Mental Health Transformation State Incentive Grant

September 30,

2011

Oklahoma was awarded a Mental Health Transformation State Incentive Grant from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration in October 2005. The goal of the grant program was to develop a consumer driven, recovery focused, integrated system for behavioral healthcare in Oklahoma. This report is a summary of transformation activities developed through partnerships with state agencies, private agencies, tribal nations, advocacy agencies, and private citizens that culminated in systems change that created greater access to care, more culturally aware practitioners, expansion of the consumer workforce and peer-run services.

MH-TSIG
Final Report

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Section D. TSIG FINAL PROGRESS REPORT

Executive Summary

Oklahoma is one of seven initial Mental Health Transformation State Incentive (TSIG) grantees awarded funding in October 2005. As stated in the original grant application, Oklahoma's vision for a transformed mental health system is, "That all of its citizens will prosper and achieve their personal goals in the communities of their choice. To realize this goal all Oklahomans must have access to the care that they need and want. Consumers and family members must receive care that they help design to achieve recovery and meet their personal goals."

Using the President's New Freedom Commission Goals, the Governor's Transformation Advisory Board (GTAB) identified Oklahoma's goals documented on the initial Comprehensive State Plan adopted in September of 2006. Over the next year and a half workgroups appointed by the GTAB met, reviewed the plan and identified priority areas for which the transformation grant would provide resources in terms of funding and/or staff support to move these priorities forward. From July 2006 to December 2007 the workgroups met and came to consensus on projects that they recommended for TSIG support. At the December GTAB meeting, the workgroups presented 25 priorities for consideration. The GTAB membership asked Commissioner White to review the priorities and to make recommendations on which priorities fit best with leadership priorities for a transformed system. In March, Commissioner White presented priority areas recommended for TSIG support and initiatives were approved by the GTAB.

In years three, four and five the action phase of the grant was mobilized. Stakeholders from state, private and advocacy agencies worked to develop projects and implementation plans to move the goals forward. Request for proposals were announced to develop leadership training and drop in centers, contracts to train the workforce to become more culturally competent and provide quality evidence based services and supervision to the workforce began. The tele-health network grew from 12 sites in 2007 to over 162 sites at the time of this report, spanning mental health, substance abuse, and primary care practitioners. Partnerships to complete cross agency initiatives such as recovery work within the prisons, and trauma informed work within the child serving systems helped to strengthen the relationships between agencies and advocates working together to make the transformation initiative a success. Final reports, publications, and illustrations related to these initiatives may be found in Section 8 of this report.

Oklahoma's transformation efforts provided the support to develop a more integrated systems and the practice to continually examine the system and strive for excellence lives on today. The infrastructure in place today with increased access to care, peer services, culturally competent staff, and integrated funding between the two largest behavioral health providers creates the necessary ingredients to provide ongoing quality and consumer driven care to the citizens of Oklahoma.

Section One: Infrastructure Developments Achieved

1.1 Policy changes. Oklahoma conducted policy change interviews over the course of the transformation journey with agencies represented on the GTAB. Of the ten state agencies represented on the GTAB, eight agencies agreed to participate. The agencies are Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), Oklahoma Health Care Authority (OHCA), Department of Rehabilitation Services (DRS), Oklahoma Department of Human Service (OKDHS), Oklahoma Commission on Children and Youth (OCCY), Oklahoma Department of Corrections (DOC), Oklahoma State Department of Health (OSDH), and Office of Juvenile Affairs (OJA). Agency directors and senior staff were interview in 2007, 2009 and 2010. A total of 340 unduplicated policy changes were enacted within the agencies related to

behavioral health transformation. Cross site trends included; expand access to care through technology, increase early intervention, and improve quality and effectiveness of service delivery through training. The five year policy change report is found in Section 8 and summarizes each agencies changes and the systematic changes as a whole.

1.2 Number of persons trained in service improvements recommended by the plan. Transformation focused on workforce development in many arenas. Training of the behavioral health workforce, corrections workforce, higher education, juvenile justice, child welfare, advocacy agencies, consumer's, family, youth, and the general public resulted in almost 40,000 (39,474) Oklahomans trained in service improvements recommended by the Comprehensive Plan. Trainings supported by TSIG include; mental health first aid, suicide prevention, recovery support, leadership, cultural competency, correctional crisis resolution, correctional recovery support, residential transition, care management, primary care screening, and evidence based service specific models.

1.3 Financing policy changes completed. Financing Policy changes are at the heart of sustaining projects and programs piloted over the past five years. Oklahoma agencies engaged in activities designed to improve accountability and expand access for services. Seventy four financing policy changes were documented that include increases in appropriations and new or revised provider reimbursement codes.
Reimbursement for family support providers and recovery support specialists created a new peer workforce in Oklahoma. Medicaid and ODMHSAS developed billing codes, rules and a certification processes to sustain this workforce. ODMHSAS provider contracts require every Community Mental Health Center to hire peer support staff and implemented a pay for performance incentive payment system, discussed further in Section Seven, in 2009 to encourage providers to expand the peer workforce.

The Screening Brief Intervention Referral and Treatment (SBIRT) code became an Oklahoma Medicaid code in January, 2008. This allows primary care providers to screen for substance use using evidence based tools and receive reimbursement to sustain this effort. TSIG funded a pilot project to train primary care staff using the SBIRT model. Mercy Healthcare Network, University of Oklahoma Health Science Center, and St John's Hospital staff were trained in this screening model through this TSIG initiative and the practice is part of routine care today. At this time the code is a physician code and not the model envisioned by SAMHSA using health educators. As expected physicians having adequate time and incentive to provide this screening has not been evidenced by using the code. What is very clear is that the screening and brief intervention service within primary care works. Efforts to embed this process into the Oklahoma system are underway through the ODMHSAS Prevention Services Division. The reimbursement issue is a national issue and Oklahoma will continue to work with other states to solve this issues. The article published in the Oklahoma State Medical Association journal about this project is located in Section 8.

Other reimbursement codes allowed expansion of consumer driven care for specialized populations. The Programs of Assertive Community Treatment (PACT) rate was unbundled in July, 2008 to allow for more individualized service delivery for consumers requiring this evidence based model of care. The Office of Juvenile Affairs partnered with Medicaid (OHCA) to develop a rate for Multi-Systemic Therapy (MST). This evidence based practice is designed to be effective with the most serious offenders; the research shows a decrease in aggression and substance use after only 13 weeks of treatment.

In order to promote more integrated community care for custody youth, the OKDHS increased the rate and the number of beds available for Level C group home care in July of 2009. Although increasing the rate for residential care may not seem to promote community integration, Level C homes are the lowest level of group home care. Residents attend public schools and have the opportunity to work and receive services in the

community setting while residing in these homes. Prior to this expansion there were only 16 available beds statewide, now there is incentive for providers to develop more community living group home beds.

Integrated financing through the Oklahoma Consolidated Claims Process (CCP) began in July 2010. OHCA and ODMHSAS, the two largest funders of behavioral health care in Oklahoma created the single payer system. There are 1,343 behavioral health providers using the system, including agencies and private clinicians. Providers now bill the CCP system and ODMHSAS is the payer of last resort. In 2008 over 5 million dollars was spent in state funding for services that could have been billed through Medicaid. This system eliminates this from occurring and maximizes state dollars in a fiscal environment where conserving ever dollar is a necessity.

1.4 Organizational changes completed. Organizational changes were evidenced in all of the state agencies surveyed, totaling 50 over the five year period. The original plan for transforming the system documented in the grant application was to embed projects and staff within multiple agencies to assure that change was manifested throughout the behavioral health system. This plan was achieved in part through the organizational policy changes documented below.

Perhaps the single most important organizational change of the transformation period was Senate Bill 1719 that went into effect in November 2008 to consider tele-health service delivery the same as face to face service delivery for behavioral healthcare. This became the avenue for increasing access to care statewide. Tele-health grew from no sites in 2005 to 162 sites within all of Oklahoma's 77 counties currently. Over 16,000 Oklahomans were served in FY10 an average of 108 persons per facility. Over 49,500 services were delivered during that same time period. The cost savings from tele-health has shown a significant return on investment. Estimates show that utilization of this technology saves the state $377,000 per quarter in mileage and staff time.

