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STATE OF OKLAHOMA

Consensus Document

INTEGRATED SERVICES INITIATIVE

Consensus System Implementation Plan for Provision of Integrated Services for Individuals and Families with or at risk for Co-occurring Mental Health and Substance Use (and other Addictive) Disorders

Purpose of the Document

The Integrated Services Initiative (ISI) is a consumer-driven and recovery-focused consensus plan of action. It is supported by key advocacy and service organizations, for the purpose of developing a system of care capable of providing integrated services to Oklahomans with or at risk for mental health, substance use and other addictive disorders in a trauma-informed manner. This document describes the overarching consensus model within which the action plan is framed and articulates the commitment of cosigners to specific activities and objectives, at all levels of the system of care.

Elements of this plan will be incorporated into contract and policy language developed by the co-signers of this document. This document will be updated as needed to reflect progress, new goals, objectives and action steps developed during implementation.

In Fiscal year 2007, the ISI will attempt to reach all audiences willing to participate in preparing for statewide implementation of this consensus plan of action.

Overview

Oklahomans needing treatment for co-occurring mental health and substance use disorders (COD) time and again have not had these issues simultaneously addressed during treatment, resulting in repeated relapses of both conditions, many times in crisis situations. People living with COD are often inadequately served in both mental health and substance abuse treatment settings. Symptoms of trauma, although common among persons suffering with COD, are sometimes not recognized during treatment. System inadequacies lead to ineffective treatment, as well as heavy spending in the criminal justice system, primary health care industry, homeless shelter system and the child protection system.

The ISI provides the opportunity to participate in the process of integrating mental health and substance abuse treatment for persons of all ages as the behavioral health system of care in Oklahoma is transformed. The ISI encourages engaging people with co-occurring disorders and providing accurate, person-first, continuous assessments and treatment services that focus on recovery of the person and their families throughout the treatment experience. The ISI welcomes every person seeking help and provides integrated services and supports in a manner that demonstrates hospitality, respect and offers choices. In this philosophy, any door through which an individual seeks treatment is the “right door” to the treatment they need. Every Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) operated and contracted program shall provide and/or make available integrated, trauma informed mental health and substance abuse services. Importantly, this

transformation facilitates an exit from the treatment system and encourages connections to one's natural community and support network.

The ISI is utilizing the Comprehensive Continuous Integrated System of Care (CCISC) model, which is based on the following points taken from clinical consensus about best practices (Minkoff, 1998, 2000). Its focus is an integrated treatment philosophy from the perspective of both the mental health and the addictive disorder treatment system. The model is being adapted in Oklahoma to incorporate issues related to a history of trauma as an expectation within all behavioral health settings, and to incorporate the expectation that individuals who have experienced trauma are likely to have mental health and/or substance abuse issues themselves, or in their families.

Care management must be balanced based on level of functioning with empathic detachment, expectation, contracting, consequences, and contingent learning for each program participant. Individuals who require high degrees of support can utilize contingency based learning strategies involving a variety of community-based reinforcements to support incremental progress within the context of continuing treatment.

Multiple diagnoses are the expectation, not the exception.

All individuals with disorders are not the same.

When mental and substance disorders coexist, both disorders should be considered primary, and integrated dual or multiple primary diagnoses-specific treatment is recommended. The system needs to develop a variety of administrative, financial and clinical structures to reinforce this clinical principle.

Clinical outcomes must be individualized in each consumer's treatment plan.

Empathic, hopeful, integrated-treatment relationships are one of the most important contributors to treatment success in any setting.

Both mental illness and addiction can be treated within the philosophical framework of the disease and recovery model.

There is no single correct intervention for individuals with or at risk for cooccurring disorders because interventions must be individualized.

Using these principles, co-signers of this document agree to make every effort to implement a CCISC in Oklahoma, with the following four core characteristics:

1. Participation from all components of the behavioral health system. This will achieve, at a minimum, basic standards for treating people with COD and planning services that respond to the needs of an appropriately matched cohort of individuals with co-occurring disorders.

2 Initial implementation within the context of existing treatment resources. This will maximize the capacity to provide reimbursable integrated treatment within each funding stream.

3 Use of the full range of evidence-based and clinical-consensus best practices for individuals with mental health and addictive disorders, and integration of appropriately matched best practice treatments for individuals with cooccurring disorders.

