A. Solicitation of input by stakeholders

Oklahoma's CCBHC steering committee. The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) utilizes the Oklahoma (OK) Planning and Advisory Council (PAC) as the primary advisory group for state planning for Certified Community Behavioral Health Centers (CCBHCs). This is efficient and optimal since this group has a long history of collaboration and has contributed greatly to system development over many years. The group meets bi-monthly with a standing CCBHC slot on the agenda. The PAC revised its bylaws in 2012 to expand and rename itself to more thoroughly embrace a larger constituency reflective of integrated and holistic behavioral health services in OK. Also, additional membership positions were added in 2013 to include individuals with experience in substance use disorder (SUD) recovery, treatment, and prevention services. The bylaws require that 51 percent of the membership be persons in recovery from mental illness or SUD, or family members.

The PAC consists of 40 members. It includes representatives of (1) principal state agencies involved in MH, substance abuse and prevention and related support services (State Departments of Medicaid, Education, Health, Corrections, Juvenile Justice, Housing, Human Services, Child Welfare, and Rehabilitations Services); (2) public and private entities concerned with the need, planning, operation, funding, and use of mental health (MH), SUD and prevention services, and related support activities; (3) adults with serious mental illnesses and/or addictions who are receiving, or have received, services; (4) families of such adults; and (5) families of children with emotional disturbances and/or addictions. The PAC will be voting on revisions of PAC bylaws in the fall of 2016, which will include the addition of youth representatives with serious emotional disturbances and/or SUDs who are receiving (or have received) services.

Presentations at meetings are around topics for which one or more PAC members has requested additional information. This process has been very helpful to the ODMHSAS in development of new initiatives, most recently the development of Behavioral Health Homes (BHHs) for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). Therefore, it was the perfect group to tag as the primary advisory body for CCBHC planning and development. All three agencies selected for the CCBHC certification process are BHHs.

The CCBHC state planning core team presents at each PAC meeting to apprise them of progress and to receive their advice and counsel for the next phase of planning. The Director of the National Association for Mental Illness (NAMI) OK chairs this group and ensures the involvement of its affiliates statewide. The PAC was particularly helpful early on by advising on the focus group and survey questions to be utilized, and by giving the council's viewpoint on each facet of the current system. They continue to give special focus and guidance regarding *access to services.* They are vocal in their support of the initiative and need for a demonstration. They are appreciative of the inclusion of outpatient SUD services as a core requirement for CCBHCs and have offered advice and council on the specific gaps in SUD and co-occurring services. A longstanding PAC member chairs the OK Recovery Alliance (OKRA), an advocacy group comprised of consumers and family

members. He has engaged OKRA's members in the feedback process at its regular meetings. Local youth and family groups were engaged through OK Systems of Care (OKSOC) and participated in the surveys and focus groups.

The ODMHSAS has increased youth and young adult partnerships in the past year. The Young Adult State Advisory Board (YSAB) is still in the beginning stages of development. The ODMHSAS, through SAMHSA grant funding, has hired two youth and young adult specialists to enhance the youth and young adult voice in relation to MH, SUD, or co-occurring disorders and overall leadership. YSAB meets once a month and has participated in several state level and community speaking events. Due to a very moving panel presentation by three YSAB members concerning their very negative experiences with engagement and intake, community mental health center (CMHC) Directors (CMHCs/CCBHCs) appointed a work group and will streamline the intake process in January, 2017, to ensure that engagement with the youth or young adult takes precedence over the completion of paperwork and duplicative questions. They continue to provide input into the ongoing development of the CCBHCs and are giving feedback on youth and young adult engagement, services, retention, policy changes, and other topics as they arise.

Oklahoma's outreach, recruitment, and engagement of the population of focus. OK's stakeholder involvement began with the online survey conducted in conjunction *with the state planning application* OK submitted to SAMHSA. The results have informed all subsequent activities. Adults with SMI, families of children with SED, and other stakeholders confirmed that access to services in OK must improve, and there must be a more robust spectrum of services available, especially in rural areas. Shortly after SAMHSA announced state planning funding, planning meetings were held with NAMI OK and Evolution Foundation in preparation for them to help lead the state level stakeholder engagement. The ODMHSAS Director of Peer Integration worked closely with these organizations to conduct a variety of surveys and focus groups. He continued as a part of the CCBHC implementation team, devoting 10% of his time to the effort. Existing contracts were quickly amended to expand the work of these agencies.

After the Request for Proposal (RFP) process and selection of three CMHCs to participate in the state planning year, a kick-off meeting was held, with teams from each of the three CMHCs, Evolution Foundation, NAMI OK, and the core CCBHC state planning grant team of the ODMHSAS. This was an intensive planning session lasting all afternoon. Priority activities were outlined and organized around each of the four essential planning components delineated by SAMHSA for the CCBHC planning initiative. During this meeting, the group ***planned*** each of the following types of stakeholder involvement: (*1) online surveys, (2) regional meetings, (3) focus groups, (4) engaging existing advisory groups and advocacy organizations, and (5) issuing emails at least monthly to keep stakeholders advised of activities.* Specific assignments were given to team members both at the state and local levels in order to ensure these activities take place. The group discussed the important ongoing tasks of broadening consumer involvement and training consumers in leadership and board participation.

Meaningful consumer input was discussed at length at the kick-off meeting, with the Director of Peer Integration and Jeff Tallent of the Evolution Foundation leading. Mr. Tallent chairs several state level consumer and stakeholder advisory groups. He was the main contact to keep these groups engaged and ensure their input was included in the state level needs assessment and planning.

During the second quarter, OK conducted a flurry of surveys and focus groups. A statewide survey was conducted by NAMI OK with approximately 400 responses. This included responses from adults with SMI, families of children with SED, state and other agencies who refer people for services in CMHCs, and other interested stakeholders.

In addition, the Evolution Foundation conducted a survey of the board members of the three CMHCs selected for state planning grant activities, as well as surveys specifically for veterans and tribal members. Regular reports and discussions have been conducted at the State Advisory Team for OKSOC, an advisory group for the MH service spectrum for children, monthly meetings, and for the PAC bi-monthly meetings. The state and the three participating CMHCs have learned valuable information from all these efforts. To name just a few examples, NAMI OK was able to learn that families need more social connectedness and group opportunities. NAMI OK and the three selected CCBHCs have already ***increased group opportunities for families*** based on this information. The ODMHSAS learned that there are ***specific types of staff*** that need improvement in their interactions with those served. In particular, the clinical staff who are conducting intakes are not always providing a warm, conversational type of interview. This has been discussed in both monthly CMHC Directors' meetings and Clinical Directors' meetings. A *paperwork reduction workgroup* was formed, and has already drastically ***reduced paperwork*** by eliminating redundancy and unnecessary questions. In addition, the group has agreed to ***produce training videos*** to increase the interview competency of intake professionals. ***Additional important feedback*** was given concerning days and hours that services are offered, locations, environmental factors, and customer service.

Coordination of efforts to ensure that services are accessible and available. The ODMHSAS has utilized its extensive existing networking relationships with other state and federal agencies and tribes to garner their input for CCBHC development. Tribal participation is particularly important in OK, due to the presence of 38 federally recognized tribes. A brief presentation about state planning efforts was given to the Oklahoma Health Care Authority's (OHCA) formal tribal consultation meeting in April, 2016. Those present were able to offer valuable input. They expressed some overarching issues to consider, such as how to best approach tribal nations and Indian Health Service clinics about establishing processes for referrals and linkages. Also, an informal consultation was held with the Chickasaw Nation Behavioral Health Director and others April. Several issues were discussed, including one specific area where two tribal members expressed inability to access the local CMHC for treatment. The ODMHSAS was able to follow up immediately on the specific issue while also applying the information to the broader CCBHC

plan. Also, *several additional local tribal consultations* have occurred, all bringing valuable perspective and input.

The state has laid a firm foundation for increasing access to services for OK's veterans. The ODMHSAS enjoys the expertise of two veteran liaisons on staff: Kerry Mucker, Specialty Courts Veterans Liaison for ODMHSAS, and John Wilson, Veterans Mental Health Liaison. Mr. Wilson was appointed as the Oklahoma Department of Veterans Administration (ODVA) Veterans Mental Health Programs Administrator in October 2015 and is outsourced at the ODMHSAS. He is working to ensure the 340,000 veterans who reside in OK are informed about and make greater use of the mental health services that are available to them. Both are experts in veteran's affairs and are familiar with the CCBHC goals. The liaisons give regular updates to the monthly Veterans Alliance group and at other formal veterans meetings. Mr. Mucker is continuing to assist with connecting the ODMHSAS and the CCBHCs to specific meetings that are scheduled pertaining to veterans with tribal affiliations.

An overview of CCBHC development was presented to the Veterans Alliance. A good discussion was held regarding how to meet the needs of veterans and those who have served or are in the reserves but considered inactive duty and cannot receive VA benefits. The two veteran liaisons were able to facilitate a meeting between CCBHC staff and Major General Deering, Secretary of Veteran Affairs and the Executive Director of the Oklahoma Department of Veteran Affairs, to educate on the CCBHC and how this evolution of services could benefit veterans, dishonorable discharged veterans, and individuals that are inactive duty but still in the reserves. The latter two populations are uninsured or underinsured and have been linked to having trauma, MH, and/or SUD issues that cannot be addressed. Initial connections are made and the foundation is laid for greater Veterans' access to services.

The three CMHCs have also been busy with Tribal Listening Sessions and Veterans Affairs meetings. They have worked hard making connections and have learned valuable information from all of these efforts. To name just a few examples, the veteran's focus group indicated veterans do not reach out for MH or SUD services due to fear of repercussions and concerns that if the military found out it would affect the direction of their careers, trainings, and promotions. Many veterans are not even aware of the services available both on and off base.