ODMHSAS created several positions during the transformation years that will continue to provide opportunities for collaboration and consumer inclusion. The creation of the Tribal State Relations workgroup and the tribal liaison position at ODMHSAS began in March 2007. This work created an avenue for the tribes and state agencies to coordinate activities while creating a learning environment of mutual respect. The Director of Advocacy and Wellness position was developed in May of 2009; it expanded the Office of Consumer Affairs to be inclusive of advocacy efforts as well as overall wellness initiatives. The Coordinator of Holistic Wellness position was also created to train and educate staff and consumers to be inclusive of physical health activities within behavioral health programs. The development of a position within the Prevention Division to promote screening in primary care facilities using the SBIRT model resulted in training of healthcare staff within major hospitals and primary care offices in Oklahoma.

OHCA, through the TSIG Care Management project housed ODMHSAS and advocacy agency staff to coordinate care for children with the propensity for using the highest levels of care. The Care Management project was a study conducted through the University of Oklahoma Evaluation Team (OU-E-Team). The project, a collaboration of all of the child-serving agencies and Federation of Families, showed significant results. Children and families receiving care coordination spent significantly less time in higher levels of care that resulted in a savings of $357 per youth per month in behavioral healthcare charges. Projections for the moderate to high end youth based on Medicaid utilization estimated that total savings for the state would be over 18 million dollars for a one year period if all participants had received care management. The Care Management unit at OHCA continues to fund these positions and the care management process continues.

The OSDH through TSIG funding established a Coordinator of Infant and Early Childhood housed at OSDH. The Developmental Screening Initiative (DSI) project was coordinated through this position and resulted in

primary care practices within 32 of Oklahoma's 77 counties receiving developmental and social emotional screening tools through Child Guidance staff that personally delivered the tools and provided consultation and training on the use and importance of screening young children. Currently, OSDH and ODMHSAS jointly fund the Coordinator position that will be sustained at the State Health Department.

The DOC collaborated with ODMHSAS and advocacy agencies to create programs and positions designed to educate the DOC workforce in recovery principles and expand the use of peer support in the prisons. During the transformation years, the DOC created a new position, Director of Female Offender Operations in July 2010 as Oklahoma leads the nation in the incarceration of women. Programs to prevent women from entering the DOC system as well as programs to help with the transition back into the community from prison now exist. Through TSIG, ODMHSAS, NAMI and the DOC partnered to provide recovery support training to inmates who are now hired as recovery support staff within the prisons. The DOC created a job classification for these positions and part of their ongoing role is to conduct NAMI Connections support groups in the prisons. Several inmates who have left prison are employed as Recovery Support staff in their communities. The DOC workforce development project facilitated by university staff provided internships within DOC facilities and provided mental health professionals and physicians' assistants with experience and training to work within the DOC system. This workforce development project will be sustained through a DOC and Oklahoma State University, Tulsa partnership and will continue to provide student internships.

1.5 Number of organizations that obtain and analyze data relevant to the goals of the grant.
During the course of the transformation grant**,** data sharing agreements were completed with the major providers of behavioral healthcare in Oklahoma. ODMHSAS, DOC, OKDHS, and OJA have agreements to exchange information related to clients within these multiple systems. The OHCA and ODMHSAS already had a data sharing agreement prior to transformation; however, further integration of the systems was created in the Consolidated Claims Process that enables providers of mental health and substance abuse services to invoice a single system for payment. This infrastructure change allows for increased data sharing between Medicaid and mental health and allows for further analysis of all consumers accessing services using GPRA and NOMs. As mentioned earlier in this report, there are 1,343 behavioral health providers with access to the CCP system. Of those providers, 574 are behavioral health agency providers that have the ability to obtain data from the system related to GPRA & NOMs measures.

1.6 Number of consumers and family members of statewide consumer and family run networks. Oklahoma began collecting information on advocacy agency membership in 2007. There were five agencies representing 3,046 individuals in 2007. In 2010 membership in those five agencies grew to 3,397, a 14% increase overall. Although the growth in membership is less than anticipated, overall the agencies have sustained membership through numerous leadership changes and difficult financial times. Advocacy agencies also transitioned to become service providers for the system, providing training and education as well as advocacy support. The advocacy agencies have a stronger partnership with each other, with the provider system and state agencies. The agencies remain committed to collaboration and developed the Coalition of Advocates a forum consisting of all of the advocacy agencies with a primary goal to provide input to legislative decision making related to behavioral healthcare issues.

Section Two: Service Changes Implemented

2.1 Suicide Prevention. The Oklahoma Youth Suicide Prevention Coalition through Senate Bill 2000 in 2008 expanded membership and focus to include all ages. Through the ODMHSAS Prevention Division, suicide prevention trainings statewide totaled 850 trainings and 18,500 trained gatekeepers. Suicide Prevention services are now available in many communities and organizations across the state. Further training and integration will continue as ODMHSAS was the recipient of the Garrett Lee Smith Youth Suicide

Prevention and Early Intervention grant in 2010. The Oklahoma goals are to decrease suicide deaths and attempts for youth ages 10-24 with a priority focus on Native American males, veterans, youth receiving behavioral health services, and college students.

2.2 Trauma Informed. A trauma informed culture is emerging within the provider system of care for children and families and in the adult system. The children's system has been working on trauma informed initiatives and trauma specific training of the workforce through a partnership with the University of Oklahoma Center on Child Abuse and Neglect for several years. Sites receive consultation and fidelity monitoring to implement Trauma Focused CBT. The Mental Health Transformation grant awarded in 2010 allows further expansion with the introduction of training for trauma specific service delivery focused on adult treatment. Evidence of the transformation that has taken place over the past six years includes Sanctuary certification for two inpatient facilities, Children's Recovery Center and Rose Rock Center (for adults with a criminal background). Griffin Memorial Hospital, the states only adult inpatient hospital, is working with the Andrus Center to become the third Sanctuary site in Oklahoma.

The trauma informed culture is not only pervasive within the ODMHSAS system, the Department of Corrections has trained 176 staff in crisis conflict resolution skills specifically designed to educate probation/parole and other prison staff on effectively handling a crisis when dealing with persons with mental health and substance abuse issues who are incarcerated. The training called Correctional Conflict Resolution Training (CCRT) is designed to educate DOC staff on the needs of persons with mental health, addiction, and trauma related issues while incarcerated. The OKDHS is developing a trauma informed child welfare system through training and consultation provided by the Chadwick Center. Oklahoma is one of three laboratory sites nationwide that will develop tools for child welfare staff nationwide over the next five years.

2.3 Consumer Driven & Recovery Focused. Recovery Support services are available within every community mental health center in Oklahoma. As of June 30, 2011, 232 consumers are certified to provide peer services for the behavioral health system. The same recovery support training provided in communities is available within the prison system at four Department of Correction facilities. Twenty- seven inmates are now certified to provide recovery support services within their respective facilities. The first peer run drop in center was developed during the course of the TSIG grant and opened their doors in November 2010. As of June, 2011, 702 unduplicated consumers' (Men 512, women 190) have participated in the center's development. The center is staffed by five consumers and 7 peer volunteers hired through the Mental Health Association. The residential transition project supported training 26 providers to help consumers move from congregate care to community living with supports provided by the residential agency staff to the consumers. Although not as successful as anticipated, two sites participated fully in this project and successfully transitioned consumers to the community and at the time of this writing those consumers remain in the community. A self-directed care model called CommonGround™ was implemented to help consumers prepare for medication clinic appointments with their physicians. Recovery support staff provided support to consumer's using the web based system and survey resulted indicated consumer satisfaction with the system. The CommonGround™ site specific evaluation narrative in Section Six will discuss this program in more detail.

2.4 Family Focused. During the course of the transformation grant the Oklahoma Systems of Care communities expanded from 14 communities to 53 communities. Oklahoma's goal to provide wraparound service delivery in all 77 counties is a goal within reach. Family members, consumers and youth attended leadership training provided by three advocacy agencies. One of the agencies developed the curriculum that was used by all to train consumers, family members and youth throughout Oklahoma to become involved with transformation as members of boards and community coalitions. Four Hundred and Five participants

were trained within 10 counties statewide. A survey conducted at the conclusion of the trainings indicated that 79% of the participants were serving on boards and other community groups post training.

2.5 Reduce Disparities. Oklahoma devoted much effort to decreasing disparities. The tele-health initiative clearly created greater access to care for rural Oklahomans. The goal in the initial grant application was to provide access to care within 30 miles of every Oklahoman either through a mental health center or via technology and Oklahoma realized this goal in 2011. TSIG brought the National Multicultural Institute (NMCI) to Oklahoma to build the internal capacity of state agencies and advocacy groups to provide culturally competent services and care to Oklahomans. NMCI provided two Level I training of trainers in 2008 and 2009 and participants were certified by the NMCI President and the Chair of the Governor's Transformation Advisory Board. Seventy-seven trainers from 26 organizations attended the training of trainers (TOT) provided by NMCI. Organizations were offered ongoing consultation and technical assistance by the ODMHSAS Cultural Competency coordinator to further integrate change by reviewing policies and procedures. ODMHSAS now has monthly cultural competency "Lunch & Learn" meetings and created the Oklahoma Partner's in Diversity (OPID) council to provide ongoing support to statewide trainers. Training is occurring on a regular basis and accessible to all state employees through the Office of Personnel Management, Human Resource training series for all state staff by trainers who attended the NMCI TOT.

