INTRODUCTION

Like many state mental health authorities (SMHAs), the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) was seeking creative solutions to improve provider performance in the face of state budget cuts.

Through a collaborative process with the Community Mental Health Center (CMHC) provider community, the Oklahoma Health Care Authority (OHCA), the state's Medicaid agency, ODMHSAS was able to accomplish something that many cash strapped state agencies are seeking to do; that is, improve quality of care, increase provider payments, and serve more people in need.
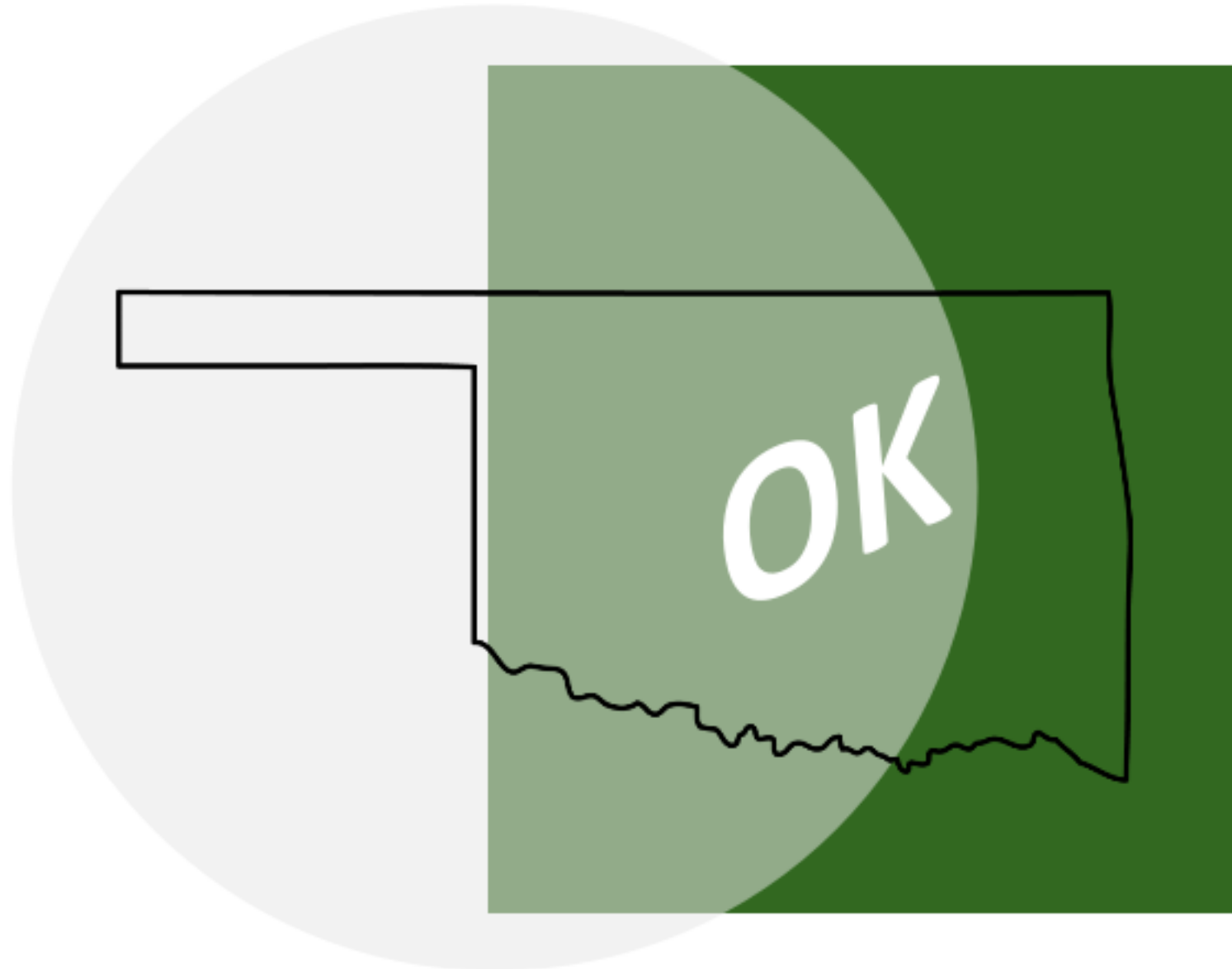
OVERVIEW OF OKLAHOMA
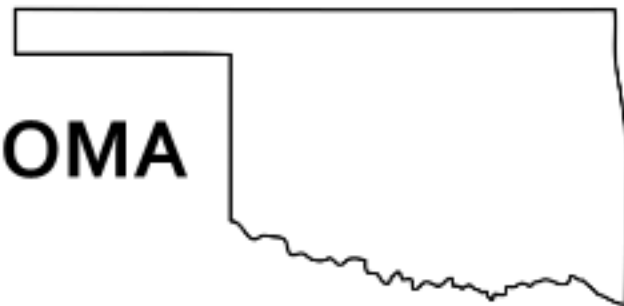
Medicaid dollars provide the largest portion of non appropriated funding for mental health and substance use services.

Oklahoma's public mental health system is centralized (as opposed to a county-based system for example) and relies primarily on state general funds to support its operating budget.

A network of 13 CMHCs serving all 77 Oklahoma's counties serve as the front door for accessing a range of treatment services including crisis services. These 4 state-operated and 9 contracted non-profit CMHCs serve as the safety net provider of mental health services for uninsured adults and children in addition to serving Medicaid recipients in need of mental health services.
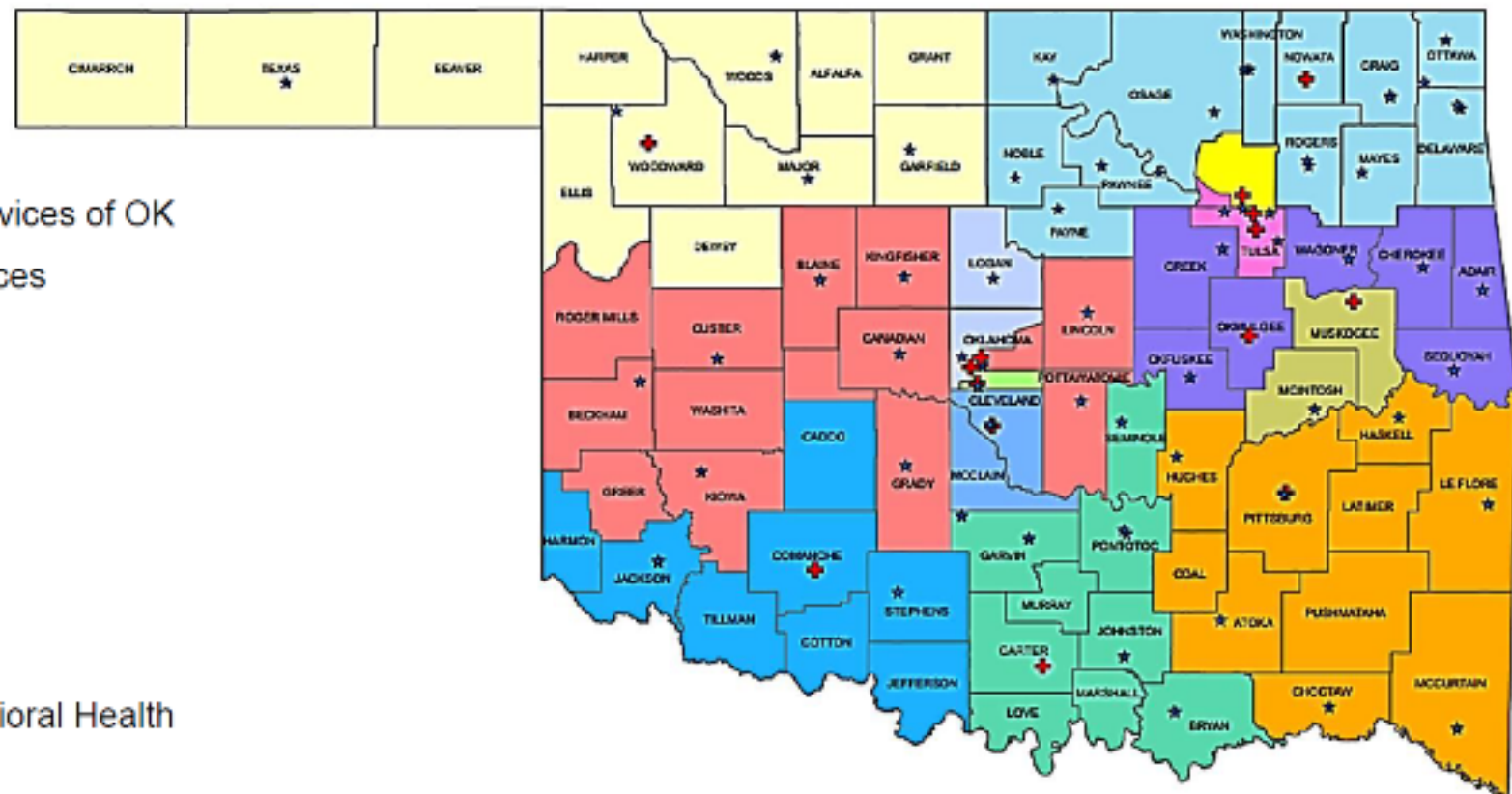
OKLAHOMA COMMUNITY MENTAL HEALTH CENTERS

