

Oklahoma Department of Mental Health and Substance Abuse Services

Combined Application Federal Fiscal Years 2012 & 2013

**Substance Abuse Prevention and Treatment (SAPT) Block Grant
&
Mental Health Services (MHS) Block Grant**



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Planning Section

NOTE TO READERS: In accordance with application guidance, Oklahoma has followed a four-step planning process as a framework to identify priorities and actions plans supported by each of the block grant programs. Steps one and two highlight characteristics of the current system and identify gaps and needed expansions. Steps Three and Four identify priorities and goals for the state and strategies and performance indicators proposed to accomplish those goals.

Step One: Strengths and Needs of the Current Treatment and Prevention Systems

This document is in effect a plan for Oklahoma and provides an overview of Oklahoma's behavioral health system, identifies needs and plans to address those needs, and articulates priorities identified by the state. That information as presented here is formulated and submitted as a *combined* Mental Health Services Block Grant (MHSBG) and Substance Abuse Prevention and Treatment Block Grant (SAPTBG) application for Federal Fiscal Years 2012 and 2013.

Overview of Oklahoma's Treatment, Recovery Support and Prevention Systems. Services statewide are available through a network of provider and community based programs that include 14 community mental health centers (CMHCs), 96 substance abuse treatment facilities, 48 prevention organizations and 83 specialty providers, including housing, faith based and consumer and family operated programs. Licensure of most treatment and support service organizations is statutorily required and administered through the ODMHSAS Provider Certification Division. Additionally, ODMHSAS supervises mandated certifications for Behavioral Health Case Managers, Alcohol and Drug Substance Abuse Courses (organizations, and individual assessors and evaluators related to drivers' licenses revocations), and Peer Recovery Support Specialists. The ODMHSAS Central Office in Oklahoma City provides planning, oversight, fiscal and accountability support for the entire system. Key Central Office functions include Decision Support Services, Information Technology Services, Consumer Advocacy, the Inspector General, Human Resources Management and Development, Finance, Legal, Grants Management, and Provider Certification. Overall leadership and management are organized under the ODMHSAS Commissioner and her executive staff including the Chief Operating Officer, and deputy commissioners for Substance Abuse Services, Mental Health Services, and Communication and Prevention.

Regional and Local Entities Providing Services and Resources. As the Single State Authority and the State Mental Health Authority, ODMHSAS fulfills state level responsibilities as regulator and purchaser of services. In some areas of the state, and with specific levels of care, ODMHSAS also operates as a direct provider of services. Other state agencies collaborate with the ODMHSAS fulfilling similar roles within their authority. Regional and local responsibilities are typically carried out by specific organizations with which ODMHSAS contracts.

Prevention Services. The 17 Regional Prevention Coordinators (RPCs) serving all 77 counties in Oklahoma are the backbone of Oklahoma's prevention service system. RPCs develop community-level prevention work plans in partnership with community coalitions. Community level prevention work is based on the Strategic Prevention Framework and aligned with state prevention priorities. Services focus on achieving sustainable, population-level outcomes. The ODMHSAS also administers 2much2lose (2m2l); the overarching moniker of Oklahoma's underage drinking prevention initiative funded by the Office of Juvenile Justice and Delinquency Prevention's Enforcing Underage Drinking Laws Block Grant program. 2m2l initiatives include a youth leadership development program and underage drinking law enforcement activities. Other programs administered through ODMHSAS prevention initiatives include the Oklahoma Partnership Initiative funded by the Administration on Children and Families; a responsible beverage sales and service training program and underage/high-risk drinking law enforcement effort funded by a Justice Assistance Grant from the Oklahoma District Attorneys Council; an emerging a statewide infrastructure for Screening, Brief Intervention, and Referral to Treatment (SBIRT) services; the Oklahoma Youth Suicide Prevention Initiative funded by the SAMHSA Center for Mental Health Services (CMHS); and, the Mental Health First Aid training program through a statewide network of trainers.

Mental Health Services. ODMHSAS funds fourteen CMHCs serve the state with programs established in approximately 70 cities and towns. Department employees operate four CMHCs in Lawton, McAlester, Norman and Woodward. The other 10 CMHCs are private, nonprofit organizations under contract with the Department. All CMHCs are also Medicaid providers. They also access funding from a variety of other sources. Community Based Structured Crisis Centers (CBSCCs) for adults operate in Oklahoma City, Tulsa, Clinton, Norman and Muskogee. ODMHSAS contracts with other organizations to provide community based mental health and recovery support services including statewide advocacy organizations, independent clubhouses, peer drop-in centers, and housing services and supports. Adult psychiatric inpatient services are provided at Griffin Memorial Hospital in Norman, the Oklahoma Forensic Center in Vinita and at smaller inpatient units located in McAlester, Ft. Supply, Tulsa and Lawton.

Substance Abuse Services. The substance abuse treatment and recovery services funded through ODMHSAS service system are provided at 76 facilities covering all 77 Oklahoma counties. . As with mental health services, all substance treatment organizations must be licensed; that process is also administered through the ODMHSAS Provider Certification Division with final decisions for licensure approved by the ODMHSAS Board. Primarily, ODMHSAS funded services are purchased through contracts with private, for-profit and non-profit, certified agencies to provide detoxification, residential treatment, halfway house, outpatient, intensive outpatient, and early intervention services with substance abuse block grant funds and state appropriations. These agencies include substance abuse treatment facilities, community mental health centers, community action agencies, youth and family services agencies, and schools. Among the contracted facilities, the University of Oklahoma Health Sciences Center provides screening, assessment and treatment planning for children with Fetal Alcohol Spectrum. An essential component to the recovery system is the state's network of Oxford Houses. Currently, there are 54 Oxford Houses throughout the state with more in the process of development. Most Oklahoma Oxford Houses have accessed loans from the revolving loan fund, which the state

continues to provide. ODMHSAS also directly operates three substance abuse residential treatment facilities staffed with state employees.

Services for Children and Their Families. Systems of Care is the preferred approach to coordinate services for children and their families. The Oklahoma Systems of Care Initiative (OSOCI) is strategically designed to have local Systems of Care available to children, youth and their families in all 77 counties. Funding from SAMHSA and the Oklahoma Legislature has been leveraged to facilitate development of the OSOCI. Currently, 60 local Systems of Care sites serve 52 counties. CMHCs host most of the local Systems of Care sites, and work in equal partnership with local teams and community organizations to ensure that children with Serious Emotional Disorders and their families have access to the full array of services they need and want. Related to crisis and inpatient services, separate Community Based Structured Crisis Centers in Oklahoma City and Tulsa address the emergent needs of children and their families. The ODMHSAS also operates the Children’s Recovery Center in Norman to provide inpatient and residential services for children up to the age of 18 with mental health, substance use, or co-occurring disorders.

Workforce Infrastructure. On a daily basis, approximately 1,400 behavioral health staff provide outpatient and other community based services to children, youth and adult consumers statewide. The majority of these are employed as case managers, counselors, social workers, psychologists, nurses and psychiatrists at the CMHCs. However, other providers are represented in this workforce including Recovery Support Specialists, Family Support Providers, and residential support staff. The ODMHSAS provides ongoing training and performance improvement opportunities to all providers throughout the system, including employees of ODMHSAS and staff from partnering organizations. ODMHSAS Human Resources Development training programs recorded combined audiences of over 32,000 participants from all areas of Oklahoma in state fiscal year 2011. E-learning and the telehealth infrastructure are now integral to the training of the behavioral health workforce.

Populations and Targeted Services. Descriptions of specific services, systems, and needs of target populations are listed below. These align with the framework historically mandated separately for both the MHSBG and SAPTBG. Each topic (items 1 through 11) also briefly highlights needs regarding access, capacity, disparity and other issues relevant to that topic. Step Two addresses unmet needs and provides rationale for priorities stated in Step Three. Performance measures proposed in Step Four relate to each of the state’s priorities.

**Service Systems for Children with SED
and their Families**

1. Comprehensive community-based system for children with serious emotional disturbances (SED) and their families. As referenced above, the CMHC network and the coordinated OSOCI sites provide statewide coverage for the comprehensive services available for children with SED and their families. All sites must be capable of treating or referring children and youth with separate or co-occurring substance abuse disorders. Local affiliation agreements and memoranda of understandings with substance abuse treatment providers are in place to assure adequate access to a wider range of services needed by the children and their families. In FY2011, the CMHCs,

Systems of Care sites and substance abuse services organizations served 4,270 children under age 18 with a SED.

- *Mental Health and Rehabilitation Services.* CMHCs and SOC's (sometimes one and the same and sometimes collaborating partners) ensure that children with SED and their families have access to basic services, specifically crisis intervention, evaluation and treatment planning, medication and psychiatric services, and case management services. Additional services for children and their families are listed below.
 - Home-based services
 - Family counseling
 - Therapeutic nursery
 - Diagnosis-related education
 - Client advocacy
 - Outreach
 - Peer/family support
 - Family self sufficiency (housing)
 - Socialization
 - School-based services
 - Respite care
 - Wraparound/flexible funds
- *Health/Medical, Vision and Dental Services.* Case managers assist parents and children in accessing treatment for health conditions ranging from vision and hearing problems to chronic illness. The Oklahoma Health Care Authority (OHCA) is designated to administer the Children's Health Initiative Program (CHIP). School based health services organized by the OHCA through the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program. This provides for services beyond the basic Medicaid program such as comprehensive screenings, immunizations, and dental services. Many schools hire nurses to implement targeted health programs related to EPSDT. The main goal of the program is help parents receive early and preventative care for their children rather than relying on emergency care. The program is statewide in most of Oklahoma's 77 counties. Collaborations continue to develop with Federally Qualified Health Centers, tribal health services, clinics, homeless clinics and county health departments. ODMHSAS is currently developing plans with OHCA to submit a proposal for a health home program within the state's plan. The health homes would be based at CMHCs and organize care for adults and children with serious mental health problems. .
- *Employment and Vocational Services.* Case managers assist children ages 14 and older with job search and job placement skills, social and interpersonal skills needed for job retention, and specific referrals to vocational-technical schools. The Department of Rehabilitation Services (DRS) offers transitional services within school districts. The Transition School-to-Work program, managed by DRS, assists students with disabilities in making a smoother transition from high school to work through counseling, work adjustment training, on-the-job training and direct job placement. Services are provided through a cooperative arrangement among DRS, the Oklahoma State Department of Education and local school districts.
- *Housing Services.* Housing services and homeless outreach services for families with children are provided in the same manner by which they are provided to adults, which is summarized elsewhere in this application. In addition to accessing an array of supportive and subsidized housing options, providers are able to utilize ODMHSAS-provided

flexible funds to address immediate and short-term needs to stabilize family housing situations.

- *Special Education.* Under the provision of the Individuals with Disabilities Education Act, children who are placed in a special education program because of a serious emotional disturbance must have an Individual Education Plan (IEP). Many CMHC staff and programs particularly affiliated with local Systems of Care are actively involved in supporting families and children for whom an IEP is needed.
- *Case Management.* Children and youth with an SED who want to access the full continuum of public behavioral services are assigned a case manager (care coordinator) to work closely with the youth and family to develop an integrated treatment and wraparound plan. Members of the wraparound team design a family and youth directed plan to address key needs on behalf of the children receiving services.
- *Substance Abuse Services and Services for Children with Co-Occurring Disorders.* In close collaboration on behalf of children with SED and their families, CMHCs and local SOC work closely with a network of ODMHSAS-affiliated programs referenced earlier to provide specific substance abuse treatment and support services. All CMHCs are also certified substance abuse service providers and meet minimum requirements to be co-occurring capable service sites.
- *Other Activities Leading to Reduction of Hospitalization.* CMHCs and other community based providers offer screening and early intervention services to diminish the need for out-of-home placements, including inpatient treatment. Collaboration between providers also facilitates more integrated discharge planning as children and their families prepare for transition from out-of-home placements. This has resulted in lower hospitalization rates and shorter lengths of stay – particularly in Systems of Care communities.
- *System of Integrated Services and Systems of Care for Children and Their Families.* A rich array of state and local partners collaborate to assure a system exists to integrate services appropriate for the multiple needs of children. The Systems of Care is the centerpiece of service integration on behalf of children with serious emotional disturbance and their families. Oklahoma began to implement local Systems of Care in 2000. Mental Health Block Grant funding provided a portion of the initial resources to support the first two Systems of Care sites. In 2002, Oklahoma received a six-year federal contract from the Substance Abuse and Mental Health Services Administration (SAMHSA) to support System of Care development. Currently, there are 60 System of Care communities covering 52 counties. Several other communities that are in the formative stages of System of Care development. A second SAMHSA grant now supports statewide expansion of the Systems of Care and is funded through 2014. Oklahoma's state-level System of Care team oversees the overall operations of the Systems of Care communities. In addition, each local community has a team comprised of agency staff, community members, parent advocates and family members.

- *Transition Services.* The Oklahoma Healthy Transitions Initiative (OHTI) grant was funded by SAMHSA in FY2010 for five years at \$480,000 per year. The grant focuses on integrated services and supports for youth and young adults ages 16 through 25 with serious mental health conditions, and their families. OHTI’s developmentally-appropriate and effective youth-guided local Systems of Care are designed to improve outcomes in education, employment, housing, mental health and co-occurring disorders, and decrease contact with the juvenile and criminal justice systems. Grant activities are based in two well- established local Systems of Care communities—Tulsa County and Cleveland County (Norman).
- *Emergency Service Provider Training on Behalf of Children, Youth and Their Families.* The ODMHSAS provides numerous training opportunities for staff development throughout the year. The Annual Children’s Behavioral Health Conference brings together approximately 1,000 participants. Many attendees work in first response settings, including emergency rooms, ambulance services and law enforcement. Systems of Care partners statewide also engage law enforcement and other first responders in various trainings, planning and wraparound work on behalf of children and families. The ODMHSAS Prevention Division also provides training in various suicide intervention and crisis techniques to emergency room, health personnel, law enforcement staff and school districts.

**Service Systems for Adults
with SMI**

2. Comprehensive community-based system for adults with serious mental illnesses (SMI). The statewide network of CMHCs is primarily responsible for comprehensive services for adults with SMI.

In recent years, this system has also intentionally expanded to proactively support diversion from the criminal justice system. Initiatives within this realm include 12 mental health courts, a day reporting center in Oklahoma City, jail-based screenings in both Tulsa and Oklahoma City, statewide training in the Memphis Model CIT program, prison-based dual treatment for co-occurring mental health and substance abuse disorders, prison-based discharge, and community-based Re-entry Intensive Care Coordination Teams. In FY2011, the CMHCs and other network mental health providers served 48,057 people age 18 and over.

- *Mental Health and Rehabilitation Services.* CMHCs, by regulation, must provide the following basic services:
 - Crisis intervention
 - Medication and psychiatric services
 - Case management
 - Evaluation and treatment planning
 - Counseling services
 - Psychosocial rehabilitation
- *Employment Services.* CMHC case managers assist adults age 18 and older with job location and placement. These activities are funded by ODMHSAS and specific service codes provide the claims and reimbursement data for this. In addition, Supported Employment Programs are provided by HOPE Community Services and Green Country Behavioral Health. Transitional employment programs are provided by both Thunderbird

Clubhouse and Crossroads Clubhouse. Both clubhouses are accredited by the International Center for Clubhouse Development (ICCD). ODMHSAS and the Department of Rehabilitation Services (DRS) assist with funding various activities within this array of employment services. ODMHSAS and DRS utilize a Memorandum of Understanding to coordinate and monitor related activities.

- *Housing Services.* Assuring satisfactory access to safe, sanitary, and affordable housing for adults with mental illness continues to be a challenge to the state. Specialized housing for people with mental illness are located in both urban and rural settings and are funded through the ODMHSAS, Housing and Urban Development (HUD), public housing authorities and private sources. Housing models include transitional housing and permanent supported housing (both congregate and scattered site). Although some specialized housing specifically for persons with mental illness continues to be developed (i.e. HUD funded Section 811 and HUD SHP projects), the ODMHSAS has placed an emphasis on creating opportunities for more integrated housing--specifically permanent scattered site housing with available support services. Some stakeholders continue to encourage the development of transitional housing services to meet the needs of consumers whose current level of recovery would make it difficult to have success in a supported housing model.

Additional housing related services and supports embedded in the system for adults with SMI include the HOME Program Tenant Based Rental Assistance; flexible funds provided to each CMHC that can be used to augment a variety of housing supports, including rental and utility deposits; a Discharge Planning Housing Subsidy specifically for adults discharging from psychiatric inpatient care, Department of Corrections, or aging out of the foster care system; a Transition Youth Housing Subsidy program to assist very low-income young adults ages 17 – 24; and Residential Care (ResCare) subsidies. ResCares provide a housing option for some adults with mental illness. In State Fiscal Year 2011, a total of 1,132 ODMHSAS clients resided in 27 separate ResCares. ResCares can receive a higher rate for services if they successfully meet criteria for designation as a Recovery Home

- *Education Services for Adults with SMI.* Some education services for adults are provided through the Department of Rehabilitation Services' supported education program. DRS funds support case management activities for individuals with disabilities attending school. Adult basic education is also facilitated through clubhouse and general psychosocial rehabilitation programs at the CMHCs. CMHCs and other providers advocate on behalf of service recipients/students to secure grants, loans and other supportive services to access educational opportunities.
- *Substance Abuse Services Within CMHCs; Services for Persons with Co-Occurring Disorders.* All CMHCs are also certified as substance abuse service providers and receive both mental health and substance abuse funding to serve persons with serious mental illness and co-occurring substance abuse disorders. Specialty substance abuse treatment providers also collaborate with local community mental health centers for mental health assessment and other CMHC-based services as needed by consumers.