Provider staff now has access on their computer desktop to Culture Vision a web based system that provides information on over 60 different cultural groups, religions, and ethnicities. The system provides agency staff with a means to gain information on individual beliefs, customs and preferences for particular ethnic or religious convictions. In this way, practitioners are better prepared to engage individuals from different cultures in treatment more successfully. The Tribal-State Relations workgroup was appointed by the GTAB in 2007 and continues to provide a forum that is sponsored by ODMHSAS Mental Health Recovery Division for state agencies and tribes to collaborate on behavioral healthcare issues. A tribal consultation policy was developed to guide the state and tribes on how to better integrate service delivery. An educational series to introduce the provider network to traditional healing practices began as a partnership between ODMHSAS and the tribes. This educational series has been delivered regionally by state and tribal staff.

The Latino Project was implemented based on recommendations from the ODMHSAS Executive Leadership Academy Capstone project and identified the need to improve access and delivery of mental health and substance abuse services to Spanish speaking members of the Hispanic/Latino community. The project named "Bienvenido" identified policy changes to increase staff training at a community mental health center located in a predominately Hispanic community. The NIATx methodology of research and implementing one or two activities to achieve results in a relatively short period of time was utilized. Rapid cycle testing of activities produced recommendations for the larger system post pilot. One of those recommendations has already been implemented adding the Latino Agency (one of the pilot organizations) to the tele-health network as a resource to the larger system. A report on the Bienveniedo project is located in Section 8.

2.6 Screening in Primary Care. Screening in primary care projects supported by TSIG provided an important emphasis on integrating care for physical and behavioral health issues at one location. The Developmental Screening Initiative (DSI) provided primary care physicians with the opportunity to be educated on developmental, social and emotional screenings for children birth through eight years of age by Child Guidance staff within county health departments. TSIG partnered with staff in state and county health departments, Medicaid, OU Health Science Center, and the Infant and Early Childhood Council to develop this project. The project was recognized at the 2009 Oklahoma Family Resource Coalition meeting and awarded the Family Matters award for outstanding contributions on behalf of children and their families in Oklahoma. During the project from April 2008 – June 2010, 410 contacts were made, 175 visits to primary care offices, representing 85 different health care organizations. Providers requested 277 screening tools for

their practices (the Ages and Stages, Social Emotional; Parental Evaluation of Developmental Status (PEDs) or the Modified Checklist for Autism in Toddlers; (M-CHAT)). Child Guidance staff visited physicians in their offices to help develop the screening process and were available for training, consultation or service provision for young children in the community. OSDH will continue to be a resource for the primary care community through local Child Guidance staff as well as the Coordinator of Infant and Early Childhood Services in the Child Guidance office.

The University of Oklahoma (OU), Department of Pediatrics partnered with, TSIG, Medicaid, and the OSDH to develop the post-partum screening protocol for the neo-natal intensive care units (NICU) in Oklahoma. A protocol to screen mothers with infants in the NICU at two weeks post-partum was developed and is now the standard of care. During the study, 111 mothers were screened. Results indicated that 50% scored positive for post-partum symptoms, and another 30% screened at risk for adjustment difficulties. Over 75% of the mothers were Medicaid recipients that lost insurance eligibility two months post-delivery. This prompted the team to move quickly so that short term services while still in the hospital and/or upon returning home was possible. Dr. Gillaspy, OU, Department of Pediatrics, led this project and continues to share the protocol with other NICU centers in Oklahoma.

Oklahoma SBIRT (screening, brief intervention, referral and treatment) is a structured set of questions designed to identify individuals at risk for alcohol use problems, followed by a brief discussion between an individual and the primary care practitioner. The screening asks several questions to determine whether individuals are misusing alcohol, or experiencing harm from their drinking. The provider evaluates the answers and then shares the results and their significance with the individual, then offers a brief intervention session that lasts 5 to 15 minutes. In Oklahoma, TSIG funded a pilot program with Mercy Healthcare to develop the SBIRT protocol. During the pilot over 2,000 individuals were screened and over 300 brief interventions in the Emergency Department in Oklahoma City were completed. The study showed a statistically significant reduction of patient visits to the ER. ODMHSAS Prevention Division houses a subject matter expert that developed SBIRT basic training curriculum as well as advanced training in motivational interviewing. Trainings occurred at Integris Health, OU, Level One Trauma Center, St John's Hospital emergency room, and Variety Healthcare Center (FQHC). Oklahoma applied for the FY11 SAMHSA SBIRT grant but was not awarded. Despite the lost funding opportunity, screening in primary care continues to be a priority and on-going conversations with the Oklahoma Medical Association, Oklahoma Hospital Association and the Oklahoma Health Care Authority to expand the SBIRT model further into the primary care network in Oklahoma will continue. A presentation on this project was made at the 21st Sigma Theta Tau International Research Conference and a publication is forthcoming in the Journal of Nursing. The draft publication for this project is located in Section 8.

2.7 Excellent Care is Delivered. Oklahoma TSIG contracted with the Beck Institute for Research and Training to educate licensed and non-licensed behavioral health practitioners in cognitive behavioral therapy techniques. Dr. Sokol from the Beck Institute provided on-site training and consultation to the licensed staff. Thirty clinicians applied to participate in the training program and committed to monthly consultation over the following year and a half. Clinical staff also committed to membership in an ongoing learning collaborative and agreed to train non-licensed staff a minimum of twice a year in cognitive behavioral techniques through the ODMHSAS Human Resource Development Training Division. For the non-licensed staff Dr. Sokol conducted regional trainings in cognitive behavioral techniques. There were 854 non-licensed staff who attended these trainings. The Oklahoma clinical staff that completed the training of trainers (20) will sustain this effort by providing the ongoing training in cognitive behavioral techniques to the system. Training in cognitive behavioral techniques for case management and the recovery support workforce was developed and presented at the Oklahoma Prevention and Recovery conference in 2011.

Correctional Crisis Response Training (CCRT) was developed through collaboration between ODMHSAS and the DOC. CCRT is modeled after the Crisis Intervention Team (CIT) training provided primarily to police officers based on the Memphis model. The curriculum was revised to accommodate training for prison guards, probation and parole officers. Officers were provided with a 40 hour training program conducted by ODMHSAS, corrections staff, law enforcement and consumers to educate officers on positive intervention techniques when dealing with an inmate or parolee with mental health issues. The year and a half program was delivered to 176 participants from the prison or probation and parole divisions. Recommendations for continued expansion of this program are being discussed within the DOC.

The Department of Correction's workforce development project is a joint effort between ODMHSAS, DOC and five universities. The project, facilitated by OSU Center for Behavioral Health through a TSIG contract, convened the university departmental heads to establish a learning collaborative and internship program for students in mental health programs at the university. Students applied for the program and over the course of the program, nineteen students participated at four DOC facilities. Students were supervised by DOC psychologists and worked on research projects and/or in the prison units. Bi-annual presentations by the students as well as faculty provided a forum to share ideas and discuss projects. The result was six presentations with 285 participants, and 3,528 clinical hours spent by the students in the program. This project will be sustained by the DOC and there are students enrolled in the FY11 Fall semester.

2.8 Use Technology to Increase Access. Oklahoma's tele-health network has been recognized nationally as a Rural Promising Practice by the Western Interstate Commission for Higher Education. All of the goals set on the comprehensive plan were accomplished. Sustainability of the network is assured through partnerships with provider organizations to fund staff and continued expansion of the infrastructure through network fees. Service delivery in Oklahoma has dramatically been enhanced with tele-health sites available in all counties. In fiscal year 2010, 49,500 services were delivered via technology serving over 16,000 Oklahomans. The average savings per quarter related to mileage and staffing costs is $377,000. Policies and procedures and a provider training manual are in place and the tele-health staff who were once Innovation Center staff are now part of the Information Technology Infrastructure of ODMHSAS. Tele-health service delivery is considered the same as face to face service delivery in Oklahoma which eliminates any obstacles to providing services in the most rural parts of the state. The network continues to expand with membership including mental health providers, substance abuse providers, primary care practitioners, private healthcare systems and the Veteran's Administration. The Tele-Mental Healthcare Toolkit, used to train providers may be viewed in Section 8.

