A Success in the Making—Oklahoma's Journey to Reconfiguration

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The MH Services Environment

- An advocates' perspective
- State MH agency viewed skeptically
- Little coordination
- Little innovation
- Recent managed care transition for Medicaid
- System had "haves" and "have nots"

Dynamics for Change

- Strong direction from the Governor's Office
- Real share of state revenue dollar declining
- Significant resource consumption by state owned psychiatric hospitals
- Negative perception of department's capacity to serve

The Change Process

- Enabling legislation
- Establishment of a constituent advisory committee
- Mandate to significantly downsize one of two remaining state hospitals
- Money could only be reallocated; no new resources could be expected

Principles for Mandated Transition

- Each CMHC in area responsible for all care for persons with serious mental illness (SMI)
- Persons with SMI to be treated in local communities
- Equitable funding for CMHCs in area

Mandates - continued

- No treatment to be interrupted and no one prematurely discharged from downsizing hospital
- Hospital staffing to continue at adequate staffing levels throughout transition
- Funding that becomes available as result of transition to be reinvested in community-based services in the area

State Strategies to Accomplish Mandates

- Objective Analyses and Planning with Stakeholders
- Inpatient Hospital Capacity
- Investments in Preferred & Evidence-Based Practices
- Partnership Opportunities with Medicaid
- Data
- Monitoring and Technical Assistance

Objective Analyses and Planning with Stakeholders

- Assessment of current community-based services – gaps and pockets of excellence
- Clarified best practices needed for successful transition – analyzed service areas' capacities
- Developed funding model based on historical service utilization for targeted persons affected
- Estimated one-time transition costs
- Proposed Implementation Plan
- Use of Center for Extended Psychiatric Care (CEPC)

Clarified best practices needed for successful transition

- Aggressive crisis intervention systems
- Varying types and intensities of case management
- Residential services and supportive housing
- Expanded vocational services
- Viable consumer-run services
- Adequate local inpatient capacities

Analysis for Funding Model

- All non-forensic clients admitted for FY99
  - –Lengths of stay; episodes of care; diagnostic classifications
- Projected array of services by major diagnostic categories
- Cost projections based on services needed

Funding continued

- Partnered with Medicaid to validate cost and service utilization assumptions
- Developed equitable funding formula based on number of adults with SMI expected to be served by each CMHC
- Identified one-time costs

Inpatient Hospital Capacity

- Focus on developing community-based beds; initial reliance on private market
- Established purchasing and cost-reimbursement systems to enable each CMHC to be at full risk for inpatient services

Investment in Preferred Practices

- State resources ramped up/realigned to support essential & preferred practices
  - Community-Based Crisis Centers
  - Inpatient Treatment
  - Mobile Outreach and Crisis Services
  - Housing Services
  - Vocational Services
  - Clubhouse or Psychosocial (Day) programs
  - Basic Services
  - Peer & Family Support
  - Pharmacological Management
  - Strengths-Based Case Management

Increased focus on Evidence-Based Practices

- PACT
- System of Care
- Pharmacological management

Partnerships with Medicaid

- Close review of existing clients for Medicaid eligibility
- Working groups to steer through process
- Concept for system model began to develop as a long-term objective

Using the Data to Drive the Decision

- Sound use of historical data
- Presentations based on stakeholder inquiries and in formats preferred by readers
- Continual education in interpretations and assumptions
- Partner with other data holders
- Near “real time” reporting to track changes
- Performance improvement strategies to reverse undesired trends

Monitoring and Technical Assistance

- Access to Crisis Services & Inpatient Care
- Follow-up subsequent to higher levels of care
- Use of newer generation medications
- Minimum Service Thresholds Plan

Lessons Learned

- The private community responds slowly to developing bed capacity
- Saving one dollar in the hospital downsizing doesn't initially translate into a dollar's investment in the community

Lessons . . . continued

- State must invest in infrastructure to provide monitoring and technical assistance
- Community partners are essential
- Seize opportunities to combat stigma and advocate for evidence-based practices

More Lessons

- Plans need to be fluid and able to change based on emerging dynamics
- Leadership at all levels (advocates, Legislative, Executive, and the Authority) must develop common objectives and operating principles

Lessons . . . continued

- Continue existing safety nets until new systems are adequately available
- Define success quantitatively as well as qualitatively
- Use change mandate as opportunity to move the system forward

Continuing the Journey

- Leadership & Reorganization
- Strategic Plan
- Reclaiming the "Authority"
- Themes for continuing the journey

Themes . . . Evidence of a Journey

FY2002

- Promotion of Evidence-based practices

FY2003

- Uniform Standards to Support Early Identification of Mental Illness and Access to Care

FY2004

- Recovery-Focused Services

FY2005

- Expanded Service System Capacity
- Cultural Competencies

Where the Journey Is Taking (Has Taken) Us* . . .

- Recovery focused
- Consumer driven
- Committed to providing evidence-based and the highest quality of care
- Integrated in terms of policies, procedures, systems
- Organized to assure better outcomes for persons served
- Accessible with a no-wrong-door-approach
- Efficient to maximize the use of limited resources

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