CRISIS CONTINUUM OF CARE:

A Strategic Olmstead Plan for the Provision of Behavioral Health Crisis Services and Other Olmstead Responsive Services in Oklahoma

Effective November 15, 2024

TABLE OF CONTENTS

EXECUTIVE SUMMARY 1

BACKGROUND 3

What is ODMHSAS? 3

What is *Olmstead*? 5

What is an Olmstead Plan? 6

What is the history of Oklahoma's development of an Olmstead Plan? 7

What is meant by the term "Behavioral Health"? 7

What is a Behavioral Health Crisis System? 8

What is a Crisis Continuum of Care and why is the Continuum important to the mission of ODMHSAS? 8

What is the Sequential Intercept Model and why is it important to ODMHSAS? 11

How has ODMHSAS implemented the State's 2006 Olmstead Plan as it relates to the provision of behavioral health crisis services? 13

Why is OMDHSAS updating the State's Olmstead Plan as it relates to Behavioral Health Crisis Services and Other Olmstead Responsive Services? 17

OVERVIEW OF PRIORITY AREAS 21

PRIORITY AREA #1: 988 HELPLINE, MOBILE CRISIS TEAMS, AND CRISIS TRANSPORTATION 23

Divert and transition individuals experiencing a behavioral health crisis from arrest and other encounters with the criminal justice system to appropriate behavioral health services where appropriate and consistent with public safety. ***23***

Why is this a Priority Area? 23

What progress has ODMHSAS made as it relates to Priority Area #1 and what challenges does it face? 24

What is ODMHSAS' action plan related to Priority Area #1? 28

Objective 1.1: Maintain a 988 in-state call answer rate of 90%, with a continued wide variation of reasons for calling, including crisis and care coordination. 28

Objective 1.2: Increase the number of PSAPs using 988 transfer protocols by 100% in the first year. 28

Objective 1.3: Expand use of mobile crisis teams, which currently prioritize urgent/immediate responses to crisis situations, to include non-acute mobile response options for individuals who would like a scheduled on-site connection with a treatment provider within the client's preferred timeline. 28

Objective 1.4: Develop workforce strategies for call center and crisis line training in partnership with vendors to support the number of trained individuals needed to maintain this service as well as ensuring high quality interactions with callers. 29

Objective 1.5: Increase State 911 PSAPs who receive behavioral health training by connecting them with training opportunities. 29

Objective 1.6: Increase coordination between 988 and 911 PSAPs by partnering with State leadership to fund a position which works within the 911 Management Authority. 29

Objective 1.7: Evaluate mobile crisis demand and response time per region quarterly to determine the need for additional mobile team investments. 29

Objective 1.8: Review data to formulate a plan in connection with the Care Coordination Team to connect with individuals who call 988 most frequently. 29

What strategic KPIs will ODMHSAS use to evaluate progress related to Priority Area #1? 29

PRIORITY AREA #2: LAW ENFORCEMENT PARTNERSHIPS 30

Provide law enforcement officers who may be the first responders to a behavioral health crisis with appropriate training and support (including CIT training) to use best practices and improve outcomes. 30

Why is this a Priority Area? 30

What progress has ODMHSAS made as it relates to Priority Area #2 and what challenges does it face? 31

What is ODMHSAS' action plan related to Priority Area #2? 32

Objective 2.1: Establish statewide regional CIT training hubs which provide local CIT training as needed to the community's law enforcement agencies to maintain at least 25% of the State's law enforcement workforce being CIT trained. 32

Objective 2.2: Provide an annual education for law enforcement on "person requiring treatment" criteria. 32

Objective 2.3: Survey police chiefs through the state association annually to inform decisions about continued or new training and support needs and receive feedback from law enforcement agencies on cultural assessments as to community awareness of available services, access to care, and the effectiveness of partnerships. 32

Objective 2.4: Update the eLearning library of CLEET trainings to ensure that content is up to date and reflective of current statutes and treatment resources. 33

Objective 2.5: Provide education and information to all criminal justice partners on level of care, access to care, and local resources for treatment needs. 33

Objective 2.6: Publish a decision tree to support the coordination between law enforcement and mobile crisis teams that balances safety and least restrictive environment in situations which may require either a co-response or local law enforcement first assuring safety prior to a mobile team responding. 33

Objective 2.7: Publish standardized call tree formats for treatment agencies answering law enforcement tablet calls to support consistency in answering processes. 33

What strategic KPIs will ODMHSAS use to evaluate progress related to Priority Area #2? 33

PRIORITY AREA #3: COMMUNITY-BASED CRISIS CENTERS 34

Divert individuals experiencing a behavioral health crisis from inpatient hospitalization and emergency departments when appropriate by using outpatient and community-based interventions. 34

Why is this a Priority Area? 34

What progress has ODMHSAS made as it relates to Priority Area #3 and what challenges does it face? 35

What is ODMHSAS' action plan related to Priority Area #3? 36

Objective 3.1: Increase the percentage of Oklahomans who have access to 24/7 facility-based treatment services within their county of residence to at least 70% and supplement availability with services in adjacent counties where necessary. 36

Objective 3.2: Ensure that each individual discharged from any URC or CSU will be discharged by way of a warm hand-off to a service provider whenever possible and will receive a written discharge plan that, at a minimum, includes at least one post-discharge follow-up call and identifies available community-based resources and contacts for follow-ups with a provider of choice by reviewing current rules and policies for all URCs and CSUs for discharge planning processes and establishing monitoring procedures. 36

Objective 3.3: Review ETPS data and Medicaid claims data related to individuals not connecting with outpatient services after discharge and identify opportunities to enhance connectivity across the system at appropriate levels of service. 36

Objective 3.4: Conduct continuous quality improvement (CQI) reviews of readmissions to state-operated URCs and CSUs within 30 days to establish a baseline and benchmark provider performance of existing centers as to the root cause(s) of such readmissions. Use this data to assess whether additional strategies around length of stay and/or community supports can be provided to reduce the risk of readmission. Set a readmission benchmark goal, if determined appropriate. 36