Individualized, gender and culturally specific substance abuse treatment is required of all providers.

- *Medical, Vision and Dental Services.* Case management services have historically been the major option by which adult consumers in the ODMHSAS system are assisted to access medical, vision, and dental services. Access has been more likely for Medicaid beneficiaries. More recently, the ODMHSAS and providers have focused on the primary health needs of adults with SMI. Two sites are currently funded by SAMHSA through the Primary Care Behavioral Health Initiative (PCBHI). Additionally, on-going planning is under way to more strategically align CMHC services with Federally Qualified Health Centers (FQHCs). OHCA and ODMHSAS are preparing an application to propose a health home initiative for adults with SMI as a waiver option in the Medicaid program. Collaborations continue with Federally Qualified Health Centers, tribal health and Indian Health services, homeless clinics, county health departments, and pro bono health care providers. Dental services are also provided in local communities through free dental clinics and pro bono providers.
- *Support Services and Psychiatric Rehabilitation.* All ODMHSAS-certified CMHCs must provide a Clubhouse or general psychiatric rehabilitation program. There are currently 26 general psychiatric rehabilitation programs within the CMHC network. Clubhouse programs must also be certified by the International Center for Clubhouse Development (ICCD). Two clubhouses (Crossroads Clubhouse and Thunderbird Clubhouse) are currently ICCD-certified.
- *Case Management.* Behavioral health case managers help participants develop networks of natural and formal supports/resources necessary to live in their communities. Case management is funded both by the ODMHSAS and the Medicaid program. The ODMHSAS utilizes the strengths based model of case management. Case management activities take place in the individual's home or community, or within a facility. A Certified Behavioral Health Case Manager, in accordance with a treatment plan developed and approved by the service recipient and qualified staff must provide the services. Billable activities include linkage with appropriate components of the service system, support to maintain community living skills, and contacts with other individuals and organizations that influence the recipient's relationship with the community, i.e., family members, law enforcement personnel, landlords, etc.

All staff that provides publically funded behavioral case management services are statutorily required to be certified by ODMHSAS. Applicants must complete a specified curriculum and examination to be eligible for Certification as a Behavioral Health Case Manager. As of July 1, 2011, over 1,350 individuals have satisfied basic requirements to be Certified Behavioral Health Case Managers. A dedicated website (<http://www.odmhsas.org/CaseMgmt>) provides access to the ODMHSAS certification information for case managers. Multiple entry points are available to becoming certified. The ODMHSAS reorganized the training and provides options for on-line training of specific elements as well as the ability to test at numerous locations statewide to qualify for provisional status as reimbursable case managers. In order to increase the

workforce of Certified Behavioral Health Case Managers, ODMHSAS also recognized the value of potential workforce members who have case management life experience and subsequently opened up certification to people who have completed 60 college credit hours or a high school diploma with 36 total months of experience working with persons who have a mental illness.

- *Other Activities Leading to Reduction of Hospitalization.* Oklahoma's service culture embraces a strengths-based and consumer-centered approach which expects service providers, consumers and their support systems to clearly identify resources and factors needed for community success, thereby reducing the use of hospital or other institutional-based resources. CMHCs are monitored to assure that services include cooperative discharge planning with inpatient programs and crisis units, early response and crisis intervention programs, and community partnerships with law enforcement. A network of crisis intervention centers is in place to provide short term stays and stabilization in lieu of placement in inpatient facilities. The proven models, such as Crisis Intervention Training (CIT), PACT, and Intensive Care Coordination Teams (ICCT) are designed to provide intervention, coordinated care, and successful community integration. Recent enhancements in terms of early intervention and transitional services on behalf of persons who interface with the criminal justice system will also prevent the use of hospitalization as well as incarceration. Further, the Enhanced Tier Payment System (ETPS) discussed elsewhere in this application provides an enhanced payment based, in part, on meeting lower inpatient utilization targets.
- *Services for Older Adults.* All CMHCs provide services to older adults but typically within the generic array of adult services. Some specialized outreach and support programs are in place, primarily for older adults. Resources, unfortunately, are not available for these to be implemented. The Oklahoma Mental Health and Aging Coalition provides a forum through which a variety of stakeholders advocate for increased services to older adults. The ODMHSAS Coordinator of Aging Services provides technical assistance and training on mental health and aging issues statewide. ODMHSAS has utilized funds from a SAMHSA Targeted Capacity Expansion grant for the past three years to further develop community based services to older adults in two separate communities utilizing wraparound planning with older adults and their families.
- *Emergency Service Provider Training.* ODMHSAS provides numerous training opportunities for staff development throughout the year to enhance skills they encounter adults with SMI. The training announcements are distributed to individuals and organizations statewide, including emergency health workers. Many participants work in first response settings, including emergency rooms, ambulance services and law enforcement. Law enforcement jurisdictions also collaborate with the ODMHSAS to cross train staff in diversionary and proactive responses with people who may be experiencing mental illnesses or addictions symptoms. The Memphis Model Crisis Intervention Training (CIT) is widely utilized. The ODMHSAS staff also provides training in various suicide intervention and crisis techniques to emergency room and other health personnel. The state expanded training offerings of Practical Front Line Assistance and Support for Healing (PFLASH), Question, Persuade and Refer (QPR),

and other early intervention response techniques to non-mental health professionals, including first responders.

**Substance Abuse Services for Children,
Youth, and Adults**

3. Comprehensive substance abuse services for children, youth, and adults. As described earlier, substance abuse services are provided through a statewide network of providers that work collaboratively to assure good access and quality care. Key functions

performed by providers and ODMHSAS personnel include referrals, reporting, monitoring and peer reviewing. Each of those functions is briefly described below to set the context within which specific SAPTBG targeted populations are served.

Substance Abuse Treatment Referrals. ODMHSAS is committed to making accurate and appropriate referrals for all individuals into and outside of the substance abuse services arena. The ODMHSAS contractually requires substance abuse treatment providers to provide for both substance abuse and mental health needs of customers. To aid providers in screening clients for co-occurring disorders, a tool has been developed by the Department to screen individuals for substance abuse and mental health issues regardless of which door they enter. This tool triggers a more comprehensive assessment process, which is able to address multiple issues inclusive of those who experience co-occurring issues. Use of this tool is encouraged but treatment providers may use the co-occurring instruments of their choice. In addition, the Addiction Severity Index (ASI) and the latest version of the American Society of Addiction Medicine Patient Placement Criteria 2-Revised (ASAM PPC-2R) instruments continue to be the backbone of the substance abuse assessment. ODMHSAS continues to provide monthly ASI and ASAM trainings.

Capacity Reporting. ODMHSAS residential and halfway house programs utilize an on-line system report capacity to ODMHSAS. The capacity reporting system provides Department staff with a daily picture of priority and non-priority individuals waiting to be admitted into treatment. Outpatient providers are more available and there are no waiting lists for those services. Department staff works with providers to help admit priority individuals into the first openings available. State staff also notes priority populations daily in the agency reports to ensure that priority individuals are moving into openings. In addition, staffs work closely with providers to aid in the timely admission of individuals.

Service Monitoring. Oklahoma monitors substance abuse treatment providers by assigning Field Services Coordinators (FSCs) to specific state-operated and contracted programs for on-going compliance reviews. The FSCs are the primary contacts for their assigned providers, visiting the agencies and conducting site reviews as well as reviewing provider staffing, services and performance reports. Plans of correction are developed as needed and technical assistance is provided by the FSC or other Department staff per the findings of the site review.

Peer Review. The ODMHSAS began a new system in SFY 2011 of requesting substance abuse block grant funded providers to coordinate peer reviews with other similarly funded providers throughout the state and forward a copy of the review to ODMHSAS. That system is working

well. In SFY 2011, 70% of the substance abuse block grant funded treatment providers received peer reviews.

Partnerships. Collaborations are discussed in Section IV. N. of this application. Specific to substance abuse services these viable partnerships have resulted in more services and improved access for Oklahomans in need of substance abuse treatment.

A range of recovery and support services are provided within the substance abuse treatment services network and specific services funded by ODMHSAS are listed in other sections of this application. A strength of the system is the manner by which services are delivered to target populations mandated by SAPTBG requirements. Those are detailed below.

- *Persons who are Intravenous Drug Users (IDU).* Intravenous drug users are served by all 70 ODMHSAS substance abuse treatment contract providers and six state operated facilities. Interim services are required by contract for IDUs who providers are not able to admit upon requesting treatment. Contracts also require providers to meet the 14-120 day standard. In addition, residential and halfway house programs are contractually required to report their capacity and waiting list information to ODMHSAS daily. Contract monitoring takes place annually.

Outreach services are contracted with two treatment providers, one in the Oklahoma City metropolitan area and one in Tulsa -- the state's second largest city. These are the two areas with the largest IDU populations. Utilizing a locally refined NIDA Indigenous Leader Outreach Model, outreach staff visits their local downtown and high-risk areas in which homeless and drug-using populations congregate. Information and education is discussed and distributed, HIV testing is provided with consent, and referrals and linkages to social services and treatment programs are made.

- *Adolescents with Substance Abuse Problems.* Oklahoma provides early intervention services for adolescents through four service providers working closely with school systems in their areas, providing brief interventions for high risk students through individual and group sessions at schools. Students are referred for additional treatment if needed. Another early intervention program called "Together with Communities" targets the communities around three charter schools, with their choice of either the Strengthening Families or Celebrating Families curricula made available by the schools to the communities each serves.

Adolescent treatment services include three adolescent substance abuse residential programs. One of the programs also provides co-occurring services for mental health issues onsite. Outpatient and intensive outpatient services are provided throughout the state by 13 providers. Family and juvenile drug court programs are also available for adolescents, with eight providers funded to provide the necessary services.

In addition to the services listed above, the CMHCs and other ODMHSAS providers also provide outpatient treatment for youth with substance use and and co-occurring mental health and substance use disorders.

- *Targeted Services for Individuals Underserved from Racial and Ethnic Minority Populations and LGBT Populations.* Oklahoma contracts with an agency in the more populous Oklahoma City area to provide LGBT services. Provider staff are trained in sexual orientation sensitivity and LGBT competency and utilize CSAT's "A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual and Transgender Individuals." Family education support groups are offered for family members as defined by the customer. Client Satisfaction Surveys are requested of customers to ensure appropriate treatment.

Substance abuse service providers also work with key agencies, such as police, social workers, community outreach workers, substance abuse agencies, health care providers, religious leaders, and others, providing training and education on various aspects of substance abuse issues of the unique social and cultural needs of the LGBT community.

- *Women who are Pregnant and have a Substance Use Disorder.* Pregnant women have priority status in Oklahoma. The Addiction Severity Index (ASI) and the American Society of Addiction Medicine Patient Placement Criteria 2-Revised (ASAM PPC-2R) are utilized to assess the severity and placement needs of all clients. Pregnant women assessed as needing outpatient substance abuse services are able to admit into any outpatient program of their choice in the state. Pregnant women assessed at a higher level, needing a residential program, are able to choose whether they prefer admittance to a pregnant women and women with children (WWC) facility or a female residential program. Upon entering a program, women receive individualized, culturally competent, gender-specific services that may include, along with treatment services, dietary information, parenting classes, case management services to help with housing, employment, education, food stamps or other basic needs, and integrating the customer back into the community. Additional needs identified by the ASI such as mental health needs are also included in treatment plans. Transportation to services is provided when needed.
- *Parents with Substance Use Disorders who have Dependent Children.* Oklahoma contracts with five residential programs to provide services for women with dependent children (WWC) and three WWC halfway house treatment programs. One organization providing halfway house for WWC also operates a residential treatment program. The Oklahoma City Housing Authority collaborates with ODMHSAS to provide women a sober-living environment in which they can focus on their family, especially their dependent children, while continuing to work on their recovery. Each resident must continue to attend self-help groups and work with the onsite case manager to meet their educational, employment, mental health and other goals while easing back into the community. Another program administers behavioral and developmental assessments for children who may have been exposed to alcohol or other drugs prenatally. All WWC providers are contractually required to give priority status to pregnant women, treat the family as a unit, provide child care, and provide health services for both the mother and children, including prenatal care and immunizations for the children. Transportation to services is also provided as needed.

ODMHSAS collaborates with the Oklahoma Department of Human Services (OKDHS), to contracts with providers statewide to provide screening and assessments of OKDHS referred parents who are on Temporary Assistance for Needy Families (TANF), applying for TANF, or involved in the child welfare system. Individuals once at-risk or in need of treatment are identified and assessed, appropriate early intervention or treatment services are provided by 31 substance abuse treatment agencies.

In fiscal year 2007, ODMHSAS was awarded a five-year Regional Partnership Grant through the Administration on Children and Families titled the Oklahoma Prevention Initiative (OPI). The purpose of OPI is to increase the well-being of, and to improve the permanency outcomes for, children affected by methamphetamine and other substance abuse. The project addresses the growing problem of children who are at high risk for substance abuse and other problem behaviors due to their parents' substance abuse. The goal of this project is to intervene effectively and early to prevent and reduce the risks for children associated with parental methamphetamine and/or other substance abuse. The Department actively collaborates with the OKDHS and contracted agencies to advance the goals of this project.

- *Services for Persons with or At Risk of Contracting Communicable Diseases: Individuals with Tuberculosis; Persons with or At Risk for HIV/AIDS.* ODMHSAS substance abuse treatment providers are contractually required to make tuberculosis services available to individuals receiving substance abuse treatment and to provide interim services for individuals waiting for admission. The required services include counseling, screening and treatment when needed. Tuberculosis services are provided through local Oklahoma State Department of Health (OSDH) facilities, or through other community health care programs. ODMHSAS provider contracts require adherence to infection control procedures as established by the Centers for Disease Control.

Oklahoma is not a designated state and, as such, does not provide early intervention programs for HIV/AIDS. However, all programs certified by ODMHSAS in accordance with Oklahoma Administrative Code (OAC 450) must provide or arrange access to education, counseling and testing for HIV, AIDS and STDs for consumers and their partners as requested.

**Services for
Military Personnel and Families**

4. Military Personnel (Active, Guard, Reserve and Veteran) and their Families.

The coordination of services provided within the ODMHSAS system to military personnel and their families is being carefully reviewed

to identify strategies to improve access and improve related services. Oklahoma was selected to attend the initial Veteran's Policy Academy sponsored by SAMHSA in 2008. The Academy team developed a work plan that has served as a foundation for continued expansion of services for military personnel and their families. Oklahoma's Academy team members and others

reconvened earlier in 2011 to assess progress confer on emerging priorities and update other information. Developments resulting from that Policy Academy and related activities are summarized below.

- Support of a veterans docket as part of Oklahoma's Drug Court program in Tulsa County and partnership to pursue "veterans treatment court" legislation through the Oklahoma legislature.
- Free training offered to ODMHSAS/other LMHP's on the Psychological Impact of War.
- Partnership w/ the Oklahoma Counseling Association in promotion of two EMDR trainings (PTSD emphasis).
- TSIG support of two community coalition building networks, delivered through CSC Tulsa and MHA of Central Oklahoma. The coalitions worked within OKC and Tulsa to build networks to address challenges faced by veterans in housing, transportation and access to services.
- Dedicated programming for veterans/actives in multiple conferences, including the annual suicide prevention conference.
- Telemedicine partnership to make ODMHSAS tele-medicine equipment at remote locations (CMHC's) available to veterans for participation in online support groups in partnership with the VA.
- Annual cultural competency training for ODMHSAS personnel to learn more about the culture of military service. The 2011 presentation included remarks by General (Ret.) Rita Aragon on the emerging role of women in the U.S. Armed Forces.
- Partnership with the Oklahoma Department of Veterans Affairs on a bond-package that would co-habitat the two agencies in a new state office building in Oklahoma City.
- Data collection within Systems of Care families to determine extent of current veteran/active involvement in existing Systems of Care and explore new program enhancements to serve this unique population.
- Continued work with Cabinet Secretary Aragon on legislative advocacy to promote greater awareness of suicide risk and criminal justice involvement among veterans.

Oklahoma anticipates additional Academy work in September of 2011 to focus on the needs of tribal affiliated veterans/guard/active.

Under the Oklahoma Youth Suicide Prevention and Early Intervention Initiative, two national guardsmen have been trained as trainers for Applied Suicide Intervention Skills Training (ASIST) and have completed three trainings for the military and those who work with veterans. The legislatively mandated State Suicide Prevention Council, which the ODMHSAS oversees, includes representatives from the Veteran's Administration (VA) who have consistently attended for the past year. In addition, staff working on the ODMHSAS' Garrett Lee Smith Suicide Prevention Grant has initiated a gun safety project using the VA's national suicide prevention lifeline labels on gun locks provided by the Oklahoma City Police Department.