4 Incorporation of an integrated treatment philosophy and common language using the eight principles listed above. This will develop specific strategies to implement clinical programs, procedures, and practices in accordance with these principles throughout the system of care.

Planning Structure

1. The Integrated Services Initiative is structured to develop and implement key policy decisions with participation from providers, persons served and other key stakeholders and in coordination with all other initiatives working toward system transformation. The goal is to build into ODMHSAS infrastructure the capacity for all divisions to routinely develop, discuss, and communicate policy and procedure – with all providers, whether Mental Health or Substance Abuse, state operated or contracted - in a consistent manner that supports integrated service delivery in line with CCISC principles. The goal is to also facilitate “regional” system development and state/regional partnerships into the system’s design. This structure currently includes the following levels:

a)**ODMHSAS State Leadership:** The ultimate decision making entity within the single state authority on mental health and addictive disorders.

b)**Integrated Services Initiative Advisory Group (ISIAG):** Responsible to investigate, disseminate, develop and submit recommendations to the ODMHSAS State Leadership about defining and implementing the overarching process of systems integration and transformation, with regional participation that is representative of the participatory elements in the state.

c)**ISIAG Sub-committees:** Five sub-committees perform the functions of the ISIAG within specific areas of integration. These sub-committees align so that each of the significant policy development activities is assigned to a specific sub-committee. Additional sub-committees may be developed, or current sub-committees may be re-named, as needed. Work at the subcommittee level will be aligned and integrated with work of the Adult Recovery Collaborative and with the Partnership for Children’s Behavioral Health. Current sub-committees are:

- 1 Outcomes/Evaluation
- 2 Welcoming, Screening and Assessment
- 3 Training/ Workforce Development/Licensure and Credentialing
- 4 Finance
- 5 Systems Integration

d)**Change Agent Planning Groups:** These regional groups are responsible for facilitating development and implementation of the CCISC principles and activities, as well as providing support, training and technical assistance to one another and to the agencies/areas they serve. The regional areas are centered around the following communities:

- 1 Oklahoma City
- 2 Tulsa
- 3 Lawton
- 4 Woodward
- 5 Vinita/Tahlequah
- 6 McAlester

e)**Regional Executive Committee:** Model and participating programs convene periodic meetings of executive directors involved in the continuum of care for their community/region with the purpose of fostering cooperation and collaboration and problem solving. These meetings could initially be held monthly as the partnerships enter their beginning stages. When the group’s consensus is that most perceived problems or barriers to collaboration have been worked through, meetings could be held quarterly or when problems arise.

f)**Regional Model Program Coordination Sites:** These sites were identified in the

ODMHSAS Co-Occurring State Incentive Grant (COSIG) for implementation of the integrated strategies, techniques and principles developed through the ISI. The model sites are as follows:

- 1 Norman/Oklahoma City
- 2 Tulsa
- 3 Vinita/Tahlequah
- 4 Lawton
- 5 McAlester
- 6 Woodward

Action Plan

ODMHSAS:

1. It is expected that ODMHSAS will adopt the final version of this consensus document as an official policy statement, disseminate it in official material to providers and incorporate its elements into official planning documents and other publications.
- 1 ODMHSAS will develop mechanisms for creation of fundamental policies and procedures that support broad implementation of CCISC across all its divisions and providers. Initially, an overarching practice guideline regarding welcoming access for individuals with co-occurring disorders in all programs will be written and communicated in an integrated manner to both state operated programs and contractors funded within each division. Practice guidelines for integrated screening, assessment and treatment planning will also be developed.
- 2 ODMHSAS will incorporate, in collaboration with agency medical directors, specific activities that are designed to engage psychiatric and medical staff throughout the system in development of practice guidelines consistent with the CCISC principles.
- 3 ODMHSAS will assist programs to design model policies and procedures for integrated release of information that are HIPAA and 42 CFR compliant.
- 4 ODMHSAS will create a process -in partnership with licensed mental health and licensed substance abuse clinicians -to identify scopes of practice for singly licensed clinicians on co-occurring treatment and provide official articulation of these scopes of practice to the field.
- 5 ODMHSAS will ensure that each internal division is specifically incorporating activities related to this process within its own infrastructure: regulations, communication and contracting. This will include mental health services (state operated and contracted, inpatient and outpatient, treatment and prevention) and substance abuse services (state operated and contracted, residential and outpatient, treatment and prevention). Prevention activities will include attention to preventing substance abuse in high risk individuals; including children and adult populations with emotional disturbance.
- 6 ODMHSAS will incorporate language into instructions for treatment planning that includes instructions on how to provide stage-specific integrated interventions for co-occurring disorders in any mental health or substance abuse treatment setting.
- 7 ODMHSAS will engage Oklahoma Health Care Authority (OHCA) to create a process for defining allowable services and Utilization Review (UR) criteria that support the principles of integrated treatment as defined in this initiative, so that funding and reimbursement policies are aligned with service delivery expectations, and to train APS Healthcare and SURS (or any medical quality audit staff) to use the allowable service definitions and UR criteria in the way that funding reviews are conducted to support this alignment.