Objective 3.5: Explore opportunities for third-party insurance coverage for crisis care to reduce dependence on State and Medicaid funding and expand the reach of available facility-based crisis resources. 36

Objective 3.6: Develop statewide admission and exclusionary criteria to ensure that facilities operate as 'no wrong door' options for crisis care, with exclusionary criteria reflecting medical emergency situations which cannot be cared for safely in the URC or CSU setting. 36

Objective 3.7: Create standardized outcomes metrics for URCs and CSUs which include community stabilization rates, law enforcement utilization, medical clearance requests, direct admissions to crisis centers, etc., to support system evaluation and improvement. 36

Objective 3.8: Present to hospitals, the Oklahoma Hospital Association, and CCBHCs a model of URC co-location in medical facilities such as emergency rooms to support rural access expansion as a cost-effective, sustainable model. 37

Objective 3.9: Pursue the renewal of Oklahoma's IMD waiver to continue Medicaid reimbursement for community-based crisis facilities that have a capacity exceeding sixteen (16) beds. 37

What strategic KPIs will ODMHSAS use to evaluate progress related to Priority Area #3? 37

PRIORITY AREA #4: INPATIENT HOSPITALS 38

Continue to improve the processes by which the State diverts or transitions individuals from inpatient treatment for behavioral health services to community-based settings. 38

Why is this a Priority Area? 38

What progress has ODMHSAS made as it relates to Priority Area #4 and what challenges does it face? 39

What is ODMHSAS' action plan related to Priority Area #4? 41

Objective 4.1: Ensure that each individual discharged from an inpatient stay at any state-operated facility will be discharged by way of a warm hand-off to a service provider whenever possible and will receive a written discharge plan that, at a

minimum, identifies available community-based resources and contacts for follow-ups with a provider of choice by reviewing and updating policies and procedures and monitoring performance. 41

Objective 4.2: Provide annual discharge planning training for all state-operated facilities that focuses on CMS and SAMHSA-supported discharge resource strategies, including social determinants of health. 41

Objective 4.3: Provide intensive discharge planning by a facility-based discharge planning evaluation committee for any individual who has an inpatient stay longer than 30 days at any state-operated facility. 41

Objective 4.4: Provide intensive discharge planning by a central office care coordination team, and managed care organization care management teams for Medicaid members, with the authority to consult outside clinical resources where appropriate, for any individual who has an inpatient stay longer than 90 days at any state-operated facility. 41

Objective 4.5: Conduct continuous quality improvement (CQI) reviews of readmissions to state-operated inpatient hospitals within 30 days to establish a baseline as to the root cause(s) of such readmissions. Use this data to assess whether additional strategies around length of stay and/or community supports can be provided to reduce the risk of readmission. Set a readmission benchmark goal, if determined appropriate. 41

Objective 4.6: Open new inpatient hospitals in Oklahoma City and Tulsa by December 31, 2026. These hospitals will expand ODMHSAS' psychiatric bed capacity and operational reach as well as include URCs to ensure patients can receive immediate access to vital services, including walk-in availability to stabilization services designed to divert patients from inpatient treatment where appropriate. 41

Objective 4.7: Review the data to determine opportunities for expanded use of telehealth to increase care within state-operated hospitals as well as discharge support transitions. 42

Objective 4.8: Standardize operations across state-operated hospitals where appropriate and based on the population served. 42

What strategic KPIs will ODMHSAS use to evaluate progress related to Priority Area #4? 42

PRIORITY AREA #5: COMMUNITY-BASED CARE 43

Expand access to and the quality of community-based supports and other wrap-around services by a high-quality network of providers that

allow individuals to receive outpatient services within their local community. ***43***

Why is this a Priority Area? **43**

What progress has ODMHSAS made as it relates to Priority Area #5 and what challenges does it face? **44**

What is ODMHSAS' action plan related to Priority Area #5? **45**

Objective 5.1: Develop, in partnership with private practitioners and inpatient hospitals, a set of recommended protocols for crisis flow and connection to ongoing services that ensures, among other things, that high acuity patients have access to specialized crisis services and evaluates instances in which patients are taken directly to emergency departments or inpatient hospitals instead of URCs and crisis centers. 45

Objective 5.2: Explore opportunities and new models that will expand reimbursement for medical services within CCBHCs. 45

Objective 5.3: Provide a regular schedule of continuing medical education training opportunities to enhance psychiatric training for medical staff. 45

Objective 5.4: Review ETPS measures for opportunities to strengthen performance by raising benchmarks where appropriate. 45

Objective 5.5: Leverage the Medicaid managed care organizations to identify and stratify individuals in need of intensive care coordination and outpatient services to ensure successful transition to the community and prevent readmissions. 45

Objective 5.6: Leverage the statewide Health Information Exchange (HIE) to create real-time notifications to CCBHCs when their clients are admitted to and/or discharged from private ERs and hospitals. 46

Objective 5.7: Create and publish a guide of statewide resources available to providers and clients dealing with transportation or other barriers to accessing outpatient services prior to being connected with telehealth resources. 46

Objective 5.8: Continuously review interventions used for treatment of first episode psychosis for new evidence-based strategies. 46

Objective 5.9: Monitor CCBHCs to ensure they have made good faith efforts to establish partnerships with all psychiatric inpatient hospitals and emergency departments in their catchment areas to provide diversion from higher levels of care and discharge support. 46

Objective 5.10: Review data from recent CCBHC visits to establish minimum score standards for CCHBCs on fidelity reviews. Develop protocols for corrective measures to include plans of correction, provisional certifications, and certification revocation. 46

What strategic KPIs will ODMHSAS use to evaluate progress related to Priority Area #5? **46**