**Services for
American Indians**

5. American Indians/Alaska Natives. The Governors Transformation Advisory Board (GTAB) was formed in 2006 by Governor Brad Henry as his lead consultative body for Oklahoma's Transformation State Incentive

Grant (TSIG) funded by SAMHSA. An early action of the GTAB, under the leadership of Chickasaw Nation Governor Bill Anoatubby, who served as GTAB chair, was to establish Oklahoma's Tribal State Relations Workgroup. Additional work of that group is described in more detail later in this application. However, the Workgroup has provided expertise and guidance for ODMHSAS to continually assesses better methods to engage with and provide culturally appropriate access to services and supports for Oklahomans with tribal affiliations.

Currently there are 39 federally recognized tribes headquartered in Oklahoma. The 2010 census reports that 8.6% of Oklahoma's population is American Indian or Alaska Natives. Disparities exist in terms of access and range of services available to American Indians and there is variation among the tribes themselves in terms of health services infrastructure and resources. In 2006, ODMHSAS created a fulltime position for a Tribal Liaison. That position continues to facilitate collaboration and address the unique aspects of tribal and state government relationships. In FY2011, 11,460 consumers identifying themselves as American Indian received services funded through the ODMHSAS and/or Medicaid reimbursement system.

In 2011, SAMHSA supported Oklahoma's participation in a National Policy Summit to Address Behavioral Health Disparities within Health Care Reform. ODMHSAS utilized the resources and support for its Summit team to strategically address the unmet behavioral health needs of American Indian children and their families. An action plan was developed to assure that all Oklahoma children and youth who are self-identified by their family as American Indian have early and easy access to needed behavioral health services and supports. The team continues to meet, assess progress, and implement strategies to accomplish the goal. Changes that occur as a result of the plan will benefit all American Indians, regardless of age.

**Services within the Criminal Justice and
Juvenile Justice Systems**

6. Targeted Services for Individuals Involved in the Criminal or Juvenile Justice Systems. ODMHSAS collaborates with various partners within criminal justice and law enforcement to provide a variety of

services. The Sequential Intercept Model is used in strategic planning and aligning of resources to have the greatest impact in terms of reducing involvement with criminal justice for adults and children with behavioral health treatment needs. Brief descriptions of related activities follow:

- *Prison-Based Substance Abuse and Community Aftercare Program.* ODMHSAS works closely with the Oklahoma Department of Corrections (DOC) to provide substance abuse treatment services to offenders in prison, to those offenders who have been released from prison through a probation/parole contract, and a Residential Substance Abuse Treatment (RSAT) aftercare program for those offenders that have completed their time and are not on probation. There are 10 prison-based programs that range from four to nine months

and use cognitive behavioral therapy as their primary therapy modality. As offenders enter the prison system they are assessed by ODMHSAS contracted agencies. Once identified as having a substance use problem, the offender is scheduled to enter more focused treatment nearer the end of the offender's prison time. ODMHSAS contracts with 17 agencies to provide probation and parole services to assist with the re-entry process. The probation and parole officer refers the offender to one of the agencies and the agency coordinates needed services. An additional six agencies provide RSAT aftercare services for offenders who have completed their sentence and are not on probation or parole or under supervision with DOC.

- *Drug Courts.* Oklahoma's Drug Courts offers court-supervised treatment to eligible, non-violent felony offenders in lieu of incarceration. These programs provide individualized treatment services while incorporating the accountability and structure of the judicial system. Individualized assessment and treatment planning, routine substance testing, supervision visits, and regular court appearances are all required throughout program participation. ODMHSAS is legislatively charged with funding and oversight to the 44 drug court programs in the state which serve the citizens of 72 of the state's counties. Recent analyses report that the programs cost the taxpayers of Oklahoma \$5,000 per person per year instead of an annual average cost of incarceration of \$19,000. Drug courts also focus on reunification of families, employment and education of participants which, in turn, improves the quality of participants' lives and leads to further cost savings.
- *Mental Health Courts.* Thirteen mental health courts were in operation in FY2010. Two are in Oklahoma City and Tulsa and all others in rural communities. Federal stimulus funding sub-granted through the District Attorneys' Council Justice Assistance Grant Board allowed ODMHSAS to add additional courts. Some courts also focus on participants with co-occurring mental health and addiction disorders.
- *Jail Diversion.* The jail diversion program (Tulsa) and day reporting program (Oklahoma City) provides flexible community based wrap around services for persons at risk of entering or returning to these metropolitan jails.
- *CIT Training.* As of July 2011, over 700 law enforcement personnel in Oklahoma had been trained in the Memphis Model/Crisis Intervention Training or a similar law enforcement-based diversion program.
- *Reentry Teams, Discharge Planners, and Co-Occurring Treatment Specialist.* The state funds three Reentry Intensive Care Coordination Teams (RICCTs). These prison based teams include a specifically trained Intensive Case Manager and a Recovery (Peer) Support Specialist to provide success oriented and strengths based reentry support following incarceration. ODMHSAS provides three Discharge Planners to work in targeted correctional facilities. Discharge Planners work alongside prison treatment staff to identify and assist inmates preparing for reentry who are expected to have ongoing mental health and substance abuse treatment needs. The Discharge Planners and the RICCT staff work under the direction of ODMHSAS Director of Community Based Services with full support from the Department of Corrections.

Three co-occurring treatment specialists, employed by ODMHSAS, are assigned to two state prisons and three community correction facilities to provide co-occurring treatment to inmates who needed integrated treatment for mental illness and addictions.

- *Benefits Reinstatement for Returning Inmates.* SAMHSA recently published a report summarizing the collaborative work between the Oklahoma Department of Corrections (DOC), the ODMHSAS, and other state and federal partners in conjunction with Mathematica Policy Research, Inc. (MPR). The report, “Establishing and Maintaining Medicaid Eligibility upon Release from Public Institutions” (DHHS, 2010) evaluated the methodologies in place in Oklahoma whereby people with SMI, upon discharge from prison, have immediate access to the Medicaid and disability benefits for which they are eligible. The findings suggested the model as one applicable to other states and other types of public institutions including state hospitals referred to in Social Security parlance as IMDs (Institutes for Mental Disease). The report is available at <http://download.ncadi.samhsa.gov/ken/pdf/SMA10-4545/SMA10-4545.pdf>.

**Services for Individuals and Families
who are Homeless**

7. Targeted Services for Individuals who are Homeless. Some of the treatment and supports for adults and children who are homeless are described other sections of this application. Additional targeted

services provided to individuals who are homeless are described below.

- *Outreach Initiatives and Projects in Assistance for Transition from Homelessness (PATH).* The current PATH allocation for Oklahoma is expected to be \$448,000 for state FY12. PATH programs are located in areas with the highest numbers of people who are homeless: the two largest metropolitan areas, Oklahoma City and Tulsa, and in the rural community of Tahlequah which is located in northeast Oklahoma. PATH funded services focus on intensive outreach and engagement (street, shelter, and hospital) and case management services, including related transportation and travel.
- *Substance Abuse Outreach.* The ODMHSAS also provides support to two urban-based substance abuse treatment programs specifically for outreach activities. Outreach activities target high risk drug using individuals, many of whom are homeless and impacted by both mental illness and addiction problems. The outreach workers gain their trust, educate them about HIV/AIDS, communicable diseases, and the harm caused by IV drug use, provide tests for HIV if requested, and assist with linkages to treatment programs.
- *The Tulsa Day Center for the Homeless.* This urban program provides linkages with needed mental health and community services on behalf of adults and children who present at their site. The Day Center also provides emergency nighttime shelter for homeless persons with SMI. In recent years, the Day Center expanded to also focus more on supporting people who leave the shelter and become housed to help ensure transition success and reduce recidivism.

- *Homeless Flex Funds.* The Oklahoma Department of Human Services (OKDHS) provides ODMHSAS funds to assist homeless individuals with a variety of one-time or short term expenses. These include shelter, rent, utilities, rent and utility deposits, some repairs/maintenance and renters insurance if required by the landlord. All CMHCs have access to the Homeless Flex Fund program.
- *HUD Continuum of Care Projects.* These sites are operated by two state operated CMHCs. Carl Albert Community Mental Health Center and Central Oklahoma Community Mental Health Center each facilitate a HUD Shelter Plus Care project that provides rental assistance to homeless persons with mental illness or co-occurring mental illness and substance use disorders. Other Community Mental Health Centers participate in local Continuums of Care, including Red Rock Behavioral Health Services that is the lead agency for the Northwest Continuum of Care.
- *Discharge Planning Bridge Subsidy Program.* The ODMHSAS provides targeted funds to assist very low-income individuals (age 18 and older) with mental illness or co-occurring mental illness and substance use disorders as they discharge from psychiatric inpatient care, Department of Corrections, or age out of the foster care system. The primary focus is to access decent, safe, sanitary, and affordable housing. The funds assist eligible applicants with housing costs such as rent, utility costs, rent deposits, and utility deposits. Individuals must be either homeless or at risk of becoming homeless if rental assistance is not received. This assistance can be accessed statewide.
- *Safe Havens.* The safe haven model emphasizes a housing first approach and allows individuals to remain in that housing even if he or she does not want to seek treatment. Oklahoma will continue to utilize MHSBG funds for safe haven housing in state FY2012 and FY2013. Current safe have programs are in Tulsa and are operated by the Mental Health Association of Tulsa.

**Services in
Rural Areas**

8. Targeted Services for Individuals with Who Live in Rural Area. Individuals residing in the rural areas generally have access to overall treatment and support systems described in earlier portions of the section. 59 of the 77 counties are

considered rural or frontier. Consequently, ODMHSAS continues to focus on improved access and provide services in more effective ways for adults and children in rural areas. Examples are discussed below.

- *Children and their Families in Rural Areas.* All rural CMHCs centers provide case management services to children. Most of the treatment is provided in the child's home or a community-based location. Transportation continues to be a problem in rural areas of the state. 50 of the state's 60 of Care sites are located within rural settings. These sites have engaged a broad stakeholder base to coordinate care, leverage resources, and improve services to children and their families in rural settings.

- *Adults Accessing Mental Health Services in Rural Areas.* Ten CMHCs health centers serve the rural areas of the state. All offer the required mental health services and also purchase or provide local acute inpatient treatment or crisis center services to stabilize individuals on emergency orders of detention. Case management services and flexible funds for case managers in rural areas provide in-home support for isolated individuals and assistance in purchasing needed goods and services not otherwise available. Most ODMHSAS certified residential care facilities are located in rural counties in the far northeast corner of the state. CMHCs target additional services to these facilities including general psychosocial rehabilitation day programs, recreation and social skills training, case management, and medication clinics.
- *Substance Abuse Treatment and Supports in Rural Areas.* Many of Oklahoma’s substance abuse treatment agencies are located in rural areas. Beginning in SFY 2011, Oklahoma’s telehealth initiative expanded to target specific rural based substance abuse treatment facilities by adding units in seven substance abuse agencies. Thirteen of the substance abuse facilities now have telehealth capabilities. The others are able arrange telehealth services at other sites within the ODMHSAS telehealth network as described below.
- *Technology Supports in Rural Areas.* The SAMHSA Transformation State Incentive Grant (TSIG) served as a major source for ODMHSAS to establish a statewide telemedicine network. Initial units were placed in community mental health centers and their satellite locations serving rural settings. Currently these units are being used to increase access to services and information including medication clinics conducted by psychiatrists, therapy sessions, court commitment hearings, and administrative meetings. The impact in terms of increased services is continually evident. In FY11, 162 separate telehealth sites were operational in the ODMHSAS system. User fees and other sources, beyond TSIG, are now in place to sustain this infrastructure.

**Children and Youth
At Risk**

9. Children and Youth who are At Risk for Mental, Emotional and Behavioral Disorders, including, but not limited to Addiction, Conduct Disorder and Depression. The ODMHSAS is building the infrastructure using the Strategic Prevention Framework to

provide a foundation for the prevention of mental, emotional, and behavioral disorders, many of which share the same risk and causal factors and could benefit from shared interventions using proven, evidence-based practices and expanded community-based services. Oklahoma supports a broadened focus on multisector prevention systems development, affording the state expanded opportunities for multiagency cooperative interventions using shared strategies to serve the same or similar populations or to target mutual outcomes, and encourages the application of systems theory and knowledge to design and evaluate comprehensive prevention initiatives. In FY 11, the ODMHSAS embarked on Step 1 (Assessment) of the Strategic Prevention Framework to assess the nature, extent and driving factors of mental illness in the state. A rigorous application of the SPF will follow to develop a state strategic prevention plan that incorporates mental illness

prevention and mental health promotion.

**Environmental Prevention
Activities**

10. Targeted Services for Community Populations for Environmental Prevention Activities. Oklahoma's public health approach for substance abuse prevention services utilizes the Strategic Prevention

Framework and focuses on decreasing risk and casual factors, such as the availability of alcohol and drugs, community norms regarding the acceptability of high-risk behaviors, the promotion of alcohol products, reducing family conflict, and youth rebelliousness. The ODMHSAS contracts with local agencies to plan and implement a public health based prevention strategy in multiple targeted communities on data-driven alcohol and other drug priorities. The funded entities build local prevention infrastructures that can support the implementation of a broad array of practices in targeted communities identified through a needs assessment process. To achieve population-level outcomes, evidence-based prevention strategies are implemented and include policies or practices that create a community or cultural environment that supports healthy and safe behavior.

ODMHSAS continues to broaden prevention activities across the behavioral health spectrum and within the broader view of overall health status. ODMHSAS prevention staff work across other divisions within ODMHSAS and train at the community level to insure that prevention activities are based on the following elements.

- Valid estimate(s) of communities' prevention needs using epidemiological data
- Community prevention capacity building focus
- Strategic plan(s)
- Evidence-based policies, practices, and programs implemented with fidelity
- Evaluation of outcomes

Direct recipients of prevention block grant funds are local prevention service agencies. Statements of work with these entities stipulate that prevention services must be implemented in partnership between these agencies, coalitions, and communities. Contracted providers have two explicit roles at the community-level. First they must provide expertise and guidance through training and technical assistance to communities and community coalitions to build substance abuse prevention capacity. Secondly, they are required to strategically coordinate the implementation of prevention services at the local-level in partnership with community stakeholders.

Environmental prevention strategies implemented in Oklahoma consists of local and state-level prevention policy development, law enforcement, media advocacy, and community organizing methods that limit access to substances and change social norms that are accepting and permissive of substance abuse. Specific evidence-based strategies include alcohol retail training and enforcement of youth access to alcohol, tobacco and other drugs.

**Targeted Prevention
Interventions**

11. Targeted Services in Community Settings for Indicated Prevention Interventions. Oklahoma will continue funding primary prevention services with the SAPTBG but ODMHSAS will also examine community needs and the impact of

providing other prevention services, utilizing available resources. Many of the targeted services and system components described throughout this section include public awareness and preventative supports within the contexts of providing those other direct services. Those often are targeted to specific community settings and groups closely affiliated with the recipients of targeted treatment and support services.

Conclusions for Step One: Service System Strengths and Needs

Items 1-11 above summarized information related to mandated systems, required services and access for target populations as required by the SAPT and MHS Block Grants. A review of these also brings to fore critical access, capacity, disparity and other issues as listed below. Steps Two through Four of this planning document build upon this information to more clearly understand gaps and unmet needs, highlight priorities for the state, and then propose goals, strategies, and measures to as framework for Oklahoma to continue focusing on its mission and to assure that recovery and improved health are realities for all our citizens!

Summary of Access, Capacity, and Other Issues

- Continued expansion of most services is needed and within a ‘good and modern’ framework.
- Capacity and resource utilization requires further analysis to determine the best way to leverage limited funding and address disparities between communities and between populations.
- A variety of activities currently address needs of adults and youth with criminal justice involvement. Expansion of these is needed to reduce future criminal justice involvement and to initially divert other adults and youth with behavioral health needs from these systems.
- Issues and needs of targeted populations should be more thoroughly analyzed.
- More information is needed to raise awareness of and plan for an integrated service approach on behalf of military personnel and their families.

- American Indians represent a significant population base within Oklahoma. Continued and engagement with governmental representatives, additional study, and consultation are needed to more expediently and appropriately work with tribal governments in relationship to behavioral health treatment and prevention strategies for American Indians.
 - Oklahoma continues to build state and local level capacity to implement a public health approach to prevention for mental health and substance abuse. Additional planning is needed to fully articulate a comprehensive state prevention plan that incorporates substance abuse prevention and mental illness prevention/mental health promotion.
 - Continued review of epidemiological data is warranted to utilize population based data to further understand many factors that should guide the state to effectively plan, implement and evaluate prevention services.
 - Oklahoma is dedicated to implementing only evidence-based prevention services. Additional capacity will be required and is being developed at the state level to review and evaluate specific strategies that meet the state's criteria for evidence-based practices.
 - The state has various accountability and system management processes in place. Further analysis of these will be beneficial to identify how these and other related methods can better leverage resources and address the mission of ODMHSAS.
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Step Two: Unmet Service Needs and Critical Gaps

Introduction. Step One in this Section summarized services and supports currently in place for to address behavioral health prevention, early intervention, treatment and support needs for Oklahomans. That review also identified a listing of access, disparity, capacity, and resource issues that are continually under review by ODMHSAS. This Section now addresses many of those in more detail and within a framework to more clearly articulate priorities for Oklahoma within the context of this combined SAPT and MHS Block Grant application for FFYs 2012-2013. Priorities are listed in Step Three of this Section.