8 ODMHSAS will develop models by which both mental health court and drug court programs can function, whether independently or collaboratively, as dual diagnosis capable, co-occurring specialty court programs to more effectively match the specialty court programs to the needs of the individuals who are already being served in those programs.

9 ODMHSAS will develop specific policies to create the expectation that all services provided through the Partnership for Children’s Behavioral Health will be co-occurring capable, both for the child and the family being served.

10 ODMHSAS will work in partnership with providers to develop screening practices that are maximally effective in each setting and in each population to identify individuals with co-occurring needs and co-occurring disorders. ODMHSAS has developed and piloted a brief integrated screening tool. It is expected that this tool will be modified with input from providers, and that over time there may be an array of acceptable tools and processes that providers can use based on what will work best in their settings. In addition, ODMHSAS will provide instructions for reporting the identification of individuals and/or families with co-occurring disorders into its data system, and providing feedback to providers so the data can be steadily improved over time.

11 ODMHSAS will provide training and technical assistance to participating programs to support the involvement of consumers in this process.

12 ODMHSAS will support the development of Double Trouble and other cooccurring self-help groups throughout the state to ensure availability of peer support for persons with co-occurring needs.

13 ODMHSAS, along with its provider organizations, will practice and encourage collaborative and cooperative processes to develop a comprehensive system of care that fosters local connectivity and regional interagency coordination of care for both adults and children.

14 Co-signers of this document will be expected to engage in planning efforts relative to the overall system of care to adopt CCISC principles into the activities and planning documents developed by all stakeholders.

15 ODMHSAS will develop a vehicle or mechanism for routine communication about ISI activities to all stakeholders (e.g. a newsletter, website linkage) and for receiving feedback regularly from around the state.

16 ODMHSAS will utilize the CCISC Outcome Fidelity and Implementation Tool (**CO-FIT 100**) to measure progress in CCISC implementation as a first step in its own CQI process. A baseline COFIT score will be calculated and the tool will be used at twelve - month intervals to measure progress in this initiative.

17 ODMHSAS will support all participating providers, including in-depth support for those programs that take on the added responsibility of being model program sites. Participating providers will be supported in engaging in a Performance Improvement process and work toward proficiency in dealing with co-occurring conditions among their program participants. ODMHSAS will provide the necessary training and technical assistance to ensure all providers can engage in processes intended to move services toward efficacy in the Performance Improvement process.

18 ODMHSAS will create a ***Co-occurring Training Academy*** and co-signers will have access to the training and technical assistance provided through this academy. When space is available, training and technical assistance will also be offered to providers not directly participating as co-signers to this document.

19 ODMHSAS will employ a Co-occurring Training Coordinator to facilitate the academy and coordinate the initial and ongoing training opportunities.

20 ODMHSAS will support a “train-the-trainer” program for change agents in each participating program in each region to ensure that Oklahoma can support the capacity of the participating providers to implement their own training plans, which will be lined up with their action plans that define continued training needs of the transforming workforce

within each program within each region in this State.

ODMHSAS PROGRAMS, PROVIDER AGENCIES, CONSUMER AND FAMILY ORGANIZATIONS AND OTHER ADVOCACY ORGANIZATIONS:

1 Provider, consumer and family organizations, including but not limited to those represented in the Integrated Services Initiative (ISI), will be offered the opportunity to become co-signers of this document and to participate in the action steps listed below.