Section Three: Consumer Outcome Improvements Achieved

More individuals and more diverse consumers are accessing services today compared to 2005. Approximately 40% more individuals received behavioral health services between FY05 and FY10. There was a 28% increase in the number of African Americans served, a 45% increase in the number of Caucasians served, and a 50% increase in the number of Native Americans served. In addition to serving more individuals, consumer physical health outcome measures improved between the beginning and the end of TSIG as indicated by improved medical domain scores from the Addiction Severity Index and Client Assessment Record assessment tools. Wellness Coach training for the recovery support staff occurred in July, 2011. Recovery support staff are now trained to work with consumers not only on behavioral health issues but also to integrate physical health awareness into behavioral healthcare. ODMHSAS is working to develop Health Homes within the Community Mental Health Center System, wellness activities and wellness staff will be part of the homes infrastructure. Wellness activities within mental health centers have become a focus to improve physical health for both center staff and consumers. ODMHSAS through Tobacco Settlement funding is embarking on an initiative to help consumers and staff quit smoking system wide. Another indication of the impact that transformation has had on recovery can be found from data collected on

the "Illness Management and Recovery" project indicating that consumers overall felt that their lives were improving. A more detailed summary of the results can be found in the evaluation section of this report.

In the NAMI Grading the States score card, Oklahoma moved from a "D" to a "B" in a three year period based largely on work that began under TSIG to improve the system. The area scored highest in the report relates to Oklahoma's work with health promotion and measurement. Oklahoma's health promotion through prevention efforts during the transformation years included, educating the public using Mental Health First Aid, training primary care practitioners to screen for mental health and substance abuse issues, training suicide prevention gatekeepers, and implementing smoking cessation programs. All of these efforts continue to move the state and consumers forward in a positive direction to improve overall health.

Section Four: New Freedom Commission Goal Achievements

Oklahoma developed and implemented projects spanning all six of the New Freedom Commission goals documented on the Oklahoma Comprehensive State Plan Implementation Summary. The final Comprehensive State Plan is located in Section 8. The accomplishments under each are as follows:

4.1 Goal One accomplishments include the anti-stigma campaigns both within agencies and targeting the entire state. The "Community Champions" initiative is an agency awareness campaign created to address misunderstanding and misinformation about mental health and addictive disorders. The campaign targeted Governors Transformation Advisory Board agencies initially and grew to include participation from private organizations. ODMHSAS Public Information staff worked with agencies to develop an individualized campaign to roll out to their staff. What exists today is a menu of services that are incorporated into all ODMHSAS public outreach efforts. Partnerships that began with this campaign helped pave the way to reduce discrimination associated with mental and addictive disorders within 24 agencies. Most notably, the Redhawks baseball organization during the 2010 baseball season developed a smoke-free/addiction-free ODMHSAS section at the ballpark. Media impressions from this campaign were estimated at 600,000 individuals. Chesapeake Energy the 2nd largest producer of natural gas in the United States and the 15th largest producer of oil and natural gas products in the nation developed an employee wellness program "Your Life Matters". This campaign touched over 4300 Chesapeake employees.

The statewide media campaign was launched in April 2011 through television public service announcements depicting that it is OK to ask for help. The campaign was developed by Jordan Associates a full service communications and advertising agency. Persons are directed to "Your Life on Course", a public website dedicated to open discussion and access to mental health and substance abuse resources. The website is supported through a partnership with OPUBCO (Oklahoma Publishing Company) the local newspaper in Oklahoma City. Efforts to continue the media campaign are underway and continued public awareness through the website touches Oklahoman's statewide on a daily basis.

The Mental Health First Aid (MHFA) initiative began as a Legislative request to fund a pilot program in Oklahoma authored by Senator Susan Paddock. Funding was not attached to Senate Bill 1433 therefore; TSIG funded the initiative bringing the Missouri Mental Health First Aid training team to Oklahoma to train trainers. In 2009 and 2010, training was offered to GTAB, faith based, higher education and advocacy agencies. Forty-six Oklahoma trainers can now provide training to the general public. The ODMHSAS training division offers MHFA training to the general public bi-annually. At the time of this report 32 trainings (310 persons trained) have been offered to Oklahomans through this training team. ODMHSAS and the National Council hosted a training summit webinar in September, 2011 for all Oklahoma trainers. A live refresher course was provided along with planning sessions for continuous roll out of this curriculum.

4.2 Goal Two accomplishments include initiatives related to consumer choice. Consumer's and family members are part of the workforce, members of boards, and service providers for the system. Peer run services have been developed in Tulsa and expansion of those services to Oklahoma City is likely in the future. Technical assistance through TSIG included training and consultation provided to improve health outcomes. Wellness Coach training was provided to the recovery support workforce by Peggy Swarbrick, Ph.D., Director of the Community Support Programs, New Jersey. Recovery support staff now have the skills to educate consumers to improve overall health outcomes. Kathy Muscari, Ph.D., from the Consumer Organization and Networking Technical Assistance Center (CONTAC) provided technical assistance to Oklahoma consumers and a strategic plan was developed. The strategic planning session resulted in development of a plan with goals for the future. One of the goals was to develop a consumer advisory group representative of consumer voices statewide. The OKRA (Oklahoma Recovery Alliance) was developed with regional representation of advocates from across the state. A statewide consumer retreat took place in September 2011 supported by two provider organizations that funded the retreat for all recovery support staff to attend. The support to expand the consumer voice has never been more apparent in Oklahoma.

4.3 Goal Three accomplishments related to reducing disparities can be evidenced by the increase in the number of Native Americans and Latinos now accessing the provider network in Oklahoma mentioned earlier in this report. Cultural Competency training for the behavioral health workforce and tools to help staff engage with persons from other cultures has been enhanced. Cultural Competency training of the workforce through the National Multicultural Institute (NMCI) produced seventy-seven trainers within 26 provider agencies who now provide training and consultation related to creating a culturally competent system. All provider staff contracting with ODMHSAS now has access to a database, Culture Vision, to help them gain information on consumers from different cultures, religions and ethnicities from their computer desktops. The Tribal-State Relations workgroup and the Tribal liaison position within ODMHSAS remains a forum for discussion and exchange between the state and tribes to integrate the behavioral health system. Oklahoma's Tribal-State Relations workgroup was nominated by the First Nation Behavioral Health Association as a best practice for American Indian and Alaskan Natives in 2009.

4.4 Goal Four accomplishments related to screening and referral includes multiple screening efforts to educate the provider network. Screening within primary care networks, outpatient clinics, primary care offices, local health departments, and hospitals have become more prevalent. The ODMHSAS Prevention Division and OSDH Child Guidance staff will continue to promote screening in primary care as well as promote integration of primary care services within mental health centers. The development of health homes within community mental health centers is currently being discussed as a partnership between ODMHSAS, OHCA and the provider network. The Screening, Brief Intervention, and Referral process has become embedded within the Mercy Health Network as well as the University of Oklahoma Level I Trauma Center in Oklahoma City. The protocol developed during TSIG is used by ODMHSAS Prevention Division staff to educate additional healthcare networks in Oklahoma.

4.5 Goal Five accomplishments providing excellent care includes training staff to provide evidence based services. Every community mental health center has staff trained to provide cognitive behavioral therapy and consultation to the workforce. The child serving staff within the state operated community mental health centers have been trained and receive ongoing consultation services from OU Center on Child Abuse and Neglect to implement trauma focused cognitive behavioral therapy. The Department of Corrections workforce development partnership with ODMHSAS and five universities continues to provide an avenue for mental health professionals to take advantage of internships and training programs within the corrections system. Care management to guide families to community based care and decrease the reliance on higher levels of care is in place through a partnership between Medicaid and all of the child serving agencies. The Care Management project will be discussed further in Section Seven.

4.6 Goal Six accomplishments using technology to increase access includes the tele-health initiative that has changed the service delivery system for rural Oklahomans. Staff within metropolitan areas, now offer service delivery for emergency evaluations, medication management and therapy to consumers in all counties. Network participants include mental health and substance abuse agencies, hospitals, primary care practitioners, group home and therapeutic foster care providers, federally qualified health clinics, and health networks like the Veterans Administration.