A summary is included for each topic listed below to provide an overview of unmet service needs and critical gaps related to that systemic issue or target population. Various data sources are cited to quantify, to the extent presently possible, that these are contemporary issues for Oklahoma and levers for actions ODMHSAS will implement to address our mission and the goals of the block grant program.

Key data have been provided by the Oklahoma State Epidemiological Outcomes Workgroup (SEOW.) The SEOW is a multidisciplinary workgroup whose members are connected to key decision-making and resource allocation bodies in Oklahoma. This workgroup, funded through a Federal grant from SAMHSA/CSAP, was established by ODMHSAS in 2006 and is patterned after the National Institute on Drug Abuse (NIDA) community epidemiological workgroup. Oklahoma's SEOW is charged with improving prevention assessment, planning, implementation, and monitoring efforts through data collection and analysis that accurately assesses the causes and consequences of the use of alcohol, tobacco, and other drugs and drives decisions concerning the effective and efficient use of prevention resources throughout the state. Other primary sources have included the National Survey on Drug Use and Health (NASDUH), the Treatment Episode Data Set (TEDS), and published formulas that calculate prevalence of adults with serious mental illness (SMI) and children with serious emotional disorders (SED).

**Health Status for Behavioral Health
Consumers with Complex Health Needs**

According to the America's Health Rankings® 2010, Oklahoma ranks 46th for overall health status.¹ The 2009 Commonwealth Fund State Scorecard on Health System Performance ranks Oklahoma 50th in overall health system performance,

with the state in the bottom tenth percentile on dimensions of access, quality, avoidable hospital use and costs, equity and healthy lives.² Many factors contribute to this ranking and review of some of those is essential to highlight how those impact individuals with mental health or substance use disorders or those at risk of developing a behavioral health disorder. Data on general health status and information specific to tobacco use are included below.

Health Status

- The State was among the bottom five states in obesity, smoking, lack of physical activity, high cholesterol, stroke, heart attack, diabetes, cardiac heart disease, preventable hospitalizations, cardiovascular deaths, poor mental health days, poor physical health days, and premature death.¹
- Oklahoma leads the nation for deaths due to heart disease.¹
- Two-thirds of Oklahomans are overweight or obese, with Oklahoma ranked as the 6th worst state in adult obesity.¹
- Oklahoma's prevalence for smoking is 25.5 percent, placing it 48th in the nation.¹
- Persons with serious mental illness die about 25 years earlier than other individuals. In Oklahoma, the years of potential life lost was found to be 26.1 years.³
- The life expectancy of a drug addict is 15 to 20 years after they start being a drug addict.⁴

Tobacco Use

- According to the 2008-2009 NSDUH, 34.8 percent of Oklahomans aged 12 and older were current cigarette smokers, which was above the national average of 28 percent.⁵
- Data from the 2009 BRFSS also showed Oklahomans' daily cigarette smoking exceeding that of the United States population as a whole, at 25.4 percent vs. 17.9 percent, respectively.^{6,7}
- Smoking among pregnant women is climbing in Oklahoma according to the Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS). In 2003, 16.2 percent of pregnant women reported they had smoked during the last 3 months of their pregnancy; in 2007, the most recent PRAMS for which data are currently available, the percentage of pregnant women who smoked during the last 3 months of pregnancy had jumped to 21.3.⁸
- Persons with mental illnesses are twice as likely to smoke as other persons and comprise nearly 45% of the total tobacco market in the U.S.⁹ (Lasser et al 2000)
- Individuals who received treatment for a substance use disorder in the past year were about 3 times more likely to be current (past month) smokers than those who did not receive treatment (74.0 vs. 23.8 percent).¹⁰
- National Vital Statistics System (NVSS) data show deaths from both chronic obstructive pulmonary disease (COPD) and emphysema for Oklahoma are above the national average.¹¹

Access and Disparities Impacting Specific Populations

Data on substance use and mental illness rates for adults and children are presented here to describe the prevalence of these disorders in Oklahoma and quantify gaps in terms service penetration and unmet treatment needs.

Substance Abuse Prevalence

- According to NSDUH, Oklahoma has been consistently above the national average among persons aged 12 and older reporting the use of any illicit drug other than marijuana. The percentages were 4.6 in 2007 and 4.95 in 2008-2009.. The national percentages for those same years were 3.7 and 3.53, respectively.^{7,5}
- The 2009 YRBS shows Oklahoma exceeds the national average in cocaine, ecstasy, steroid, and inhalant use for grades 9 -12.⁶
- According to the 2008-2009 NSDUH, Oklahoma was among only five states showing an increase in the percentage of persons aged 12 or older who used alcohol in the past month.⁵
- Oklahoma is consistently above the national average in alcohol-related mortality. Long-term alcohol consumption is associated with chronic liver disease. The relationship between alcohol use and suicide is also well documented, according to CSAP. Both chronic liver deaths and suicide deaths have been on the rise in Oklahoma since 2003.^{12,13,14}
- According to the Uniform Crime Reports (UCR), Oklahoma has also been consistently above the national average in crimes related to alcohol use which include aggravated assaults, sexual assaults, and robberies. Since 2003, there has been an 18.1 percent increase.¹⁵
- Fatality Analysis Reporting System (FARS) data show that Oklahoma has maintained a steady rate of fatal crashes involving an alcohol-impaired driver. In 2003, Oklahoma's alcohol-impaired driver fatality rate was 31.3 percent, and in 2008, that figure remained relatively stable at 31.6 percent. National percentages for those years were 30.3 and 31.4, respectively.¹⁶

Serious Mental Illness (Adults) Prevalence and Services Access

- One study estimates that Oklahoma has the third highest rate of SMI in the nation. The rate of serious mental illness (SMI) in the past year for Oklahoma is 10.93, compared to the national rate of 8.76.¹⁷

- Utilizing methodology applied in previous block grant applications, Oklahoma's estimate of prevalence of adults with a serious mental illness (SMI) is based on federal guidelines from the Center for Mental Health Services, published March 28, 1997 (using 1990 census data). Data from two major national studies, the National Comorbidity Survey (NCS) and the Epidemiologic Catchment Area (ECA) Study, were used to estimate the prevalence of adults with serious mental illness. The estimated prevalence for adults with SMI is 183,366. In state FY08, the ODMHSAS served over 31,000 adults with serious mental illness or 16.5% of the estimated. The gap between prevalence rates and those service decreased somewhat in FY10, when the ODMHSAS served 41,408 adults with serious mental illness or 21.2% of the estimated SMI population.

Serious Emotional Disturbance (Children and Youth) SED Prevalence/Penetration

- Using the CMHS methodology referenced above for estimating SED, Oklahoma has an estimated 56,476 (13%) youth age 9 to 17 with SED.¹⁸ In state FY10, the ODMHSAS served 2802 children, ages 9-17, with SED or 4.8% of the estimated population in CMHCs and related mental health programs.

American Indians

The U.S. Commission on Civil Rights, in its report, Broken Promises: Evaluating the Native American Health Care System, state that it has long been recognized that Native Americans are dying of diabetes, alcoholism, tuberculosis, suicide, and other health conditions at shocking rates. Beyond disturbingly high mortality rates, Native Americans also suffer a significantly lower health status and disproportionate rates of disease compared with all other Americans. The disparities in healthcare are especially significant for Oklahoma because it has the highest percentage of Native Americans than any other state.

- In 2000, the American Indian and Alaska Native (AI/AN) population in Oklahoma was 266,801, comprising 8 percent of the state's total population and ranking Oklahoma second among all states for the number of AI/AN in its population.¹⁹
- According to data from the 2009 BRFSS, 14.2 percent of AI/AN adults reported binge drinking, and 4.0 percent reported heavy drinking; both percentages exceed those reported by any other race.²⁰
- Smoking consumption was highest among this group according to the BRFSS. In 2009, 31.9 percent AI/ANs reported current smoking compared to all other races (25.0%).²⁰
- Data from the Oklahoma State Bureau of Investigation (OSBI) show Oklahoma's AI/AN population had substantially greater alcohol-related arrests (i.e., driving under the influence, liquor law violations and drunkenness) at 44 percent, compared to all races combined at 29 percent.²¹

Adult with Criminal Justice Involvement

Many studies have shown that individuals with mental illness and addiction are overrepresented in jails and prisons in the United States. This is even more pronounced in Oklahoma, as the State's incarceration rate is ranked 4th nationally for males and 1st for females. Approximately 24,000 people are incarcerated in Oklahoma today.³⁸

- Of the 8,625 offenders who exited Oklahoma prisons in CY 2009, 5,437 had an assessed need for substance abuse treatment during this incarceration (63%).²²
- 4,428 offenders who released from prison in CY 2009 had an assessed need for substance abuse treatment during this incarceration but did not receive treatment while in prison (81%).²²
- The Department of Corrections indicates that approximately 12,600 offenders have a mental health need. Of the 2,700 female offenders, 79 % have a mental health need, compared to 46% of the 22,500 male offenders. Of inmates diagnosed with a mental illness, 57 % of inmates were incarcerated for non-violent offenses.²³
- For the two largest jails, serving half of the state population, the Oklahoma County Jail has as many as 500 persons with a mental illness at any one time and the Tulsa County Jail has at least 200 persons with a mental illness at any one time.²⁴

Youth with Juvenile Justice Involvement

Research indicates that from one-quarter to one-third of incarcerated youth have anxiety or mood disorder diagnoses, nearly half of incarcerated girls meet criteria for post-traumatic stress disorder (PTSD), and up to 19 percent of incarcerated youth may be suicidal. In addition, up to two-thirds of children who have mental illnesses and are involved with the juvenile justice system have co-occurring substance abuse disorders, making their diagnosis and treatment needs more complex. Many programs are effective in treating youth who have behavioral health care needs in the juvenile justice system, reducing recidivism and deterring young people from future juvenile justice involvement. Generally, regardless of the type of program used or the youths background, recidivism rates among those who received treatment are as much as 25 percent lower than the rates of those children and teens in untreated control groups.^{41,40}

- In a 2001 face-to-face survey with 274 juveniles in the custody of the Oklahoma Office of Juvenile Affairs (OJA), results indicated that over half of those 65 surveyed had used alcohol in the past 30 days (57.5%). For lifetime use, youths had a rate of 93.5 percent, and for past year use, a rate of 82.9 %.²⁵
- Every youth surveyed had used an illicit drug in his or her lifetime. Over eight out of ten youths (83.1%) had used an illicit drug in the last year and 71 percent had used in the last month.²⁵

- Of the total weighted sample, 353 (46.6%) were estimated to be in need of treatment for alcohol abuse and 548 (72.3%) were estimated to be in need of treatment for illicit drug use. This results in an overall estimated need of treatment for alcohol and/or drugs of 79 percent.²⁵
- Four percent reported that their overall emotional or mental health was poor, 41 percent reported that they had seen a health professional for emotional or psychological problems, 36 percent reported taking prescribed medication for psychological or mental health problems, and 20 percent said they had been hospitalized for their psychological or mental health problems.²⁵

Military Personnel and Families

The first of four goals of the White Report: Strengthening Our Military Families, is to enhance the well-being and psychological health of the military family. The report recognizes with the increased exposure to combat stress due to longer and more frequent deployments, there has been a growing number of service members with behavioral health needs. Further, it recognizes that military families are not immune to the stresses of deployment and cites a growing body of research on the impact of prolonged deployment and trauma-related stress on military families, particularly spouses and children.

- In Oklahoma, 12.5 percent (333,358) of our citizens are veterans, with 20.7 percent having served in the Gulf War.²⁶
- Over 47,000 individuals based in Oklahoma are active in military operations and 24,500 have been deployed since American troops entered Afghanistan.²⁷
- Oklahoma ranks third among states and territories for military recruits per capita. (http://www.statemaster.com/graph/mil_tot_mil_rec_arm_nav_air_for_percap-navy-air-force-per-capita)²⁹
- A 2008 Rand study found that 14% of returning service members meet criteria for PTSD and 14% meet criteria for depression. It is estimated that 300,000 veterans who have returned from Iraq and Afghanistan are currently suffering from PTSD or major depression. (Rand, 2008)²⁸
- According to the National Violent Death Reporting System, about 20% of suicides are committed yearly by veterans. There were in excess of 21% of suicides through 2007 among Operations Enduring Freedom and Operations Iraq Freedom.³¹
- More than 60% of suicides among utilizers of Veterans Health Administration services are among patients with a known diagnosis of mental health condition. (Serious Mental Illness Treatment Research and Education Center)³⁰

**Prevention and Early
Identification Information**

Suicide Prevention. According to the American Society for Suicide Prevention, every 15 minutes someone dies by suicide. It remains the 11th leading cause of death in this country. Though suicide attempts are not

reported, it is estimated that close to one million people make a suicide attempt each year. Research has shown that 90 percent of people who die by suicide have a diagnosable psychiatric disorder at the time of their death, most often unrecognized or untreated depression.

- Suicide is the most common manner of violent death in Oklahoma and the second leading cause of death to Oklahomans age 10-24.³⁶
- The first quarter of 2010 yielded an alarming increase in calls to Oklahoma's suicide prevention hotline; 53 percent greater than the same quarter in 2009.³⁷

Early Screening and Referral. As stated in the President's New Freedom Report, for individuals of all ages, early detection, assessment, and linkage with treatment and supports can prevent behavioral health problems from compounding and poor life outcomes from accumulating. Early intervention can have a significant impact on the lives of children and adults who experience behavioral health problems. Emerging research indicates that intervening early can interrupt the negative course of some illnesses and may, in some cases, lessen long-term disability.

- The direct costs of untreated needs of people with mental illness and substance addictive disorders for Oklahoma businesses, governments and families is \$3.2 billion annually and the total cost on the Oklahoma economy due to untreated and undertreated mental illness and substance abuse is placed at more than \$8 billion annually.³⁹
- Oklahoma's criminal justice system spends 63 percent of its annual budget (over \$1 billion) to address the untreated needs of people with mental illness or addictive disorders.³⁹
- A needs assessment study found that 18,253 adults received publically funded substance abuse treatment in 2005, leaving an estimated 70,118 adults with low income not receiving needed treatment. For the same year, 58,225 adults received publicly funded mental health services leaving an estimated 69,976 adults with low income not receiving treatment.²⁶

Underage Drinking. The National Institute for Alcohol Abuse and Alcoholism published a News Alert which showed that many adolescents start to drink at very young ages. In 2003, the average age of first use of alcohol was about 14, compared to about 17 1/2 in 1965. People who reported starting to drink before the age of 15 were four times more likely to also report meeting the criteria for alcohol dependence at some point in their lives. In fact, new research shows that the serious drinking problems, typically associated with middle age, actually begin to appear much earlier, during young adulthood and even adolescence.

Other research shows that the younger children and adolescents are when they start to drink, the more likely they will be to engage in behaviors that harm themselves and others. For example, frequent binge drinkers (nearly 1 million high school students nationwide) are more likely to engage in risky behaviors, including using other drugs such as marijuana and cocaine, having sex with six or more partners, and earning grades that are mostly Ds and Fs in school.

- According to Oklahoma's Youth Risk Behavior Survey (YRBS), in 2009, 39.0 percent of students in grades 9–12 reported current alcohol consumption. That percentage is consistent with data collected by the National Survey on Drug Use and Health (NSDUH) for the population aged 12 and older, which showed 42.5 percent of respondents were current drinkers in 2007.²⁰
- The 2009 YRBS data showed 28 percent of adolescents were binge drinkers at the time of the survey. Although youth binge drinking is on the decline, with the exception of 2009, Oklahoma has been consistently above the national average for this behavior according to the YRBS.²⁰
- NSDUH data from 2007 indicated 37.4 percent of 18- to 25-year-olds and 9.0 percent of 12- to 17-year-olds were binge drinkers.⁷ ***(OK data?)**
- The 2009 YRBS showed 19.4 percent of Oklahoma students in grades 9–12 reported early initiation of alcohol.²⁰
- In 2009, Oklahoma's percentage of adolescent drunk driving was 11.0 percent, compared to the national average of 9.7 percent.²⁰

Misuse of Prescription Drugs. In the United States, prescription drugs are the second most commonly abused category of drugs, behind marijuana. There may be a perception, especially among younger people, that prescription drugs are safer than illegal street drugs. Most people do not lock up their prescription medications, nor do they discard them when they are no longer needed for their intended use, making them vulnerable to theft or misuse. According to SAMHSA, the number of teens and young adults (ages 12 to 25) who were new abusers of prescription painkillers grew from 400,000 in the mid-'80s to 2 million in 2000. New misusers of tranquilizers, which are normally used to treat anxiety or tension, increased nearly 50 percent between 1999 and 2000 alone. Like many other states, Oklahoma is experiencing a dramatic increase in the misuse of prescription drugs.