PRIORITY AREA #6: HOUSING SUPPORTS **47**

Expand access to housing supports and services designed to assist individuals being served to live in the most integrated and least restrictive setting of their choice that is appropriate to their needs. ***47***

Why is this a Priority Area? **47**

What progress has ODMHSAS made as it relates to Priority Area #6 and what challenges does it face? **48**

What is ODMHSAS' action plan related to Priority Area #6? **49**

Objective 6.1: Improve documentation and data collection on the use of housing Flex Funds to better understand how they can make the most impact for those with behavioral health treatment needs. 49

Objective 6.2: Expand contracts with housing providers around supported and transitional living programs. 49

Objective 6.3: Implement a pilot program with a community partner to create a master leasing arrangement. 49

Objective 6.4: Increase housing-specific flexible funding opportunities to providers from $750,000 annually to $1 million annually. 50

Objective 6.5: Facilitate an initial housing conversation between ODMHSAS staff and Oklahoma Housing Finance Authority (OHFA) regarding the potential for partnerships. 50

Objective 6.6: Facilitate local partnership development and strengthening between Norman and Oklahoma City public housing authorities with project-based vouchers and relevant CCHBC partners. 50

Objective 6.7: Explore the potential for new housing-related opportunities under Medicaid with the ODMHSAS Director of Medicaid Behavioral Health Policy and OHCA, including without limitation opportunities under Section 1115 and Section 1915(i), to fund certain housing supports for those leaving hospitals and crisis facilities. 50

Objective 6.8: Review other recommendations and develop a plan to implement appropriate strategies included in the TAC housing consultation report. 50

What strategic KPIs will ODMHSAS use to evaluate progress related to Priority Area #6? **50**

PRIORITY AREA #7: RECOVERY SUPPORTS AND SERVICES 51

Expand access to recovery supports and services designed to support community integration and that may prevent, or reduce the severity of, a behavioral health crisis and facilitate recovery. *51*

Why is this a Priority Area? **51**

What progress has ODMHSAS made as it relates to Priority Area #7 and what challenges does it face? **52**

What is ODMHSAS' action plan related to Priority Area #7? **53**

Objective 7.1: Augment existing IPS services to implement a continuum of employment support strategies through ODMHSAS contractors, such as workshops, mock interviews, assistance with building resumes, and other job-related skills by strengthening the peer and case management workforce use in employment support tools and interventions. 53

Objective 7.2: Require CCBHCs to demonstrate they have made good faith efforts to establish partnerships with all shelters in their catchment areas to provide access to services. 53

Objective 7.3: Develop and expand a continuum of intensive community-based supports (to include peer recovery support services, PACT, critical time intervention, and the Clubhouse model) to support engagement with high-need individuals. 53

What strategic KPIs will ODMHSAS use to evaluate progress related to Priority Area #7? **53**

PRIORITY AREA #8: COMMUNITY EDUCATION AND OUTREACH 54

Identify and expand opportunities to raise public awareness of mental health and wellness issues, provide education about available community-based resources, and reduce stigma toward help-seeking. *54*

Why is this a Priority Area? **54**

What progress has ODMHSAS made as it relates to Priority Area #8 and what challenges does it face? **54**

What is ODMHSAS' action plan related to Priority Area #8? **54**

Objective 8.1: Increase the number of business sectors developing policies and practices to train supervisors on Mental Health First Aid (MHFA) so they can assist employees experiencing a behavioral health crisis. 54

Objective 8.2: Provide a regular schedule of crisis services training to enhance the knowledge of crisis best practices for the public and private provider network. 55

Objective 8.3: Implement three (3) workforce development strategies annually to support expansion of services across all levels. Strategies may include increased resources or contractual, administrative rule, or statutory amendments which allow expansion of state behavioral health workforce or improved workforce efficiencies. 55

Objective 8.4: Measure baseline and create role-specific marketing strategies to increase the number of behavioral health professionals in the field. 55

Objective 8.5: Review and expand opportunities for ODMHSAS to receive concerns or complaints directly from service recipients for each of the priority areas. 55

Objective 8.6: Provide a regular schedule of legal and ethics trainings to stakeholders beyond law enforcement, including at least one annual training on "person requiring treatment" criteria. 55

Objective 8.7: Review opportunities to increase public awareness and perception of service availability in their communities, driven by data identified in response to Priority Area #9. 55

Objective 8.8: Provide statewide training opportunities which target behavioral health providers, medical professionals, and preventionists to educate the field on Zero Suicide best practices and expand the use of Zero Suicide care pathways in behavioral health and medical treatment settings. 55

Objective 8.9: Provided targeted workforce trainings to support peer roles in crisis services. 55

What strategic KPIs will ODMHSAS use to evaluate progress related to Priority Area #8? **55**

PRIORITY AREA #9: DATA MANAGEMENT **56**

Continuously improve data collection, management, and reporting systems to develop an aggregate understanding of overall utilization patterns to drive decision-making regarding system investment, service delivery, and other policies. ***56***

Why is this a Priority Area? **56**

What progress has ODMHSAS made as it relates to Priority Area #9 and what challenges does it face? **56**

What is ODMHSAS' action plan related to Priority Area #9? **57**

Objective 9.1: Annually review data reports to identify gaps with specific adult populations which are least likely to connect to outpatient services after receiving higher level of care. This includes, but is not limited to, evaluation of individuals

discharging from inpatient settings and whether they connect to outpatient care by diagnosis, age, and gender. 57

Objective 9.2: Create and regularly review a data dashboard for each of the priority areas to review key performance indicators. Evaluate which, if any, of these dashboards should be made publicly available. 57

Objective 9.3: Partner with OHCA to evaluate the use of SoonerRide benefits for those with behavioral health treatment needs to determine opportunities for increased access to services through existing resources. 57

Objective 9.4: Review data sharing opportunities annually for updates and to determine if any additional agreements are needed. 57