Section Five: Adult and Child Recovery and Resilience Proof of Concept Studies

5.1 Adult recovery proof of concept study.

The adult recovery study focused on the inclusion of "Illness Management and Recovery" (IMR) curriculum in a psychosocial rehabilitation setting (PSR). The study included consumers in PSRs from four metropolitan community mental health centers in Oklahoma. The study relates to transformation goal two consumer driven care. The intent of including the IMR curriculum in PSR programs was to provide consumers with information needed to better facilitate their recovery process through engaging consumers in discussions over vital topics such as relapse prevention, illness management, and self-care. By providing consumers within the PSR programs with these skills consumers were empowered to take hold of their recovery, and were equipped with skill sets that aid them in developing and maintaining relationships, finding employment and living a full rich life.

Study data indicated that consumer's within psychosocial programs who participated in the IMR curriculum felt that their lives were improving. A summary of the results indicated (1) IMR participants reported a 28% increase in the measure "My life is pretty normal" while non-IMR participants reported an 8.1% decrease, (2) IMR participants reported a 28% increase in the measure, "I feel good about myself" while non-IMR participants reported a 3% increase, (3) IMR participants reported a 10% increase in the measure "I advocate for the rights of myself and others with mental health problems" while non-IMR participants reported a 13% decrease, (4) IMR participants reported a 10% increase in the measure "I socialize and make friends" while non-IMR participants reported a 12% decrease. In addition, consumers participating in IMR experienced a 23% increase in living in their own residence compared to a six percent decrease for those in non-IMR. IMR participants experienced a 31% decrease in living with friends/family compared to a 14% increase for non-IMR and IMR participants experienced an 82% decrease in clients living in transitional living facilities compared to a 23% increase for those in non-IMR. Finally, IMR participants experienced a 94% reduction in inpatient hospitalization days, one year prior to IMR and one year post IMR, compared to a 28% reduction for non-IMR. This reduction averages a two day per consumer savings in inpatient treatment costs. The IMR curriculum continues to be a part of the PSR programs within those pilot sites and ODMHSAS continues to expand to other CMHCs. When funding is available consideration is being given to adding this as an incentive measure to encourage all providers to use the curriculum in their PSR programs.

5.2 Child resilience proof of concept study.

The Care Management Oversight Project utilized a randomized control trial experimental research design to compare outcomes for youth who received Care Management services (CM) to youth who received standard behavioral health services. The study population included 1,943 projected moderate to high-resource utilization youth ages 6-17 years eligible for Medicaid in 70 of the 77 Oklahoma counties.

The interview data were mixed. Adolescent Resiliency Attitude Scale (ARAs) scores increased slightly over time; however, there were no statistically significant differences in scores between the two groups over time. Based on caregiver ratings using the Ohio Scales problem scale, the percentage of youth who were impaired

increased over time for the Control Group youth (55% to 75%) and decreased over time for the CM youth (57% to 52%). Satisfaction levels of caregivers in the Control Group increased slightly and remained stable over time (69% to 71% satisfied). Satisfaction levels of caregivers in the CM group were initially lower than the Control Group caregivers and increased over time from baseline (59%) to caregivers satisfied at the 12-month interview (90%). Total charges decreased for the 12 month time period from $3,042,484 in the year prior to CM to $2,254,447 during the year of CM. This drop was the result of decreases of nearly $800,000 in inpatient charges. There was a 60% reduction in average inpatient charges for the CM Group over time compared to a 17% reduction for the Control Group. There was a trend toward a higher proportion of CM youth receiving outpatient follow-up care within seven days of discharge from a behavioral health hospitalization (78%) vs. the Control Group (73%). There was a 16% increase in average outpatient charges (including physical health claims) for the CM Group over time compared to a 12% decrease in outpatient charges for the Control Group. For behavioral health specific outpatient charges there was a 19% increase over time for the CM group compared to the Control Group with a 17% decrease. There was a trend toward a greater reduction in average total charges (combined inpatient and outpatient) for the CM Group over time (35% vs. 15%). There was a significantly greater reduction in average total inpatient and outpatient behavioral health charges for the CM Group over time (41% vs. 17%). CM resulted in overall healthcare savings of $458 per youth per month compared to the Control Group during the 12-month CM time period and savings of $720 per youth per month for the entire 24 month time period. CM resulted in savings of $357 per youth per month in behavioral health charges compared to the Control Group during the 12-month CM time period and savings of $779 per youth per month for the entire 24 month time period. These per member per month savings were used to project savings for the 1,943 moderate to high Medicaid utilization youth in the population resulting in total estimated behavioral health savings over a one year period of between $8,340,938 and $18,162,398 if the study population had all received CM. The care management staff continues to provide oversight and is now embedded within the Oklahoma Health Care Authority (OHCA) care management unit. The staff is sustained by OHCA.

Section Six: Site-specific Evaluations

6.1 Oklahoma Behavioral Healthcare Workforce Study. The Oklahoma Behavioral Healthcare Workforce Survey and associated studies were conducted by Advocates for Human Potential, Inc. through a contract with the ODMHSAS and its Decision Support Services Division. The statewide survey included an organizational survey focused on accreditation, benefits and basic information on organizational structure; a program manager survey related to program staffing, vacancy, recruitment barriers, causes of staff turnover, program and staff capacity and training needs; and a staff survey focused on work experience, job satisfaction, education and training, and demographic characteristics. Additional data sources were used including: economic modeling systems data provided by the Oklahoma Department of Commerce; data drawn from a University of North Carolina staffing needs study; and information on historical and anticipated behavioral healthcare-related degree completion rates from the Oklahoma State Regents of Higher Education.

Key findings from the study indicate: Oklahoma salary rates across the board in all categories are below the regional and national averages and are believed to have significant implications for both recruitment and retention of staff. Staff separation rates are high particularly for direct care staff. Both current and projected shortages of professional and nonprofessional staff exists system wide with an insufficient pipeline of new entrants from higher education to meet the demand currently and within the next ten years. A substantial proportion of staff and program managers self-identify as behavioral healthcare consumers or as family members. Staff report knowledge of psychiatric medication and their side-effects is the most commonly requested training need. Positively, staff report high job satisfaction and a positive overall work experience within all of the GTAB agencies surveyed.

6.2 Outcomes of the CommonGround™ Pilot Program. The ODMHSAS implemented a pilot program within medication clinics at two locations, Griffin Memorial Hospital and Central Oklahoma Community Mental Health Center, to engage consumers in directing their recovery. The tool chosen for this project was CommonGround™ a user friendly, touch screen based program designed to guide consumers through questions intended to aid in thought organization and question formulation before visiting with the doctor.

The ODMHSAS developed a short survey that consumers were asked to complete after their medication clinic appointment. Results from this survey indicated that 95% of all respondents reported that CommonGround™ helped them to better communicate with their doctor, 98% indicated they would recommend using the tool to others, 74% indicated they felt their meetings with the doctor went better when they used the tool, and 80% indicated that the tool aided them in developing their own set of "Personal Medicine", defined as things that they could do other than taking medications to prevent symptoms from appearing or to help them appear more mildly than normal. The ODMHSAS also surveyed doctors using the CommonGround™ tool and found that 100% felt that communication between themselves and the consumers they served was improved, 67% indicated they felt that the tool was helpful in providing important information to consumers and in providing important information to doctors about the consumers they serve. Eighty-three percent of doctors also indicated that they would recommend using this program to their colleagues and 67% said that they would recommend having a recovery support specialist on staff within the med-clinic to support consumers. Although the survey results were positive, due to budget constraints related to the monthly user fees associated with the program the CommonGround™ program will not continue.

6.3 Survey of Participants attending the Consumer, Family and Youth Leadership Academies. ODMHSAS worked with behavioral health advocacy organizations to develop and deploy a consumer, family and youth leadership academy to educate participants to develop skills to effectively participate on community boards and other leadership capacities. ODMHSAS developed a survey intended to gain feedback about the training as well as understanding on how consumers utilized the training they received. Results indicate 90% of participants in the academies felt confident in leadership roles, 85% felt they would be able to apply the skills to advocate for themselves and others and 93% indicated the skills were applicable to everyday life. Post training, 79% of the participants reported that they were members of community boards and coalitions.