- Oklahoma had the highest percentage, 8.1% of persons aged 12 and older reporting using pain relievers non-medically of all states. Nationally, the rate is 4.8% a rate that stayed constant from the previous year.⁵
- Oklahoma hospital data associated with opiates have shown a 91 percent increase since 2003. Although this is a general category for opiates, for all practical purposes, heroin is the only illicit opiate taken into account.³¹

- The latest NVSS data show that Oklahoma exceeds the nation in number of deaths due to drug-related behavior. In 2006, the rate per 100,000 was 17.3 for Oklahoma and 12.8 for the United States as a whole.[5] The number of drug-related crimes (larceny, burglary, motor vehicle theft) in Oklahoma also outstrips that of the Nation; in 2008, Oklahoma reported 3,442.4 per 100,000 compared to the national rate of 3,212.5 per 100,000. However, Oklahoma's 2008 rate does represent a decline for the state, which reported drug-related crimes of 4042.0 per 100,000 in 2005.³²
- In 2006, NVSS data ranked Oklahoma 4th in the Nation for fatal opioid poisonings, and in 2007, NSDUH data showed Oklahoma was 232 percent above the national average in consumption of painkillers for nonmedical use—a 22-percent increase since 2004. Oklahoma has experienced a 328-percent increase in opiate deaths since 1999. In 2006, Oklahoma's opiate-related death rate was 123 percent higher than the national average. Hospital data associated with opiates has shown a 91-percent increase since 2003 in opiate admissions.^{12,7}

**Needs Related to Good and Modern
Service Delivery**

Use of Peer Recovery Support Specialists.

The Peer Recovery Support Specialist (PRSS) fulfills a unique role in the support and recovery from mental illness and substance abuse disorders. A PRSS is a person in recovery from a mental illness and/or substance abuse disorder, who has been trained to work with others on his/her individual road to recovery. This training incorporates the PRSS's recovery experience as a means of inspiring hope in those they serve, as well as providing a positive role model to others. A PRSS works in collaboration with recipients of behavioral health services as well as clinical staff in the best interests of the individual's recovery process. Peer Recovery Support Specialists offer the advantage of lived experience from serious mental illness and/or substance abuse. They know the journey to recovery is real and attainable, because they have traveled the path.

- Recovery Community Services Program has shown consistent, positive results. The most recent data collected for individuals accessing services at baseline and 6 month follow-up revealed:³³
 - 75% of clients reported no substance use, an increase of 16.8%
 - 95.9% of clients reported no arrests at six-month follow-up
 - 51% of clients reported being employed, an increase of 33.9%
 - 51% of clients reported being housed, an increase of 31.8%
 - Clients experiencing serious depression decreased 19.6%
 - Clients experiencing serious anxiety decreased 21.7%
 - Clients experiencing trouble understanding, concentrating, or remembering decreased 25.8%
 - Clients attempting suicide decreased 23.1%
 - 20% of clients were prescribed medication for psychological/emotional problem at six-month follow-up

Impact of Trauma. Results from the Adverse Childhood Experiences (ACE) Study indicates that childhood abuse and household dysfunction lead to the development of the chronic diseases that are the most common causes of death and disability in this country. A strong relationship is shown between the number of adverse childhood experiences and reports of cigarette smoking, obesity, physical inactivity, alcoholism, drug abuse, depression, suicide attempts, sexual promiscuity, and sexually transmitted diseases. Traditionally viewed as public health or mental health problems, these behaviors appear to be coping mechanisms for people who have had adverse childhood experiences. Trauma-Informed Services can address the impact of trauma on people's lives and facilitate trauma recovery.

- As many as 80 percent of men and women in psychiatric hospitals have experienced physical or sexual abuse, most of them as children.³⁴
- The majority of adults diagnosed with Borderline Personality Disorder (81%) or Dissociative Identity Disorder (90%) were abused as children.³⁴
- As many as two-thirds of both men and women in substance abuse treatment report childhood abuse or neglect.³⁴
- Nearly 90 percent of alcoholic women were sexually abused as children or suffered severe violence at the hands of a parent.³⁴
- 82 percent of young people in inpatient and residential treatment programs have histories of trauma.³⁴
- Violence is a significant causal factor in 10-25 percent of all developmental disabilities.³⁴
- 80 percent of women in prison and jail have been victims of sexual and physical abuse.³⁴
- In one study, 92 percent of incarcerated girls reported sexual, physical or severe emotional abuse.³⁴
- Boys who experience or witness violence are 1,000 times more likely to commit violence than those who do not.³⁴

Use of Technology. According to the 2000 Census, 68% of the State's population lives in an urban area, with nearly one-third residing in a rural or frontier area. This leads to barriers to care for many Oklahomans who live in areas without the appropriate level of care and who do not have resources to get to the needed services. Telehealth is a primary strategy used by ODMHSAS to increase access to mental health and substance abuse information and services to underserved areas. Through the Oklahoma TeleHealth Network, Oklahoman's who were once unable to receive services due to geographical, economic and workforce barriers are now able to receive the care that they desire.

- In fiscal year 2011, over 16,000 Oklahomans were given behavioral health care services via Telehealth.³⁹
- For this same year, over 49,500 services delivered via telehealth.³⁹
- The average savings per quarter from the use of telehealth equipment is \$377,000.³⁹

Step Two Summary. The data used above do not represent what the state would consider complete in terms of a comprehensive gap analysis. That was not possible during this application cycle due to time and resource constraints. Regardless, substantial data are available and have aided the state in this block grant planning process. In fact, use of those data has driven a process by which Oklahoma has identified priorities on which to focus this plan and application. Those priorities are listed in Step Three and relate to the areas of health promotion, improved access, reduced disparities, service accountability, criminal justice concerns, and prevention of substance abuse and mental health disorders. Step Four will then articulate specific objectives, strategies, and performance indicators related to the needs and priorities identified by the State.

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Step Three: State Priorities

Steps One described the Oklahoma public behavioral health system, highlighted strengths and unique characteristics of the system and set, in general, challenges that face the state. Step Two then further reviewed those challenges along general topics and reviewed data that quantify the extent to which gaps exist and point to more significant issues for state. A review of that information was used in a data driven process to identify priorities the state will address in Federal Fiscal Years 2012 and 2013 and in accordance with requirements for the combined Substance Abuse Prevention and Treatment (SAPT) and Mental Health Services (MHS) Block Grant programs. Those are listed below.

1. Overall Health Promotion
2. Improve Access and Reduce Disparities
3. Improve Service Quality and Accountability
4. Reduce Criminal Justice Involvement
5. Prevention of Mental Illness and Substance Use Disorders
6. Public Awareness of Behavioral Health, Prevention, and Recovery.

Specific goals aligned with these priorities are detailed in Step Four. Strategies to accomplish those goals and performance indicators by which the accomplishments will be measured are also included.

Step Four: Goals, Strategies and Measures*

Step Three listed out state priorities for the FFY 2012 and 2013 block grant cycles. Those priorities appear below along with supporting goals and strategies.

Priority	Goals
Overall Health Promotion	<ul style="list-style-type: none"> • Further integrate behavioral health with primary care • Improve the health status of behavioral health consumers with complex health needs • Reduce use of tobacco
Improve Access and Reduce Disparities	<ul style="list-style-type: none"> • Expand services for American Indians • Target services to improve access for military personnel and their families • Expand services for children and youth with Serious Emotional Disorders • Develop local wraparound systems to enhance services for older adults • Utilize specific programs to address the needs of targeted populations
Improve Service Quality and Accountability	<ul style="list-style-type: none"> • Expand use recovery support services • Utilize evidence based practices for individuals impacted by trauma • Increase options for self-directed care • Leverage technology to improve access and quality of care • Further develop service management systems for more efficient use of resources and improved service outcomes
Reduce Criminal Justice Involvement	<ul style="list-style-type: none"> • Utilize treatment and supports to divert individuals from incarceration • Reduce recidivism for offenders • Improve workforce capacity and skills in response to individuals with criminal justice/public safety involvement
Prevent Mental Illness and Substance Abuse Disorders	<ul style="list-style-type: none"> • Reduce rates of suicide • Reduce substance use • Early identification and intervention of substance use problems (SBIRT) • Reduce underage drinking • Reduce misuse of prescription drugs
Public Awareness	<ul style="list-style-type: none"> • Address discrimination and stigmas related to behavioral health • Provide public information for improved access to services • Expand partnerships with media outlets

*Pending receipt of public comment on the proposed priorities and goals, ODMHSAS will define specific strategies to attain these goals and measurements to be used to track related outcomes and processes as reportable to SAMHSA.

III. Proposed Use of Block Grant Funds

Following is a draft of the proposed use of the funds based on an estimate of allotments for the Substance Abuse Prevention and Treatment (SAPT) Block Grant and the Mental Health Services (MHS) Block Grant for Federal Fiscal Year 2012. Actual amounts will be adjusted based on final allotments, known to the state upon receipt of the formal Notice of Award.

Federal Fiscal Year 2012 Estimated Use			
Category	SAPT Block Grant	MHS Block Grant	Subtotals
Substance Abuse Treatment and Supports	13,213,303.00		13,213,303.00
Mental Health Treatment and Supports (Adults)		3,169,473.05	3,169,473.05
Mental Health Treatment and Supports (Children and Youth)		789,572.18	789,572.18
Advocacy Development		188,077.73	188,077.73
Primary Prevention	3,523,548.00		3,523,548.00
SAPTBG Administration	880,887.00		880,887.00
MHSBG Administration		174,225.00	174,225.00
Totals	\$ 17,617,738.00	\$ 4,321,347.96	\$ 21,939,085.96

IV. Additional Information Requested by SAMHSA

Note to readers for draft copy: The following items are topics for which SAMHSA requested specific comments from each state submitting an application for block grant funds. These, to an extent, reflect SAMHSA's Key initiatives that can be viewed at <http://store.samhsa.gov/product/SMA11-4629?from=carousel&position=4&date=04192011>.

Activities that Support Individuals in Directing Services

Policies and Approaches to Participant-Directed Services.

Oklahoma Administrative Rules (OAC 450) stipulates standards for behavioral health treatment programs. Compliance with standards must

be achieved and maintained in order to be licensed to operate in the state.. The specific chapters that articulate standards and criteria for substance abuse treatment (OAC 450:18) and for community mental health services (OAC 450:17) require that providers develop all plans for services with active participation of the consumer and a support person or advocate, if requested by the consumer. Further, contracts for services purchased by ODMHSAS clarify similar requirements in all related statements of work.

As such, service plans are developed based on information obtained through an assessment process that is intended to be facilitated in partnership between the consumer and the service provider. Consumers are considered the key informants and decision drivers in this process. In addition to the planning and providing treatment services, providers must offer case management services to further empower consumers to access needed supports and meet their self-defined goals. Self-determination is a key principle embedded in all case management activities.

Current Self-Directed Services. As referenced above, all services offered through the ODMHSAS treatment network are expected to be self-directed and to naturally engage with social and family networks. Individuals who seek services have the freedom to choose where they receive care and supports. Providers are monitored to ensure consumers are actively informed of their right to direct their care and evaluate its effectiveness. Both the Mental Health Recovery Division and the Substance Abuse Recovery Division provide training and technical assistance to treatment providers throughout the state in assessment-driven treatment, as well as consumer-driven, individualized service plan development and case management services.

Following are some specific examples that demonstrate self-directed services within the ODMHSAS system.

- A Peer Run Drop-In Center in Tulsa is funded by ODMHSAS and viewed as the pilot program for statewide expansion, as resources allow. The Drop-In Center was developed

with leadership and support from a Certified Peer Recovery Support Specialist. The Peer Recovery Support Specialist initiative is described later in this section.

- The state has a well-established “wraparound service” approach in place for children, youth and families with access to local Systems of Care programs. This is facilitated through a team-based process involving the child, youth and family, with professional and natural supports involved. Wraparound data demonstrate that these strengths-based individualized plans lead to achieving positive outcomes as assessed by the consumers. The core values embedded in this approach assure fidelity to the model. All planning and decisions must be family-driven. As such, families have a primary decision making role in the care of their own children, as well as the policies and procedures governing care for all children. Much of the wraparound development occurred as a result of SAMHSA-funded statewide Systems of Care grants and, more recently, the Oklahoma Healthy Transition Initiative (OHTI) grant. Wraparound has been a significant driver to empower consumers and providers to more genuinely engage in consumer-directed services.
- Significant attention has been given, with the OHTI, to develop tools and supports to help youth transitioning into the adult service system do so with the specific knowledge and skills needed to direct their own care. Youth receive training to assure their services are youth driven. Youth driven communities include families, providers and contributing support agencies that fully embrace youth as partners and are dedicated to authentic youth involvement. Youth take on meaningful roles in planning their individual care and support, and assume leadership positions that focus on governance and program development. There are paid positions for youth in every decision making group throughout the System of Care and within the community. Youth also form and facilitate youth groups and provide training in the community based on their personal experiences.

Accomplishments within the Peer Run Drop-In Center, the state Systems of Care initiative, and the OHTI are having a broader systemic impact on all services within the ODMHSAS network. These projects have developed training, tools, policy changes and monitoring mechanisms that have led to services that much more clearly reflect a consumer-directed approach.

Participant-Directed Options. As referenced earlier, administrative code and contractual language require that admission into services is predicated on a strengths-based, consumer-centered, biopsychosocial assessment and that patient placement criteria are utilized at admission for the purpose of developing assessment-driven, individualized, client-directed treatment. ODMHSAS offers training in the correct administration of the Addiction Severity Index (ASI) and American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC-2r). Consumer -directed care is the key component of the training curriculum. The curriculum was developed based on the understanding that the participant is empowered to choose what to address while in treatment based on the severity determined through assessment and where to receive that treatment.

Other provisions are in place to provide options for consumer-directed care. Oklahoma Statutes (O.S. 43a) also provide that consumers are informed of and able to select a treatment advocate of

their choice. Statewide advocacy organizations also facilitate training for consumers and families to assure that services are person-centered and that recipients have tools to genuinely participate in service planning and direct their own care. One example is the Wellness Recovery Action Plan (WRAP). The ODMHSAS Advocate General and her staff regularly monitor facilities, review complaints, and support consumers and providers in taking corrective action to ensure individual preferences, needs, and personal rights are properly addressed.

Additional information regarding progress being made in terms of services to children, youth, and their families is included earlier under this topic.

Percent of Consumers Who Direct Their Care. All consumers whose treatment is funded through the ODMHSAS are engaged in directing their own care. Consumer feedback is also encouraged with continuous assessment throughout one’s treatment process, which allows the state to determine the extent customers report satisfactory experiences with self-directed care.

State Support Available for Assisting Self-Directed Care. ODMHSAS has actively taught and credentialed Peer Recovery Support Specialist (PRSS) positions for several years. In 2010 the statutes were revised to authorize ODMHSAS to establish regulations and procedures to officially certify Peer Recovery Support Specialists. Oklahoma is one of the first states to cross train PRSSs for mental health, substance-use and trauma disorders. A pay for performance project, the Enhanced Tiered Payment System, provides additional payment for providers based on utilization of PRSSs. A key function of PRSSs is to serve as a navigator and coach for consumers to more actively participate in directing their own care.

Related to wraparound for services to children, youth, and their families, ODMHSAS provides Care Coordinators and Family Support Providers to support families in directing, planning and coordinating their plans. One component of wraparound is to provide the knowledge to the family that they will have the skills and support to continue this process after formal wraparound ends, approximately a year in duration. The Family Support Provider also mentors, models and provides opportunities and support for families to strengthen advocacy and self-advocacy skills.

**Data and Information
Technology**

Overview of Information Systems for Treatment and Prevention Services.

Treatment Services. In SFY2010, ODMHSAS entered into a joint initiative with the state Medicaid agency – the Oklahoma Health Care Authority (OHCA) – to merge the two agencies’ management information systems into a jointly designed Consolidated Claims Process (CCP) system. This system went live July 1, 2010.

The CCP includes access to an on-line enrollment system whereby information on individuals who request services is entered to determine eligibility for both ODMHSAS and OHCA funded services through a single application process. A variety of client demographics are collected and retained in the client eligibility file for all behavioral health clients for whom services are

purchased by either the ODMHSAS or OHCA. All requests for specific authorizations for service are also processed through the CCP. Client characteristics, assessment scores and level of care needed are reported for all clients. Data includes information about demographic characteristics, living arrangements, employment, income, legal and marital status, language proficiency, education, disabilities, diagnoses, level of functioning, drugs of choice, frequency of use and client assessment results. Consumer information is collected and reported initially and continually as a contact, admission, update, correction, or discharge transaction. All required information must be entered to obtain prior authorization for payment of services and the eventual billing of the claim for payment. Claims follow the 837 Professional Electronic Data Interchange (EDI) format and include the type of service provided and the duration of the service. Effective October 2011, the rendering provider information will also be required.

Prevention Services. The ODMHSAS operates a web-based prevention service reporting system. Block grant contracted subrecipients receive authorization to access the system. Subrecipients are required to report prevention service activity in the system. Reported items include number of persons served, demographics of persons served, service types/categories, service hours, and detailed information on the circumstances/outcomes of tobacco purchase surveys (Reward Reminder Visits) and alcohol compliance checks. ODMHSAS utilizes the prevention reporting system to monitor subrecipient state and federal contract and product reports. In SFY 2012, the ODMHSAS will launch a revised prevention reporting system that incorporates more detailed data fields related to prevention subrecipient service activity and outcomes.