PAYMENT and TARGETED OUTCOMES

ODMHSAS created a payment system based on quality-of-care targeted outcomes.

- Federal regulations place a ceiling (Upper Payment Limit or UPL) on State Medicaid expenditures eligible for federal matching funds.

- Because CMHCs were being reimbursed at 75% of the UPL , ODMHSAS saw room to create an incentive corridor with the remaining 25%.

- Changing the provider payment methodology from volume-based fee-for-service to a new incentive system required Oklahoma to amend its Medicaid state plan.

ENHANCED TIER PAYMENT SYSTEM

The Enhanced Tier Payment System (ETPS) is an innovative payment structure developed to enhance the recovery outcomes of customers in the mental health and substance abuse system.

FINANCING & PAYMENT METHODOLOGY

Calculate the difference between the providers claimed activities (as a whole) and the allowable UPL (upper payment limit: maximum amount that could be paid for Medicaid services under Medicare payment principles) = pool of funding to distribute based on performance.

Dollars Earned
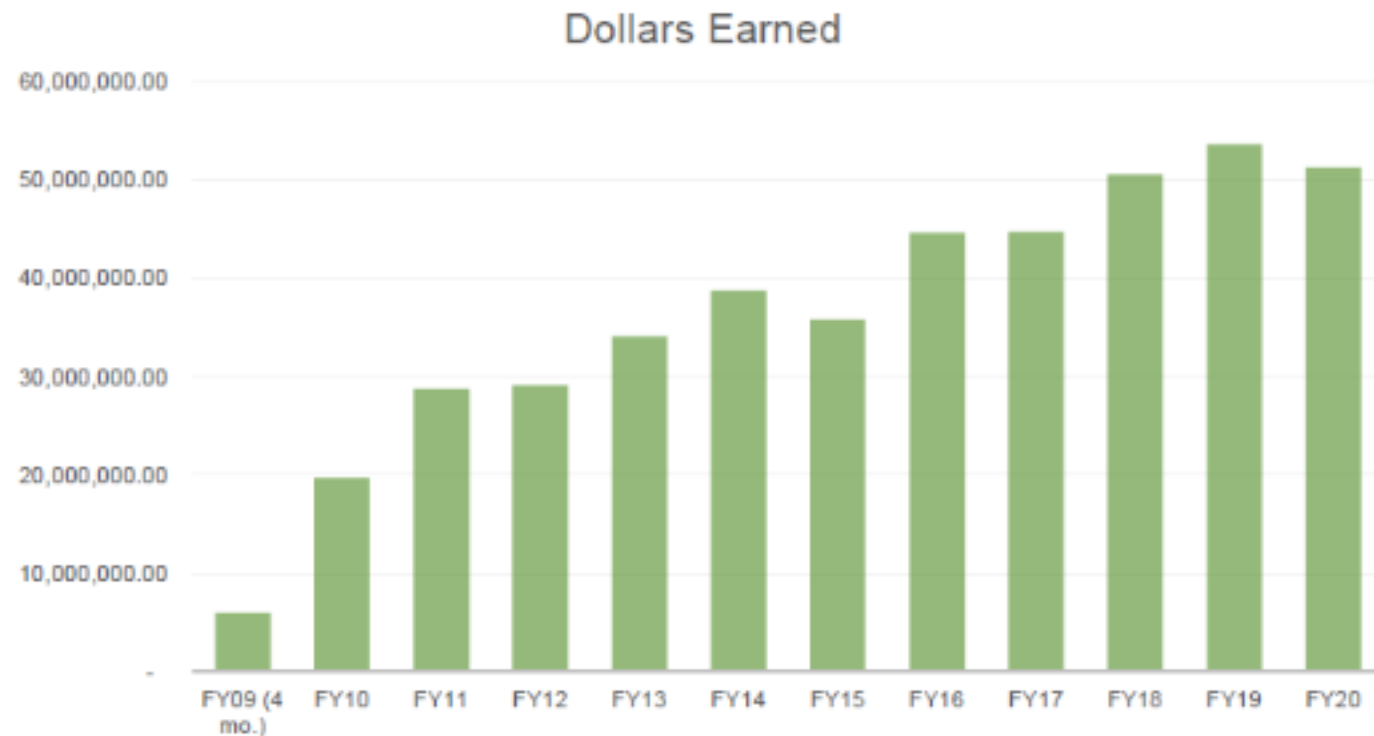
STATE PLAN AMENDMENT

(e) Supplemental Payments for Behavioral Health Community Networks (BHCN)

In order to maintain access and sustain improvement in clinical and nonclinical care, supplemental payments will be made to CMHCs that meet the following criteria:

- Freestanding governmental or private provider organization certified by and operates under the guidelines of the ODMHSAS as a CMHC.

- Participate in behavioral quality improvement initiatives based on measures determined by and in reporting format specified by the Medicaid agency.

- The state affirms that the clinic benefit adheres to the requirements at 42 CFR 440.90 and the State Medical Manual at 4320 regarding physician supervision.
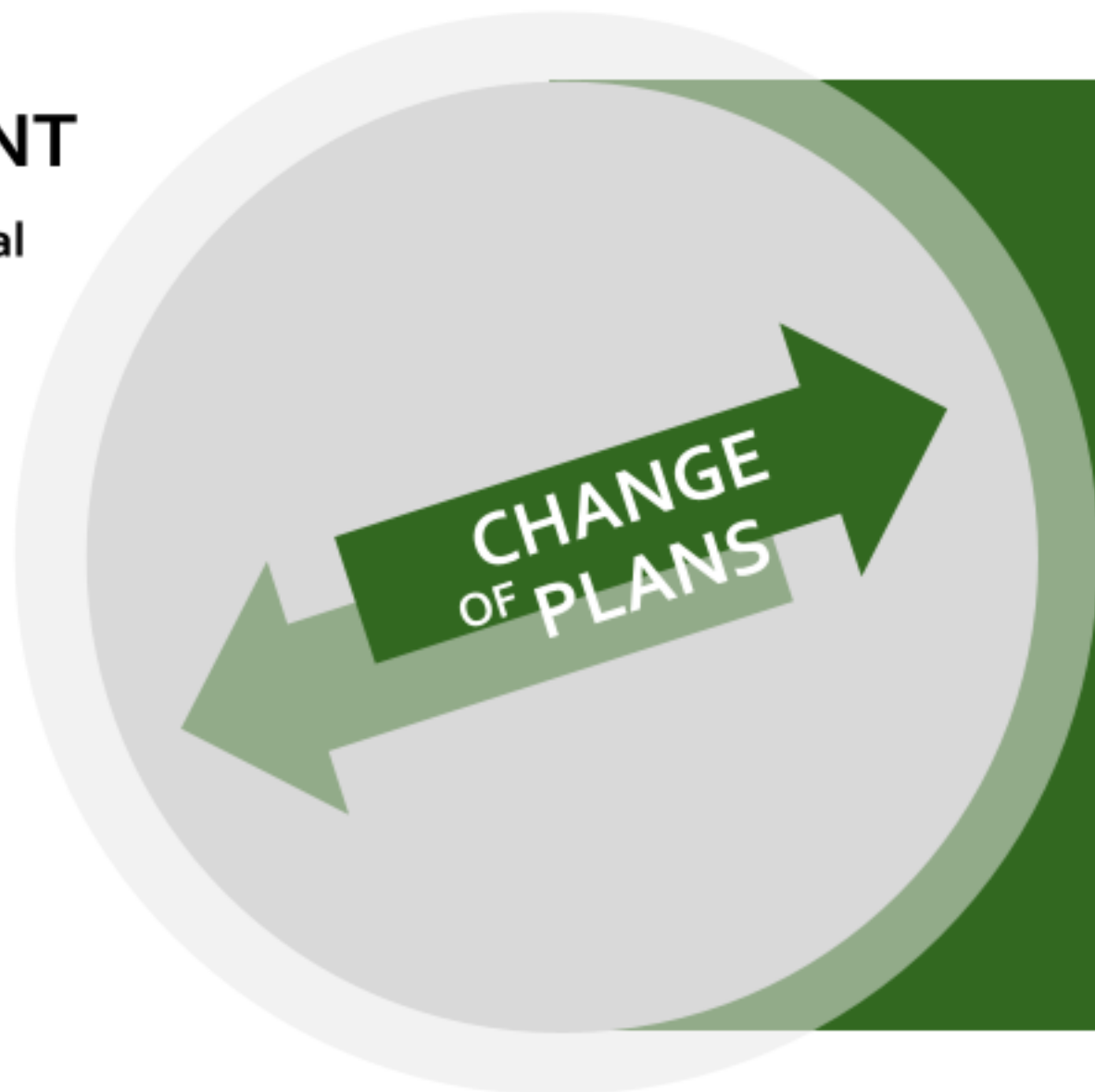
MEASURES