Objective 9.5: Continue to conduct formal service gap analysis annually to support resource investment planning, including analysis of populations not accessing treatment resources. 57

Objective 9.6: Launch a new electronic health record (EHR) system across all State-operated facilities. 57

Objective 9.7: Obtain expert consultation to guide development of a data-based-performance-improvement (CQI) strategy and process for ongoing assessment and improvement of the crisis continuum, including recommendations published from the National Council for Mental Wellbeing whitepaper *Quality Measurement in Crisis Services*. 57

Objective 9.8: Support, train, and fully enforce new opportunities to improve coordination of care through data sharing. This includes but is not limited to the development of a new statewide, ODMHSAS-endorsed consent template provided to state-operated and private treatment facilities. 57

What strategic KPIs will ODMHSAS use to evaluate progress related to Priority Area # 9? 59

CONCLUSION 60

ACKNOWLEDGEMENTS 61

OKLAHOMA'S CRISIS CONTINUUM OF CARE:

A Strategic Olmstead Plan for the Provision of Behavioral Health Crisis Services and Other Olmstead Responsive Services

EXECUTIVE SUMMARY

Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS or the Department) is committed to adopting and implementing national best practices and providing leadership in transforming behavioral health crisis services in the State of Oklahoma in alignment with its obligation to meet the requirements of *Olmstead*.

Since it originally adopted its Olmstead Plan in 2006, Oklahoma has been a leader in several national initiatives involving the provision of behavioral health crisis services designed to enhance service quality and availability, maximize resources, and allow Oklahomans to receive services in the most integrated and least restrictive setting appropriate:

- In 2008, recognizing that its volume-based fee-for-service reimbursement system was not achieving desired outcomes and faced with budgetary challenges, ODMHSAS created a payment system based on outcomes for meeting certain established quality-of-care targets. This performance outcomes payment plan (the Enhanced Tier Payment System) improved access to services, follow up, and engagement, as providers were paid for the services that everyone agreed were most important. Improving access to services, follow-up, and engagement are key strategies to achieving *Olmstead* requirements for integrated care in the community. Oklahoma's system was considered innovative and a model for how other state mental health authorities could address mutual goals by promoting health improvement and aligning financial incentives to pay for outcomes, not simply based on the volume of service provided.[1]

- Oklahoma was an early adopter of the Certified Community Behavioral Health Clinic (CCBHC) model for the provision of behavioral health crisis services, participating in original U.S. Department of Health and Human Services (HHS) demonstration project beginning in 2016. The CCBHC model helps individuals with behavioral health

[1] Suzanne Fields and Kelly English, "The Oklahoma Enhanced Tier Payment System: Leveraging Medicaid to Improve Mental Health Provider Performance & Outcomes" (Alexandria, VA: National Association of State Mental Health Program Directors, 2011) (https://www.tacinc.org/resource/the-oklahoma-enhanced-tier-payment-system-leveraging-medicaid-to-improve-mental-health-provider-performance-outcomes/), at 14.

disabilities live and work in their local communities consistent with *Olmstead* requirements. It is designed to significantly increase the comprehensiveness of community-based services and reduce higher level of care stays.

- In December 2020, through the collective efforts of the Oklahoma Health Care Authority (OHCA) and ODMHSAS, Oklahoma was granted a Section 1115 demonstration waiver of the Institutions for Mental Diseases (IMD) exclusion (the IMD Waiver) by the Centers for Medicare & Medicaid Services (CMS), which permitted Oklahoma to receive Medicaid reimbursement for certain services provided to Oklahomans suffering from severe mental illness (SMI). Some of the overarching goals Oklahoma sought for the SMI population through the IMD Waiver included: reduced utilization of emergency departments for beneficiaries with SMI awaiting mental health treatment; reduced preventable readmissions to acute care hospitals; improved availability of crisis stabilization services and community-based services; and improved care coordination. These goals are in alignment with *Olmstead* principles.

- Oklahoma was an early adopter of the 988 Crisis Line, launching a statewide 988 network in partnership with Solari Crisis & Human Services (Solari), with back up call centers for overflow needs and supported by statewide mobile crisis teams, in July 2022. The aim of the 988 Crisis Line and the mobile crisis teams is to divert individuals from unnecessary encounters with law enforcement and inpatient hospitalizations when appropriate and consistent with public safety and to avoid unnecessary institutionalization.

- Oklahoma has been a national leader in developing and expanding behavioral health crisis services into rural communities via ODMHSAS service focus and legislative enactments, including through the creation and expansion of a statewide network of CCBHCs, transportation initiatives, and distribution of iPads to provide telehealth options to those in need of services, as well as providers, law enforcement, and other first responders. The Crime and Justice Institute (CJI) has recognized and lauded Oklahoma's effort "as a key example of how a change in statutory requirements can shift some crisis response responsibilities away from law enforcement agencies and build alternate response programs' capacity to perform necessary duties."[2]

---

[2] Andrea Tyree and Lauren Leonard, "Behavioral Health Crisis Response Landscape Analysis." (Boston, MA: Criminal Justice Institute, 2024) (https://www.cjinstitute.org/assets/sites/2/2024/05/AV-Crisis-Response-Report.pdf), at 12 [hereinafter "CJI Analysis"].

As Oklahoma continues to build and expand its crisis continuum of care, this is an important time to revisit and update Oklahoma's 2006 Olmstead Plan in the context of these recent and ongoing transformative expansions which have substantially advanced *Olmstead's* intent and in which Oklahoma is not only participating but emerging as a national leader. The nation as a whole is undergoing an unprecedented expansion in crisis services, catalyzed by the 988 Crisis Line and increased awareness and funding availability. Additionally, in November 2022, the United States Department of Justice (DOJ) announced that it was opening an investigation into how the State and local agencies in Oklahoma County, including the Oklahoma City Police Department, respond to people experiencing a behavioral health crisis and whether a lack of community-based mental health services leads to unnecessary police contact and/or inpatient hospitalization.[3] In 2024, Allie Freisen was appointed and confirmed as the new commissioner for ODMHSAS. Commissioner Friesen, who has a background in private sector healthcare with a focus on behavioral health, recognizes the need for transformative solutions and smart growth within the behavioral health field.