Use of National Provider Identifiers and Other Systems for Provider Data. *Treatment Services.* Individual providers and facilities are required to obtain a National Provider Identifier (NPI) number, which is entered into web-based agency and staff profiles. The facility NPI is entered into each claim. Beginning in October 2011, the individual clinician's NPI will be used on every claim to indicate the rendering provider of the service. In addition to the NPI, each agency has a Medicaid identifier. Both the NPI and the Medicaid ID can be used to segment or aggregate by provider. *Note:* Prevention service providers must obtain a unique provider identifier from the ODMHSAS to submit data in the prevention reporting system.

Unique Client Identifiers. For treatment services, the CCP enrollment process described above assigns a unique ID for each publicly funded behavioral health consumer. This remains the same ID regardless of the pay source or treatment provider.

Encounter Data. All claims for treatment services follow the 837 Professional EDI format, which provides the date of service, type of service and duration of service. Currently, only the facility NPI is provided on the claim but effective October 2011, the individual clinician NPI also will be included.

Use of ICD-10 or CPT/HCPCS Codes. The CCP behavioral health reporting system for treatment services complies with the use of ICD-9 and CPT/HCPCS codes. The CCP is preparing for the 2013 implementation of ICD-10 and x12 HIPAA 5010 transaction sets.

Linkage with Medicaid Data and Behavioral Health Reports. As described above, the CCP system includes both ODMHSAS and OHCA treatment data. Accordingly, a unique client identifier is used for both Medicaid and ODMHSAS funded clients and services. Medicaid and state-funded client information and claims data reside in the same files. Combined reports are used to review behavioral health trends in the state and comparisons are made to determine difference in populations served, service utilization and outcomes.

Interoperability, Partnerships and Collaboration. The ODMHSAS IT staff routinely meets with OHCA IT staff and vendors regarding the CCP single payer system. The two agencies are currently developing a proposal for a CMS-funded, patient-centered health home within the statewide CMHC system. ODMHSAS staff are also involved with the State Agency Health Information Organization (HIO), which is developing a health information exchange among state government health agencies; the statewide HIO, the Oklahoma Health Information Exchange Trust; and the Oklahoma Health Information Privacy and Security Council.

State Health Information Exchange Grant. Under the leadership of ODMHSAS Commissioner Terri White, who also was Oklahoma Secretary of Health at the time, Oklahoma applied for the State Health Information Exchange Cooperative Agreement Program and was awarded \$8.8 million on Feb. 12, 2010. More than 40 health organizations, including ODMHSAS, worked together to develop the state's strategic and operational plans. Legislation was passed appointing a seven-member board of trustees to act as the governing body for the state health information exchange. The legislation also required that up to 23 representatives to serve as an advisory group to the Trust, one of which must be a representative from ODMHSAS.

Planning for Improved Medicaid IT Systems. The Oklahoma Health Care Authority, which serves as the state's Medicaid agency, recently completed its re-procurement process for its Medicaid Management Information System (MMIS), which ODMHSAS also utilizes. System improvements include a state agency HIO, an electronic Master Patient Index (eMPI), an electronic Master Provider Index (eMPX), an electronic health record "lite," a personal health record, and a DIRECT network for providers without access to a health information exchange. ODMHSAS participates in all workgroups.

Electronic Health Records. The Senior Planning Coordinator for the Oklahoma Health Care Authority has informed CMHC directors how to apply for HITECH meaningful use incentive payments. All CMHCs indicate they are now working with their vendors to upgrade to an ONC-certified her. One Oklahoma CMHC was the first behavioral health provider in the nation to receive an incentive payment. Substance abuse treatment directors also received this information, but many of these facilities have few staff members that will qualify as eligible professionals under the meaningful use incentive payment program. Colleen O'Donnell, with the National Data Infrastructure Improvement Consortium, has presented to this group, as well, about upcoming healthcare reform and implications for treatment providers. In mid October, staff from the Mid-America Addictions Technology Transfer Center will present a 1½ day workshop for substance abuse treatment facility leaders titled "The Changing Health Care Landscape: Is Your Organization Ready?" Objectives of the workshop are: to gain awareness on how change impacts organizations and systems, understand how national healthcare reform will bring significant and multiple changes to the behavioral health field, complete an organizational

readiness assessment for purposes of evaluating the extent to which one's organization is able to meet new healthcare system demands, reexamine organizational priorities and strategies that may or may not lead to successful outcomes in the changing environment, and identify at least one potential next step in response to a transformational health care system.

Through the MMIS re-procurement process, an EHR "lite" and a DIRECT network are being developed for providers who do not have access to an EHR or an HIE to enable them to electronically exchange healthcare information.

Finally, two CMHCs are recipients of the SAMHSA Primary Care Behavioral Health Integration (PCBHI) grants and, within that, have requested additional funding from SAMHSA to expand functions related to interoperability and meaningful use.

Barriers Related to Encounter/Claims Based Approaches. Few barriers remain and ODMHSAS, along with OHCA, has moved forward with the CCP that is primarily encounter and claims based. Present concerns are not necessarily barriers, but challenges in implementing a pay for performance system correctly. Related issues for continued review and improvements are listed below:

- Data quality
- Stakeholder agreement and understanding of standards
- Manageable methods to calculate cost determinants
- Risk-adjusting data
- Discouraging providers from avoiding "high-risk" clients

Quality Improvement Reporting

ODMHSAS utilizes a variety of quality management practices to monitor services, assess effectiveness, and address areas for needed improvement and expansions. The state has worked to further develop outcome and performance measurement systems in

recent years. The analyses of information from those systems have proved useful to demonstrate effectiveness, clarify performance improvement areas, and advocate for added resources and policy changes. This report summarizes the culture of stakeholder involvement and the data infrastructure utilized to assure that ODMHSAS is continually addressing important issues that comprise its total quality management report. Following that information, specific activities are described.

Consumer and Family Participation in Continuous Quality Improvement (CQI). An important value held by ODMHSAS is the inclusion of consumer and family participation at all levels of operation and service delivery. One way this is accomplished is through the use of consumer surveys, in which individuals and caregivers participate in quality improvement activities by rating various aspects of their treatment experience. The ODMHSAS Decision Support Services has adopted and adapted a survey developed by consumers for use throughout

the treatment system. The surveys capture information related to many of the fundamental components of recovery.

ODMHSAS staff prepared and mailed out 21,000 pre-notification and discharge packets for use with the adult mental health consumer survey. To date, 3,110 surveys have been returned and analyzed. Results are distributed via 14 individual community mental health center (CMHC) reports and a statewide summary. This is available on line and data are provided to permit each CMHC to individualize reports to better address local community needs and CMHC-specific performance improvement issues.

A new methodology for obtaining children's caregiver assessment of mental healthcare was developed and implemented in 2010 to improve response rates. More than 800 telephone calls were made in an attempt to establish contact with families of children who received mental health services and to interview caregivers about their perception of their child's care. Results of the 105 completed interviews are distributed through an annual report to the CMHCs.

To obtain substance abuse treatment service recipients' assessment of care, staff prepared and mailed out 12,300 survey packets. The 5,200 returned surveys were scanned and analyzed, and results were distributed through 226 quarterly reports to 80 provider agencies.

As part of the transformation grant, the Consumer Involvement Study Group of the Governor's Transformation Advisory Board's Evaluation Work Group developed consumer involvement standards and an assessment tool to objectively measure consumer involvement in provider agencies. This work was funded by the SAMHSA Transformation State Incentive Grant (TSIG).

The Oklahoma Mental Health Planning and Advisory Council (OMHPAC) meets at least six times a year. The majority of those in this group are persons in recovery or family members. The remaining members are representatives of numerous state agencies and advocacy organizations. A standing agenda item includes reports from programs offering specific services. In that regard, the stakeholder group monitors and advises, on an on-going basis, the services and programs available to consumers and their families.

Decision Support Services Systems for CQI. A major function of the Decision Support Services Division is to measure and support ongoing efforts to improve services, processes and outcomes. Toward this end, the DSS primary responsibilities focus on evaluating programs, producing monitoring reports and educating others on a variety of topics to improve behavioral healthcare within the state and across the nation. Audiences include treatment providers, ODMHSAS staff, legislators, the general public, and peers in other states and at the federal level. Selected DSS activities are discussed below.

- DSS staff has developed and maintains 361 reports to monitor performance and continually increase the efficiency and effectiveness of various processes and procedures and improve outcomes. Currently, there are four different report formats for each National Outcome Measure (NOM), ranging from an easily understood format for non-technical groups to a highly detailed report that allows an agency to "drill down" to the client level for each measure. Also, a Provider Performance Management Report

(PPMR) is produced that is a compilation of every measure calculated for a provider agency, and includes information on whether the agency is above or below the statewide trend, where the agency falls in relation to other similar agencies and how the agency is doing compared to the previous year. The performance improvement reports are available on the department's secure and public websites.

- An assortment of reports have been designed for different audiences' needs, such as detailed staff productivity reports for local PACT program managers, a violations-to-sanctions ratio for drug courts and brief cost offset reports for legislators.
- In addition to producing and publishing performance improvement reports, DSS staffs routinely educate users to the uses of the reports available at the state, facility and individual clinician level for performance monitoring. In 2010, DSS staff provided more than 30 webinars to providers, and presented at 15 different conferences and five agency meetings.
- DSS staff developed and maintains a user-friendly, web-based query tool, the Health Information Integrated Query System (HI IQs), which permits consumers, advocates, providers, legislative staff and the general public to submit requests for data summaries and receive the results immediately through a web-based application.

To ensure ODMHSAS' providers were delivering services that positively impacted people's lives, DSS conducted evaluations of a variety of programs, which encompass promising, best and evidenced-based practices (EBPs). In 2011, these evaluations included:

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| <ul style="list-style-type: none">▪ Mental Health Transformation State Incentive Grant II (TSIG)▪ Oklahoma Partnership Initiative for Children of Methamphetamine-Involved Parents▪ Oklahoma Youth Suicide Prevention and Early Intervention Initiative▪ Older Adult Targeted Expansion Capacity Grant▪ Correctional Discharge Planning (CDP)▪ Children Affected by Methamphetamine Family Drug Court | <ul style="list-style-type: none">▪ Drug Courts▪ Mental Health Courts▪ Juvenile and Family Courts▪ Program of Assertive Community Treatment (PACT)▪ Day Reporting Program▪ Re-entry Intensive Care Coordination Teams (RICCTS)▪ Intensive Care Coordination Teams (ICCTS)▪ Co-occurring Treatment Team Specialist (COTTS)▪ Tobacco Settlement Endowment Trust |
|--|---|
- DSS staff participates in ongoing workgroups at the federal level to develop standardized performance measurements. These included the Department of Justice Advisory Board, the Washington Circle Group, the National Association of State Alcohol and Drug Abuse Directors (NASADAD) NOMs Performance Data Workgroup, the Centers for Mental Health Services Client-Level Data Project, the National Association of State Mental Health Program Directors Research Institute (NRI) Criminal Justice Measure Validation

workgroup, the NRI Employment Measure Validation workgroup, the NRI Social Connectedness Measure Validation workgroup, the NRI School Attendance Measure Validation workgroup and the NRI Health Status Measure Validation workgroup.

- In late 2010, Oklahoma and two other states formed the Interstate Performance Monitoring Community of Practice initiative to share ideas and innovative practices among state agencies. The initial call was held in November and six states and one university participated. Quarterly webinars have been presented for 2011.

In an effort to improve the quality of treatment data being reported, the ODMHSAS Data Integrity Review Team (DIRT) was formed in the fall of 2007 (2nd quarter of SFY08). The team consists of senior staff members and other newer staff in the Decision Support Services (DSS) Division. Throughout the first year of implementation, DIRT members modified the review protocol to better meet the needs of treatment providers and ensure that minimal time is taken out of clinicians' schedules. Initially, the protocol consisted of reviewing 30 pre-selected client encounter records and comparing the information reported to the statewide data reporting system to that found in the client treatment record. Inconsistencies were highlighted and reviewed with clinical staff. However, many of these data reporting errors were common among agencies so, to minimize treatment provider time, DIRT members no longer conduct record reviews at each site but go over common reporting errors. The main objectives of the visits are to educate treatment staff about: (1) NOMs and how to properly report the measures; and (2) the use of various reports available at the facility and individual level to use the data to improve treatment performance.

To date, the DIRT members have conducted 69 visits with both community mental health centers and substance abuse treatment providers. In addition to positive feedback from participants, the data demonstrate that reporting of NOMs outcomes has substantially improved during the period that the DIRT has been in place. To reduce the travel costs, webinars with individual agencies are now being conducted.

ODMHSAS CQI Projects. Examples of significant continuous quality improvement projects are briefly described below.

1. Pay-For-Performance. In 2009, ODMHSAS implemented the Enhanced Tier Payment System (ETPS) as a pay-for-performance plan to proactively support provider level activities that improve consumer outcomes related to recovery from mental illness and substance abuse. Two primary objectives were to: (1) improve treatment and support outcomes; and (2) pay for outcomes with no additional costs to the state.

ODMHSAS developed 12 measures that guide positive outcomes for consumer recovery. In addition, the ETPS was approved by the Center for Medicare and Medicaid Services (CMS), which then allowed Oklahoma to receive federally-matched funds for the project. For every state dollar contributed to the outcome measures, the federal government contributes \$1.93, a match rate of 65.9%. The funds are returned to communities to provide data-driven, research-based recovery outcomes to improve the lives of Oklahomans.

Benchmarks were established for 10 quality measures based on data from a previous six-month time period and knowledge of best practices. Two additional access measures are determined through “secret shopper” phone calls made to the facilities. Funding is allocated based on number of clients served and agency performance on each measure. Facilities may earn zero dollars, 50% of their allotment, 100% of their allotment, or more than 100% of their allotment depending on where each lands in relation to the benchmark.

The amount available to a facility is based on the percent of clients a facility serves. If Agency A serves 10% of the state’s mental health population, their ‘Amount Available’ would be 10% of the total. If a facility’s scores are above the benchmark on all scores, they would earn 100% of their funds. If any of their scores were below the benchmarks, there would be money ‘left on the table.’ Facilities scoring more than one standard deviation above the benchmark earn bonus money.

From the start of the new payment system in January 2009, all measures have shown improvement. The greatest improvement has been shown in the outpatient crisis follow-up measure, improving from 34% of the consumers being followed up in December 2008 to a 68% follow-up rate in March 2011. While only five facilities met or exceeded the benchmark for this measure in December 2008, 14 facilities had reached the benchmark in March 2011. Reduction in drug use has shown the least improvement, however, consumers showing a reduction in drug use have increased by 6% in the following two months and 12 of the 15 facilities have now met or exceeded the benchmark for this measure. After the initial round, all of the providers were so satisfied with the process, they agreed to voluntarily take money from their budgets to use as the matching funds. More attention has been paid to data quality and ongoing performance improvement processes have been put in place, resulting in higher quality care for citizens of Oklahoma.

Current Pay for Performance Indicators for mental health services are listed below. Resources to support a similar approach for substance abuse treatment services will be explored.

- Outpatient Crisis Service Follow-up within 8 Days
- Inpatient/Crisis Unit Follow-up within 7 Days
- Reduction in Drug Use
- Engagement: Four Services within 45 Days of Admission
- Medication Visit within 14 Days of Admission
- Access to Treatment - Adults
- Access to Treatment - Children
- Improvement in CAR (Client Assessment Record) Score: Interpersonal Domain
- Improvement in CAR Score: Medical/Physical Domain
- Improvement in CAR Score: Self Care/Basic Needs Domain
- Inpatient/Crisis Unit Community Tenure of 180 Days
- Peer Support: % of Clients Who Receive a Peer Support Service

2. Systems of Care CQI. A core principle for Systems of Care and Wraparound services in Oklahoma is “Outcome Based and Cost Responsible.” Related quality initiatives specifically benefit the children, youth, and families who access local Systems of Care and the partner

agencies that participate. Data are collected from 50 plus sites across the state. State level Systems of Care staff meet with lead evaluators from the University of Oklahoma's Evaluation (E) Team each month to review data and discuss ways to improve processes and outcomes based on the data, much of which are generated from the Youth Information System (YIS). The YIS is an electronic data reporting system developed by the E-Team for Oklahoma Systems of Care. Recent topics and recommendations are described below.

- Pay-for-performance system to incentivize sites to meet certain benchmarks. Three of the benchmarks being discussed are improved functioning (as reported by the caregiver) of youth, length of time from receipt of the referral to services by the site until the completion of the family's Initial Wraparound Plan, and length of stay for youth who have a positive discharge from services.
- Comparing outcome data for those youth who are involved with DHS versus those youth who are in the custody of DHS who have received wraparound services through Systems of Care.
- Evaluating the impact of Systems of Care among child serving agencies across the state.
- Dashboards that local sites could utilize to monitor data, caseloads and performance in real time.
- Modifying the current site review process to be less burdensome to sites, as well as more accurate regarding how the sites are performing.