CURRENT DATA SYSTEM

- Fee-for-service based payments.
  - Provider submits ODMHSAS and Medicaid claims together.
- Demographic information collected at admission, discharge, level of care change, and at treatment plan update.
  - Information includes age, race, sex, living situation, TEDS data elements, assessment scores, etc.

MEASURE IDENTIFICATION

- Improving access to care is high priority.
- Measures based on current data.
  - Providers already submitted claims and periodic demographic data.
  - Access to Treatment is the only new measure and was based on a "secret shopper approach conducted by ODMHSAS staff.

MEASURE TRANSPARENCY

- ODMHSAS met with providers face to face and via conference calls and webinars to discuss measures, secure buy-in, and obtain consensus on how measures were defined.
- Each provider received detailed reports at the individual client level.
- Each provider received summary reports of other providers.

MEASURES

IMPLEMENTED JANUARY 1, 2009

1. Outpatient Crisis Service Follow Up within 8 Days

2. Inpatient/Crisis Unit Follow Up within 7 Days

3. Four Services within 45 Days of Admission (Engagement)

4. Medication Visit within 14 Days of Admission

5. Reduction in Drug Use

6. Access to Treatment (Adults)

MEASURES

IMPLEMENTED JULY 1, 2009

7. Improvement in CAR Score: Interpersonal Domain

8. Improvement in CAR Score: Medical/Physical Domain

9. Improvement in CAR Score: Self-Care/Basic Needs Domain

10. Inpatient/Crisis Unit Community Tenure of 180 Days

11. Percent of Clients who Receive a Peer Support Service

12. Access to Treatment (Children)
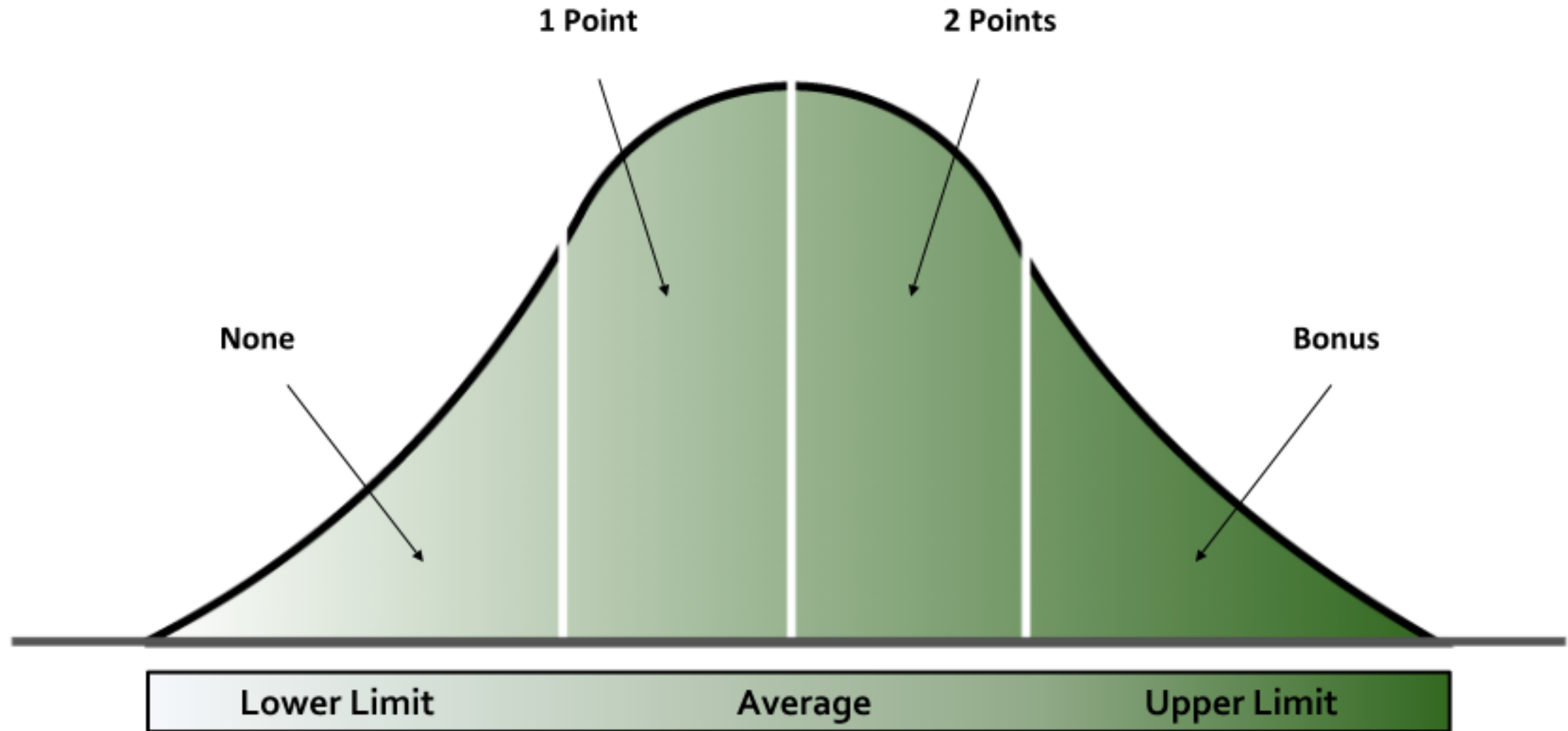
FINDINGS

- Infusion of dollars has stabilized workforce by increasing salaries and training to ensure staff tenure.

- Agencies use clinician level reports with staff as part of supervision and have tied merit raises and bonuses to staff performance.

