

Office	Intakes Assigned	Charts Opened	Percent Opened	Avg # business days from initial contact to intake
Bethany	31	24	77%	7.8
Brookfield	170	120	71%	5.1
Chillicothe	365	301	82%	7.1
Trenton	350	263	75%	5.5
BWI	23	23	100%	0
CWI	31	31	100%	0
TWI	38	38	100%	0
Total	1008	800	79%	6.4

Legend:

BWI = Brookfield walk-in CWI = Chillicothe walk-in, TWI = Trenton walk-in

Admissions and Discharges by Program

The following table shows the number of admissions and discharges in various services for the first and second half of FY26. The table reflects some services divided out by adult and youth services. Others are reflected as a combination of both adult and youth services.

Program	Admissions		Discharges		Difference	
	July-Dec	Jan-June	July-Dec	Jan-June	July-Dec	Jan-June

Adult Rehabilitation (590)	264	209	277	264	-13	-55
Youth Rehabilitation (590)	129	132	103	106	26	26
Adult Outpatient (573)	454	412	454	440	0	-28
Youth Outpatient (573)	176	185	148	158	28	27
Health Care Home – Adult/Youth	231	146	229	210	2	-64
DM3700 - Adult/Youth	11	8	10	20	1	-12
DOC (Department of Corrections)	38	41	39	35	-1	6
ITCD – Adult	45	48	51	54	-6	-6
IPS - Adult/Youth	33	24	51	36	-18	-12
Youth Intensive (597)	0	0	0	0	0	0
Zero Suicide – Adult/Youth	20	12	36	27	-16	-15
ASAM Adult	4	4	3	6	1	-2
ASAM Youth	5	4	7	6	-2	-2
Total	1410	1225	1408	1362	2	-137

Group Activity

The following table shows the types of NCMMHC groups and the number of times that each group met for FY26.

Group Name	July – Dec 2025	Jan – June 2026
Adult PSR (Psychosocial Rehabilitation) group in Laredo (M-F)	105	108
Adult PSR (Psychosocial Rehabilitation) TELEHEALTH	1	4
ASAM Grief	11	15
Ashbury Coping Skills Group	11	10
Brookfield Financial Wellness Group	1	-
Brookfield YMCA Physical Activity Group	20	23
Chillicothe Manor Group	7	6
Emotional Wellness Recovery TELEHEALTH	25	22
Family First: Combating Substance Abuse Together	6	-
HCH Wellness Class	4	4
ITCD/ASAM – Stress & Anxiety Recovery Skills	-	8
ITCD/ASAM – Stress & Anxiety TELEHEALTH	-	14
ITCD/ASAM – Understanding Trauma in Recovery (hybrid)	-	19
ITCD/DOC/ASAM Anger Management	12	15
ITCD/DOC/ASAM Self-esteem and Self-compassion	12	20
Journey to Recovery (hybrid)	22	25
Living the Promises – Chillicothe	-	9
Living the Promises – Trenton	-	2
Smoking Cessation - Bethany	-	5
Smoking Cessation – Trenton	5	5
SPARCS Group – Chillicothe	-	14
SPARCS Group – Trenton	10	11
Strengthening Recovery – Chillicothe	3	34

Strengthening Recovery – TELEHEALTH	34	7
Summer Group – Youth – Brookfield	6	
Teen Summer Group – Chillicothe	6	3
Time out! For me. (Self-care)	15	2

Community Mental Health Treatment Project (CMHTP)

(Department of Corrections [DOC] MH3/MH4)

Several years ago, the DMH developed a cooperative program with Missouri Department of Corrections (DOC) to provide mental health and substance use treatment to clients under the supervision of Probation and Parole. The DOC has agreed to reimburse DMH for specific comprehensive psychiatric services identified as per a formal Memorandum of Understanding. After the agency became certified as a CCBHO, the agency's utilization of this funding had decreased. In FY26, no billings were made to this allocation. However, the agency continues to work with the DOC partnership and continues to provide services for DOC referrals through our CPRC program and following the same process as Probation & Parole referrals.

The clients who are identified by Probation and Parole who need mental health services are served by NCMMHC through the existing CPRC community service program as contracted with DMH. Throughout NCMMHC services, clients in this program remain under the supervision of Probation and Parole. This collaborative project is intended to promote public safety and improve natural outcomes for these individuals involved with probation and parole.

On June 30, 2026, there were 75 clients being tracked by the DOC program.