The formal and informal regional tribal consultations have provided valuable information to both the CMHCs and tribal entities. Tribal entities reported they handle outpatient services for MH, SUD, and health services. They reach out to other service systems for residential, detox, and youth services. Gaps in services that were identified at these meetings were for: children, suicidality, medical detox, and crisis. Most people felt they knew who the local CMHC was, but lacked contact information, which has since been provided to everyone who attended.

Through these connections, the three participating agencies have received VA Cultural training from the Veterans Affairs and future training is in the works for Native American population to be

provided by the Indian Health Clinic in Oklahoma City. The VA cultural training provided by Alan Doerman, Psy.D, of the VA Medical Center presented excellent information that increased understanding of military and veteran culture and the right approach working with this population. Successful outreach tools developed by the Reaching out to Educate and Assist Caring Healthy Families (REACH) program, start by asking the veterans and their families what they would like to be different in their lives. A handout on resources, questions to ask in order to engage this population, and information about their unique health risks was provided to all participants.

Additional stakeholder information was collected through the tribal listening sessions. Tribal and military/veteran sessions provided valuable information on strengths, needs and gaps. An overview on CCBHC development was given to OK Veterans Council Department of Veterans Affairs in May and June. The Choctaw Nation hosted a formal tribal consultation meeting in June. The ODMHSAS provided an overview of community based services, prevention and specialty court services. Those present were able to offer valuable input. They expressed some overarching issues to consider, such as identifying how their data can connect into ODMHSAS data so their numbers can be counted. It was agreed the next formal tribal consultation will focus on data analysis. This will be held in November.

The CCBHC model was presented to the board of inpatient providers and the Oklahoma Psychiatric Hospital Association to ensure there is good communication on how to best connect with providers once an individual returns to the community. This will ensure a continuum of care that will benefit the individual receiving services. Because of *feedback regarding lack of coordination between inpatient and outpatient services*, a Building Bridges project will be established during the first year. This is a model championed by Dr. Gary Blau of SAMHSA. It fosters warm handoffs and family centered care between outpatient and inpatient levels of care, and helps inpatient facilities develop a culture of connection with other levels of services. Meanwhile, the CCBHCs (all of which are behavioral health homes for adults with SMI and children with SED) are ***required*** to establish connection and to ensure smooth transition back and forth between outpatient and inpatient services.

Many additional groups are actively engaged at the state and local levels, such as health departments, schools, domestic violence agencies, legal aid, homeless alliances, child welfare, juvenile justice, rehabilitation services, occupational therapists, youth services agencies, therapeutic foster care agencies, domestic violence shelters, etc. The process of engagement for CCBHC development has opened doors for many exciting new partnerships.

B. Oklahoma's Approach for CCBHC Certification

OKs application process and review procedures. The ODMHSAS conducts the state statutory certification processes by which facilities in OK are granted a license/certification to provide behavioral health services and related supports. The OHCA and the ODMHSAS enter into an annual Memorandum of Agreement agreeing on the use of this certification and monitoring

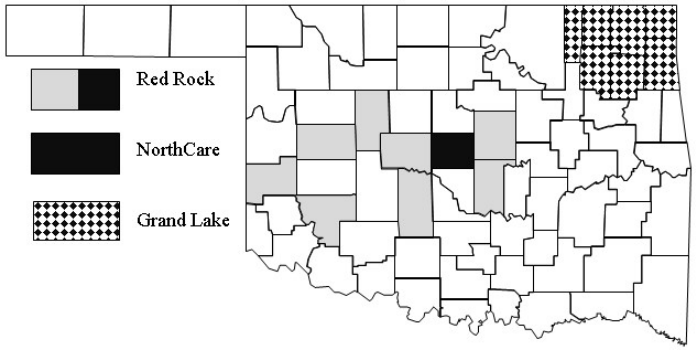
process in order to ensure compliance with standards. The ODMHSAS is also responsible for promulgating state administrative code which establishes specific processes that must be followed by certified providers as well as articulates detailed standards and criteria related to behavioral health services offered to the citizens of OK. ODMHSAS staff members review all organizations that apply for certification in accordance with specific protocols, including quality, access, and availability of services. Subsequently, a certification status is recommended to the ODMHSAS Board of Directors for approval. In order to be certified as CCBHCs under the new standards and criteria, agencies submitted an application to the ODMHSAS provider certification, along with the required application fees. Provider certification staff members performed a rigorous and thorough review of application materials (agency policies and procedures for providing the required services, staffing, and credentials). After staff members determined that the agency's policies and procedures met the established criteria, a site review was performed. Once the agency successfully completed all of these steps, the agency was recommended for certification by the ODMHSAS Board. After initial certification and Permit to Temporarily Operate (PTO), the agency is reviewed again after six months to ensure that all quality clinical standards are being met. Certification can be one to three years depending on the provider's score and approval of the ODMHSAS Board. Time-limited certification ensures that access to quality care is available to persons eligible for CCBHC services.

Working closely with our Medicaid partners at OHCA, rules for CCBHCs were promulgated and submitted to the Governor's office for approval to move forward during the first few months after notice of award for planning. Once approved, they were posted for public comment. The legislature approved them during the spring session, and the Governor signed them in June of 2016. They went into effect on September 1, 2016.

In order to ensure that certification of selected CMHCs would take place prior to October 31, the ODMHSAS Provider Certification division sent out application packets to the three agencies on June 14, 2016. Upon receipt of the completed applications, desk reviews of policies and procedures began and pre-certification site visits were scheduled. These visits ensured that the CMHCs were on target in their preparation to meet standards. This process ensured certification of those who met standards and was completed by September 30, 2016. This includes three CMHCs with 16 locations, including satellites. ***These certifications took place on schedule!***

In addition to certification, our agency has a contract monitoring team that will provide ongoing support and technical assistance as it relates to the CCBHC contract with the ODMHSAS. The contracts division will write a report on any items that may need improvement and will refer to ODMHSAS program staff for technical assistance if the area is out of their scope of practice.

The ODMHSAS creates an overall statement of work (SOW) for CMHCs and CCBHCs for each state fiscal year. In addition to the SOW, innovative and evidence based practices (EBPs) are disseminated through grant and other specialized funding. Each of these has an accompanying SOW. It is through the deliverables in the various SOWs that the ODMHSAS continually works with contracted agencies to improve the access and quality of the services, as well as the dissemination of core, state-chosen EBPs that meet the needs of Oklahomans and the financial constraints of our public behavioral health system. The ODMHSAS offers required training, technical assistance, and ongoing consultation after EBP training. Data and required reports are used to monitor quality. Invoices can be held due to deficit in delivering the contracted service and when necessary contracts are terminated.



Diversity of CCBHCs. The counties selected to participate in the CCBHC demonstration program vary dramatically. The seven-county GL service area in far northeast OK is rural and is in the heart of the Cherokee Nation. NC's service area is in central OK and contains the capitol city of Oklahoma City (OKC). RR's area covers nine counties with both the central urban region, including OKC, and rural Southwestern OK. The population density varies from 1,035/square mile in OK County, included in two of the CCBHC service areas, to 18.2/square mile in a GL County (Index Mundi, 2010). The demonstration sites include 37% of the State's population. A county in the RR area has the highest median household income ($64,200) and the lowest poverty rate (7.7%), while counties in the GL area have the lowest median household income ($36,198) and the highest poverty rate (22.1%). High school graduation rates range from 91.5% in a RR county to only 83.5% in GL's area. The rate of languages other than English spoken at home ranges from 2% in the GL area to 16.6% in the RR and NC areas. The percent of the population that is "White alone" ranges from 88.4% in a RR county to 66.7% in GL's area. While OK has the second largest Native American population in the nation at 9%, the rate varies from 3.4% in a RR county in southwest OK to 21.7% in a northeast GL county (American Community Survey, 2015).

The majority of Oklahoma is designated by Health Resources and Services Administration (HRSA) as a medically underserved area (MUA), including six of RR's counties, NC's county and five of GL's counties. The other two GL counties are designated as having medically underserved populations. Of the 77 counties in OK, only six are not designated as a primary care health professional shortage area (HPSA). Three of the nine counties located in the RR services area are HPSAs and five of the seven counties in the GL service area are HPSAs. Sixty-nine counties are designated as MH professional shortage areas: three in the RR area and all of the GL area. Sixty-

one counties are designated as dental health professional shortage areas. This includes the RR area and all but one of the GL counties (OK State Department of Health, 2016).

How the state facilitated cultural, procedural, and organizational changes to CCBHCs. The ODMHSAS has conducted major systemwide cultural and operational changes over the past decade. Because of this successful experience, a bi-directional development model has advanced wherein new initiatives are developed interactively with providers. The SAMHSA funding opportunity for a state planning year was discussed in monthly provider meetings, the decision to move forward was agreed upon, and initial plans were developed. A request for proposal was quickly released upon notice of award. Once providers were selected, monthly working meetings were established. Implementation teams from each agency participated regularly, including clinical directors, chief financial officers, technology designees, and often, the chief executive officers. When necessary, special meetings were called to drill down into specific areas. For example, several working meetings were held regarding selection of the PPS and preparation of cost reports. In addition, the ODMHSAS employed a temporary field service staff member to travel to the CCBHCs to facilitate changes, and contracted with an accounting firm to consult with them on their cost reports. These processes were absolutely critical to the successful planning year.