- State has used this initiative to further promote community integration and recovery-oriented approaches, including use of peer services and implementation of important community approaches not funded by Medicaid.
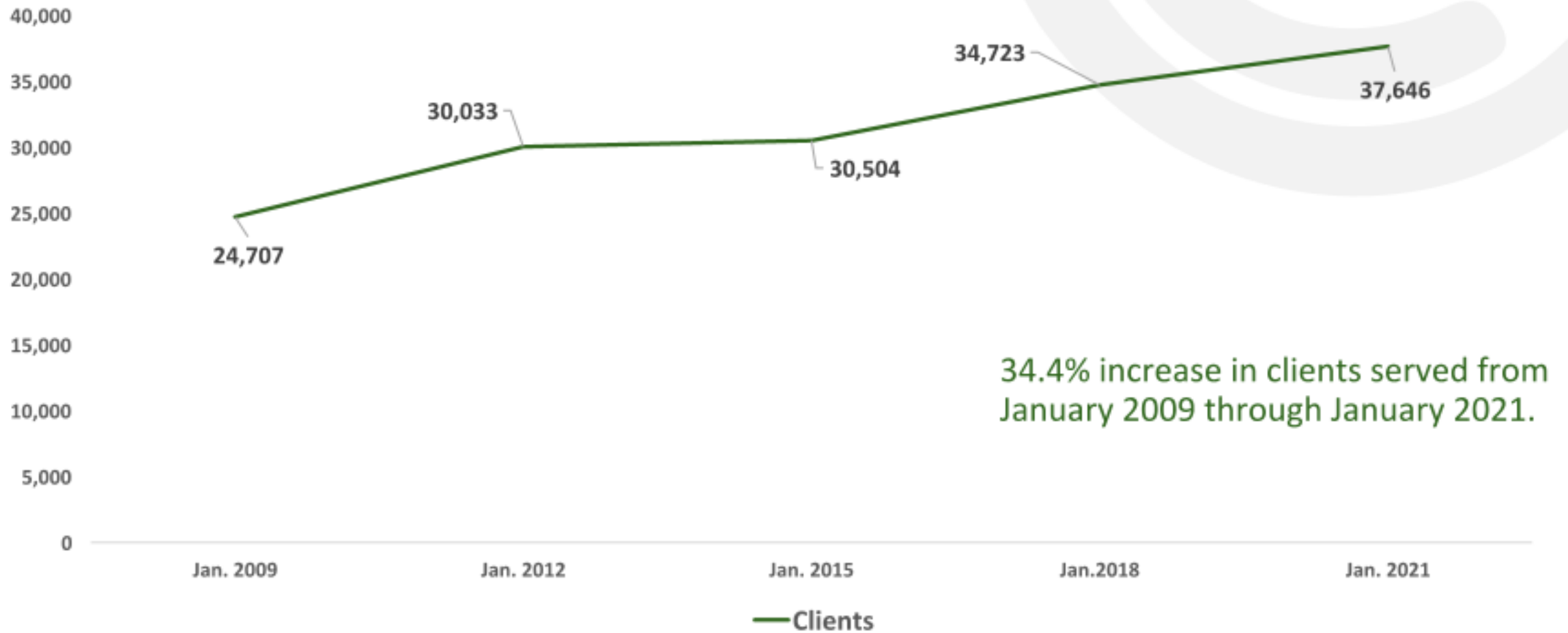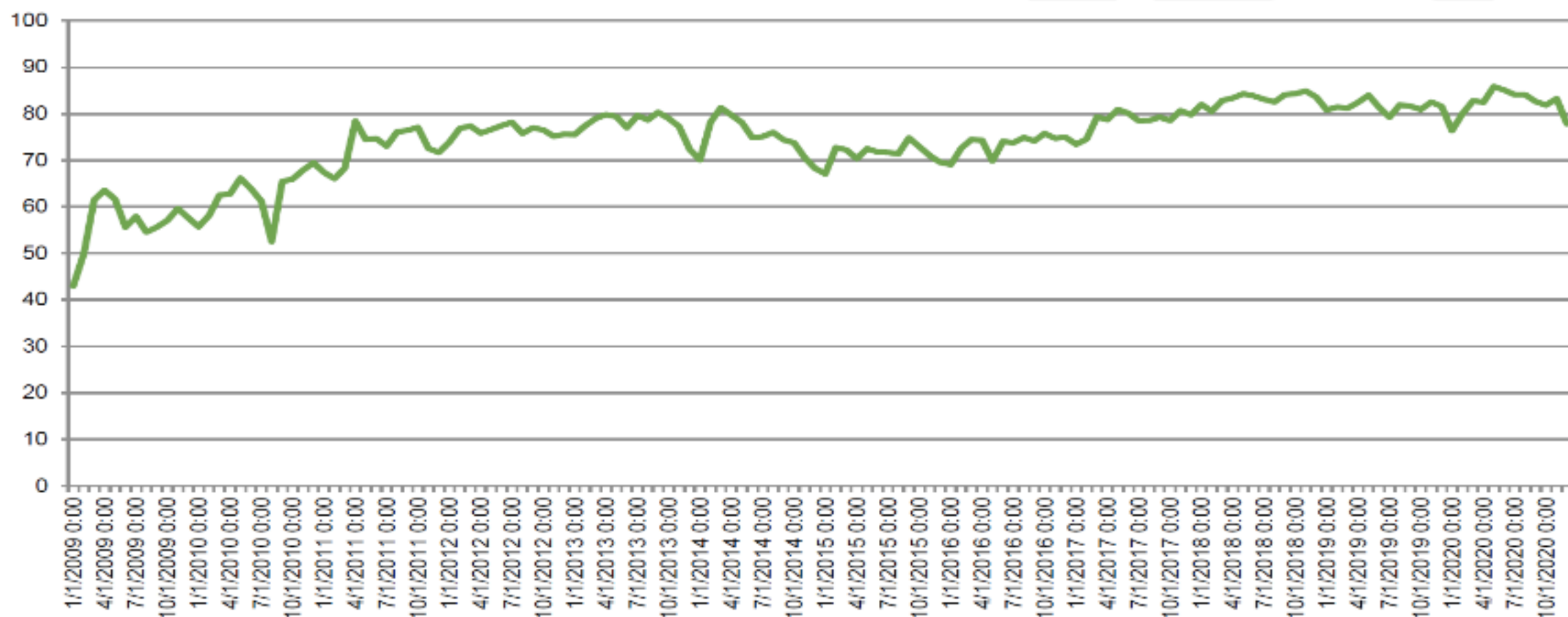
CRISIS FOLLOW UP IMPROVEMENT
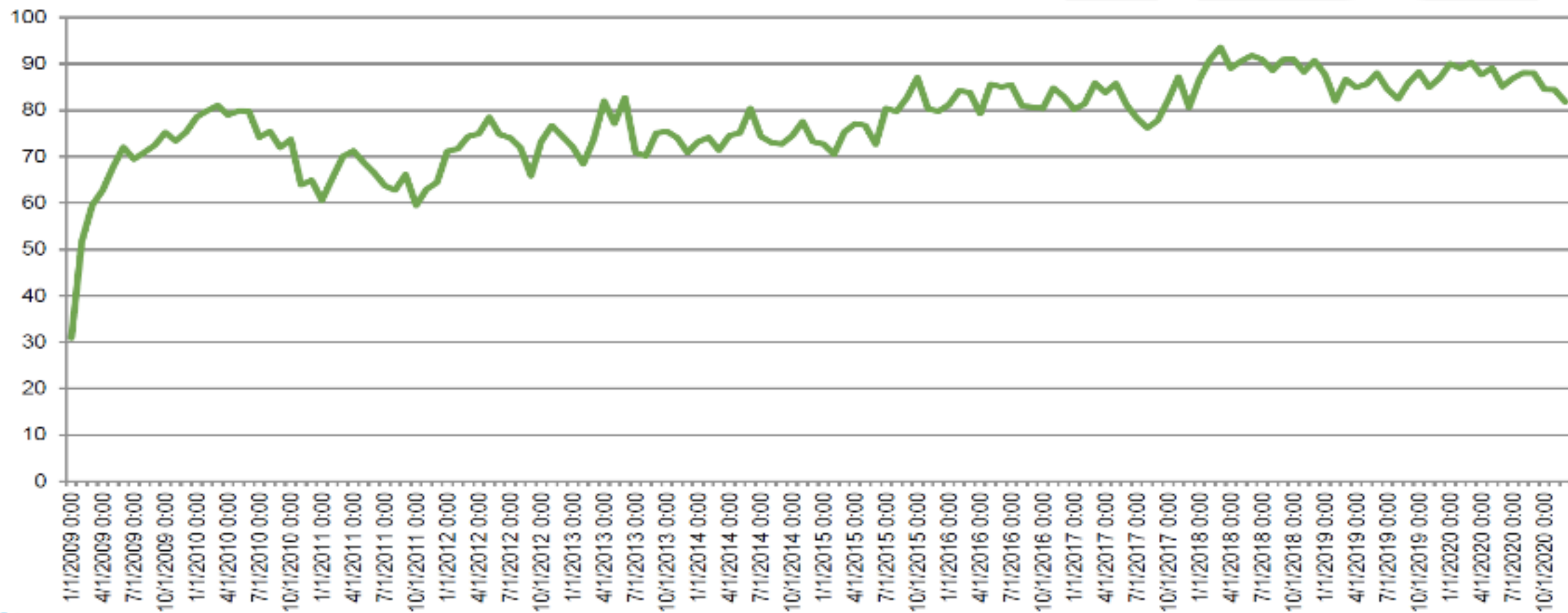
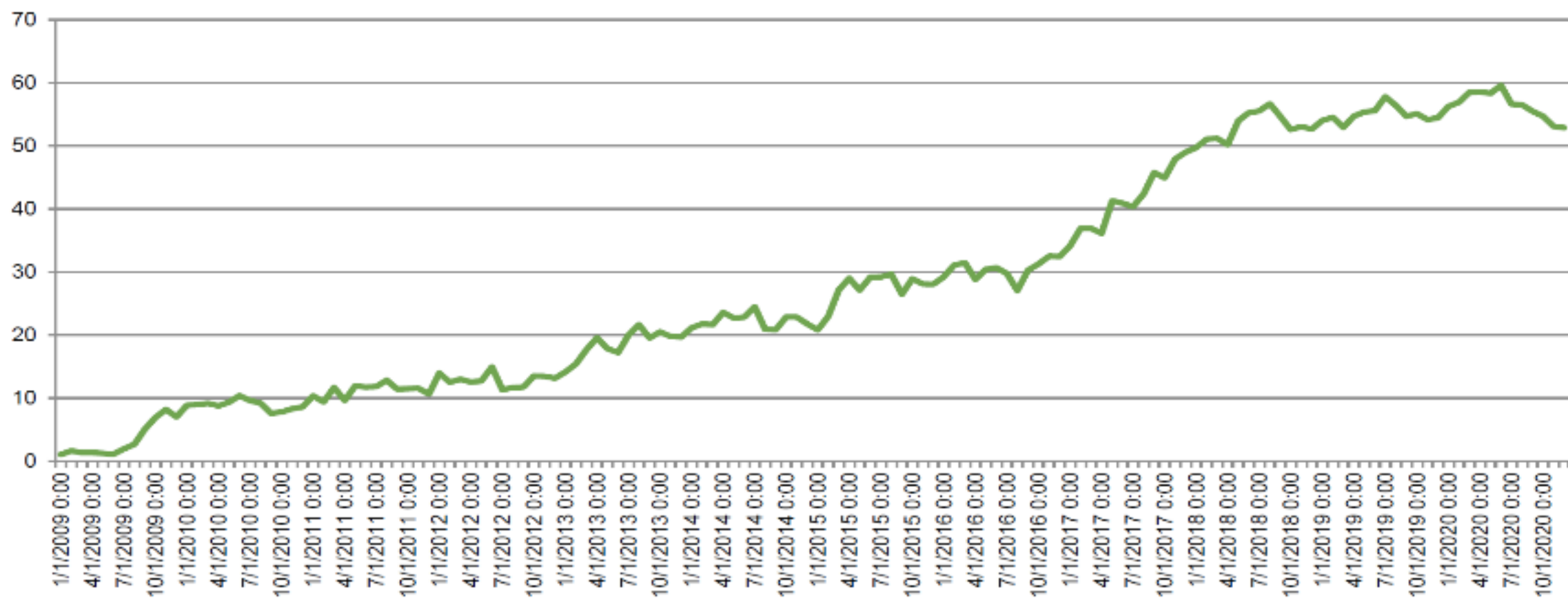# TREATMENT ENGAGEMENT IMPROVEMENT