In the context of these developments, ODMHSAS has undertaken a critical review of its behavioral health crisis system and, in particular, how the State provides crisis services as well as additional responsive services and recovery supports. The result of that review is this document: "A Strategic Olmstead Plan for the Provision of Behavioral Health Crisis Services and Other Olmstead Responsive Services in Oklahoma" (the Plan). This Plan identifies nine (9) Priority Areas related to Oklahoma's continued development and expansion of its behavioral health crisis continuum and the provision of other recovery support services to help as many Oklahomans as possible. Crisis services are designed to prevent unnecessary police contacts and inpatient hospitalization by providing 24/7 access to services designed to allow individuals to be stabilized and treated in the least restrictive setting appropriate.

BACKGROUND

What is ODMHSAS?

ODMHSAS is the state agency responsible for oversight of prevention, treatment and recovery services for mental illness, substance abuse and addictive disorders in the State of Oklahoma.

[3] *See* "Justice Department Launches Investigation of Oklahoma's Mental Health Service System and Oklahoma City's and Oklahoma Police Department's Response to Mental Health Crises" (DOJ Press Release dated Nov. 17, 2022) (https://www.justice.gov/opa/pr/justice-department-launches-investigation-oklahoma-s-mental-health-service-system-and). The State, including OMDHSAS and OHCA, are cooperating in the investigation, through coordinating facility tours, providing documents, and making staff and leadership available for interviews.

The mission of ODMHSAS is to promote healthy communities and provide the highest quality care to enhance the well-being of all Oklahomans.

ODMHSAS, along with its many active partnerships, is dedicated to excellence in behavioral health services to promote quality of life, safety and well-being for the people of Oklahoma.

The vision of ODMHSAS is to provide services that promote productive lifestyles and set the national standard for prevention, treatment, and recovery for those impacted by mental illnesses and substance use disorders, helping restore overall well-being to communities and families.

The Department values consumer choice, hope, family involvement and the belief in human potential. ODMHSAS serves as the State's safety net mental health and substance use treatment services system. ODMHSAS provides services for both adults and children.[4]

One of the Department's core missions is to provide prevention and treatment services for Oklahomans who are indigent and without a means to pay. Because of limited resources, services are primarily targeted to address the needs of the most seriously ill, including persons who experience ongoing, persistent medical issues associated with mental illness or addiction and persons who are in crisis or have been found to be a danger to self or others.

Treatment services include inpatient hospital and outpatient community-based mental health treatment services, forensic services, supportive housing, residential treatment and outpatient services to address substance use dependence and addiction, in addition to targeted services designed to address the needs of high-risk populations, criminal justice diversion initiatives, and efforts to address other priority concerns.

ODMHSAS provides prevention services at the State and local levels, in partnership with area health providers, schools, law enforcement, veterans groups and other community stakeholders. ODMHSAS manages the State's behavioral health Medicaid services and has statutory responsibility for rulemaking and oversight of certification processes for approximately 3,300 treatment providers, organizations and individuals throughout the State.

[4] The primary focus of this Plan is the adult population in Oklahoma.

What is *Olmstead*?

Olmstead is the name of a landmark Supreme Court ruling that applied Title II of the Americans with Disabilities Act (ADA) to institutionalized persons, including those suffering from SMI.[5]

The ADA was passed into law in 1990 to "provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." Title II prohibits state and local governments from discriminating against people with disabilities in the provision or administration of public services and programs. Specifically, the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of services, programs, or activities of a public entity, or be subjected to discrimination by any such entity."[6]

After its passage, Congress authorized DOJ to issue new regulations to implement the ADA. To effectuate the ADA's prohibition against segregating disabled persons, DOJ issued a regulation stating that: "[a] public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."[7] This DOJ rule became known as the "integration mandate."

The *Olmstead* case addressed the integration mandate in the context of persons institutionalized for mental illness. The facts in *Olmstead* were straight-forward. Two adult women had been voluntarily hospitalized in a Georgia state hospital for mental illness. After a period of treatment and stabilization, the treating doctors determined that these two individuals did not need to remain at the hospital and instead could be appropriately cared for in a community-based program. Despite this determination, both women were kept in the state hospital for more than a year, which prompted them to sue the state.

In reliance on DOJ's integration mandate, the Supreme Court ruled that states are required to provide community-based treatment for persons with mental illness when three (3) conditions are met: (1) the state's treatment professionals have determined that such community-based placement is appropriate; (2) the persons affected do not oppose the community-based placement; and (3) the community-based placement can be reasonably accommodated, while taking into account the state's resources as well as the needs of other persons with disabilities.

In announcing its ruling, the Supreme Court also recognized several important limitations on states' obligations. First, "nothing in the ADA or its implementing regulations condones termination

---

[5] Olmstead v. L.C. ex rel. Zimring, 527 U.S. 581 (1999).

[6] 42 U.S.C. § 12132.

[7] 28 C.F.R. § 35.130(d)

of institutional settings for persons unable to handle or benefit from community settings." Second, community-based treatment cannot be forced on patients who do not want it. Third, the ADA does not require states to phase out institutions, and indeed, the Court recognized that for some persons "placement outside the institution may never be appropriate." Further, other individuals (like the plaintiffs in the *Olmstead* case) may be able to handle or benefit from community-based placement for periods of time but may still need institutional treatment from time to time in order to stabilize acute psychiatric symptoms that may arise. Finally, the Court noted that nothing in the ADA requires states to "fundamentally alter" their mental health system, and a state satisfies its obligation under Title II's integration mandate provided it can demonstrate that it has "a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that move[s] at a reasonable pace. . .."[8]

What is an Olmstead Plan?