In addition to discussing this information in the monthly Data Review Meetings, reports are provided at a bi-monthly local Project Directors meeting and at Quality Assurance meetings facilitated by our lead evaluators from the E-Team. Periodic summary presentations are provided to the State Team for Systems of Care.

3. CQI Related to Critical Incidents, Grievances and Complaints. Programs providing services within the ODMHSAS system are required by administrative code and specific ODMHSAS policies to report critical incidents, records of grievances, and other related complaints. Reported incidents as well as overall trends are closely monitored. Corrective action plans are stipulated as indicated. Those plans are then monitored for completion. Summaries of reports are submitted to the ODMHSAS Board Corporate Accountability Subcommittee and also provided to all Board members. Problematic resolutions and other factors surrounding the incidents and complaints can result in sanctions, revocation of certification/licensure, and specific employee disciplinary actions, including termination. These processes are closely coordinated by the Chief Operating Officer with regular involvement of the ODMHSAS Advocate General, the ODMHSAS Inspector General, the ODMHSAS General Counsel and the Director of Provider Certification.

4. Oklahoma Quality Team Awards. Each year the Governor's Office and the Office of Personnel Management (OPM) host Quality Oklahoma Team Day at the Oklahoma State Capitol to recognize projects demonstrating employee initiative, collaboration and accomplishment. All projects must be described using an acceptable total quality management approach, including reports on data and quantified results. ODMHSAS participation has been a major emphasis shepherded by the Commissioner's Leadership team. Prior to 2008, ODMHSAS rarely submitted more than two projects in a single year. In 2008, the Department entered a total of

seven projects, winning three Governor’s Commendation Awards, including the Quality Crown Award - the premier award for Quality Oklahoma Team Day. The Quality Crown Award is the highest recognition included in the event and is awarded to the single project that best documents the use of the quality processes, continuous improvement and performance excellence.

In 2009, ODMHSAS entered 18 projects, more than any state agency had ever entered in a given year. These yielded 13 Governor’s Commendations, three specialty awards, and the Quality Crown Award for the second straight year. The Department set a new record of most projects entered by a state agency in 2010 with 23 submissions and received 19 Governor’s Commendations. For 2011, ODMHSAS submitted 21 projects, earned 10 Governor’s Commendations, one specialty award, and, for the third time in four years, was recognized with the highest ranking project, receiving the Quality Crown Award.

5. ODMHSAS Board Quality Improvement Committee. The ODMHSAS Board Chair designates a subcommittee to review and report on system wide performance improvement activities and initiatives. The ODMHSAS Systems Process Improvement Coordinator staffs the committee and coordinates the activities for each meeting. ODMHSAS Leadership and other key staff also attend each meeting. The Subcommittee reviews activities and projects that have been performed by various state-operated facilities or contracted organizations. Members of the committee provide feedback regarding the projects and results, as well as make suggestions to spread the improvements on a statewide scale. The Subcommittee Chair reports to the full board at each meeting. On occasion, presentation on an exemplary performance improvement project is made at the full board meeting as well.

6. Other CQI Activities. The Systems Process Improvement (SPI) Coordinator hosts quarterly meetings with all state-operated facility Performance Improvement Coordinators. In this forum, staffs share information on performance improvement activities at the facilities and at the central administrative office. One product of these meetings is an e-PI Library currently being developed by the SPI Coordinator and Information Technology staff. The e-PI Library will be an electronic, searchable database that will house all ODMHSAS performance improvement projects and will be accessible to facilities as a project resource.

**Tribal and State Government
Collaboration and Consultation**

Consultation with Tribal Governments. Consultation with tribal entities in Oklahoma, including specific discussions related to SAPT/MHS Block Grant programs, occurs with tribal participants who are members of the Oklahoma Mental Health

Planning and Advisory Council (OMHPAC) and through the Oklahoma Tribal State Relations Workgroup (OTSRW).

Planning Council. Two members of the OMHPAC have key positions with two tribal governments in Oklahoma. One representative is the Director of Cherokee Nation Behavioral Health Services and the other is on staff with the Kiowa Nation. An additional member is the

Director of the American Indian Institute (University of Oklahoma), a training and research organization. The ODMHSAS Tribal Liaison and other staff involved in a variety of American Indian activities provide updates to the OMHPAC.

Oklahoma Tribal State Relations Workgroup. Consultation with a broader spectrum of tribal entities in Oklahoma is facilitated through OTSRW, which was initially formed in 2006 by the Governor's Transformation Advisory Board (GTAB). The GTAB was the formal advisory group guiding the implementation of the state's SAMHSA Transformation State Incentive Grant (TSIG). The GTAB specifically chartered a group to advise the GTAB and state agencies on tribal issues related to mental health and substance abuse services and to explore multiple avenues for interagency work between tribal nations and state government. The initial activities of the workgroup were informed by the technical assistance provided by Holly Echo-Hawk, a SAMHSA consultant, and in collaboration with the Oklahoma Partnership for Children's Behavioral Health. The mission of the OTSRW is to create the infrastructure to support a mutually beneficial government-to-government relationship between the state and tribes that is based on sovereign equality and includes urban and rural Indian programs as partners to promote the wellness of all tribal people in a holistic and strength-based way.

Under the guidance of the OTSRW, ODMHSAS established a state level position for a Tribal Liaison in 2008 to coordinate ODMHSAS activities that may impact American Indians who live in Oklahoma. With the Liaison in place, more frequent and culturally responsive interaction occurred with tribal governments in Oklahoma and with a variety of urban and rural Indian programs. Outreach to tribal communities continues to support coalitions, consensus building around behavioral health issues, and recruitment to state advisory groups and community level organizations.

Ongoing OTSRW consultation is centered around the following projects:

- *Community Defined Evidence* to explore traditional healing alternatives within behavioral health realms.
- *ODMHSAS Tribal Consultation Policy* to address ODMHSAS operations and interaction involving Oklahoma's tribal governments, tribal serving organizations, their communities, and tribal members.
- *State Contract Language* analysis to negotiate ODMHSAS contracts with respect to tribal sovereignty.
- *E-News* coordinated by the Tribal Liaison to promote behavioral health for Oklahoma tribes. This online resource provides updated information to promote the advancement of successful behavioral health in Oklahoma tribal communities.
- *The Resource Guide* is a listing of behavioral health programs and behavioral health resources available to Oklahoma tribal communities.

- *Trainings and Technical Assistance* to promote professional development, facilitate recruitment activities, and assist with building local coalitions and community teams.

Other ODMHSAS Initiatives. Other initiatives also have continued to develop and are facilitated by the Tribal Liaison. These initiatives provide ongoing and practical interface with a variety of American Indian behavioral health concerns. The initiatives provide an informal and useful venue to expand consultations with tribal members around a variety of topics. These include the Kiowa Suicide Prevention Partnership; Choctaw Nation Health Lifestyles; State Epidemiological Outcomes Workgroup; Drug Courts; and the Oklahoma Systems of Care Initiative with specific attention on underserved populations, including American Indian children and their families.

ODMHSAS merged its statewide data reporting system with the Oklahoma Health Care Authority (OHCA), the state Medicaid agency, to create the Consolidated Claims Payment (CCP) System in FY2011. One benefit of the combined system is a prior authorization system for all services that must be reported into the system. By using pre-programmed algorithms, the cap amount, array of services and length of authorization are determined based on clients' needs and severity.

**Service Management
Strategies**

Service Management Strategies and Processes. The CCP Prior Authorization System has been and will continue to be the primary service management tool utilized by ODMHSAS, including services purchased

with SAPTBG and MHSBG funds. The prior authorization parameters mirror those of OHCA, *except* for additional recovery-type services or levels of care that ODMHSAS funds and OHCA does not. The ODMHSAS algorithms are all computerized and do not require direct staff intervention unless an exception request is being made for **extenuating** circumstances.

Utilization Management Results. The prior authorization system has established some degree of standardization throughout the system at the direct practice level. Use of the system requires providers to justify providing higher levels of care. Therefore, one immediate result of the system is that service utilization is managed pro-actively at the provider and consumer level. A wealth of service utilization data also is available to analyze and use for better care management.

The system has been operational for a year and some performance monitoring reports have been designed and utilized. A next step will be for ODMHSAS and OHCA staff to expand utilization management reports for multiple uses. The following measures will likely be used:

- Percent of prior authorization (PA) dollar amounts utilized by provider and PA type
- Percent of PA caps that maxed out (and denied services showing the provider provided more services than the PA cap allowed)
- Percent of PA extension requests that remain at the same level or at a reduced level by provider and PA type
- Frequency of types of PAs requested at different agencies (for example, do some facilities routinely ask for more restrictive PAs?)

- Changes in the assessment scores at six-month follow up
- Analysis of authorizations over time for various consumer sub-groups

Reports from this system will interface with quality of care indicators developed with provider input and now routinely measured by ODMHSAS. Those are also described in Section F. Quality Improvement Reports submitted as a component of this 2012-2013 MHS/SAPTBG Plan, are incorporated in the Enhanced Tier Payment System, and include the following:

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| • Outpatient crisis service follow-up within eight days | • Use of outpatient peer recovery support services |
| • Inpatient/crisis unit follow-up within seven days | • Percent of clients referred and seen at referral agencies (for both referring and receiving agency) |
| • Initiation into treatment | • Percent of treatment completers |
| • Engagement in treatment | • Consumer/caregiver -reported access to care |
| • Medication visit within 14 days of admission | • Consumer/caregiver -reported appropriateness of treatment |
| • Inpatient/crisis unit readmissions within six months | |

Results of the utilization management measures will be used to guide further refinements of the prior authorization system. Utilization patterns of specific facilities and clinicians will be monitored to identify outliers and the need for technical assistance and training. Data also will be reviewed for emerging trends and quality benchmarking.

Timeframes and Resources. The service management system has been implemented and operational for approximately one year. Further development will continue. ODMHSAS, OHCA and experts throughout our provider network will provide the majority of resources needed for operation and refinement.

**Involvement of Individuals
and Families**

Utilization of Individuals in Recovery and Family Members in the Development of Recovery Oriented Services.

Leadership in this regard begins with the ODMHSAS governing body. State statutes require the ODMHSAS Board include at least one person who is a consumer or former consumer of mental health services. Similarly, the Board must include persons who are qualified in the area of substance abuse recovery. Consequently, it is not unusual given the rotating terms of members for four or more members of the ODMHSAS Board to be individuals in recovery or family members.

ODMHSAS also has been fortunate to engage a diverse group of consumer and family member stakeholders who assist on various advisory groups and task forces. Key among these and specifically related to this MHSBG/SAPTBG application is the Planning and Advisory Council (OMHPAC) describe in Section IV. O.

Many ODMHSAS staff members also are people in recovery and provide internal assistance and leadership so the agency benefits from their expertise. For example, the Office of Advocacy and Wellness within the Mental Health Recovery Division includes the Coordinator of Holistic Recovery and Wellness (CHRW) and the Peer Support Services Coordinator. The CHRW works to ensure that providers have the opportunity to learn about techniques and strategies for providing culturally competent consumer directed care. Specifically, this person travels to facilities to teach staff specific strategies geared toward providing holistically based consumer driven services. Training is strengths-based and focuses on recovery centered in the eight dimensions of wellness. The Coordinator of Peer Support Services coordinates training and the state wide certification registry for Certified Peer Recovery Support Specialists. Further, the state has undertaken these and other initiatives based on its commitment to assure that each person in recovery and their family members are active participants in improving recovery outcomes at the state, local, facility and personal level. Some initiatives are summarized below:

- Family and youth representatives serve on the Oklahoma Systems of Care Initiative (OSOCI) State Advisory Team, the Expansion Team, the Behavioral Health Advisory Team, the SoonerCare (Medicaid) family advisory committee, Oklahoma Healthy Transition planning group, and the Oklahoma Adoption Wraparound Initiative. At the local level, community teams at 53 sites across the state include family and youth members as part of advisory and decision-making groups. Each of these planning and advisory groups has full family participation and shared responsibilities with agency employees and representatives. At the individual level, the wraparound process empowers families with a Care Coordinator and a Family Support Provider (FSP) assigned as support to their team. The FSP takes an active role by providing support and education to families, as they identify what supports are needed to help families drive their own plans and services.
- With resources from the SAMHSA Transformation State Incentive Grant (TSIG), ODMHSAS provided start-up funding for a peer-run wellness drop in center in Tulsa. The Mental Health Association in Tulsa is the sponsoring organization, but the center operates exclusively under the direction of a staff of Recovery Support Services Specialists.
- Oklahoma's Recovery Support Specialist Initiative began in 2004 by training people with a serious mental illness or a co-occurring disorder to work primarily in CMHCs and advocacy organizations. Then and now, trainings are conducted by people in recovery. The program continues to expand and, as referenced earlier in this application, can culminate in an individual being recognized by the state as a Certified Peer Recovery Support Specialist (C-PRSS). Since 2008, this role has been expanded to more intentionally include people with a primary diagnosis of addiction who work in substance abuse treatment centers, advocacy organizations, and also in faith-based settings. In 2010, trainings began for offenders in the Oklahoma Department of Corrections to become PRSSs to work with their fellow offenders. Trainings have now occurred in five of the state's correctional facilities. Some faith based programs have also arranged for individuals who have been incarcerated to be trained as PRSSs to assist with reentry work

included in their ministries. To date, ODMHSAS has trained 893 individuals in peer recovery support and 226 currently hold state certification as a C-PRSS.

- The first Oklahoma Wellness Academy was hosted by ODMHSAS in July 2011. PRSSs from CMHCs, substance abuse treatment programs and the peer-run wellness drop-in center attended the 40 hour training. The training was designed to teach PRSSs “wellness coach” techniques based on such multiple evidence-based modalities as Motivational Interviewing that focus on consumer directed services.
- Oklahoma is benefiting from SAMHSA resources through the Oklahoma Alternatives to Seclusion and Restraint (OASAR) program to better equip staff and consumers to respond to situations with trauma-informed approaches. Consumer and family involvement in this process is key. Strategies involve formal inclusion of adult consumers, children, families and external advocates in various roles to assist in the reduction of seclusion and restraint. It includes consumers of services and advocates in event oversight, monitoring, debriefing interviews and peer support services, as well as mandates significant roles in key facility committees.
- Several ODMHSAS substance abuse and mental health treatment facilities have achieved or are in the process of becoming Sanctuary Certified Programs, based on the Sanctuary Model© developed by Andrus Children’s Center. One fundamental Sanctuary Commitment is social responsibility to help rebuild social connection skills, establish healthy attachment relationships, and establish a sense of fair play and justice. Through this commitment all consumers and family members are considered equal to staff and management.
- The Freedom, Recovery and Empowerment (FRE) Grant is also funded by SAMHSA with transformation funds. FRE is implemented with CMHCs as a structured trauma-informed system of care to support and empower recovery within a trauma-informed environment for all (consumers and staff) that includes evidence-based, trauma-specific treatments and practices for adult consumers who need and choose them. Recovery support staff introduces the program and services available to consumers at each site. Recovery staff provides ongoing support to consumers throughout the treatment process and comprises part of the treatment team working with consumers. When consumers complete the program, the goal is for consumers to remain involved in the center and/or community by becoming involved in community support groups as members or group leaders. Consumer representation from the pilot sites are part of the FRE steering committee. This committee meets quarterly to review program development, data on service delivery and consumer outcomes, and make recommendations on how to proceed with implementation. The steering committee also will present updates to the OMHPAC at least annually for additional consumer-based input and guidance. From the beginning, starting with the decision to apply for the grant, the design of the proposed program and its subsequent implementation has been totally consumer inclusive.
- A Consumer Involvement Study team was established as a sub-committee of the TSIG Evaluation Workgroup. The group developed consumer involvement standards to

measure how involved consumers were with their own care, and at the community and state level. The project involved working with evaluators from three state agencies who were members of the TSIG Evaluation Workgroup to design standards, an evaluation tool, and to test the tool at the provider level. Approximately 40 self-identified consumers contributed to the development of the standards. The pilot of the standards at the provider level involved surveying consumers and provider staff within the same programs, asking the same questions regarding information given to consumers and opportunities for consumers to provide input at the centers. Evaluation findings were compared and analyzed to enhance validity of the tool. Consumers and providers generally agreed that consumers were given a choice in their treatment options and had input into treatment planning and satisfaction with their services. Some areas in which consumer perception was less favorable than provider perspectives involved consumers being able to access a computer at the center to locate resources such as support groups in the community, or assistance in locating agencies outside of the center to report concerns or complaints. All surveys were administered by peer staff at the pilot site centers. Peer staff from the Consumer Involvement Study group met with center directors at the conclusion of the pilots to review outcomes and provide input to center staff on how to increase involvement. Information from this project continues to fuel attitudinal and systemic changes throughout the ODMHSAS services and supports network.

Available Training. The ODMHSAS Human Resources Development (HRD) Division conducts trainings attended by more than 32,000 people each year. HRD works closely with ODMHSAS staff and representatives from other organizations to ensure that training is delivered using the best educational practices, appropriate and current content, and delivered in a manner that is culturally competent and accessible through various media. Likewise, HRD works closely with advisory and consumer stakeholder groups to critique content and improve sensitivity to a variety of audiences. The HRD training and distribution infrastructure supports a variety of training activities in this regard.