6.4 Oklahoma Provider Survey of Evidence Based Practices. ODMHSAS conducted a survey of all licensed mental health professionals with an active license in Oklahoma in 2009 for the purpose of determining what Evidence-Based Practices the behavioral healthcare workforce is familiar with and to what extent those practices are being used in treatment settings. In addition, the survey was intended to gather information about what training would be most beneficial and their preference for training delivery. Results indicated that clinicians that actively treat clients do not have a strong knowledge base in all Evidence Based Practices. Survey respondents were provided with a list of EBPs and asked a series of questions including how familiar these EBPs were, how often the EBP was used, and whether or not they felt that more training was needed by the provider community regarding the EBPs. Clinicians felt most comfortable with Cognitive Behavioral Therapy (CBT), Trauma Focused CBT and Reality Therapy. The top five responses when asked in which EBPs they would like more training included: Trauma Focused CBT, Brief Strategic Therapy, Dialectical Behavioral Therapy, Motivational Interviewing and Functional Family Therapy. Clinicians actively treating clients were asked what types of training setting was most preferable. Results indicated preference in the following order, Out of Office Trainings/Seminars/Workshops, On Site Seminars/Trainings/Workshops/In Services, Web-Based Training. In addition, the ODMHSAS found that behavioral healthcare professional demographics do not mirror the population served. Oklahoma's population is 51% female and the survey indicated that females are over-represented in the workforce making up 72% of clinicians actively treating clients. Finally, the behavioral healthcare workforce is predominantly Caucasian

with 91% of clinicians actively providing services compared to 77% Caucasian in the general population. Another key finding in the survey was the age of the workforce with 69% above the age of 45 and of those, 41% are above the age of 55 indicating a high percentage of the workforce is nearing retirement age.

6.5 **ODMHSAS consumer representation in the workforce, 2010.** The ODMHSAS was interested in gaining information about the number of consumers currently in the agency's workforce and as a result developed a survey to gather this information. Results indicate that 10% of ODMHSAS staff are self-identified adult mental health consumers, 2% are self-identified substance abuse consumers, 8% are self-identified former mental health consumers, 3% are self-identified former substance abuse consumers, 3% self-identify as former youth mental health consumers and 1% self-identify as former youth substance abuse consumers. In addition, 28% indicated that they had shared this information with either a supervisor or co-worker. Lastly, 62% indicated that they had either a family member or friend with a mental health or substance abuse disorder and approximately, 47% indicated that this information had been shared with a supervisor or co-worker.

6.6 Correctional Conflict Resolution Training. The ODMHSAS in conjunction with the Department of Corrections (DOC) designed a study to determine the impact resulting from applying a Crisis Intervention Team (CIT) model within a correctional setting. DOC and ODMHSAS consulted with CIT trainers from the Oklahoma City and Midwest City police departments who assisted them in designing the experiential part of the CCRT model to better fit the needs of probation and parole and correctional facility staff. The evaluation plan post training included reviewing training logs to determine the number of correctional, probation and parole officers were trained in CCRT. Data sets were reviewed pre training and post training of those officers who participated in training. The data sets were reviewed to determine the number of misconducts of offenders with mental health classifications, the reported number of use of force incidents with persons with mental health classification, as well as, the number and percentage of revocations to prison among offenders in generic probation and parole (PP) with officers who attended CCRT compared to offenders in generic PP with officers who did not attend CCRT.

Pre/post knowledge test data indicated that in every domain covered during training the officers increased their level of knowledge and understanding. The most significant increase was found in the areas of Crisis Intervention Techniques, Skills and the Crisis Cycle. Three months after training, the number of misconducts were compared to a three month period prior to training. Results indicated that misconducts for clients in a medium-security men's facility decreased between 24% and 70%. Results at a maximum-security men's facility indicate that misconducts decreased between 32% and 63%. However, results at the maximum-security women's facility decreased for 2 types of misconducts, but class B misconducts increased 95%. Results also indicate that CCRT trained officer probation and parole revocation rates were 35% lower than non-CCRT trained officer rates.

6.7 Anti Stigma: Community Champions and Market research survey, "Oklahoma Statewide Mental Illness and Substance Abuse Attitude and Perception Survey Report". ODMHSAS Public Information staff developed an anti-discrimination campaign designed to provide participants with an overview and basic working knowledge of mental health and substance abuse issues. The program was also intended to help foster a learning environment that would help dispel myths and fears surrounding behavioral health disorders. The first stage of this campaign was the Community Champions initiative, an education and awareness program for members or constituents of state agencies, businesses and nonprofit organizations, civic and social groups, communities of faith and any other organized entity or group with the ability to communicate with its individual stakeholders. The program was designed to understand the way in which the people of Oklahoma viewed behavioral health disorders and then provide educational opportunities to help reduce stigma surrounding these disorders. The initial purpose of the program was to generate supportive discussion

in Oklahoma workplaces and community organizations regarding mental and addictive issues, create acceptance of positive health messaging and increase public understanding. Partnerships developed through this campaign have helped pave the way to reducing discrimination associated with mental and addictive disorders, which will have a lasting impact on Oklahoma's public health and mental health care delivery systems.

The Community Champions campaign was conducted with partnership from multiple organizations at the state level and within individual communities. Results from the Community Champion campaign indicated that: participants reported a 22% positive shift in their opinion of whether or not a person with a mental illness could recover and that participants were more likely to have a more positive view of mental health clients being able to be successful at work and lead normal lives. Results pertaining to views on substance addiction also showed shifts in opinions: participants indicated that they believe a person with substance addiction would improve if given treatment and support; participants indicated that they believe a person with substance addiction can eventually recover; and participants indicated that they felt that people with addictions feel the way we all do at times.

6.8 Policy Change Reports. ODMHSAS conducted a 5-year study of policy changes affecting people with mental illnesses and substance use disorders. The study involved eight state agencies, all of which are represented on the GTAB. Despite a challenging fiscal environment for most of the 5-year study period, all eight agencies adopted significant policy changes affecting people with behavioral health disorders. Agencies planned and/or implemented a total of 507 policy changes, of this *duplicated* total: 330 were general policy changes; 74 were financing policy changes, which include increases in appropriations and changes to provider reimbursement; 53 were training policy changes; and 50 were organizational changes reflecting new policy priorities within the agency. All agencies reported specific policy changes designed to increase access, quality and the effectiveness of services, and improve accountability and funding. Within these categories, significant themes emerged around state priorities, in particular, agencies in all study periods identified significant policy changes related to increasing the use of technology and data, implementing screening and early intervention initiatives, and conducting training activities. In every study period across the 5-year study, internal policies and procedures were the change mechanism comprising the largest number of policy changes. Appropriation increases were most likely to involve interagency collaborations and statutory changes were least likely to involve interagency collaborations.

All agencies reported efforts to involve consumers and families in policy decisions. Agency officials reported varying levels of formality in the ways in which consumers and family members were involved in policy discussions and decisions, ranging from majority consumer representation on policy-making boards established by statute to informal conversations between family members and field staff. Many agencies reported using ad hoc advisory committees, public hearings, and surveys to solicit input from consumers and other stakeholders.

6.9 Culture Vision. ODMHSAS purchased the Culture Vision web based tool and made it available to all contracted treatment agencies for their staff to better understand the cultures and customs of consumers. Providers now have access to this on-line tool to research questions they may have concerning customs, beliefs, religion, spirituality, language, communication, family/social issues, gender roles, diet/nutrition needs, health promotion/disease prevention, treatment issues, mental health issues, death and dying for 60 different ethnicities, 14 religious groups, and 7 additional communities including the blind and hard of hearing. ODMHSAS developed a survey to request feedback about the tool. The survey was deployed when a customer had used the site 5 or more times. Survey results indicated that 95% of users liked the tool, 88% of users indicated that they were more comfortable talking to persons of varied cultures/religions/ethnicities/ populations after using the tool to gain information, 86% of users indicated that the tool increased their desire

to learn about other cultures/ religions/ethnicities/ populations and 95% of users indicated that they would suggest the tool to others, 83% indicated that they believe the tool has helped them provide more culturally competent services to their consumers.

6.10 Consumer Involvement Standards. Oklahoma developed a Consumer Involvement Study Group, comprised of both mental health and substance abuse consumers, who were tasked with developing a set of core standards to guide mental health and substance abuse services in Oklahoma. This group with assistance from the GTAB's Evaluation Workgroup developed a set of standards designed to determine the degree of involvement consumers have in all levels of care, including involvement in state governmental processes, community level processes and individual treatment provider level processes. After the standards were developed and tested for ease of understanding by surveying consumers, family members and behavioral health professionals from across the state the standards were piloted at four provider agencies. The evaluation workgroup and the Consumer Involvement Study Group developed measurement tools so that results at the agencies from the consumer perspective and the provider perspective could be discussed with agency leadership. The provider agencies met with the Consumer Involvement team members to discuss areas of strengths and areas for improvement. The dialogue proved to be a productive way for providers to gain consumer input in a non-threatening manner and for consumers to provide technical assistance to providers regarding ways consumers could be more involved.

Section Seven: Transition and sustainability.