Drawing upon the language of the Supreme Court's decision in *Olmstead*, many states have developed plans designed to meet the objectives of Title II's integration mandate (i.e., "a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings").

According to DOJ, "[a]n Olmstead plan is a public entity's plan for implementing its obligation to provide individuals with disabilities opportunities to live, work, and be served in integrated settings. A comprehensive, effectively working plan must do more than provide vague assurances of future integrated options or describe the entity's general history of increased funding for community services and decreased institutional populations. Instead, it must reflect an analysis of the extent to which the public entity is providing services in the most integrated setting and must contain concrete and reliable commitments to expand integrated opportunities."[9]

In a webinar developed pursuant to a contract with SAMHSA, Kevin Martone, Executive Director of the Technical Assistance Collaborative, Inc. (TAC), stated that an Olmstead Plan should be "comprehensive but realistic," "actionable and achievable."[10]

---

[8] Olmstead, 527 U.S. at 583-84.

[9] *See* U.S. Dept. of Justice, "Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.*" (https://archive.ada.gov/olmstead/q&a_olmstead.htm).

[10] A copy of this presentation is available at the following site: https://www.nasmhpd.org/sites/default/files/Olmstead%20Planning%20Draft_Final.pdf.

What is the history of Oklahoma's development of an Olmstead Plan?

Oklahoma Senate Bill 1512 was enacted on May 30, 2002, establishing the Oklahoma Olmstead Strategic Planning Committee (the Committee), which was formed to look across service categories and implement the *Olmstead* decision in Oklahoma. Senate Bill 1015 (2005) enacted 56 Okla. Stat. § 198.11b, which instructed the Committee to "monitor the implementation of the comprehensive, strategic plan for the State of Oklahoma regarding the Olmstead Decision."

The Committee was tasked with drafting a plan to be submitted to the Legislature and the Governor to outline strategies to ensure that persons with disabilities are being provided with the services and supports necessary to move out of institutional settings, if they so desire. On August 3, 2006, the Committee released the "Oklahoma Olmstead Strategic Plan" (the Olmstead Plan).[11]

The Olmstead Plan adopted by the State in 2006 was intended to be a comprehensive, statewide plan to meet the objectives of Title II's integration mandate, consistent with the Supreme Court's *Olmstead* decision. ODMHSAS had subject matter expertise and regulatory responsibility over some areas of the Olmstead Plan adopted by the State in 2006, specifically as it related to services provided to Oklahomans with SMI who may suffer a behavioral health crisis. The plan identified service funding needs to provide, among other things, home and community-based services and other support services.

What is meant by the term "Behavioral Health"?

In its March 2021 "Roadmap to the Ideal Crisis System" published by the National Council for Mental Wellbeing, the Committee on Psychiatry and the Community for Group for Advancement of Psychiatry (the GAP Committee) defined behavioral health as "a term of convenience that refers to both mental illnesses and mental health needs (e.g., trauma) and substance use/addictive disorders and substance use needs and issues, as well as to the overlap of those behavioral health issues into primary health, cognitive disabilities, criminal justice, child welfare, schools, housing and employment, and to prevention, early intervention, treatment and recovery."[12]

---

[11] A copy of Oklahoma's 2006 Olmstead Plan is available at the following link: https://digitalprairie.ok.gov/digital/collection/stgovpub/id/10128/rec/6.

[12] Committee on Psychiatry & the Community for the Group for the Advancement of Psychiatry, "Roadmap to the Ideal Crisis System: Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response" (Washington, D.C.: National Council for

What is a Behavioral Health Crisis System?

Rather than any single program, team or service, a behavioral health crisis system is "an organized set of structures, processes and services that are in place to meet all the urgent and emergent behavioral health crisis needs of a defined population in a community, as soon as possible and for as long as necessary. In short, a crisis system involves an array or continuum of components, processes and services managed collaboratively and interlinked."[13] In responding to the challenge of the legal community to "define understandable, achievable and measurable expectations for ideal behavioral health crisis system performance," the GAP Committee recognized that no crisis system can be "perfect," acknowledging that states do not have unlimited resources to achieve outcomes.[14] Therefore, according to the GAP Committee, an "ideal" crisis system is one that invests limited resources efficiently to incorporate known best practice processes to achieve "the best possible results, as effectively, efficiently and flexibly as possible."[15]

What is a Crisis Continuum of Care and why is the Continuum important to the mission of ODMHSAS?

The Crisis Continuum is the array of specific services designed to assist when individuals face a behavioral health crisis that is beyond their ability to manage alone. Suicide is the worst-case outcome of a behavioral health crisis and is also the most common manner of violent death in Oklahoma. Reducing suicides is critical to ODMHSAS's mission. ODMHSAS has set a goal of dramatically reducing the number of suicides in Oklahoma. Crisis services, and the development of a crisis continuum of care, are a central focus of accomplishing this goal.

The crisis continuum of care vision of ODMHSAS is to work toward barrier-free, 24/7 access to crisis services for all Oklahomans provided within their local communities, recognizing (as did the GAP Committee in the Roadmap to the Ideal Crisis System) the State's limited resources and incorporating known best practices. Some of the key principles of ODMHSAS's crisis continuum include services that are:

- Available at no cost to all Oklahomans, regardless of income or insurance status

---

Mental Wellbeing, 2021) (https://www.thenationalcouncil.org/resources/roadmap-to-the-ideal-crisis-system/), at 14 [hereinafter, "Roadmap to the Ideal Crisis System"].

[13] *Id.*

[14] *Id.*, at 13-14.

[15] *Id.*, at 14.