STATE AVERAGE & CHANGE

MEASURE	AVERAGE		CHANGE
	JUNE 2009	DECEMBER 2020	
Outpatient Crisis Service Follow up within 8 Days	29.8	81.8	52
Outpatient Peer Recovery Support Services	1.1	52.2	51.1
Engagement in Treatment within 45 Days	45.2	77.8	32.6
Inpatient/Crisis Unit Follow up within 7 Days	53.9	80.3	26.4
Improvement in CAR Score Domain: Interpersonal	25.6	50.7	25.1
Medication Visit within 14 Days of Admission	41.4	62.9	21.5
Improvement in CAR Score Domain: Self Care/Basic Needs	40.0	59.8	19.8
Reduction in Drug Use	36.7	50.2	13.5
Inpatient/Crisis Unit Community Tenure of 180 Days	73.2	82.0	8.8
Improvement in CAR Score Domain: Medical/Physical	47.1	55.1	8.0
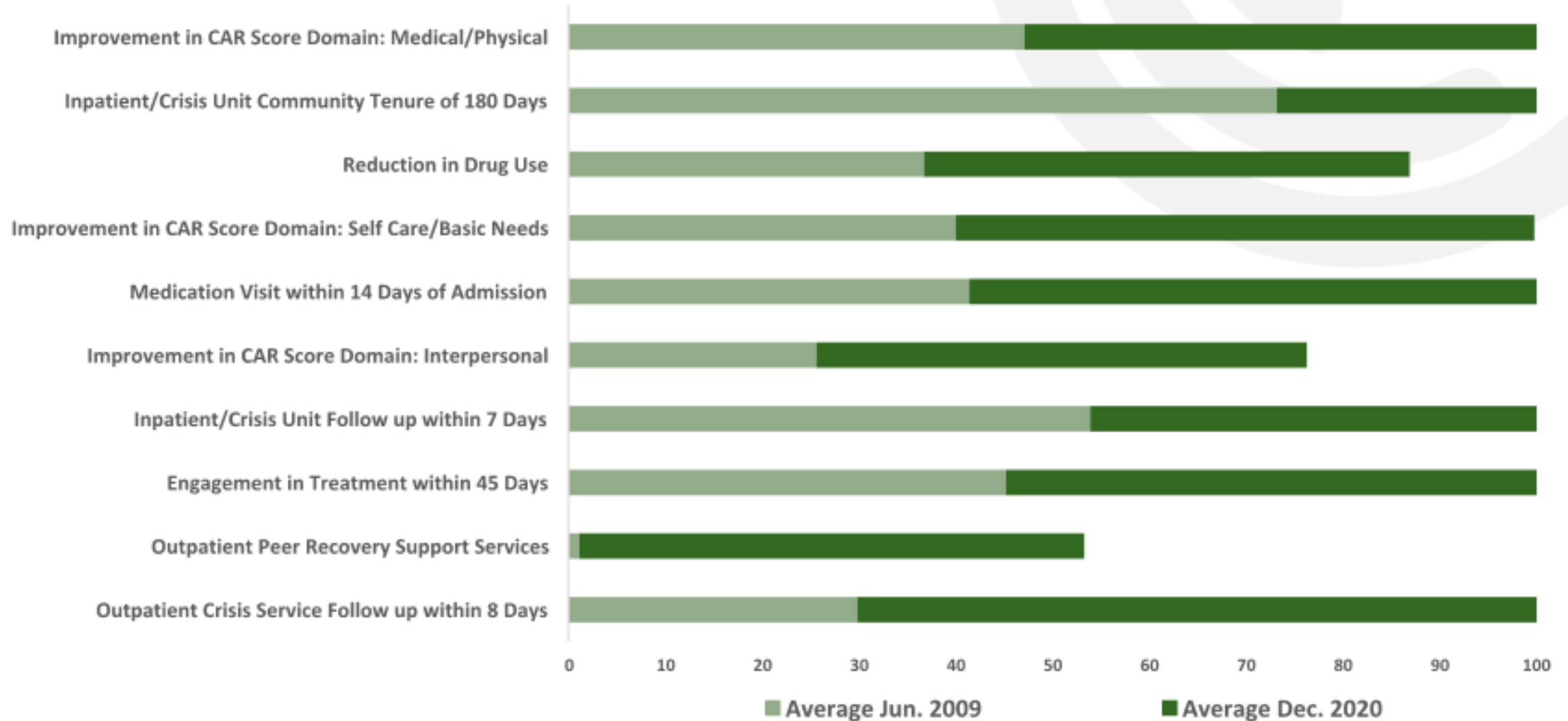
OKLAHOMA INNOVATIONS

CONSUMER REPORT CARD

Individualized, one page consumer "report card" with lab results, medication compliance, services received & screenings. Report cards assign a grade to agency based on how well services to each client were coordinated and provided. Results are available to staff involved in the individual's care.