ODMHSAS contracts with the Oklahoma Federation of Families (OFF) to provide technical assistance to the System of Care communities and partners with the Oklahoma Family Network (OFN) to offer support to families. Wraparound trainings are presented to families and youth, including Family Support Provider training. In addition, OFF and OFN sponsor a Family Leadership Academy. ODMHSAS also partners with the Oklahoma Parents Center and the Oklahoma Disability Law Center to provide training on Individualized Education Plans (IEPs) and educational advocacy. The Center for Learning and Leadership partners with ODMHSAS to train on person-centered planning. The State Systems of Care (SSOC) also recently implemented the first Oklahoma Family/Youth Leadership Institute - a yearlong commitment involving training in leadership, advocacy, community speaking, and local/state family youth involvement. Wraparound adoption training is provided to adoption professionals and, more importantly, to the adoptive families themselves. Family Support Providers have statewide quarterly meetings/trainings, as do National Evaluation family/youth interviewers.

Participation in State Sponsored Meetings. SSOC specifically supports involvement of children, youth and families at local and state level meetings, including large training events, with stipends, travel costs, lodging, etc. Four times a year, the Family Involvement Coordinator

attends and presents at “On the Road” family perspective conferences in rural Oklahoma. These provide information, support, contacts and information about services to families who have family members or loved ones living with disabilities. In addition to providing outreach, participant evaluations provide valuable information about specific community needs, as defined by family members themselves. Each local System of Care is required to sustain development of a family group that meets regularly so family members can support each other and grow in leadership and advocacy skills. Currently, Oklahoma has 28 family groups operating in 36 counties.

Also, each local System of Care is required to sponsor a youth group, of which 10 are currently in existence. The key principle embedded within the philosophy of youth-driven groups is that young people – regardless of race, ethnicity, color, socioeconomic status or cultural background – have the right to be empowered. Youth should have a key decision-making role in the care of their lives as well as the policies and procedures governing care for all youth in the community. This includes creating a safe environment where youth can develop and sustain healthy developmental techniques. State-level staff and peer advisors work with youth and local communities to effectively focus on both youth empowerment and youth leadership development.

Regarding adults, ODMHSAS provided assistance and support, as requested, to people in recovery in the formation of a structure to strategically address issues and needs of the system from their perspectives. From this, the Oklahoma Recovery Alliance (OKRA) formalized a steering committee of people in recovery and recovery advocates representing regions statewide. They are dedicated to promoting a united voice for hope, empowerment, representation, and recovery through an inclusive network of communication, education and advocacy. OKRA meets quarterly at the state level with representatives from six geographic regions, as well as staff from the ODMHSAS Wellness and Recovery Division and advocacy organizations. The local level meeting frequency is determined by participants of specific geographic regions. OKRA, with resources from the SAMHSA Transformation State Incentive Grant (TSIG), utilized the consultant services of K. Muscari, Ph.D., to build consensus around priorities and staff a strategic plan for the group. That plan articulates key principles and strategies that will increase and sustain involvement of consumers in decision making regarding behavioral health services at personal, local organizational and state levels.

Individual and Family Member Participation in Treatment and Recovery Planning. This is also addressed in Section IV. D. of this application. Also, as referenced earlier, each individual’s right to name a treatment advocate, as provided by O.S. Title 43a, is essential to preserving and perpetuating meaningful involvement by individuals and family members in treatment and recovery planning.

ODMHSAS-sponsored programs continue to “push the envelope” in this regard. For example, the wraparound model for children’s services must be individualized for each family. Families are actively supported by staff – many of whom are consumers and parents with lived experiences – to determine resources that may assist families in making informed choices about services and supports they need and prefer. At both local and state levels, families are provided leadership training, mentorship, and support to serve on planning and advisory committees

Support to Strengthen and Expand Recovery Organizations. ODMHSAS actively participates in and promotes anti-stigma events sponsored by advocacy organizations. Events such as the annual NAMI Walk in May and Addiction Recovery Walk every September include ODMHSAS staff on the planning and implementation committees. Also, the CHRW serves as the chair of the state chapter of the National Recovery Project, in which a state representative is selected to attend the national recovery walk sponsored by Voices of Recovery and the A&E network.

ODMHSAS is also helping to develop a statewide consumer network by offering facilities and support of staff from the Office of Advocacy and Wellness. This September, the first annual Peer Recovery Support Specialist retreat will be held. The retreat has been fully planned by consumers with support from the ODMHSAS Office of Advocacy and Wellness.

Three ODMHSAS Central Office staff specifically work together to support and strengthen family, youth and cultural awareness. These three staff members – the Coordinator of Family Involvement, Youth Coordinator and Cultural Competence Coordinator – provide trainings and presentations to local communities, agencies and families. Services purchased from the OFF and OFN and referenced earlier in this section provide technical assistance and support to families and consumers.

ODMHSAS continues to utilize state and federal funds, to support local and statewide advocacy organizations in their activities that increase consumer involvement. These include:

- Federal of Families for Children’s and Youth Mental Health
- Mental Health Association in Tulsa
- Mental Health Association of Central Oklahoma
- National Alliance for Mental Illness – Oklahoma (NAMI-OK)
- National Alliance for Mental Illness – Tulsa (NAMI-Tulsa)
- National Association of Black Veterans (NAMVETS)
- Oklahoma Chapter of the Depression and Bipolar Support Alliance
- Oklahoma Citizen Advocates for Recovery and Treatment Association (OCARTA)
- Oklahoma Mental Health and Aging Coalition

Use of Technology

Technology Overview. ODMHSAS has invested substantial resources in recent years to develop and implement technological supports for services and community development statewide. Much of this was

developed in partnership with SAMHSA as a result of the Transformation State Incentive Grant (TSIG). The TSIG and related innovations established a foundation upon which the state will continue to build. Other resources have been accessed and providers assisted with the development of a user-fee mechanism by which funds are replenished to sustain the program.

Two fulltime staff are available to support the expanded use of technologies and specifically the use of telehealth: a Director of Telehealth Services and a Video Conference Engineer. Both travel extensively throughout the state to provide real-time support to consumers and staff needing to access telehealth technologies. Additional planning and development are led by the ODMHSAS Director of Information Services.

Strategies Deployed to Support Recovery and Leverage Interactive Communication Technology. Telehealth is a primary strategy used by ODMHSAS as an interactive technology to support recovery statewide. ODMHSAS has successfully implemented a statewide non-traditional treatment delivery system through the use of video-conferencing technology (TeleHealth). This technology allows ODMHSAS and community providers to deliver mental health and substance abuse services to consumers in rural communities who, without this technology, would continue to be at a significant disadvantage due to lack of access to services. The telehealth technology has enabled ODMHSAS to provide previously underserved areas of Oklahoma with a significant increase in access to mental health and substance abuse information and services. This method of service delivery also has increased the overall quality of mental health and substance abuse care delivered to the community. Through the Oklahoma Telehealth Network, Oklahomans who were once unable to receive services due to geographical, economic or workforce barriers are now able to receive the care they desire. This network has also facilitated new partnerships, strengthened existing ones and contributed to the goal of merging physical and mental healthcare by providing a mechanism for physicians and behavioral health professionals to consult with each other in a more rapid fashion. As a result of this network, the landscape of the service delivery system in Oklahoma has been forever changed.

ODMHSAS has also deployed the Statewide Telehealth Network as a mechanism to support the work and advocacy of Oklahoma's recovery efforts. Before leveraging this technology, Oklahoma faced several geographic barriers when it came to engaging its citizens in the work of organizing and promoting recovery in our state. However, by utilizing the Statewide Telehealth Network (which consists of over 160 telehealth sites across 76 of Oklahoma's 77 counties), state agencies and advocacy organizations are able to engage citizens across the state in the work of recovery without the usual geographic, time and cost barriers frequently associated with accessing these services and supports.

In addition to interactive treatment and advocacy applications, the Statewide Telehealth Network has on-demand content distribution capabilities. This provides for further use as a tool for trainings and meetings; and allows for development of promotional messages and other recorded materials, which can be housed on an ODMHSAS server and made available to anyone across the state that has access to an internet connection. This means that the messages of recovery and the resources to support recovery are immediately accessible to a broader audience.

Finally, the System has been widely adopted by local judicial entities for court hearings. This greatly reduces burdens on consumers, law enforcement (for transportation) and local courts.

Additional Planned Applications of Interactive Communication Technologies. ODMHSAS is developing an iPad application to interact with Avatar, the electronic health record (EHR) used

by state-operated treatment facilities. The application will provide real-time access to medical information to clinicians via iPad anywhere within the facility. While with a consumer, clinicians can easily access the patient's treatment protocol and other information, e.g., current medication and drug-allergy lists. Physicians can prescribe medications through the application and the prescription will process through drug-drug and drug-allergy interaction checks and a drug formulary for immediate feedback in supporting the consumer and physician decision-making processes. Information contained in the EHR will be available through the iPad. Data can also be displayed in a graphic format. For example, clinicians can instantly see trends for health indicators such as weight and blood pressure.

Access to data will be appropriately restricted and maintained through ODMHSAS Access Control, a system that enables electronic and secure access to data based on the user's role. The same security restrictions that apply to desktop computers apply to the iPads, such as unique user IDs, password protection, and automatic logoff after a short period of inactivity. The data that will be passed to the application resides on the server, not on the iPad itself. If the tablet is lost or stolen, no confidential information can be obtained through it. ODMHSAS will be diligent in all efforts to educate consumers, administrators and end-users to the security of the data and the proper handling of all mobile devices.

The prototype was recently demonstrated to clinicians who were very enthusiastic. It is expected that the implementation of the application will lead to greater acceptance of EHRs, specifically the Avatar system, overall. Barriers to adoption of the iPad application include lack of IT resources and limited funding for purchasing iPads, despite the fact the application will provide consumers and clinicians access to information and mobility at far less cost than other mobile computer technologies.

Incentives Planned to Encourage Use of Technologies. The O OHCA, the state's Medicaid agency, will increase its site origination fee per encounter in accordance with Centers for Medicaid and Medicare Services (CMS) guidance. Likewise, ODMHSAS will increase its site origination fee to match that of the OHCA. This will immediately impact consumers in need of behavioral health services who are not covered under Medicaid, but receive services through the ODMHSAS network of providers. Access to an originating site fee has proven to be a useful incentive for providers. As referenced earlier, ODMHSAS has utilized telemedicine technology since November 2007. Early on in the use of the technology it was apparent that added financial support through the site's original fee structure supported the early adopters and increased the rate by which other providers adopted the practice.

Support System for Use of Interactive Communication Technologies. ODMHSAS provides an extensive training program to support its providers who deliver mental health and substance abuse services via telemedicine technology. ODMHSAS has worked with local and national vendors to develop a training that addresses several of the barriers associated with telemedicine acceptance and integration. The implementation of this training has resulted in an increase in the adoption rate of this technology, as well as increased the effectiveness of the clinicians who use this technology.

Implementation Barriers. Some of the barriers involved with statewide adoption of telemedicine technology are network infrastructure, licensure requirements and Medicaid billing. Network infrastructure at some remote CMHCs and substance abuse facilities is not well developed and does not possess adequate bandwidth to properly conduct telemedicine sessions. To address this, ODMHSAS has deployed a flexible set of telemedicine solutions that work in various network environments. With this capability, ODMHSAS is able to adjust various network and firewall settings to allow for proper communication and increased bandwidth.

Another potential barrier is the acceptance of telemedicine by various licensure boards as a valid method of service delivery. ODMHSAS has had discussion with the Medical Licensure Board , which had questions regarding the validity of telemedicine services and whether they should be considered as “face-to-face” service delivery. After discussions among ODMHSAS, the Medical Licensure Board and the Oklahoma Legislature, in May 2008 Governor Brad Henry signed a bill into law stating that telemedicine services would be considered the same as face-to-face as it relates to behavioral health services.

CMHC providers initially expressed concerns as to whether they could bill Medicaid for the services provided via telemedicine. To clarify this issue, ODMHSAS and OHCA amended rules, policies and procedures to allow for telemedicine services to be properly billed to Medicaid. This occurred in April 2008.

Planned Work with Federally Qualified Health Centers s and Other Organizations to Support Use of Interactive Communication Technologies (ICTs). One way that Oklahoma is accomplishing this is through the formation of the Oklahoma Telemedicine Consortium. Consortium members include representatives of hospital networks, Federally Qualified Health Centers, state telemedicine organizations, advocacy organizations, university telemedicine systems, and local service providers. The mission of this consortium is to create a statewide knowledge base for telemedicine and promote the use of telemedicine as a way to integrate behavioral and primary healthcare.

Program Evaluations and Measures and Data Collection Related to ICT Effectiveness. Software utilized within the Statewide Telehealth Network captures a variety of utilization data that are available for cross analysis with other data to assess impact, satisfaction and recovery outcomes.

The following measures have been utilized recently to promote and determine effectiveness of the Statewide Telehealth Network:

- Treatment outcomes (compared to face-to-face)
- Level of usage
- Consumer satisfaction
- Cost Savings (wages, productivity)
- Other operating efficiencies
- Numbers served
- Time before receiving assessment (for emergencies)
- Overall travel time
- Accessibility to specialists

A recent analysis also documented the following:

- Average savings per quarter of \$377,000
- More than 16,000 Oklahomans served last fiscal year via telehealth
- More than 49,500 services delivered via telehealth last fiscal year
- Average of 108 additional Oklahomans served via telehealth per facility
- Saved more than 1.2million kilograms of carbon dioxide last fiscal year

**Behavioral Health
Planning Council**

Overview. Currently the Oklahoma Mental Health Planning and Advisory Council (OMHPAC) fulfills the mandated requirements as stipulated in mental health block grant regulations. OMHPAC leadership and ODMHSAS staff are in open

dialogue to review the best method by which the Council could transition to a broader-based state behavioral health advisory council. This will require a review of current OMHPAC bylaws, engagement and planning with stakeholders representing substance abuse treatment systems and community-based prevention partners, and coordinating a transition plan with the ODMHSAS Commissioner. The Council and ODMHSAS predict the transition to a broader council will occur in conjunction with appointments for new terms to the present council prior to Jan. 1, 2012. A summary of OMHPAC’s present operations follows:

Council Duties. The Oklahoma Mental Health Planning and Advisory Council’s purpose is to: (1) Review plans, including the Federal Mental Health Services Block Grant Plan provided to the Council, and to submit to the state any recommendations of the Council for modifications to the plans; (2) Serve as an advocate in promoting an enhanced quality of life for all adults with serious mental illness, children with an emotional disturbance and their families, and other individuals with mental illness or emotional problems; (3) Monitor, review and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state; and, (4) Exchange information and develop, evaluate, and communicate ideas about mental health planning and services.

Council Membership. The Council consists of no more than 35 members and is comprised of Oklahoma residents representing adults with a serious mental illness; the families of adults with SMI; families of children with emotional disturbances; principal state agencies involved in mental health and related support services; and public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support activities.

Directors of the following state agencies appoint one member each to the Council: Oklahoma Health Care Authority; Oklahoma Department of Rehabilitation Services; Oklahoma State Department of Education; Oklahoma Department of Corrections; Oklahoma Office of Juvenile Affairs; Oklahoma State Department of Health; Oklahoma Housing Finance Agency; and Oklahoma Department of Human Services.

The ODMHSAS Commissioner appoints two staff representatives, one representing mental health and one representing substance abuse services. Boards of Directors of the following

statewide advocacy organizations also appoint one person each to serve as a Council member: National Alliance on Mental Illness – Oklahoma; Oklahoma Mental Health Consumer Council; Oklahoma Federation of Families; and Depression and Bipolar Support Alliance of Oklahoma.

The ODMHSAS Commissioner, with recommendations from the Council, appoints all remaining members of the Council including consumers of mental health services, family members of adults with serious mental illnesses receiving services, family members of children with serious emotional disturbances, providers, advocates, and other individuals interested in the quality and effectiveness of mental health services.

Membership Terms. State agencies have permanent membership. Appointments are at the discretion of each agency director. Statewide advocacy organizations designated in Council Bylaws also have permanent membership, with designees serving at the discretion of their Boards of Directors, to be verified to the Council secretary by Jan. 1 of each year. All other members, including consumers, family members of consumers, and family members of children with serious emotional disorders (SED), consumer advocates, and providers are appointed for one three-year term, with the option of a second three-year term. They can be eligible for membership on the Council again after a one-year break following the second three-year term.

Council Meetings. The Council typically conducts six meetings each year. The Executive Committee may call special meetings at the request of a majority of the members of the Council. All meetings of the Council are open to the public. Time is set aside at all meetings of the Council for members of the public to address the Council. All meetings are announced and posted in accordance with state open meetings law. In 2011, each Council meeting has included specific presentations and discussions around each of the SAMHSA Strategic Initiatives.

Involvement With the 2011-2012 Plan and Application. A committee of Council members, appointed by the Chair, worked with ODMHSAS planning staff to provide suggestions and guidance in the preparation of this application. Further, the full Council will review the entire application and plan on August 24, 2011. A letter summarizing their comments will be included with this application.