The ODMHSAS is requiring providers to use EBPs that are client-centered and recovery-oriented such as a ***high fidelity Wraparound Model*** for children (Bruns, et al., 2004). The ODMHSAS maintains a staff of coaches that train and coach in Wraparound fidelity. Wraparound is under review for inclusion in the National Registry of Evidence-based Programs and Practices (NREPP) as an EBP. It is a promising practice that is gaining in research evidence (Suter and Bruns, 2009). In 2005, Bob Friedman and David Drews stated in *Evidence-Based Practices, Systems of Care, and Individualized Care*, "It should be noted at the outset that the Wraparound process may be considered to be an evidence-based process by itself." The ODMHSAS has enjoyed great success in disseminating the Wraparound process and outcomes, as analyzed and reported by external evaluators, the University of Oklahoma E-TEAM (Educational Training, Evaluation, Analysis and Measurement), and results continue to prove strong each year.

The ODMHSAS contracts for 11 teams of the intensive adult model, ***Programs of Assertive Community Treatment (PACT/ACT),*** which is a comprehensive EBP for adults who are SMI with high needs (SAMHSA, 2008). Both RR and NC offer the model in Oklahoma City. Since this EBP has been operating since 2003 in Oklahoma, there is currently a process underway to strengthen and update PACT programs. The ODMHSAS is conducting analysis of data, review of the literature, and a study of ACT implementation in other states, which will result in updates of rules and contract language, and increased training and technical assistance.

In January, 2015, the ODMHSAS established BHHs for adults with SMI and children with SED which is reimbursed through a per-member, per-month payment rather than the previous fee-for-service method. This has allowed providers to do whatever the client and their families need rather than providing only the services for which they can bill 15-minute increments. The motto is *"do*

whatever it takes" to meet the individual client and family's needs. The ODMHSAS and our providers are excited to take this philosophy to the next level with the CCBHC model. BHHs will remain at the heart of CCBHCs and they will continue with integrated services. The state plan amendment for BHHs was made possible through the Centers for Medicare and Medicaid (CMS) because of the Affordable Care Act. Care coordination is the lynchpin of the core BHH services, utilizing the evidence-based ***Chronic Care Model*** for care coordination (Wagner, 2000). The CCBHCs certified for participation in the demonstration have been implementing integrated care for almost two years as BHHs. This makes them uniquely qualified to conduct at successful CCBHC demonstration.

According to the 2014 Child Trends report, Oklahoman's have consistently high rates of adverse childhood experiences (ACEs) due to high rates of child abuse and neglect, high rates of incarceration, a large military presence experiencing deployments, natural disasters, and other risk factors (Child Trends, 2014). The ODMHSAS conducted a several-year process throughout the public behavioral health system designed to create a trauma-informed culture. Organizational models such as the Sanctuary model and the Systemic, Therapeutic, Assessment, Resources and Treatment (START) model were implemented by some agencies. The Strengthening Hope and Resiliency Everyday (SHARE) website was created to provide free introductory training in trauma issues and links to a plethora of information. Screening for trauma has become universal throughout the system as a result of this multi-year process. And, once identified, trauma is treated specifically. The ODMHSAS, through a contract with the University of Oklahoma Child Study Center, provides regularly scheduled trauma-focused cognitive behavioral therapy (CBT) training and follow up consultation calls where cases are staffed in real time for all CMHCs.

As stated previously, creating a trauma-informed system that delivers trauma-specific services has been underway for several years. Beginning in July, 2016, CMHCs are required to screen all adults entering the system for trauma. This requirement was already in place for children. Fidelity to these practices is monitored through site visits that include chart reviews and interviews with clients and family members, when appropriate. In addition, fidelity scales that quantitatively measure the degree of fidelity are used at each site. The ODMHSAS produces a report in real-time that shows providers which clients are not showing improvement on assessment scores at each update, indicating the current treatment modality or medication is not having the desired effect and a change may be in order. Early in the state planning year, the ODMHSAS asked the CCBHCs to conduct a cultural and linguistic competency self-assessment checklist survey. Though this process, RR discovered some areas in which improvement could be made which includes: lack of pictures, posters, artwork, and other printed materials in the reception area that reflect the different cultures and ethnic background of clients served; printed information that take into account the average literacy levels of clients and families served; keeping abreast and being well versed of major health concerns and issues for ethnically and racially diverse client populations residing in the area. GL determined it needs to have signage and welcoming and informational materials translated into Spanish. While it does not serve a diverse population,

Spanish is the most prevalent language after English with <2% of its community speaking it. NC utilized the Promoting Cultural and Linguistic Competency Self-Assessment Checklist and addressed the concerns revealed through their needs assessment and planning process throughout this planning year.

Oklahoma's CCBHC Needs Assessment Process. The ODMHSAS conducted a multi-faceted needs assessment. From February through September, 2016, 23 different events were held across the State to gather meaningful stakeholder input. These included listening sessions, surveys, and focus groups with participants comprised of youth and adult clients, family members, military groups, tribes, and community and state organizations. The CCBHCs as well as ODMHSAS staff were able to hear this input loud and clear and take action to improve care. In addition, data analysis was conducted utilizing several sources for the needs assessments. County-level census data was heavily employed to compare the general population's demographics to persons currently served and also to the staff. Examples of demographic and cultural variables include race, ethnicity, language, disability, and military status. Multiple tables were produced to display data by agency locations so weaknesses at the site or agency level could be addressed. In addition, a staff survey was administered by the ODMHSAS to determine distribution of sexual orientation, disability, lived experience/family member, race, age, gender, languages spoken, length in the MH system and at agency, license/certificate/credential held, EBPs trained in, and primary age group of clients seen. Staff were also questioned about attitudes concerning training and development program, opportunities for advancement, salary, benefits program, working conditions and hours, co-workers, supervisors, overall satisfaction, and likelihood of leaving the field within five years. The results of these analyses were provided to CCBHCs to augment their own needs assessments and take appropriate actions to correct any gaps.

Prevalence of BH Needs and Gaps. OK has a high prevalence rate, with 22.4% experiencing mental illness (3rd highest among states), and 11.9% experiencing a SUD disorder (2nd highest among states). Between 700,000 to 950,000 Oklahomans are in need of MH or SUD treatment (Mental Health America, 2015). There are 189,454 youth, ages 0-18, estimated to have a mental illness. It is estimated that 144,510 Oklahomans have an SMI (SAMHSA, 2012). Estimates of children suffering from serious emotional/behavioral problems vary significantly depending on the study cited. The ODMHSAS utilizes SAMHSA's prevalence rate for SED of 10%. This means that out of approximately 954,000 children in the State of Oklahoma, approximately 95,400 can be expected to have an SED (Census Bureau, 2015).

Half of all lifetime cases of mental illness begin by age 14; however, four out of ten children in OK with MH problems do not get access to treatment, services, or support. This is unacceptable, for the reason that if intervention occurs early, resilience can be built and life outcomes can drastically improve.

Race and Ethnicity. When looking at clients served by race, Whites are served roughly equivalent to the distribution in the population. African Americans and American Indians are overrepresented

in the client mix at the three CCBHCS. It is the Hispanic population that is found to be underrepresented. In the GL region, the percent of Hispanics in the population is larger than that of the staff or clients served (3.9% vs. 2.3%, 2.1%, respectively); however, the larger disparity is in OK County, with the greatest concentration of Hispanics at 16.2%, but only 6.4% and 1% of the clients seen at NC and RR are Hispanic, respectively.

Language: In OK, 3.8% of the population has limited English proficiency. Reporting on a county basis only includes specific languages if more than 499 persons or five percent of the population speak the language. In the GL region, the only language meeting these criteria was Spanish in three counties with an average of 1.4% speaking it. OK County, served by RR and NC, had the most diversity with 6.2% of the population speaking Spanish. Vietnamese, Chinese, 'other Asian languages,' and Arabic were spoken by more than 500 people but each by less than 1% of the population. In the other RR counties, an average of 5.3% of the population speak Spanish, with Vietnamese spoken in one other county at less than 1% of the population.

SUD Services. Traditionally in OK, the CMHCs have not been funded or trained to do comprehensive outpatient treatment of SUD, and there has been somewhat of a chasm separating a smooth transition to and from outpatient services to residential SUD treatment. This has been changing in recent years, especially with the advent of the BHH model which requires integration of all needed services. However, it is clear from the ODMHSAS data analysis and all of the surveys and focus groups that more must be done to accomplish integration of fully co-occurring services. With the demonstration, the remaining pieces will be put into place to ensure a fully comprehensive scope of outpatient services within the three CCBHCs, as well as a smooth coordination of services between these and OK's inpatient and residential services.

RR has implemented an internal credentialing process to build skills to provide SUD services for clinical staff. All new employees are required to complete Motivational Interviewing (MI), validated screening, assessment and placement tool training within the first six months of hire. In all subsequent years, clinical staff are asked to complete one-hour of SUD-related CEUs annually. The RR trainer will also provide SUD training for RR staff included in the 20 hours of free CEUs provided for clinical staff. RR has just opened a Medication Assisted Treatment (MAT) unit composed of a medical doctor, licensed alcohol and drug counselor (LADC), case manager and peer recovery support specialist.

GL has designated a Director of Addiction Services and will begin expanding the number of LADCs on staff. Its electronic bio-psychosocial already contains screens for ASAM compilation. In becoming a CCBHC, GL will be expanding its SUD services to include consumers diagnosed with a primary diagnosis of a SUD. It will be prepared to provide outpatient and intensive outpatient services utilizing EBP-based curriculum, as well as 24-hour crisis intervention services, including ambulatory and medical detoxification.

NorthCare currently provides MAT for 25 consumers and is expanding that to 100 in this upcoming year. It has hired additional peer support staff in recovery from SUD in order to provide additional individual and group support. It continues to send therapists to *Adolescent Community Reinforcement Approach* training, an EBP, in order to reach the transition age youth and will provide family SUD education groups.