MOST IN NEED

Prioritized treatment recipients accounting for the most crisis center and inpatient stays, distributed information in real time to each provider identifying clients for whom to prioritize stabilization.

TELEHEALTH

Approximately 12,000 tablets with built in cellular connection are distributed to homes, health and emergency departments, and law enforcement and provide immediate access to care and treatment services.

LAW ENFORCEMENT

Partnering with County Sheriff and City Police Departments providing telehealth devices, training, and collaboration in crisis response.

Technology use Increase

900%

On any given month, over 317 hours of services are provided through mobile technology established through CCBHC

ODMHSAS

Infant, Children, Youth, and Young Adult Services

Continuum of Care

OUTCOMES MEASURES

- Reductions in Days-out-of-Home Placement, including:
  - Inpatient Hospitalization
  - Foster Care
- Decreases in school suspensions and detentions.
- Decreases in contacts with law enforcement.
- Decreases in self-harm and suicide attempts.
- Decreases in problem behaviors.
- Increases in resiliency.
- Clinically significant improvement in functioning.

OKLAHOMA SYSTEMS OF CARE

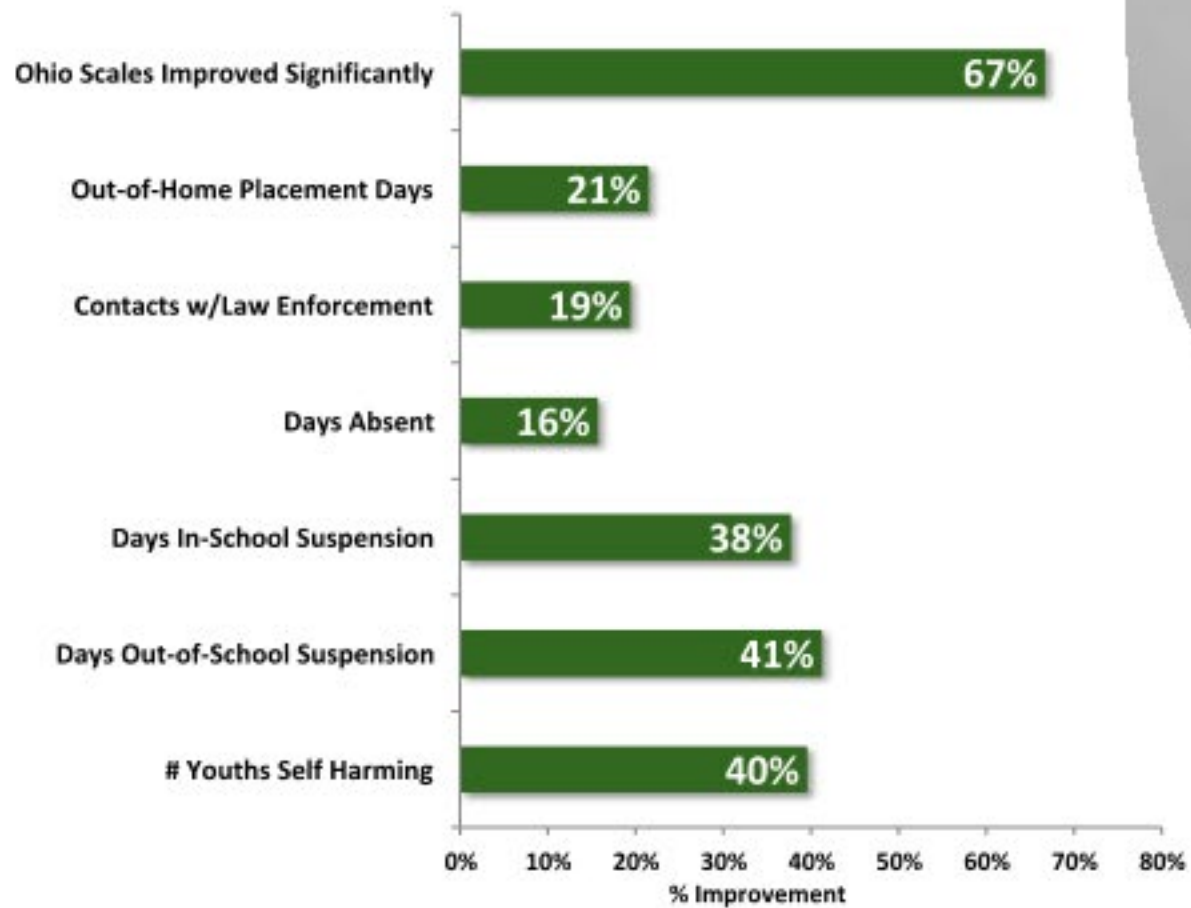OKLAHOMA DEPARTMENT OF MENTAL HEALTH
AND SUBSTANCE ABUSE SERVICES

These measures are presented to the Oklahoma State Legislature every year and have been instrumental in the sustainability and continued growth of OKSOC services.

OKSOC OUTCOMES

Baseline to 6-month Improvement

(Data for 17642 Youths)

Category	% Improvement
Ohio Scales Improved Significantly	67%
Out-of-Home Placement Days	21%
Contacts w/Law Enforcement	19%
Days Absent	16%
Days In-School Suspension	38%
Days Out-of-School Suspension	41%
# Youths Self Harming	40%

% Improvement

Oklahoma's Youth Crisis Mobile Response is an integral component of Oklahoma Systems of Care (OKSOC) and founded on the OKSOC values and principles, which provide the driving force for the provision of behavioral health services to Oklahoma's children, youth, young adults, and families.

Youth Crisis Mobile Response provides **statewide** rapid, community-based mobile crisis intervention services for children, youth, and young adults up to the age of 25 who are experiencing behavioral health or psychiatric crises.

Youth Crisis
MOBILE RESPONSE

- Single point of access

- Streamlines process and removes barriers for crisis treatment

- No wrong door: mechanism and protocol in place by which to connect youth, family, or agency to the single point of access

- 1-833-885-CARE (2273) toll-free, 24 hours a day, 7 days a week, 365 days a year

- Assessment and screening to determine presenting issue of crisis and needs of child, youth, or young adult

- Assessment of risk of harm to child, youth, or young adult and/or others

- Initial determination of appropriate level of response

- Call Center staff determine level of service needed for each call
    - Emergency face-to-face response within 1 hour
    - Non-Emergency face-to-face meeting within 24 hours
    - Active listening and information only