2. Participating agencies and advocacy organizations, including those representing consumers and families will be supported in engaging in planning efforts relative to the overall system of care to adopt CCISC principles into the activities and planning documents developed by all stakeholders.

2 Participating agencies and advocacy organizations, including those representing consumers and families, will be encouraged to adopt this consensus document as an official policy statement, disseminate it in official material to its staff or members and incorporate its elements into official planning documents and other publications.

PARTICIPATING CONSUMERS AND FAMILIES

1 People in multiple stages of recovery, including but not limited to those represented in the ISI, will be offered the opportunity to participate as change agents and engage in the planning, training and implementation of the integrated model.

2 Participating consumers and families will be encouraged to engage in planning efforts relative to the overall system of care to adopt CCISC principles into the activities and planning documents developed by all stakeholders.

3 Participating consumers and families will be encouraged to identify consumer participants in dual recovery who are interested in partnering in the development of Double Trouble in Recovery meetings in their communities.

ADVOCACY ORGANIZATIONS:

1 Participating advocacy organizations will be encouraged to engage in planning efforts relative to the overall system of care to adopt CCISC principles into the activities and planning documents developed by all stakeholders.

2 Participating advocacy organizations will be encouraged to develop official materials recognizing individuals with co-occurring disorders as an expectation within the population for which they are advocating, and supporting statewide implementation of co-occurring capable services as a formal advocacy goal.

OTHER STATE AGENCIES:

1 Other participating state agencies will be encouraged to engage in planning efforts relative to the overall system of care to adopt CCISC principles into the activities and planning documents developed by all stakeholders. These agencies will be requested to also encourage representatives of their agency delivery systems to participate in developing co-occurring capability (for service programs, including but not limited to Specialty Court programs) and to participate in training and policy development activities as indicated.

2 ODMHSAS will engage with OHCA to create a process for defining allowable

services and UR criteria that support the principles of integrated treatment as defined in this initiative, so that funding and reimbursement policies are aligned with service delivery expectations, and to train APS and SURS (or any medical quality audit staff) to use the allowable service definitions and

UR criteria in the way that funding reviews are conducted in order to support this alignment.

AGENCIES WITH MODEL PROGRAMS:

1 Participating agencies in model sites agree to adopt this consensus document as an official policy statement, disseminate it in official material to staff and board members, incorporate its elements into official planning documents and other publications, and engage in planning efforts relative to the overall system of care to adopt CCISC principles into the activities and planning documents developed by all stakeholders.

2 Participating agencies in model sites in each region agree to assume leadership, to practice and encourage collaborative and cooperative processes to develop a single comprehensive system of care that fosters local connectivity and regional interagency care coordination to meet the local needs and support the overall State-wide system of care.

3 Participating agencies in model sites agree to formally adopt the goal of achieving co-occurring capability for the entire agency as a formal element of agency planning, and are encouraged to develop a plan for creating a continuum of services for co-occurring clients throughout the agency, that includes both standard services and any specialized services offered by the model program. The purpose of the model program is to permit the agency to “model” the process of agency wide co-occurring capability development for other agencies in the region and the state.

4 Participating provider agencies model sites agree to participate in an agency self-survey for all agency programs using the Co-morbidity Program Audit and Self-Survey for Behavioral Health Services (**COMPASS**) at twelvemonth intervals, more often if needed, to evaluate the agencies’ status regarding COD service capabilities and use the findings to develop an agency-specific CQI action plan for implementation of DDC and an accompanying training plan.

5 Practitioners in the provider agencies in model sites agree to participate in a competency self-survey using the Co-occurring Disorders Educational Competency Assessment Tool (**CODECAT**) at twelve-month intervals, more often if needed, and use the findings to inform the agency-specific Performance Improvement action plan and training plan. Participating agencies in model sites agree to identify trainers or change agents that will be able to participate in and attend the Co-Occurring Training Academy to help all individual practitioners improve their ability to effectively deliver services to persons with COD. Individual practitioners in the participating agencies will be encouraged to support the efforts of the change agents.

1 Participating agencies in model sites agree to participate in a system-wide effort to improve welcoming access and retention for individuals with COD by adopting agency-specific welcoming policies, materials and staff competencies.