Military. A population that surfaced as underserved in the needs assessment is that of military personnel, veterans, and their families. To address this issue, the CCBHCs have reached out to and networked with referral sources for this population. GL has established a contract with the US Department of Veterans Affairs (VA) to provide services for their members if they live more than 40 miles away from the VA outpatient center in the GL service area or if they are on a waiting list for services with the VA. It has produced flyers and is doing public relations communications in all of its communities. It has prominent posters in all outpatient clinics to advertise veteran services. Staff have visited American Legion Posts and Veterans of Foreign Wars posts, left flyers and/or are scheduled to come back to speak to the members.

RR is working to enhance its abilities to provide services to veterans. The Oklahoma City Veterans Administration (OKCVA) is currently working on obtaining approval from the VA Director to co-locate staff within RR offices.

The NC veteran liaison is the point of contact for any veteran seeking services in the community. He attends numerous collaborative meetings and provides group services in the Veteran's Diversion program. He educates staff on the needs of veterans and their families, and is an advocate within the agency to help better serve this population.

Transportation and Income. Since OK is a relatively large rural state, transportation has long been a challenge for lower socio-economic groups. Even in the four large metro areas, the public transportation system is not as well developed and widespread as urban cities in other states. The CCBHCs have had to be resourceful and innovative to meet the transportation needs of their clients. GL serves a very poor and large rural area and is utilizing many approaches to address income and transportation barriers. It has vans and cars to provide transportation for consumers. It also purchases vouchers for the only public transportation system in the area and utilizes flex funds to help purchase gasoline when necessary. Further, it provides services in the consumer's homes and schools. Part of the intake process is to determine the best place for services to be offered to the consumers. It also maximizes use of telemedicine services. In FY 2014-2015, GL submitted 25,813 claims that were delivered through telemedicine. More recently, GL has initiated a program to address transportation using health information technology. To date, the agency has deployed 179 iPads to clients, staff, emergency workers and law enforcement officers. These devices are distributed to clients and families who have difficulty accessing services due to transportation or financial difficulties or inability to consistently receive services in a traditional office setting. The iPads are wiped of all applications except a HIPAA compliant connection which allows the consumer to connect with their service provider from any location. Local sheriff and police

departments, the Juvenile Detention Facility, residential care facilities, and ERs have also received iPads to utilize for consultation with GL staff when dealing with an individual with MH and/or SUD issues. Licensed behavioral health professionals, case managers, and care coordinators have been given iPads to assist with engagement, therapy, assessment, and crisis resolution.

RR's urban offices have transportation vouchers available to clients who need assistance to attend services. In its rural areas, RR vans provide transportation for clients to attend psychosocial rehabilitation programs. RR is modeling the success GL has had using iPads and is developing procedures for clients to access services through this technology in the near future. RR also plans to expand the use of telemedicine. Currently all offices are equipped to provide services and telemedicine services for medication management and are already being used on a regular basis. In FY 2014-2015, RR submitted 17,172 telemedicine claims. Both rural agencies will expand use of telemedicine services to further meet the demands of large rural areas with sparse populations.

Responsible for an area of town where many people with SMI live, as well as a large number of homeless individuals, NC is preparing to move to a new building located next to a city bus stop for which it provides bus tokens to its clients needing transportation. Its van transportation runs five days a week on a route that includes three homeless shelters and a peer-run drop-in center, to encourage socialization. Also, this new building is located next door to the Oklahoma City Crisis Intervention Center (OCCIC) and NC has an MOU for utilizing OCCIC for immediate access to crisis beds if needed. In addition, NC is preparing to implement the digital health solution called myStrength. With myStrength, NC clinicians will have the ability to augment direct intervention with 24/7 virtual care for their consumers and families. The myStrength system offers a range of mood-improving resources for the mind, including step-by-step e-learning modules, interactive tools, weekly action plans and daily inspiration personalized to each consumer. This consumer-centric and highly confidential HIPAA-compliant platform reduces the stigma and provides inexpensive access to evidence-based resources. Using the digital tools available with myStrength, NC will expand service capabilities through the use of technology to reach more clients; provide relapse management post-intervention; offer interactive, evidence-based tools to assist clinicians in case management and treatment planning; and provide emotional wellness resources to staff to cultivate their own health and wellbeing.

Accessibility. There is clearly a need for the providers to be accessible to people with disabilities and language barriers. All have demonstrated plans for increasing accessibility. RR offices are equipped to provide services to persons with physical disabilities and have ramps for persons in wheel chairs as well as handicap bathroom facilities. RR is planning on making additional improvements such as automated doors for persons in wheel chairs. GL's site locations are handicap accessible and it utilizes iPads and telemedicine as well as home-based services to assist consumers who have limited mobility. It utilizes speech-to-text software to assist consumers with completion of documentation and will further expand by looking at new software possibilities for access to services for speech and hearing impaired consumers.

The two urban centers recognize and were reminded through the needs assessment process that there are those who are still unserved individuals who speak languages other than English. RR is contracting with the Language Line, providing access to 240 professional linguists twenty-four hours, seven days a week. Language Line provides phone, video, and onsite interpreting, translating, and localization. RR is revising the sliding scale to be more linguistically appropriate for clients with limited English proficiency. Clients are screened for services and based on income may be able to attend services for no or reduced charge. RR has always been available for those clients most in need and will continue to serve the communities with that philosophy.

NC's new building was designed to be accessible to those with disabilities. All services are on the first floor, the hallways are wider, and there are individual bathrooms and double doors leading into the clinical area. It is working to make access to all types of services needed by the population served more available. NC has staff embedded at the Health Department, located in the part of the city with the worst health outcomes, and has domestic violence liaisons at each location. Staff from the Child Abuse Response and Evaluation Center, who serve families impacted by physical and sexual abuse are co-located at NC. Others services co-located at NC include: GED classes, Legal Aid, adult art classes; Narcotics Anonymous groups; and Spanish speaking *Seeking Safety* groups. Forms and handouts have been translated into Spanish, and individual therapy, family therapy, and case management services are also provided in Spanish. Its Intensive Transition Team makes rounds at all private and state funded psychiatric hospitals and crisis centers in its area to meet with consumers who are discharging and works to engage them in outpatient services. A pilot program to provide juvenile bureau involved youth and their families with comprehensive and integrated health care and service coordination has been implemented. Also, NC co-locates clinicians and case managers with Child Welfare and Juvenile Court to provide assessment and care coordination for child welfare families. NC is currently working with a federally qualified health center (FQHC) on a collaboration with St. Anthony hospital, for those patients hospitalized due to chronic disease issues that also have MI and SUD.

Workforce. Critical needs that have long been recognized are staff shortages and an aging work force. OK is 48th in the nation for MH spending per capita. Services rates have rarely increased in the last 10 years. Publically funded behavioral health organizations have stretched their budgets and staff to keep their doors open but, as a result, it is difficult to hire and retain staff. Some of this has been alleviated through the use of telemedicine, which OK invested heavily in during the early 2000s through a SAMHSA state incentive grant. Another service extension has been through the use of Peer Recovery Support Specialists. However, staff shortages have led to clients getting what services can be provided by what staff are available rather than what they need. A large part of the CCBHC planning grant was spent determining the workforce needed to provide a wide range of services and holistic care. RR plans to raise salaries for licensed therapists currently employed by $5,000 across the board and intends to add 20 new therapists to expand the service array to meet CCBHC requirements. RR will offer a sign-on bonus for new therapists who agree to remain with the agency for two years and will continue to fully cover medical and other insurance premiums

for employees, as well as encourage continuing education through dedicated professional growth funds. RR supports staff continuing education by offering 20 hours of in-house trainings through RR's trainer at no cost to the staff and offers no-cost licensure supervision for staff pursuing licensure status. Healthy competitions to help staff focus on personal wellness such as walking challenges and a drawing for persons who complete their annual wellness check-up are just a couple of events sponsored throughout the year to encourage employee wellness.

In order to meet the new standards of care required to become a CCBHC and improve the quality of care and outcomes for its clients, GL has been in the process of actively expanding the number of clinicians serving in its seven-county area. Due to the fact that its clinics all reside in rural areas, this also required it to increase the salaries for qualified clinicians in order to attract new staff and retain current staff, particularly for its 24-hour unit requirements. It has already begun to see a difference in the scope and level of service it is able to provide. By actively recruiting additional staff and by paying more competitive rates to existing and future staff, GL firmly believes that it will be able to provide a higher level of service, at ultimately a reduced overall cost per service by reducing employee turnover and by being able to accept only the best of candidates. To date, new hires include seven nurses and one nurse practitioner, 16 behavioral health professionals, 13 peer recovery support specialists, 11 family support specialists, 13 care coordinators, 11 rehab specialists, and administrative staff such as a medical records specialist and human resource administrator.

In an effort to hire and retain staff, NC is providing frequent training and consultation in EBPs, offering strong clinicians the opportunity to become trainers in EBPs, taking on the additional expense of recruiting and supervising larger number of practicum students, offering flexible schedules and increased autonomy, increasing salaries to be competitive in the market, and offering a new campus with diverse clinical experiences, modern amenities, and an onsite café. They anticipate hiring a adult and a child psychiatrist, two psychiatric nurses, a SUD specialist, 12 case managers, one peer recovery support specialist, 14 licensed behavioral health professionals, a nurse practictioner, a medical assistant, and three van drivers.

EBPs Required by Oklahoma. The ODMHSAS disseminates evidence based practices (EBPs) and promising practices strategically and systematically. It starts with analyzing need, readiness, and sustainability prior to model selection. Once a model is selected, a budget is developed for contracting with purveyors for training. Models which provide a train the trainer model are preferred, and at times the ODMHSAS has been successful negotiating with purveyors who have not previously offered that option. In addition, training is not put into place without follow-up consultation and/or coaching. The agency enjoys a successful track record of statewide dissemination. It typically utilizes grants to contract with purveyors and offer training and consultation free of charge. When possible through grant funding, agencies are reimbursed for lost billing time in order to bring effective practices to scale with fidelity. EBPs that are practical and affordable for statewide implementation within a public behavioral health system are chosen, with

preference to those tested on a wide group of persons. EBP models that will not eventually result in state capacity to sustain, without ongoing high payments to the purveyor, are rejected.