ITCD (Integrated Treatment for Co-Occurring Disorders)

Integrated Treatment for Co-occurring Disorders (ITCD) treatment is an evidenced based treatment integrating substance use treatment with other CPRC services such as community support for individuals with co-occurring psychiatric and substance use disorders. Through integrated treatment, clients can live lives in which co-occurring disorders are not the dominant driving factors. Recovery-oriented services will encourage clients to define and fulfill their personal recovery goals.

Clients are actively involved in their treatment design and have the ability to self-direct the person-centered and family-centered services they receive. Person-centered and family-centered care includes care that recognizes the particular cultural and other needs of the individual. Clients have choices regarding their services including the amount, duration and scope of services and supports received from NCMMHC.

As of June 30, 2026, there were 178 clients enrolled in the ITCD program. This is an increase from 168 on June 30, 2025.

Healthcare Home (HCH & Disease Management)

Healthcare Home (HCH) services are part of the CPRC (Community Psychiatric Rehabilitation Center) program where a nurse care manager is provided to carry out metabolic screenings and enhance community support services for high-cost Medicaid enrollees who are having difficulty navigating the community health care system.

The goal of the HCH service is to assist the client in achieving the best possible health care while managing cost containment. We believe HCH services and interventions will continue to reduce the cost to the state of providing care and treatment and improve the health outcomes for the enrollees.

Members of the Healthcare Home Team provide care coordination services designed to streamline plans of care, reduce hospital admissions, ease the transition to long-term services and supports, and interrupt patterns of frequent hospital emergency department use. One way Nurse Care Managers (NCM) do this is by conducting hospital and ER visit follow-ups. Follow ups may also be conducted by community support specialists or the HCH care coordinator. Members of the Healthcare Home Team collaborate with NCMMHC & community behavioral health providers, physicians (primary care and medical specialists), hospitals, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing clients' and family members' ability to manage their care and live safely in the community and shift the use of reactive care and treatment to proactive health promotion and self-management.

On June 30, 2026, NCMMHC was providing HCH services to 811 adult and youth clients, a decrease from FY25. However, in early June 2026, DMH reported that HCH slots were decreasing across the state due to state budget cuts. The HCH team started working with clients and their teams to ensure all clients who need HCH support will remain in HCH while finding ways to decrease enrollment to DMH guidelines. The new allocation for FY27 is 771.

IPS (Individual Placement and Support) Employment Services

NCMMHC has been designated as an approved vendor to provide supported employment services. IPS is an evidenced based program funded through Vocational Rehabilitation (VR). NCMMHC recognizes that people who are employed typically have decreased mental health symptoms. People will often see themselves in a more positive way when they are gainfully employed. Work gives people structure and routines. Having an income gives them more choices about what to buy and where to live. A client must be enrolled in the CPRC program to participate in the IPS program. An Employment Specialist will help people find jobs in the open labor market that pay at least minimum wage and that anyone could have, regardless of their disability status. Once a job is found, the employment specialist will continue to provide ongoing support as needed. Vocational Rehabilitation will reimburse NCMMHC for the IPS services when the client is enrolled in VR. As of June 30, 2026, there were 50 clients receiving IPS services. A joint team from DMH and VR conducted a fidelity review of the IPS program in early July 2026.

Zero Suicide

NCMMHC has a program called Zero Suicide. This program calls for suicide prevention to be a core component of NCMMHC services. This program will involve the implementation of effective clinical practices for assessing and treating those at risk for suicide. This program specifically promotes the adoption of “zero suicides” as an aspirational goal by NCMMHC. This model of care aims to improve care and outcomes for clients at risk of suicide by developing a competent, confident, and caring workforce to systematically identify and assess suicide risk. Every person who has been identified as at risk of suicide will be given evidenced based assessments that directly target suicidality. Two of those evidenced based assessments are the PHQ-9 and the C-SSRS.

The PHQ-9 (Patient Health Questionnaire-9) is a quick 9 question depression assessment. It is a self-report questionnaire that is verified by a clinician while with the client. If there are at least 5 positive responses the clinician will consider a Depressive Disorder diagnosis. A definitive diagnosis is made on clinical grounds considering how well the client understood the questionnaire.

The C-SSRS (Columbia-Suicide Severity Rating Scale) involves the assessment of suicidality. The C-SSRS is available in over 100 different languages. It is part of a national and international public health initiative including behavioral health agencies, psychiatric emergency departments, hospital systems, managed care organizations, hospices, schools, college campuses, US Army, National Guard, VAs, Navy and Air Force settings, frontline responders such as police, fire department, EMTs and more. No mental health training is required to administer the C-SSRS assessment. The main goal of the C-SSRS is the prediction of suicidal behavior and to foster targeted interventions.