- Calls are triaged and documented according to appropriate triage protocols
    - Mobile Response
        - Live form in the Youth Information System
    - Emergency (fire, medical or police)
    - 211 referral for resources / information only
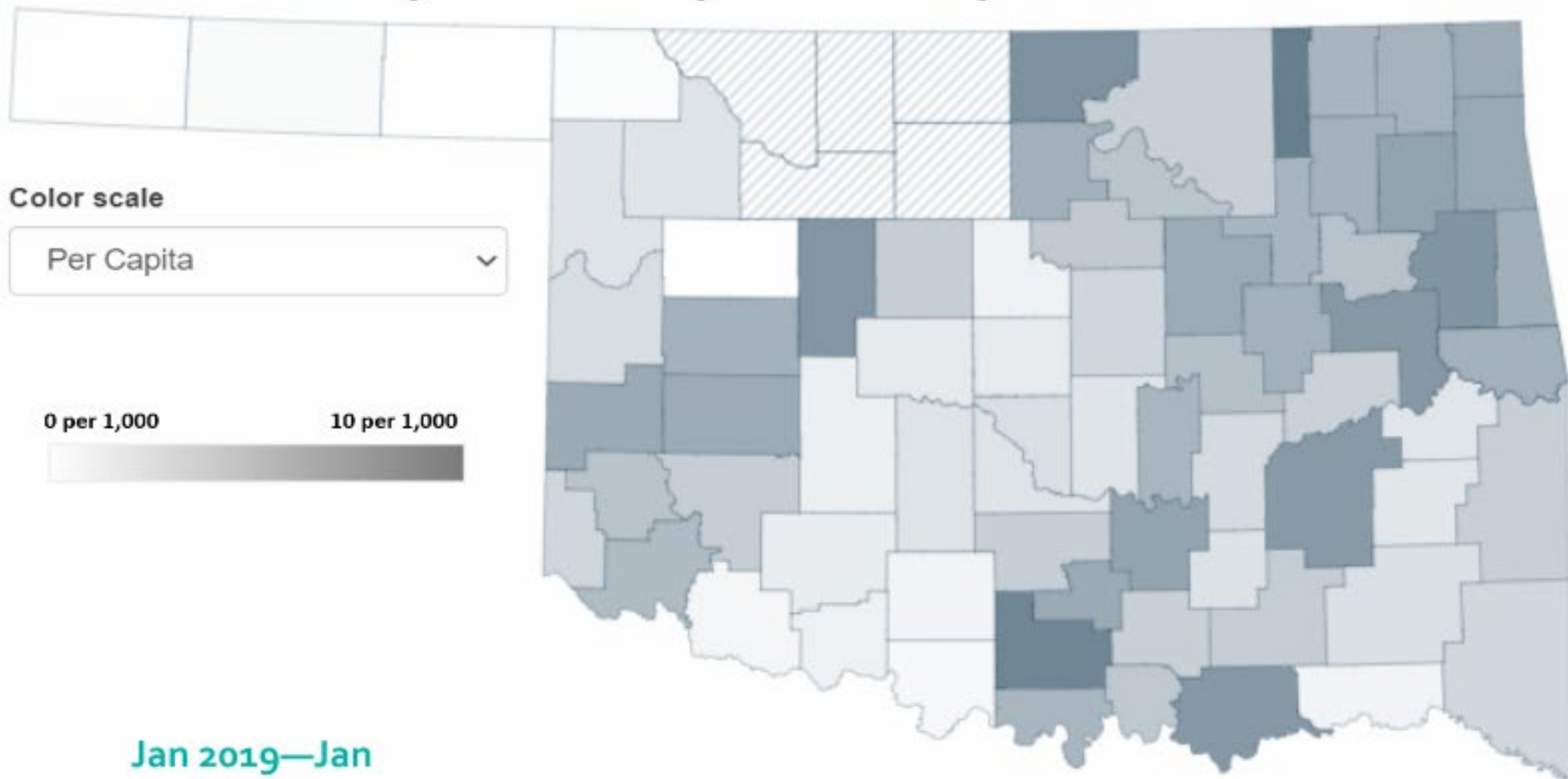
Youth Crisis
MOBILE RESPONSE

- Crisis Call Center staff enter call information in the OKSOC Youth Information System (YIS) where it is immediately available to the Mobile Response Team (MRT).

- Crisis Call Center staff then facilitate a warm handoff or transfer of care to the MRT while on the phone with the caller.

- More impactful than a simple referral and ensures that callers and children, youth, young adults, and families are actively connected to service providers.

- Improves knowledge and comfort level of callers and partners, such as DHS, schools, etc.

- Improves safety and comfort levels for MRT staff.

- MRTs provide mobile, on-site, face-to-face response (can be via telehealth) within one hour of receipt of referral. This can be changed to a 24-hour time window at the request of the involved family.
- Can go into homes, communities, emergency rooms, police stations, detention centers, shelters, schools, etc.
- Cannot go into psychiatric hospitals that provide treatment at the residential and acute levels of care.
- Trained and equipped to assess for medical criteria to meet the need of acute and/or residential level of care hospitalizations.
- Assist with locating hospital placements, if necessary.
  - If none are available, MRTs can assist with intensive safety planning for continued crisis control (documenting behaviors, assisting with timelines, reserving a bed, etc.).
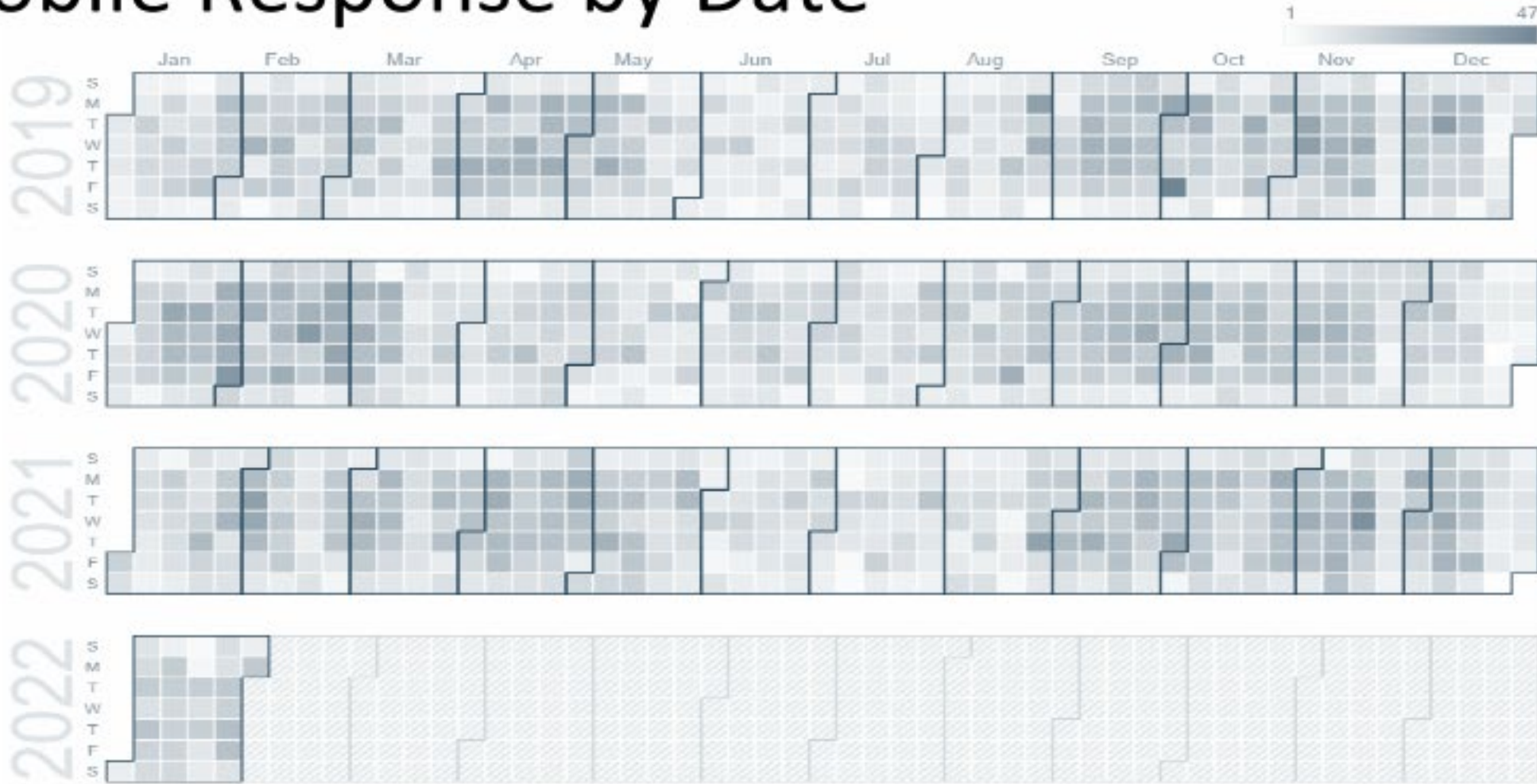
Mobile Response by County