The following models were chosen for statewide dissemination and the state planning process has reinforced this direction and fit all the criteria explained above. In addition, they are effective for prevalent MH and SUD issues and conditions in our state. Oklahomans experience a high degree of trauma from a variety of sources which predisposes them to negative MH, overall health, and SUD outcomes. We are consistently ranked near the top nationally in percentage of adults with serious mental illness and unhealthiest citizens. For all of the reasons given in the previous two paragraphs, the following models were chosen:

1) Cognitive Behavior Therapy (CBT) is one of the few forms of psychotherapy that is scientifically tested and found to be effective in hundreds of clinical trials for many different disorders. In contrast to other forms of psychotherapy, CBT is more focused on the present, is more time-limited, and is more problem-solving oriented (Beck Institute, n.d.). The ODMHSAS has provided CBT training to CMHCs through the Beck Institute. All CMHCs employ clinical staff trained in CBT. This will be a requirement for CCBHCs ongoing. Also, a review of literature of EBPs reveals quickly that CBT is the most common element between EBPs.

2) Collaborative Assessment and Management of Suicidality (CAMS) is being implemented at the state level as the required clinical training for the treatment of clients presenting with risk of suicide. CAMS is an evidence based approach to the care of clients at risk of suicide. It can be used by a clinician regardless of his or her preferred form of therapy. CAMS has been proven to reduce suicidal thoughts of patients in six published, peer reviewed trials and one randomized clinical trial (Jobes, 2012). A number of trials show success in working with veterans, an identified at-risk population in OK. The ODMHSAS chose this framework based on its adaptability across a variety of therapeutic disciplines and efficacy in reducing symptoms. CAMS is the chosen model for the OK Zero Suicide Initiative. The ODMHSAS provided training and consultation to clinical staff in all CMHCs, and will continue to do so. This will be a requirement for CCBHCs ongoing.

3) Trauma-focused Cognitive Behavioral Therapy (TF-CBT) has consistently demonstrated its usefulness in reducing symptoms of PTSD, depression, and behavioral difficulties in children who have experienced sexual abuse and other traumas (Cohen and Mannarino, 1996; Deblinger, et al., 1996; Stauffer and Deblinger, 1999; Cohen and Mannarino, 1997; Deblinger, et al., 1999; King et al., 2000; Deblinger et al., 2001; and Cohen et al., 2004). Furthermore, TF-CBT is identified as a model program by SAMHSA (SAMHSA, 2005). TF-CBT is effective for children in foster care who have experienced any trauma, including multiple traumas. It has been demonstrated to be effective with children from diverse backgrounds and works in as few as 12 treatment sessions. It is used in home-based and residential treatment facilities. The model works even if there is no parent or caregiver to participate in treatment. To provide a culturally competent approach TF-CBT has been used effectively in a variety of languages and countries. OK has been involved with training the workforce in the TF-CBT model. TF-CBT training is required for all CMHCs, along

with the screening tool and protocol selected through the BeMe initiative, and will be required ongoing for all CCBHCs.

4) Wraparound: Wraparound is under review for inclusion in the NREPP as an EBP. It is a promising practice that is gaining in research evidence (Suter and Bruns, 2009). In 2005, Bob Friedman and David Drews stated in *Evidence-Based Practices, Systems of Care, and Individualized Care*, "It should be noted at the outset that the Wraparound process may be considered to be an evidence-based process by itself." The ODMHSAS has enjoyed great success in disseminating the Wraparound process, and outcomes and results, as analyzed and reported by external evaluators, continue to prove strong each year. Wraparound is the process model that OK has chosen for children up to age 21 who experience SED. It is also listed as an EBP by the California Evidence-Based Clearinghouse for Child Welfare, the State of Oregon Inventory of EBPs, and the Washington Institute for Public Policy.

5) Motivational Interviewing (MI) is a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. The operational assumption in MI is that ambivalent attitudes or lack of resolve is the primary obstacle to behavioral change, so that the examination and resolution of ambivalence becomes its key goal. MI is applied to a wide range of problem behaviors related to SUD, as well as health promotion, medical treatment adherence, and MH issues. As of 2013, MI is implemented at more than 30,000 sites in all 50 states and around the world, with an estimated 3 million clients (SAMHSA, 2005). This is one of the foundational models to ensure successful outcomes and will be an ongoing requirement for all clinicians in CCBHCs.

6) Chronic Care Model is well established within primary care as best practice for managing chronic illnesses. However, this model has not been fully established in specialty care settings, such as MH (Woltmann, et al., 2012). Chronic diseases are the leading cause of disability and death in the United States (CDC, n.d.). People with mental illness are especially vulnerable: 68% of people with a mental illness also have a physical health condition such as cardiovascular disease, diabetes, and hypertension. These high-need individuals often receive uncoordinated, inefficient care, resulting in higher costs and poorer health outcomes (SAMHSA, 2012). This model has been adopted for BHHs in OK and will be required for the CCBHCs. Training in integrated care is provided and required.

In addition to the required EBPs for CCBHCs, the ODMHSAS is disseminating the following EBPs to address service gaps already known and/or identified in the needs assessment process:

Adolescent Community Reinforcement Approach (ACRA): Selection of A-CRA was based on the strength of evidence as an effective treatment model and the documented skill of the purveyor to efficiently disseminate the practice through training and consultation. In addition, it is a cost effective approach which must be a priority for a publicly-funded behavioral health system. The effectiveness of A-CRA is supported by several randomized clinical trials (Godley et al.,2001).

This will assist in addressing the following statistics listed by SAMHSA: "An estimated 1.3 million U.S. adolescents 12 to 17 had an SUD in 2014 which is 5% of all adolescents and youth transitioning into adulthood have some of the highest rates of SUD.

Seeking Safety is a very cost effective evidence based model for helping individuals with SUD or co-occurring disorders. There is currently a pilot project that trained Peer Recovery Supports in this model to provide the service, which will assist in addressing the workforce shortage issues. This EBP addresses cultural needs around trauma for youth and adults. All three CCBHCs have been trained and are actively utilizing the model. The blended Wraparound/Transition to Independence Process (TIP) model will also be used to serve the young adults with SED or severe SUD issues (Clark, 2009; Suter and Bruns, 2009). The Wraparound/TIP model is an adaptation to meet the growing need for youth and young adults who are transitioning through life, potentially without familial support.

Child Parent Psychotherapy is a treatment for trauma-exposed children ages birth to five (0-5). This will be offered within the demonstration period to enhance the services for the birth to five population who are in need of early infant MH services. *Circle of Security*® (COS) protocol is an early intervention program designed to prevent insecure attachment and child mental disorders. It includes a user-friendly, visually-based approach, utilizing extensive graphics and video clips to help parents better understand the needs of their children. It is based upon attachment theory and current affective neuroscience. COS is considered a promising practice based on research to date. All providers are trained in *Strengthening and Celebrating Families* Programs (SAMHSA, n.d.) to meet the cultural needs of the whole family whether they have SUD, MH, or familial issues. RR will be trained in the *RA1SE NAVIGATE Early Treatment Program* (ETP) model and provide this program within the year to serve youth and young adults in transition with a first episode of psychosis (NIMH.nih.gov, n.d.).

OK's guidance regarding the CCBHCs organizational governance. The ODMHSAS promulgated CCBHC rules which took effect September 1, 2016, as follows:

450:17-5-171. Organizational authority, governance, and accreditation: In addition to the board composition requirements found in 450:17-25-2, facilities certified under this Part will incorporate meaningful participation by adult consumers with mental illness, adults recovering from SUD, and family members of facility consumers, either through 51 percent of the board being families, consumers, or people in recovery from behavioral health conditions, or through a substantial portion of the governing board members meeting this criteria and other specifically described methods for consumers, people in recovery and family members to provide meaningful input to the board about the facility's policies, processes and services. Any alternative to the 51% standard must be approved by the Director of Provider Certification.

The ODMHSAS has a long history of including consumers and family members in decision making processes. In 2001, when the SOC model was introduced, the ODMHSAS required the

Advisory Board to consist of 51% youth or care givers and meetings were initially held on Saturdays to accommodate their schedules. OK was one of the first states to develop a Peer Recovery Support Staff (PRSS) certification and provides incentives to CMHCs for utilizing PRSS services. CCBHCs were asked to survey their board members to determine the ratio of consumers, persons in recovery, and family members. All board members at GL said they or a family member have lived with a mental illness. Historically, a GL board requirement is recruitment of members who represent their respective communities. Currently GL recruits board members who have issues with MH and/or SUD (in recovery) or have a family member with MH/SUD issues. In addition, GL asks its clients to complete Customer Satisfaction Surveys every quarter. It also has a Consumer Advisory Panel that meets quarterly. Stakeholder surveys are done with clients attending Medication Clinic and the Intensive Outpatient Center, and with referral sources for Wraparound and residential care owners/operators. Data collected during this continuous process helps the management team make decisions about quality care.

Of the RR governing board, 83% self-reported that they are either consumers of services or have family members who are/were consumer of services. RR's bylaws state that persons on the board must have knowledge of the MH or SUD field, must include minorities, and must represent the population. No more than 40% of the members shall be providers of MH services. Bylaws also prohibit the board membership from being composed of individuals who are not familiar with the field of work. RR policy and procedures require that board membership must be at a minimum, 51% composed of persons who have been consumer's themselves or family members of persons who have been consumers of services.