Clients who are found to have a significant risk of suicide are encouraged to go on Zero Suicide Tracking. Those who accept are placed on the Zero Suicide Tracking List (Zero Suicide), which is maintained by the Crisis Director and the ACI Outreach Specialist (or others, as designated).

To add a client to the list:

- A) the client must voluntarily consent after being informed about Zero Suicide
- B) the Crisis Director or ACI Outreach Specialist must be notified
- C) if the client has a Community Support Specialist, the CSS and team leader must be notified

A client on Zero Suicide will be called or visited daily by their CSS. If the CSS is unavailable, the team leader will make contact. If a client does not have a CSS, a member of the ACI department will make daily contact. During weekends, holidays, and after business hours, the on-call crisis specialist will contact the client. The on-call crisis specialist will then inform any additional staff for that client of any updates or concerns.

When making contact, a staff member will ask how the client is doing and gather information to complete a C-SSRS. This will be done daily while the client remains on Zero Suicide. Once the client is feeling more stable and says they feel capable of being safe, the client can be removed

from the list. Clients should be encouraged to contact their CSS or NCMMHC if they again feel they are a danger to themselves.

Trauma Informed Services

Over the past 20 years, there has been a growing acknowledgement of the prevalence and impact of trauma in our personal lives and in the lives of our clients. We at NCMMHC advocate for a trauma informed approach to services for several reasons.

First, trauma is pervasive. The experience of trauma is not a rare exception. It is part of our society. Secondly, the impact of trauma is very broad and touches many areas of our lives. Trauma exposure increases the risk of vulnerabilities such as mental health problems like posttraumatic stress disorder, depression, excessive hostility, anxiety, substance use, suicidality and more. The impact of trauma is often deep and life-shaping. Trauma can shape a person's ability to navigate their life.

As a trauma-informed agency, NCMMHC has begun implementing strategies like training all staff regarding trauma. Example scripts regarding how to communicate with a client so as not to re-traumatize someone who shows up too late to be seen at their previously scheduled appointment have been provided to the front desk staff. Other trauma informed initiatives that have been implemented include mindfulness activities during supervision, glider chairs in agency lobbies, de-cluttering agency lobbies and "rocker" chairs in the therapy offices. The consumer satisfaction survey was updated to include three new trauma care questions that speak to client safety, choice and the assessment process. Trauma sensitive questions have been designed for both the hiring and supervision process. The orientation process for newly hired staff is now spread across the first three weeks of employment. The Trauma Task Force (included in the STIC – Suicide and Trauma Informed Care – committee) has designed a debriefing procedure for any staff person who may have experienced trauma while carrying out their duties for NCMMHC.

NCMMHC currently has a Trauma Task Force of nine NCMMHC staff. This Task Force developed Staff Peer Support Team designated as trauma peer mentors to all other agency staff. The trauma peer mentor is expected to be available to talk with staff, allowing the staff to express their needs without threat, judgment or coercion. The trauma peer mentor will listen to the thoughts and concerns of the staff person and focus on supporting the staff person through learning and personal growth. The Trauma Task Force continues to inform staff of peer mentor access at all quarterly staff meetings.

In early June 2026, the Trauma Task Force developed Trauma Informed Culture Assessment (TICA) workgroups for each of the main offices to help the agency continue its growth as a Trauma Informed agency.

Grievances

NCMMHC is committed to the promotion of best practices and to hearing and responding to client concerns in a fair, expedient, open and client-centered manner. All informal complaints are resolved daily. Within 10 days of any informal complaint, the Quality Assurance

Coordinator/Chief Operating Officer will review and resolve the informal complaint to the satisfaction of the client and make any systemic changes as necessary.

Any formal complaint documented in the client's complaint form will be formally investigated, resolved according to agency policy and reviewed during the next scheduled Clinical Review Committee. The Quality Assurance Coordinator will conduct a review of all formal complaints to determine trends, areas needing performance improvement and actions to be taken. There was one formal complaint in FY26. The complaint was regarding the client's feeling that their personal experiences and medical diagnoses were disregarded by their therapist. At the time the complaint was received, the therapist was out of the office. The COO communicated the delay in the response to the client, who understood. The complaint was resolved via phone call and email on 7/15/2025.