8. Participating agencies in model sites agree to assign appropriate clinical leadership to participate in interagency care coordination meetings as they are developed and organized, and to create organized mechanisms for interagency collaboration and support.

2 Participating agencies in model programs agree to support staff members, people

receiving services and families to participate in system-wide efforts to develop COD capability standards and systemic policies and procedures to support welcoming access and retention in both emergency and routine situations.

3 Participating agencies in model sites agree to work toward implementation of universal integrated screening and Performance Improvement process to improve the quality of data capture to support accurate identification of COD clients, and track those who are screened positive in order for them to have a process to receive an appropriate integrated assessment and an appropriately documented integrated treatment plan.

4 Participating agencies in model programs agree to work toward implementation of policies to support integrated billing and documentation of integrated services within each single funding stream and type of service offered at their agency.

5 Participating model programs agree to play a part in a system-wide effort to identify required attitudes, values, knowledge, and skills for all personnel regarding COD and adopt the goal of COD competency for all staff as part of the agency's long-range plan.

6 Participating model programs agree to provide input into the development and refinement of scopes of practice for single licensed clinicians regarding co-occurring treatment, and endeavor to adapt these scopes of practice into human resource policy and clinical practice instructions for their clinicians.

7 Participating model programs serving adults agree to initiate a process to develop at least one Double Trouble in Recovery meeting as appropriate for their setting and populations.

Model program sites will be assisted to assume the following responsibilities:

- Engage in planning, implementation and training on the integrated model, to facilitate development of local or regional structures for interagency coordination of care meetings for adults and/or children, and to demonstrate leadership to other participating provider organizations in the model site's service area.
- Design policies and procedures that are models for others to utilize (for example, confidentiality and release of information policies and procedures that are compliant with HIPAA and 42 CFR; screening and identification processes; or methods and protocols for developing Double Trouble meetings).
- Provide technical assistance to participating programs in their regions on planning and implementing the integrated model.
- Provide training and support to similar programs around the state.
 - Facilitate the organization and delivery of training and technical assistance within their regions, and to help to demonstrate the creation of service area infrastructure capacity that brings everyone to the table.
- Allow change agent(s) to work with other participating providers and take time to provide training and technical assistance.

Participating agencies with model programs will receive:

- ODMHSAS funded access to training and technical assistance for development of co-occurring capability.
- Access to the COMPASS and CODECAT and training in utilizing this tool to develop action plans and monitor progress.
- Training and technical assistance for the integrated model, integrated case management and DTR orientation groups

- Opportunity to participate with ODMHSAS in policy and practice development committees and workgroups at the state level.
- Have the opportunity to have one or more change agents on staff that will participate in statewide and regional training activities and be able to assist the program in implementing clinical practice and policy changes to support DDC development.

Additional participating agencies with model programs may be identified in the project to provide regional leadership following evaluation of the first year of participation by existing model programs.

OTHER PROVIDERS:

All behavioral health service delivery agencies in the ODMHSAS system (and the systems funded by other collaborative agencies, e.g., DOC) will be welcomed to participate in the ISI, with the following parameters and incentives:

All agencies are encouraged to engage in any or all of the activities listed below, to begin to become familiar with the process of developing dual capability.

Agencies are also encouraged to become full participants in this process along with the agencies at the model sites. If an agency chooses to become a participant, it should agree to engage in all of the following activities, and will have access to the resources and incentives listed below. Additional participants will not have access to as many supports as have been planned for the model sites in the coming year, but will have access to participation in change agent training and some technical assistance, **and will be able to have additional access to resources that are planned in the future.**

1 Participating provider organizations and agencies will be asked to practice in and encourage collaborative and cooperative processes to develop a single comprehensive system of care that fosters local connectivity and regional structures for interagency care coordination for co-occurring clients and families to meet the local needs and support the overall state-wide system of care.

2 Other participating provider organizations and agencies will be encouraged to engage in planning efforts relative to the overall system of care to adopt CCISC principles into the activities and planning documents developed by all stakeholders.

3 Participating provider organizations and agencies will be asked to adopt this consensus document as an official policy statement, disseminate it in official material to staff and board members and, where possible, incorporate its elements into official planning documents and other publications.