The NC Board of Directors is committed to the continuing appraisal of behavioral health services to ensure that each client receives the best care possible with the resources available. In a recent survey by the ODMHSAS, 56% of NC's board members reported being current or previous consumers of services and/or having a family member(s) who currently or previously received services. NC's bylaws outline the eligibility for the board to include: skills and knowledge of NC's vision and mission to provide recovery oriented, culturally competent, trauma-informed, and co-occurring capable services. This eligibility may be met through personal and/or professional experiences.

Additional guidance is provided to CCBHCs regarding meaningful input by consumers, persons in recovery, and family members, as follows: In addition to board governance rules, CCBHCs are encouraged to identify additional methods for consumers, people in recovery, and family members to provide meaningful input to the board about the CCBHCs policies, processes, and services. For example, a CCBHC may facilitate formation of an advisory group consisting of active consumers and their family members. The CCBHC will create a policy/procedure for this process and submit to the Director of Provider Certification.

C. CCBHC Data Collection and Reporting.

The ODMHSAS has successfully collected and reported Government Performance Results Act (GPRA) measures, National Outcome Measures (NOMs), Client Level Data (CLD), Uniform Reporting System (URS) tables, the Mental Health Treatment Episode Data Set (TEDS), and is currently developing processes to submit quality measures used in the CMS Health Home Quality Reporting Program. The Decision Support Services (DSS) Division will oversee the data collection and performance measurement and utilization. The DSS has considerable experience devising, managing, and coordinating large and complex data collection efforts and has been responsible for evaluating a number of SAMHSA-funded programs. All of the DSS analytic staff hold masters or doctorate degrees in research fields and have years of experience evaluating behavioral health programs.

Claims and encounter data. The ODMHSAS designed and manages the prior authorization system which is integrated with the Medicaid Management Information System (MMIS). The prior authorization system, the Person-centered Integrated Client Information System (PICIS), not only authorizes services and payment amounts but also collects data for outcome measures and reporting requirements such as the TEDS and URS tables. These data are collected on *all* clients served and include information about such things as: living arrangements; employment; income; legal and marital status; language proficiency; education; disabilities; diagnoses; level of functioning; drugs of choice, including tobacco; frequency of use; and client assessment results. Consumer information is collected and reported at admission, six-month update, and discharge transactions. Comparisons can be made from admission to updates/discharge on items such as employment status, housing status, frequency of substance use, and level of functioning. PICIS data on age, race, ethnicity, gender, marital status, language, physical disabilities, drugs of choice, level of functioning scores, and other elements will be cross-tabulated with services, retention, and outcome information to determine where behavioral health disparities are occurring.

The PICIS/MMIS system uses a unique identifier that allows consumers to be linked across providers and over time. Because it is a relational database, pharmacy and dental claims and all encounter data in the MMIS, including inpatient and outpatient claims, can be linked back to the individual. Demographics, diagnosis, assessment scores, and outcome data are also linked. This unique identifier is used to compile the TEDS and URS tables.

EHR and patient registries. All CMHCs are required to have a meaningful use certified electronic health record (EHR). Two of the CCBHCs utilize the *Netsmart myAvatar* EHR. The third CCBHC, GL, uses the *Echo Group's Clinician's Desktop* EHR. GL was the first behavioral health center in the nation to qualify for meaningful use incentive funding.

The ODMHSAS has procured a population health analytics tool (registry) to which all claims are populated from the MMIS. The registry maintains current specifications of measures, including the CCBHC measures which use claims data, collects the needed data, and provides ongoing monitoring at the individual and facility-level. This continual feedback to the facilities addresses

gaps in services and identifies risks and appropriate evidence-based practices to ensure members receive the highest quality of integrated primary and behavioral health care.

Surveys: Through a CMHS-sponsored initiative in the mid-1990s, Oklahoma worked with other states to develop a framework of performance indicators within the domains of access, appropriateness, outcome, and prevention, to be applied in MH service programs. From this work came the Mental Health Statistics Improvement Program (MHSIP) Consumer-Oriented Report Card, introduced in 1996. Since that time, the ODMHSAS has utilized the MHSIP Consumer Survey, and later the Caregiver Survey, as an ongoing source for client and family input. In addition to the standardized questions, Oklahoma has added questions related to physical health and tobacco use to monitor the overall well-being of the people it serves. It has also adapted it for use with its SUD treatment centers.

Administrative reports. DSS staff produces meaningful reports that can be used for finance, operations, and clinical and outcome monitoring. Since merging data systems in 2010 with the OHCA, the Medicaid agency, DSS staff has developed over 80 continuous quality improvement (CQI) reports, available on the ODMHSAS website. Data are integrated from claims, patient demographics, eligibility, encounter data, and other data sources. Topics include survey results, data quality, consumer demographics, financial, provider performance, and provider requested reports. Reports are available at the facility and client level and user-specified time frames. Some of the financial reports include reconciliation reports; financial summary for ODMHSAS services; amount paid by week, contract source, and fiscal year; pended services; provider budget in MMIS; services paid by Medicaid; special payments and recoupments; corrections reconciliation; Medicaid reimbursable services by fiscal year; and reprocessed claims. Any reports necessary for reporting for the PPS2 will be developed in collaboration with finance staff.

Cost and Staffing. PICIS-MMIS records include information about which staff (and at which agency) provided the service, who received the service, what service was delivered (determined through the use of over 100 HIPAA-compliant procedure code and modifier combinations), the duration or intensity of the service (duration and frequencies are recorded), and the rate attached to each service for cost determination. Services can be designated as screening, prevention and treatment, care coordination, and other care processes.

Data on all clients served at each of the CCBHCs and potential designated collaborating organizations (DCOs) are reported to the PICIS-MMIS integrated system. All state-level quality measures with the exception of the consumer satisfaction surveys will be compiled through the data reporting system. DCOs will report CCBHC services to the data reporting system as "zero pay" services with the DCO clinician as the rendering provider and the CCBHC as the pay-to-provider. This will allow the State to compile these services in the quality measures while ensuring the DCOs are not being paid inappropriately and providing documentation for CCBHC payment. All required data elements will be submitted to the evaluators at the client-level using a consistent unique client identifier.

Data Collection Systems. As stated above, all CMHCs are required to have a meaningful use certified EHR. All CMHCs, by virtual of being a BHH, must electronically exchange data through a health information exchange (HIE). The HIE is a vehicle for improving quality and safety of patient care by reducing medication and medical errors, increasing efficiency by eliminating unnecessary paperwork, and providing caregivers with clinical decision support tools for more effective care and treatment. Two CCBHCs use the MyHealth Access Network HIE and one uses the Care Coordination Oklahoma HIE. Another requirement is that the CCBHCs use the population management analytics tool (registry) provided by the ODMHSAS.

GL currently partners with Coordinated Care Health Oklahoma (CCHO) for their pharmaceutical needs. The pharmacy has developed a data system that enables the CCBHC to produce a report card of consumer and agency progress. The report card provides key health indicators such as blood pressure, medication adherence, cholesterol, hemoglobin A1c (to screen for, diagnose, and monitor diabetes), toxicology, and other key health indicators. A fundamental piece of the report card is the toxicology/hematology lab test that reveals whether the client is taking the prescribed medication and if the client is taking unauthorized substances. Clients not following their medication regimens can be identified early before circumstances escalate to a crisis. Clients who are adhering to medications but not making sufficient progress can be changed to a new regimen. The other two CCBHCs are in the process of interfacing their systems with the CCHO.

These EHR, registry, and HIE systems working together ensure the CCBHCs have access to the most complete picture of the client's past and current medical records, can communicate with other treating providers and have the predictive analytical tools that provide best practice recommendations on a client-by-client basis.

The SAMHSA Transformation State Incentive Grant served as a major source for ODMHSAS to establish a statewide telemedicine network. Units were placed in CMHCs and satellite locations serving rural settings. These units increase access to services, including medication clinics, therapy sessions, court commitment hearings, and administrative meetings. The network supports 54 different provider agencies located in 144 locations. Locations include MH facilities, ERs/hospitals, court houses, and other type of entities that work with people with MH and SUD issues. In addition to the entities supported through the telemedicine network, users telecommunicate with numerous other entities in the delivery of services. In FY2015-2016, 26,000 behavioral health claims were submitted using telehealth services.

Supporting CCBHC CQI Efforts. The ODMHSAS is contracting with the University of Oklahoma, School of Medical Informatics to provide technical assistance to the BHH through its Learning Collaborative and will continue to assist providers in the transition to CCBHCs. Dr. Eric Vanderlip, the primary trainer and consultant, is a former Senior Fellow at the University of Washington where he studied integrated health services design and delivery. During monthly learning collaborative workshops, Dr. Vanderlip has worked with providers on using data at the client level to guide treatment practices and at the aggregate level for population care management.

A large focus has been on the use of patient registries and measurements, patient-centered outcomes, quality improvement, and benchmarking. He is currently working to record videos that can be utilized to train new staff and develop online training modules on topics such as the chronic care model, population management, and use of data.

Health information technology has also been used to develop performance measurement infrastructure and guide CQI processes. Through a HRSA-SAMHSA-funded Behavioral Health and Physical Health Care Data Exchange grant, safety net providers were able to secure health information exchange (HIE) connectivity and secure direct messaging at no initial cost to the agencies. All 14 CMHCs have contracts with an HIE. The ODMHSAS has procured a Behavioral Health Home Information Management System, referred to as the "registry" through Care Management Technologies (CMT). The registry provides abstraction, aggregation, analysis and interpretation of data, both prospectively and retrospectively, to aid clinical risk analysis and management of a population. The registry integrates large volumes of disparate data (including claims data, medical services, and pharmacy data) and analyzes this convergence of information for the eligible population in respect to proportional risk, including adherence markers, gaps in care, substandard or inappropriate care, co-morbid physical and MH conditions that are associated with elevated cost burden, and chemical dependency or underlying addictions that may be undermining overall health care and increasing costs. The registry provides secure, 24/7 access to patient health care analytics by providing data on best practice for psychopharmacologic application relative to psychotropic and pain medicines and disease management flags relative to gaps in care for chronic disease states most frequently associated with those suffering from mental illness. All data and data analytics are displayed for each patient in an Integrated Health Profile (IHP) for holistic health management. These data are used by care coordinators, quality improvement staff and clinical and financial administrators to understand the patient/population needs and to direct intervention. CMT staff have trained each CMHC individually, using its own respective data, to demonstrate actionable insights in population management, compliance measurement, and complex case management.