Color scale

Per Capita ⌄

0 per 1,000   10 per 1,000

Jan 2019—Jan
2022

Youth Crisis
MOBILE RESPONSE

Total Calls = 19,493

Mobile Response by Date

Jan 2019—Jan 2022

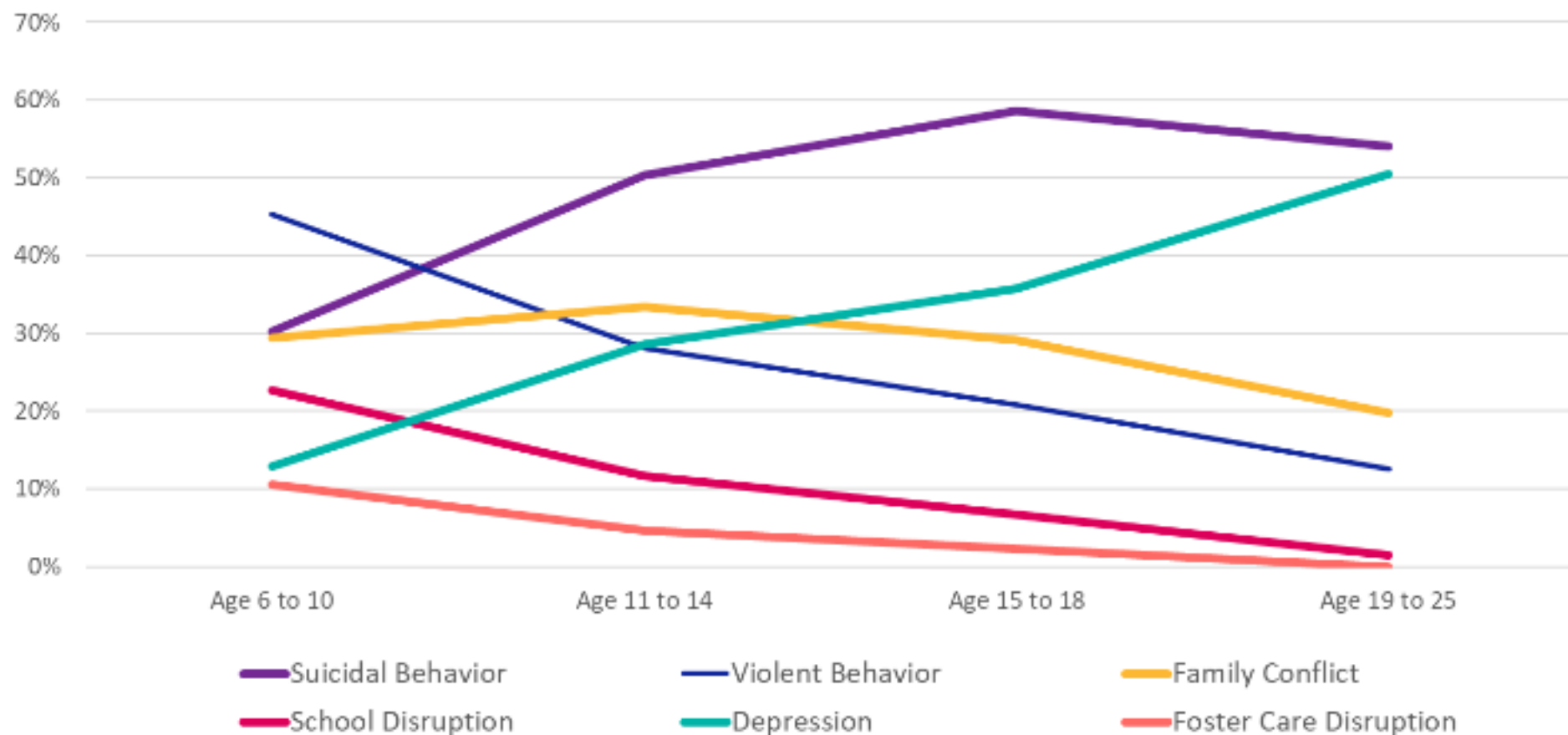Total Calls = 19,493

Mobile Response by Time of Day

0   247

Youth Crisis
MOBILE RESPONSE

Total Calls = 19,493

Time

Midnight
2am
4am
6am
8am
10am
Noon
2pm
4pm
6pm
8pm
10pm
Midnight

S M T W T F S

Day
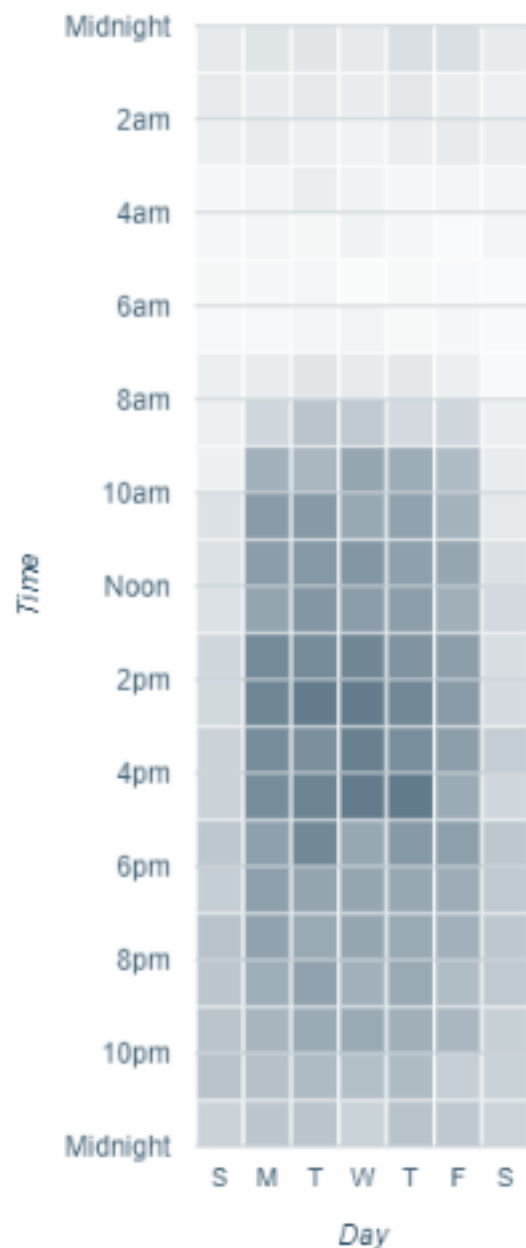
Reasons for Crisis Calls by Age Group

80% of children, youth, and young adults were diverted from a change in placement/living environment.

Jan 2019 – Jan 2022
Total Calls = 19,493

Youth Crisis
MOBILE RESPONSE

- **Community Supports**
    - Trainings
    - Telehealth (iPads)
    - Community Partnerships

Community Crisis Support

Youth Crisis
MOBILE RESPONSE

89% of students at risk of school disruption returned to class.

Jan 2019 – Jan 2022
Total Calls = 19,493

Youth Crisis
MOBILE RESPONSE

LESSONS LEARNED:
PRE AND POST PANDEMIC

- Cost
- Mental Health Stigma
- Access (URCs, CCBHC Walk in Clinics)
- Emergency Rooms (Special Staffing's)
- Specialized Supports (ID/DD, Transition age, Homeless)
- Importance of Caregiver Support
- Workforce
- Technology
- Rural and Frontier

CONTRIBUTORS

Carrie Slatton-Hodges, Deputy Commissioner of Mental Health
Chodges@odmhsas.org
405-522-3878

Wendy Larsen, Director of Program Enhancement
wlarsen@odmhsas.org
405-522-6765

Mark A. Reynolds, Director of Decision Support Services
mareynolds@odmhsas.org
405-522-3824

Geneva Strech, Associate Director, OU E-TEAM
strech@ou.edu
(405) 325-4132

SHEAMEKAH WILLIAMS
DIRECTOR OF CHILDREN, YOUTH, AND FAMILY SERVICES

OKLAHOMA
Mental Health &
Substance Abuse

SXWILLIAMS@ODMHSAS.ORG

HTTPS://OKLAHOMA.GOV/ODMHSAS.HTML