4 Participating provider organizations and agencies will also be encouraged to formally adopt the goal of achieving co-occurring capability for the entire agency as a formal element of agency planning, and develop a plan for creating a continuum of services for co-occurring clients throughout the agency.

5 Other participating provider organizations will be asked to take part in an agency self-survey using the Co-morbidity Program Audit and Self-Survey for Behavioral Health Services (**COMPASS**) at twelve month intervals, more often if needed, to evaluate the agency's status regarding COD service capabilities. Providers will be asked to use the findings to develop an agency-specific CQI action plan for implementation of co-occurring capability and an accompanying training plan.

6 Practitioners within the participating provider organizations will be encouraged to

take part in a competency self-survey using the Cooccurring Disorders Educational Competency Assessment Tool (**CODECAT**) at twelve -month intervals, more often if needed, and use the findings to inform the agency-specific CQI action plan and training plan.

7 Other participating provider organizations will be asked to identify trainers or change agents who will be able to participate in and attend the training academy to help all individual practitioners improve their ability to effectively deliver services to persons with COD. Individual practitioners within the participating agency are expected to support the efforts of the change agent.

8 Those who choose to become other participating provider organizations and agencies will be expected to participate in a system-wide effort to improve welcoming access and retention for individuals with COD by adopting agency-specific welcoming policies, materials and expected staff competencies.

9 Other participating provider organizations will be asked to assign appropriate clinical leadership to participate in interagency care coordination meetings as they are developed and organized, and to create organized mechanisms for interagency collaboration and support.

10 Other participating provider organizations will be asked to support staff members, people receiving services and families to participate in system-wide efforts to develop COD capability standards and systemic policies and procedures to support welcoming access and retention in both emergency and routine situations.

11 Other participating provider organizations will be encouraged to work with ODMHSAS toward implementation of universal integrated screening and Performance Improvement processes to improve the quality of data capture to support accurate identification of co-occurring clients and families, and track that those who are screened positive have a process to receive an appropriate integrated assessment and an appropriately documented integrated treatment plan.

12 Other participating provider organizations will be asked to work toward implementation of policies to support integrated billing and documentation of integrated services within each single funding stream and type of service offered at their agency.

13 Other participating provider organizations will be asked to participate in a system-wide effort to identify required attitudes, values, knowledge, and skills for all personnel regarding COD and adopt the goal of COD competency for all staff as part of the agency's long- range plan.

14 Other participating provider organizations and agencies will be encouraged to provide input into the development and refinement of scopes of practice for single licensed clinicians regarding co-occurring treatment, and to endeavor to adapt these scopes of practice into human resource policy and clinical practice instructions for their clinicians.

15 Other participating provider organizations serving adults will be requested to develop at least one Double Trouble in Recovery meeting as appropriate for their setting and populations.

The participating provider organizations will receive:

1 Access to the COMPASS and CODECAT and training in utilizing this tool to develop Performance Improvement action plans and to monitor progress.

2 ODMHSAS funded access to training and technical assistance for DDC development.

3 Training and technical assistance in the integrated model, integrated case management, and DTR orientation groups.

4 The opportunity to participate with ODMHSAS in policy and practice development committees and workgroups at the state level.

5 The opportunity to have one or more change agents on staff who will participate in statewide and regional training activities and be able to assist the program in implementing clinical practice and policy changes to support development of Co-Occurring Capability. Funding will be provided for selected regional representatives to attend statewide and/or national meetings.

REGIONAL CARE COORDINATION STRUCTURES:

1. All participating stakeholders will be encouraged to engage in the development of regional interagency care coordination and collaboration efforts involving Mental Health and Substance Abuse providers in their

region, relative to the overall system of care, to adopt CCISC principles into the activities and planning documents developed by all stakeholders at the regional.

2 Regional interagency care coordination structures, as they are developed, with the leadership of any identified agencies with model programs in that region, will be asked to adapt this consensus document as indicated to their local regions and priorities and disseminate to their constituencies for adoption.

3 Regional interagency care coordination structures, as they are developed, with the leadership of any identified agencies with model programs in that region, will be asked to develop mechanisms for organizing regional teams of trainers or change agents, and for collecting data on screening and identification of co-occurring disorder clients and families, COMPASS scores and action plan progress, at the regional level.