Support for CQI, including fidelity to EBPs, and person-centered and recovery-oriented care. The ODMHSAS has worked with its providers for several years to establish robust continuous quality improvement systems. Its performance monitoring system began in 1994 and has evolved over the years as new lessons are learned and technology advances. Today the system produces a variety of reports, including provider report cards, a web-based dashboard, an executive information system for the agency's management, and population demographic data at the county level. Individuals can build their own specific reports on the dashboard. Each facility is required in the ODMHSAS contract to have a CQI policy, conduct routine and ongoing improvement practices, and must have at least two measures which specifically address consumer suicide attempts and deaths, and 30-day hospital readmissions.

The ODMHSAS Data Integrity Review Team (DIRT) was formed in the fall of 2007 to educate treatment staff about performance measures and how to properly report the data, and the use of

various reports available at the facility and individual level to use the data to improve treatment performance. The DIRT staff members provide webinars to provider agencies, and present at various conferences and numerous agency meetings regarding CQI. In July 2016, the ODMHSAS procured the Care Management Technology's population health analytics registry, ProAct, discussed above. The registry has provided agencies with the ability to query clients based on certain attributes, such as diabetes or tobacco use, and provided targeted interventions to the groups, greatly enhancing quality improvement practices.

One of the most effective promotions of CQI has been through pay-for-performance. In 2009, the ODMHSAS established an Enhanced Tier Payment System in which CMHCs were given incentive payments for good outcomes based on use of best practices. Benchmarks were established based on the prior six months of performance data; one standard deviation was used to establish the upper and lower performance levels. If, for example, a CMHC saw 10 percent of clients during a set amount of time, the CMHC was allocated 10 percent of the total maximum funding for each measure, with the payment for each measure allocated as follows: more than one standard deviation below the benchmark: 0%; below benchmark, but not more than one standard deviation: 50%; above the benchmark, but not more than one standard deviation: 100%. One standard deviation above the benchmark: 100%, plus the allocation of the providers who were below the benchmark, distributed based on the percent of clients served during the reporting period.

The improvement in the measures has been dramatic. For example, for the measure of time to first service, only five CMHCs were seeing clients within three days. Within nine months all CMHCs had achieved this goal, with many of the CMHCs offering same-day, walk-in services. Approximately $32 million in performance pay has been distributed and CMHCs have become very invested in improving performance and learned very quickly how to implement rapid change models using Plan-Do-Study-Act (PDSA) cycles (NASMHPD, 2011).

For the CCBHC CQI process, historic data claims already in the registry will be used to develop baseline measurements. Based on these, each CCBHC will select at least four measures they are doing the poorest on for their annual CQI plans, which will be evaluated annually in conjunction with the DSS staff. Selected measures will change as each target is achieved.

To ensure fidelity to EBPs, the ODMHSAS uses several processes based on what has been proven effective in statewide dissemination. Follow-up consultation and coaching is routinely paired with training. In most cases, a supervisory training is also developed to ensure that supervisors of those trained in EBPs also understand the EBP models and how they apply to day-to-day clinical practice. This model continues to work well for the system and will be adhered to with the CCBHC development. The ODMHSAS sets out training and EBP requirements in program-specific statements of work attached to providers' annual contracts. ODMHSAS program staff members conduct site visits that include chart reviews and interviews with clients and family members, when appropriate. The results of these coaching sessions, site visits, and chart reviews, and any plans of correction are documented and used to inform the evaluation of adherence to the models.

In addition, many of the EBPs selected have fidelity scales such as for motivational interviewing, ACT, CBT, and MI that can quantitatively measure the fidelity.

CCBHC Data Format and Access. Client-level data will flow from the CCBHCs to the State where identifying information will be removed, and a "dumb" persistent identifier will be used to link a client's records together. The data will then be sent to the evaluator, in the specified time frame. Demographics and clinical information are submitted at admission and must successfully go through edits of the data system before claims can be filed and paid. For outpatient services, these data must be updated every six months before payment is continued. This encourages the timely submission of data. Claims must be filed within six months of the date of services but are submitted much more frequently as payments are made weekly. Historical data can be provided to the evaluators very quickly once file formats and layouts have been clarified. A data dictionary will also be made available. The data are collected and stored at the State level as structured query data (SQL). Data can be submitted in any format requested by the evaluators, including the formats of comma separated value, pipe delimited, flat files, etc. In addition, data can be transmitted to the evaluators through the method they request. The ODMHSAS staff have provided data to numerous entities, including federal partners, universities, research organizations, and other state agencies and will work with the evaluators to ensure the needed data is provided in the correct format and in a timely manner.

D. Evaluation of the Demonstration Program.

Capacity and Willingness to participate in the National Evaluation. The ODMHSAS has participated in multiple cross-site evaluations and is willing to provide the needed data in the appropriate format in a timely manner. As stated earlier, the ODMHSAS captures over 100 unique services including inpatient, emergency, and ambulatory services and distinguishes among MH, SUD, and co-occurring treatment services. The codes are used for Medicaid-funded (including CCBHC services), state-funded, and services paid through other funding sources. Because of the unique client identifier, behavioral health services can be linked to other types of services to determine the scope and cost. These codes will continue to be reported by the CCBHCs at a zero-pay so the PPS payment can be compared to the fee-for-service costs paid under the previous payment structure. The CCBHCs, ODMHSAS, and OHCA will provide state-match costs and other payments made to the CCBHCs and the comparison sites for a complete cost comparison. The quality measures can be compiled for the three years previous to the initiation of CCBHCs to determine quality in relation to costs. During the TA Data Collection group calls, several variables and data sources were discussed. The ODMHSAS feels confident it will have access to the required fields once the evaluation plans have been finalized and is eager to participate in the national evaluation.

Through participating in the TA Data Collection group calls and listening to various strategies, the ODMHSAS sought a comparison group that would be as similar as possible with respect to other factors that could influence the outcomes being studied (eliminating possible confounding factors)

and information collection could be as accurate and as comparable as possible for both groups to avoid biasing association. The preferred method for OK is to use clients seen at CMHCs that are not participating in the CCBHC Demonstration project. Clients would be matched on similar demographics, level of functioning, symptomatology, and other variables. This method would allow for a more robust comparison because very detailed data are being collected on all CMHC consumers and submitted to the registry, including data needed to compile cost reports and quality measures. Another benefit of using this population is that the severity of behavioral health and physical health problems are documented to allow for a fairer comparison with the CCBHC population. Just as with the CCBHC populations, data for the comparison group can be accessed through the ODMHSAS prior authorization system, claims, eligibility files, administrative reports, and MHSIP surveys.

Institutional Review Board (IRB) Status. An IRB application was submitted to the ODMHSAS IRB and legal staff. The opinion is that no IRB approval is needed for the CCBHC or comparison groups because no data other than that collected for normal business operations will be completed. If this should change, the IRB has agreed to review the application quickly.

E. Impact of Oklahoma's Participation in the CCBHC Demonstration.

Oklahoma Selected Goals. *OK has chosen Goals 1, 2, and 3*. Goals 1 and 2 will be explained together, as many of OK's proposed solutions address both goals.

*Goals 1 and 2***.** The ODMHSAS has built a strong comprehensive community MH center model through dissemination of innovative best practices and evidence based practices. This is accomplished through utilization of detailed rules and contracts, a healthy certification and contract monitoring process, and an interactive continuous quality improvement process with our centers based on a multitude of data reports. Furthermore, multiple EBPs are continuously trained with consulting/coaching components in place. For these reasons, OK has a very good behavioral health system in place in spite of very low state spending per capita compared to other states (Kaiser Family Foundation, 2013). However, *more must be done* to ensure the clients are *easily accessing the services*, are *getting a full scope of services,* and *all of their mental health/health/SUD needs are met in an integrated manner.* And, it is critical that those with SMI and SED receive intensive care coordination and have access to peer support, with a full Wraparound approach utilized for children. OK can ensure this and therefore, can assure SAMHSA that they will receive a full scope of services. Our philosophy is "whatever it takes."

Adults with SMI and children with SED remain a priority population. The decreased life span of persons with SMI has been well documented (Brown, 1997; Harris and Barraclough, 1998; Saha et al., 2007). The majority of excess deaths in this population are due to physical illnesses, in particular cardiovascular disease, respiratory illness, and cancer (Kisely et al., 2005; Lawrence et al., 2001; Leucht et al., 2007). A meta-analysis of quality of medical care for people with co-morbid mental illness reported that the majority of studies demonstrate significant inequalities in

the provision of medical care for people with SMI (McIntyre, et al., (2007). Children with SED are (1) least likely to graduate from high school (Hagner, et al., 1999); (2) three times more likely to be involved in criminal activity (Vander Stoep, et al., 2000); (3) more likely to engage in substance use (HHS, 2002); (4) less likely to find, obtain, and keep a job (Pandiani, et al., 2004); and (5) least likely to achieve independent living in a community of their choice.

The mind/body connection is vitally important. OK will ensure that our CCBHCs provide *integrated treatment*, utilizing their BHH model of practice. Because BHHs are in place in all three selected CCBHCs, OK can assure SAMHSA that individuals will be offered *integrated treatment services and supports.* We can assure this because CCBHCs are built on the firm foundation of CMHCs/BHHs, and because the State has committed deeply to improving the overall health and wellbeing of all persons.