- Person/family-driven, consumer-oriented, and engaged
- Accompanied by a full array of co-occurring, wrap-around services
- Welcoming and accessible, where every entry point is the "right" entry point for the individual
- Designed to eliminate unnecessary admissions to hospitals and to divert individuals from the criminal justice system where appropriate and consistent with public safety

In 2020, the Substance Abuse and Mental Health Services Administration (SAMHSA)[16] issued its "National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit" (the Crisis Toolkit) with the stated purpose of helping "mental health authorities, agency administrators, service providers, state and local leaders think through and develop the structure of crisis systems that meet community needs."[17] This was the first guideline on behavioral health crisis care issued by the federal government since crisis care was included as a core service in President Kennedy's Community Mental Health Center program. The Crisis Toolkit "responds to SAMHSA's mission by providing science-based, real-world tested best-practice guidance to the behavioral health field." In the Crisis Toolkit, SAMHSA emphasized that crisis services are for "**anyone, anywhere, and anytime**,"[18] a simple guiding principle that is consistent with ODMHSAS' own "no wrong door" approach to the provision of behavioral health services to Oklahomans. According to SAMHSA:

> [C]risis services include (1) crisis lines accepting all calls and dispatching support based on the assessed need of the caller, (2) mobile crisis teams dispatched to wherever the need is in the community (not hospital emergency departments) and (3) crisis receiving and stabilization facilities that serve everyone that comes through their doors from all referral sources. These services are for **anyone, anywhere and anytime.**

---

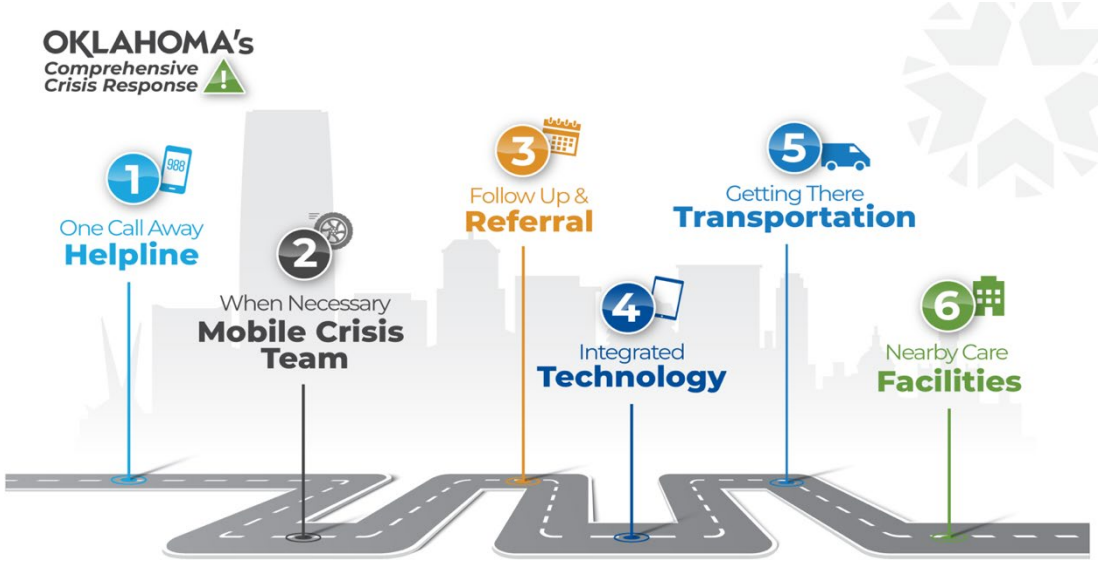
[16] SAMHSA is the U.S. Department of Health and Human Services (HHS) agency that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission "is to reduce the impact of substance abuse and mental illness on America's communities." *See* "National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit" (Rockville, MD: Substance Abuse & Mental Health Services Administration, 2020) (https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf), at 6 [hereinafter, "SAMHSA Crisis Toolkit"].

[17] SAMHSA Crisis Toolkit, at 3.

[18] *Id.*, at 8 (emphasis in original).

> With non-existent or inadequate crisis care, costs escalate due to an overdependence on restrictive, longer-term hospital stays, hospital readmissions, overuse of law enforcement and human tragedies that result from a lack of access to care. Extremely valuable psychiatric inpatient assets are over-burdened with referrals that might be best-supported with less intrusive, less expensive services and supports. In too many communities, the "crisis system" has been unofficially handed over to law enforcement; sometimes with devastating outcomes. The current approach to crisis care is patchwork and delivers minimal treatment for some people while others, often those who have not been engaged in care, fall through the cracks; resulting in multiple hospital readmissions, life in the criminal justice system, homelessness, early death and suicide.[19]

As the SAMHSA narrative implies, the urgency associated with improving behavioral health crisis care is great, but the problems associated with a fragmented system are long-standing. The 911 system, with its reliable call-answering and law enforcement response, has been under development since the first 911 call in February 1968. As a result, law enforcement has become the *de facto* mental health crisis response system nationally, assuring that a response is provided but contributing to "criminalization" of individuals with behavioral health conditions and occasional tragic outcomes. Consistent with these trends, since 2020, ODMHSAS' focus has shifted to the further development and expansion of its crisis continuum of care to provide behavioral health services throughout the State, with the goal of providing those services in the least restrictive level of care appropriate based on the needs of the individual, while offering connections to the rest of the service system. In doing so, ODMHSAS continues to be an early adopter of emerging models and to incorporate national best practices and cutting-edge strategies, drawing from guidance



[19] *Id*. (emphasis in original).

issued by SAMHSA, the National Association of State Mental Health Program Directors (NASMPHD), and other industry leaders.

Figure 1. Oklahoma's Comprehensive Crisis Response Continuum.

The State's crisis continuum of care system, depicted in Figure 1, is comprised of a variety of service components and elements designed to address: (1) prevention; (2) treatment; and (3) recovery. Each of these service components plays a role in collectively providing Oklahomans in need:

- Someone to contact
- Someone to respond
- A safe place for help

In addition to developing better service options, ODMHSAS places a high value on continuous performance improvement, is always working to improve its services, and welcomes feedback on opportunities to improve. As this Plan indicates, this value includes a practice of seeking reviews of Oklahoma services by national experts who provide structured feedback, allowing us to make improvements based on the best available insight.