Building broad social support for transformation that can withstand transitions in government is a multi-faceted process. The Governor's Transformation Advisory Board embodied representation from the state, private, tribal, advocacy, law enforcement organizations as well as consumers and family members. Transition plans from the beginning were to enlist multi-agency staff to become leaders within the transformation process so that all agencies would have internal champions to continue. Transformation is a way of business in Oklahoma and there is no danger that the momentum developed during TSIG will not continue. The support developed through this Board also led to a stronger consumer and family voice. The Coalition of Advocates (COA) developed during TSIG is composed of all advocacy agency representation as well as individual consumers and family members. The Coalition's primary mission is to become educated and involved in the legislative agenda. The COA and ODMHSAS leadership review important legislation related to behavioral health and coordinate efforts at the Capitol. During legislative session, the COA sponsors "coffee chats" facilitated by different advocacy groups weekly to be sure that legislators hear from the consumer voice. Consumers and family members partnering with state agency officials has proven to be an effective way to get the message to the legislature that recovery is a reality. Although ODMHSAS was not spared from funding cuts, the voice of consumer's and advocates helped to lessen the blow for cuts to mental health and substance abuse services and for the first time, the "Smart on Crime" initiative was partially funded despite the state deficit. The united voice of consumers and state officials that behavioral healthcare is essential to overall health will keep the transformation agenda alive and when funding improves will continue to move the agenda forward.

7.1 Identifying and empowering external champions (other than grant staff) who will ensure the continuation of transformation activities.

Staff within multiple agencies have and will keep the transformation activities in motion. When projects were developed initially, individuals were asked to include their sustainability plans. Although all activities were not sustained, most have been due to careful planning from the start. Internal champions exist at the leadership and senior staff levels at most of the state agencies represented on the GTAB including OKDHS, OHCA, OSDH, and DOC. These agencies developed data sharing agreements and have ongoing

collaborative team meetings to keep transformation of the system on everyone's agenda. Advocacy agencies such as NAMI, Consumer Council, AWARE, Mental Health Association (Tulsa and OKC), and Federation of Families participated fully in the transformation process and continue to support one another, ODMHSAS and other state agencies to continue the transformation process.

7.2 Incorporating policies and mechanisms to ensure continued involvement of consumers, families and youth in policy development, planning, implementation, and evaluation of systems activities and mental health and related services;

The Mental Health Planning Council, the Coalition of Advocates and regional consumer involvement groups are three avenues for continued consumer, family and youth involvement. The ODMHSAS Governing Board and all of the Community Mental Health Center advisory boards have consumer/family member representation. The policy change interviews of the eight GTAB state agencies revealed that the degree in which consumers are involved in policy discussions and decisions varies. Federal statute requires both ODMHSAS and the Department of Rehabilitation Services (DRS) to establish councils with specific statutory roles and required meeting schedules. The DRS planning council must have at least 51% of the council composed of persons with disabilities. Other agencies have formal advisory councils, including OCCY's Family Perspective Committee. OCCY also has family member representation on the Commission on Children and Youth Board. OHCA has the Behavioral Health Advisory Council, co-led by a provider and a consumer/family member. OKDHS surveys adoptive parents, about their experience with the adoption process and their needs as adoptive parents as well as conducts interviews with children leaving group homes. As part of their continuous quality improvement process community forums are conducted which includes foster families, birth parents, judges, and youth.

7.3 Instituting policies, laws, reforms, financing regulations and other infrastructure changes to reinforce transformation;

Over the course of transformation there were 340 unduplicated policy changes within the state agencies that participated in the survey. These changes included statutory changes, appropriation increases, administrative rule changes, contract language changes, and internal policies and procedures. Some of the legislative changes enacted over the five year period relevant to mental health and substance abuse includes:

SB 1433 develops and implements a mental health first aid pilot program,
SB2000 changes the Youth Suicide Prevention Council to expand to the Suicide Prevention Council for all ages,
HB 2705 provides prenatal classes for drug court participants educating on the effects of drug and alcohol use during pregnancy,
HB 2765 provides for treatment via technology the same as face-to-face,
SB1772 approves certification process for recovery support specialists,
HB 1741 establishes family drug courts,
HB2998 creates a pilot program for re-entry for female inmates with children,
SB 0246 appropriation for the expansion of the COPES program (mobile crisis for adults in Oklahoma City.
HB 2172 establishes an Oklahoma Native American Liaison position, appointed by the Governor December 2011.

7.4 Identifying funding streams to continue the system change activities;

Financing policy changes helped to sustain many of the activities born in transformation. There were 74 financing changes over the course of TSIG. Reimbursement for family support providers (July 2007) and recovery support providers (July, 2008) allow provider agencies to hire peer staff to work with consumers and cover the expense of their salary and benefits through reimbursement from Medicaid and ODMHSAS. The PACT rate was unbundled in July 2008 to promote individualized services for consumers in the program. The OJA system and OHCA partnered to develop reimbursement for Multi-systemic therapy, an evidence based treatment effective with the most difficult young people in their system. A reimbursement code was developed in July 2010 for residential transition services to encourage residential providers to help consumers who are ready to move back to the community. A reimbursement code was developed for SBIRT to sustain screening for substance use in primary care. The Consolidated Claims process provides a single billing entity for Medicaid/ODMHSAS contracted providers.

In addition to these policy changes integrated funding to support TSIG projects is evident through the Mental Health Block Grant to fund the peer run drop in center, partnerships between OSDH and ODMHSAS to fund an Infant and Early Childhood position and ODMHSAS and OKDHS to fund the Aging Coalition. DOC will continue to fund the workforce initiative in that system, OHCA continues to fund the care management staff, and as mentioned earlier in this report the tele-health network is funded through ongoing user fees.

7.5 Instituting quality improvement mechanisms to ensure that evidence based practices continue to be delivered with fidelity and culturally appropriateness.

The policy change interviews revealed that training is a priority in Oklahoma. Fifty-three percent of all policy changes enacted over the five year period were training policy changes related to mental health and substance abuse. Through TSIG the Beck Institute provided the mental health provider system staff training to provide evidence based cognitive behavioral therapy and to provide ongoing consultation and training to their staff. ODMHSAS provides ongoing opportunities for staff to improve their skills through seminars, consultation calls, and trainings provided throughout the year. The trauma informed initiative in Oklahoma allows staff from multiple agencies to develop skills in EBPs. Two of the inpatient facilities in Oklahoma are Sanctuary certified and the adult inpatient state hospital is working on becoming certified. The new transformation grant, Freedom, Recovery and Empowerment is providing opportunities for staff to develop skills in trauma specific service delivery and the roll out to the larger system began in October, 2011 at the Prevention and Recovery conference hosted by ODMHSAS. The Child Welfare trauma informed initiative will push the system even further as child welfare staff are now asking provider agencies about their knowledge and skill set to provide evidence based trauma specific services. ODMHSAS staffs are working side by side with Child Welfare to train agency staff and will receive ongoing consultation from the Chadwick Center to build a trauma informed system.

7.6 Instituting processes and accountability mechanisms to monitor and manage transformation efforts after the grant ends.

ODMHSAS instituted an Enhanced Tier Payment System in FY09. Measures were developed with incentive payments for providers to enhance desired outcomes. The current measures are as follows:

- Outpatient Crisis Services Follow-up within 8 days,
- Inpatient/Crisis unit follow up with 7 days,
- Reduction in Drug Use,
- Engagement: Four services within 45 days of admission,
- Medication clinic within 14 days of admission,
- Improvement in interpersonal domain (CAR score),

- Improved in Medical/Physical Domain (CAR score),
- Improvement in Self Care/basic needs domain (CAR Score),
- Inpatient/Crisis unit community tenure of 180 days,
- Peer support: Percentage of clients who receive a peer support service,
- Access to treatment for children,
- Access to treatment for adults.

All agencies improved within the first four months of review. Some examples of improvement include: 13 agencies increased access to care by seeing consumers for treatment within 4-5 days of first appointment, 10 agencies provided four or more services to consumers within 45 days of admission, and 9 agencies reported a reduction in consumer drug use over a seven month period.

Providing incentives to obtain outcomes consistent with systems reform and recovery has already proven to be a methodology that will move the system in a positive direction. ODMHSAS will continue to support transformation through providing incentives for providers to support recovery.

Conclusion

The transformation initiative in Oklahoma provided the funding and resources to move collaboration to a new level. Each of the agencies represented on the GTAB has become more engaged and more reliant on joint decision making and sharing information with other agencies and those that they serve. Transformation agents remain within many of those agencies to continue the efforts only begun during the transformation years. The original plan that transformation agents should be part of the other agencies infrastructure proved to be relevant in the continuation of transformation and the integration of care.