Based on the needs assessment, the CCBHCs are intensifying their linguistic and cultural abilities in order to serve more Oklahomans who are veterans, Hispanic, or who are LGBT. There are plans to expand the bi-lingual workforce and use translational services. CCBHCs have: reached out to veteran groups for advice and counsel for effective methods for outreaching to military personnel, veterans and their families; conducted cultural assessments and made adjustments to be more welcoming to all cultures; and are training staff in additional EBPs. *Therefore the goals of (1) providing the most complete scope of services required in the CCBHC, and (2) improving the availability of, access to, and participation in, services have been selected.*

Thanks to OK's experience and lessons learned during the first two years of our BHH implementation, and the CCBHC planning year, we are poised to accomplish these goals. We are confident that with the enhanced standards, expanded scope of services required, increased workforce and the new payment methodology of the CCBHC demonstration, OK will demonstrate greatly improved ***availability, accessibility, and scope of services*.**

*Goal 3**:** OK's third goal is improving the availability of, access to, and participation in* ***assisted outpatient mental health treatment***. Based on the 2014 National Survey on Drug Use and Health report, the national rate of SMI among adults 18 or older was 4.0%, and OK ranked among states with the highest SMI rates at 5.2%. These individuals and families get caught in a revolving door which includes: non-compliance – law-enforcement intervention – possible hospitalization and/or jail time – outpatient treatment – and back to non-compliance, which begins the cycle again. Those that are in need of medication possibly are not receiving or adhering to treatment. Their disorders create deficits in their ability to make good and healthy choices about their treatment needs. The ODMHSAS is very concerned with the increase in negative outcomes for individuals who are not receiving necessary services due to their hesitance to seek or adhere to treatment.

Over the past few years, ODMHSAS leadership team has spent countless hours meeting with local law enforcement, court officials, and providers to analyze better ways to reach out to those individuals with SMI who are not yet able to realize the importance of treatment in order to recover

and live in the community safely. Beginning in OK County, a model of a 23-hour/59-minute crisis center has been very effective in adding a layer of service as a safety net for this group, as well as the community response team that follows up with these individuals to ensure they are linked to outpatient services. Most recently, in 2016, the leadership team worked with the OK legislature as it crafted a change to OK's MH statute to encourage the therapeutic use of civil court commitments for assisted outpatient treatment (AOT). The new law became effective November 1, 2016. OK's AOT law is treatment-oriented and provides the impetus for developing a strong, treatment-oriented system. The ODMHSAS recently was awarded SAMHSA funding for AOT implementation. All CCBHCs are creating community outreach teams, which will include MH staff and crisis intervention trained (CIT) trained police officers when needed, to assist with community outreach visits, and will have full-time coordinators.

The ODMHSAS is working with its provider agencies to have an adequate workforce trained in AOT to serve this population and build a strong infrastructure of procedures, protocols, and treatment guidelines. Local community summits/trainings to educate the local judicial systems and the public in appropriate use of this treatment modality are scheduled. Because of the groundwork laid, the new law and the state's firm commitment, ***OK will be able to improve the availability of, access to, and participation in assisted outpatient mental health treatment.***

CCBHC Measures to Show Impact. ***Goals 1 and 2***. Provide the most complete scope of services required in the CCBHC criteria to individuals that are eligible for medical assistance under the State Medicaid program and improve availability of, access to, and participation in, services to individuals eligible for medical assistance under the State Medicaid program.

- Increase the number of services to adults age 16—25 years of age - *ensure age-appropriate services are being provided and address gaps identified through the needs assessments.*
- Increase the number of SUD services provided.
- Increase the number of mobile crisis services - *targeted towards the span of services that the needs assessment identified as lacking in the treatment system.*
- Increase the number of MOUs or other formal agreements with consulting physicians - *ensure coordination with and inclusion of primary care in the CCBHCs*.
- Increase the number of clients served - *demonstrate the improved availability to persons who may not have been able to access services in the past*.
- Increase the number of clients receiving PRSS services - *PRSSs foster hope and promote a belief in the possibility of recovery (SAMHSA, 2015). Measure promotes PRSS use.*
- Increase the number of clients engaging in treatment as defined by a 3rd and 4th service within 30 days of the 2nd service - *ensure improved participation in services*.
- Increase the number of veterans and military personnel served.
- Increase the number of Hispanics served.
- Increase the number of LGBT community served - *address underserved populations identified through the needs assessments*.

Goal 3. Improve availability of, access to, and participation in AOT in the State.

- Increase in treatment adherence for persons served through the AOT program.
- Reduction of inpatient hospitalizations for persons served through the AOT program.
- Reduction in homelessness for persons served through the AOT program.
- Reduction in arrests/incarceration for persons served through the AOT program - *address treatment adherence and the desired outcomes of the AOT programs*.

Table 1: SFY2016 Baseline Data for Measures from the three CCBHCs

Measure	# / %
The number of services to adults age 16—25 years of age	3,563 / 17%
The number of SUD services provided	316 / .02%
The number of mobile crisis services	0
The number of MOUs with consulting physicians*	112 / 23%
The number of clients served	20,499 / 100%
The number of clients receiving PRSS services	6,742 / 33%
The number of clients engaging in treatment	44.8%
The number of veterans and military personnel served	21 / .001%
The number of Hispanics served	1,137 / 6%
The number of LGBT community served	17
Treatment adherence for persons served through the AOT program	Unknown
Inpatient hospitalizations for persons served through the AOT program.	Unknown
Homelessness for persons served through the AOT program.	Unknown
Arrests/incarceration for persons served through the AOT program.	Unknown

**Percent is the number of clients' PCPs with which the agency has an MOU.*

Data Collection, Documentation, Tracking of Outcomes, and Analysis. Data will come primarily from two sources: the prior authorization system and claims data. The following measures will be compiled from claims: clients served; services provided to transitional youth age 16-25; SUD and mobile crisis services; clients receiving services from a PRSS; clients engaging in treatment; and inpatient hospitalizations and treatment adherence for persons served through the AOT program (a procedure code will be submitted to the MMIS for tracking no-shows and claims will be used to determine length in treatment).

The number of veterans and military personnel, Hispanics, and homelessness and arrests/incarceration for persons served through AOT will use data from the prior authorization system, as the demographics and outcomes are collected at admission and each update.

MOUs with primary care physicians (PCP) will be collected from the CCBHCs quarterly (assigned PCPs for clients are tracked through the MMIS so a percentage can be calculated). For the number of members of the LGBT community served, a demonstration project will be used due to the State not being able to collect this information from the general population. The Oklahoma Now Is The Time - Healthy Transitions (ONITT) project focuses on transitional age youth and give participants the option of reporting their sexual orientation (heterosexual, lesbian or gay, bisexual, other, refused, don't know). Only 3% of participants refuse to answer.

For each measure, the numerator and denominator will be defined and disseminated to the CCBHCs so they are aware of how each measure is calculated and can monitor their progress internally for CQI processes. Measures will be compiled quarterly by the DSS staff and reports will be available to the CCBHCs on the PICIS website. CCBHCs will only be allowed to see their own data but can drill down to satellite location and individual client. Trend lines, starting with the baseline numbers, will be used to display results for each subsequent quarter. Predictive analysis, such as multiple regression, can be used to establish relationships among three or more variables so combinations can be created to further define the relationship. For instance, if veterans' outcomes are lower than non-veterans, models can be used to explore if it is all veterans or specific groups such as American Indian veterans. Data will also be analyzed by agency to isolate any program or contextual effects.

Table 2 OK's projected impact of the intervention on the measures. To account for the difference in the three CCBHCs' baseline numbers, impacts are given as percent increases based on each CCBHC baseline measure. In conjunction with the federal project officer, measures will be reviewed after the first year to determine if modifications need to be made.

Table 2: Projected Impact on Target Population

Measure
Goal 1. Increase in the number of young adults age 16-25 years of age served by 3% each year
Goal 1. Increase in the number of SUD services provided by 5% each year
Goal 1. Increase in the number of clients receiving mobile crisis services by 3% each year
Goal 1. Increase in the number of MOUs with consulting physicians by 5% each year
Goal 2. Increase in the number of clients served by 5% each year
Goal 2. Increase in the number of clients receiving services from a PRSS by 5% each year
Goal 2. Increase in the number of clients engaging in treatment by 5% each year
Goal 2. Increase in the number of veterans and military personnel served by 10% each year.
Goal 2. Increase in the number of Hispanics served in the OK County by 8% each year.
Goal 2. Increase in the number of LGBT community served in the ONITT project by 5% each year.
Goal 3. Increase in treatment adherence by 30% and 25% of participants who voluntarily stay in treatment three months after their orders expire for AOT participants.
Goal 3. Reduction in homelessness by 15% one year pre/post admission to AOT.
Goal 3. Reduction in arrests/incarceration by 25% one year pre/post admission to AOT.
Goal 3. Reduction of inpatient hospitalizations by 25% one year pre/post admission to AOT.

OK will capitalize on the high standards required for CCBHCs to build on the foundation laid the past several years with our pay-for-performance and BHH initiatives to ensure: (1) better access to and availability of service; (2) integration of MH, SUD, and primary care to individualize holistic care for all individuals; (3) high quality of service through disseminating EBPs with an OK-proven method to ensure fidelity; (4) innovative financial solutions to ensure service regardless of ability to pay; (5) formal relationships with emergency departments and other crisis services; (6) ability to assist with transportation and/or deliver service through telemedicine; and 7) meaningful consumer involvement and voice at every level of the system.

We assure SAMHSA, CMS, and ASPE that OK possesses the experience with system change, success with EBP and BHH implementation, innovative thinking, and a can-do attitude to carry out a successful demonstration of the CCBHC model.