The final policy change interviews were structured to ask the agency directors and their senior staff about their impression of the impact of transformation on their agency's interest and capacity to better serve people with mental illnesses and substance use disorders. Selected responses illustrate this perspective are as follows:

OHCA: "Our state already had good collaboration across agencies, but TSIG gave it a foundation and prestige to move things forward…..without it some collaborations might have petered out".

DOC: "Our natural tendency is to protect our agency's turf. Through the GTAB and other collaborations it supports, we have defied the odds. We have product-oriented workgroups that work well together."

OJA: "Through the GTAB meetings, we began to understand how consumers and people receiving services should have direct input, and we learned some specific strategies for doing that. It also gave us a better understanding of adult corrections. "

OKDHS: "Our trauma work might not have happened without the TSIG grant, which paid for a lot of training for the workforce that had a large impact and led to resource sharing."

ODMHSAS: "TSIG provided flexible funding to try new things and helped build relationships with other agencies that saw ODMHSAS as a leader bringing resources to the table to try new initiatives.''

The Governor's Transformation Advisory Board had its final meeting in June 2011. Although the GTAB meetings will not continue in its current structure, agency leaders are committed to continue the work begun in the transformation years and all agreed they would reconvene when needed to solve complex issues related

to systems improvement. Commissioner White and the ODMHSAS leadership are committed to continual improvement of the system. Regular meetings of leadership between OHCA and ODMHSAS occur monthly. The Mental Health Block Grant Strategies submitted for the coming year include many of the priorities born in transformation. Priorities such as; continue overall health promotion, continue to improve access and reduce disparities, enhance service quality and accountability through evidence based practice, reduce criminal justice involvement, continue prevention strategies to reduce suicide, substance use, underage and problem drinking, and continue educating the public on mental health and substance abuse recovery.

At an early TSIG grantee meeting, advanced transformation was described as:

"A state where reform has occurred across multiple agencies for multiple populations and multiple reform components. There is a history of sustainability with state initiated reform and grants and other federally supported initiatives. Innovative ways to fund and advance system transformation have already been implemented."

Oklahoma has achieved this advanced state. Change has occurred within multiple agencies represented on the GTAB including corrections, tribal agencies, consumer advocacy agencies, law enforcement, child serving agencies, and the behavioral health provider network. Multiple populations such as Native Americans and African American are accessing services more frequently. Multiple reform components are evident such as; development of consumer run services, expansion of the consumer workforce, advancement of partnerships between the tribes and the state, and partnerships between the state and the provider system to strive for consumer driven care and increased access through incentives programs. Initiatives such as the tele-health network are fully embedded within the system and sustainability is assured. These changes and others will continue to move the agenda forward through continued partnerships with the goal to continually strive to improve Oklahoma's behavioral health system to be the best that it can be.

Section Eight: Attachments, illustrations, and publications

8.1 **Bienvenidos Project.** (2009) David C. Harris, B.S., Transformation Agent, Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), Innovation Center, Oklahoma City, Oklahoma.

8.2 **Brag Book Magazine & Web,** Kandace Dodson; Summer/Fall 2010, "Postpartum Depression". Edmond, Oklahoma.

8.3 **Evaluation of the Care Management Oversight Project.** (2011) Geneva Strech, M.Ed., M.H.R Betty Harris, M.A., John Vetter, M.A., University of Oklahoma, College of Continuing Education, E-Team, Norman, Oklahoma.

8.4 **Common Ground: Peer Recovery Support in Medication Clinics in Oklahoma**. (2011) Lorrie A. Byrum ,M.A., Karen A. Frensley, M.B.S., L.M.FT., David C. Harris, B.S,; and David E. Wright, Ph.D., ODMHSAS, Oklahoma City, Oklahoma.

8.5 **Community Champions: A Study of Discrimination Reduction in Oklahoma**. (2011) Lorrie A. Byrum, M.A., and David E. Wright, Ph.D., ODMHSAS, Oklahoma City, Oklahoma.

8.6 **Comparative Estimates of Oklahoma Behavioral Healthcare Workforce** (2009) John Hornik, Ph.D., Jenneth Carpenter, Ph.D., and Randy McCrary, Advocates for Human Potential, Albany, NY; David Wright, Ph.D. and Lorrie Byrum, M.A., ODMHSAS, Oklahoma City, Oklahoma.

8.7 **Consumer Involvement Standards.** (2009) TSIG Consumer Involvement Study Group, TSIG Evaluation Workgroup, David Wright, Ph.D., and Lorrie Byrum, M.A., ODMHSAS, Oklahoma, City, Oklahoma.

8.8 **Consumer Leadership Academy.** (2010) Lorrie Byrum, M.A., and David Wright Ph.D., ODMHSAS, Oklahoma City, Ok.

8.9 **Correctional Crisis Resolution Training** (2011) Lorrie A. Byrum, M.A., Tania Rubio-Rosas, M.A., David E. Wright, Ph.D., ODMHSAS, Oklahoma City, Oklahoma.

8.10 **Culturevision User Report** (March 11, 2011), Cortney Yarholar, Cultural Competency Coordinator, ODMHSAS, Oklahoma City, Oklahoma.

8.11 **Developmental Screening in Primary Care Initiative.** (2011) Amy Chlouber, M.S., L.P.C., Oklahoma State Department of Health (OSDH), Oklahoma City, Oklahoma.

8.12 **Evidence-Based Practices: Results of the Licensed Professionals Survey**. (2010) Lorrie A. Byrum,M.A., Karen A. Frensley, M.B.S., L.M.F.T., David E. Wright, Ph.D., ODMHSAS, Oklahoma City, Oklahoma.

8.13 **Higher Education Workforce Report.** (2009)John Hornik, Ph.D., Jenneth Carpenter, Ph.D., and Randy McCrary, Advocates for Human Potential, Albany, NY; David Wright, Ph.D. and Lorrie Byrum, M.A., ODMHSAS, Oklahoma City, Oklahoma.

8.14 **Illness Management and Recovery in a Psychosocial Rehabilitation Setting.** (2011) Lorrie A. Byrum, M.A., Jin-Song Chen, M.A., Derek Lewis, M.B.A, and David E. Wright, Ph.D., ODMHSAS, Oklahoma City.

8.15 **Implementing Drug and Alcohol Screening in Primary Care (2011)** Dr. Gary Parker, M.D., Stuart Schrader, Tracy Higgs, Linda Fanning, Sisters of Mercy Health Systems; Dane Libart, MSW, Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

8.16 **The Journal of the Oklahoma State Medical Association, "Screening Brief Intervention and Referral to Treatment (SBIRT) Saves Lives and Improves Health"**, July 2010, pages 163 - 165, Gary Parker, Ph.D., Mercy Healthcare System, Oklahoma City, Oklahoma.

8.17 **Mental Health First Aid Program** (2011) Dane Libart, M.S.W., ODMHSAS, Oklahoma City, Oklahoma.

8.18 **National Association of State Chief Information Officers (NASCIO) Recognition Awards Nomination (2009) 'Oklahoma's Tele-Health Network"**

8.19 **National Multicultural Institute (NMCI) Evaluation Summary Report,** Cultural Competency Workforce Training, April 5-8, 2010, Washington, DC.

8.20 **Oklahoma Behavioral Healthcare Workforce Study: Final Statewide Report.** (2011) John Hornik, Ph.D., Jenneth Carpenter, Ph.D., and Jeanine Hanna, Ph.D., Advocates for Human Potential, Albany, NY, and David Wright, Ph.D., and Lorrie Byrum, M.A., ODMHSAS, Oklahoma City, Oklahoma.

8.21 **Oklahoma Comprehensive State Plan Final Update (2005- 2011)** Project Director Karen A. Frensley, M.B.S., L.M.FT.

8.22 **Peer Recovery Support Specialists in the Oklahoma Department of Corrections Final Report.** (2010) Wayne McGuire, Ph.D., Mac McCrory, Ed.D. National Alliance on Mental Illness (NAMI), Oklahoma City, Oklahoma.

8.23 **Policy Change Interviews Final Five Year Report.** (2011) Jenifer Urff J.D., Advocates for Human Potential, Albany, NY, David Wright, Ph.D., Lorrie Byrum, M.A., and Karen Frensley, M.B.S., L.M.F.T., ODMHSAS, Oklahoma City, Oklahoma.

8.24 **State Tribal Collaborations** (2009) Cortney Yarholar, M.A., Transformation Agent, ODMHSAS Innovation Center, Oklahoma City, Oklahoma.

8.25 **Telemental Health, A Toolkit for Providers.** (2009), Sean Couch, B.S., ODMHSAS, Oklahoma City, Oklahoma.