What is the Sequential Intercept Model and why is it important to ODMHSAS?

SAMHSA has recognized the use of the Sequential Intercept Model (SIM) to detail how individuals with mental health and substance use disorders come into contact and move through the criminal justice system. This framework was introduced nationally in the early 2000s with the goal of mapping predictable "intercepts" within the criminal justice system to develop a systemic approach to identifying and supporting individuals with behavioral health treatment needs.

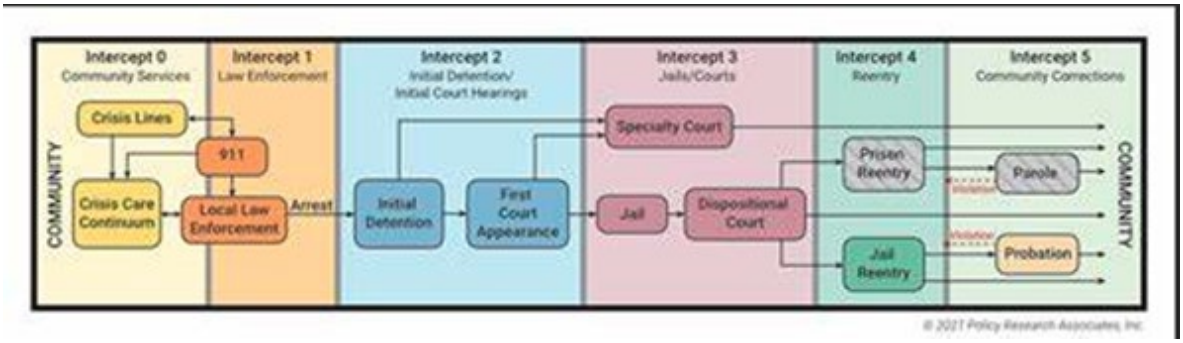


Figure 2. Sequential Intercept Model Framework.

The framework (Intercepts 0-5) is depicted in Figure 2. Initially, the model began at Intercept 1. However, with the advancement of 988 and mobile crisis teams, there is a push toward Intercept

0, where people are connected with services before they come into contact with the criminal justice system. As such, the SIM framework is an important compliment to the crisis continuum of care, as Intercepts 0 and 1 of focus on the resources developed to help those experiencing a behavioral health crisis in the community and without the involvement of law enforcement where appropriate and consistent with public safety.

ODMHSAS was an early adopter of the SIM approach and designed a nationally-recognized continuum of responses framed as Oklahoma's Smart on Crime approach. Since the adoption of the SIM model, the Department has participated in SIM mapping exercises with communities to reevaluate criminal justice and behavioral health systems in the counties to identify system strengths and weaknesses in the evolving environments. The latest of these mapping sessions occurred in February 2024 when Oklahoma County partners applied for, and were accepted to participate in, a one-and-a-half-day workshop awarded by SAMHSA to the Oklahoma County Diversion Hub.

The Department's vision is to continue to work toward behavioral health interventions at each criminal justice intercept. While many of the criminal justice partnerships are beyond the scope of this Plan, the examples of work occurring and expanding at each of the intercepts include:

- Intercept 0: Community Services – 988 call center and 911 integration and training, urgent recovery centers, mobile crisis teams, and CCBHCs
- Intercept 1: Law Enforcement Based Interventions – Crisis Intervention Team (CIT) training for law enforcement, law enforcement iPads connecting to community-based services, and designated mental health officers for community support and outreach
- Intercept 2: Initial Detention/Court Hearing – Jail-based screening programs provided to individuals criminally charged which offer individualized diversion recommendations to defense counsel and courts and jail-based prosecution and defense teams
- Intercept 3: Jails/Courts – Jail-based medications for opioid use disorder, felony and misdemeanor treatment courts, county-specific diversion funding through the Community Safety Investment Fund, court ordered outpatient diversion programs
- Intercept 4: Reentry – Pretrial reentry support services and criminal justice navigation resources, prison-based reentry staffing coordination
- Intercept 5: Community Corrections/Parole/Probation – Probation/parole training, 988 call center and 911 integration and training, urgent recovery centers, mobile crisis teams, and CCBHCs

How has ODMHSAS implemented the State's 2006 Olmstead Plan as it relates to the provision of behavioral health crisis services?

As to behavioral health issues, the 2006 Olmstead Plan recognized several critical areas that needed to be addressed for persons with mental illness to avoid placing them at high risk of institutionalization and allowing people with disabilities to integrate with non-disabled persons to the fullest extent possible. Specifically, the 2006 Olmstead Plan recognized the need for adequate funding for evidence-based and emerging best practices in the following areas:

- Program for Assertive Community Treatment (PACT)
- Supported Employment
- Illness Management and Recovery
- Family Psycho-Education
- Consumer-Run Programs

ODMHSAS has made significant progress in developing the programming and support needed to address the goals identified in the 2006 Olmstead Plan. To continue improving its service offerings and provider performance, ODMHSAS next turned its attention to an innovative performance improvement payment system. Through a collaborative process with the CMHC provider community, OHCA, and CMS, ODMHSAS was able to accomplish something that many other state agencies had tried to do – improve quality of care, increase provider payments, and serve more people in need. ODMHSAS did this through the adoption of Oklahoma's Enhanced Tier Payment System (ETPS). The ETPS is a performance outcomes payment plan, with an overarching goal to proactively support the recovery of Oklahomans with mental illness and substance abuse. The two primary objectives of ETPS are: (1) to improve both access to and outcomes of care; and (2) to creatively pay for improved outcomes with no additional state funds.

A total of twelve (12) performance measures were implemented, with the first six starting on January 1, 2009, and the remaining six starting on July 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)

7. Improvement in CAR[20] 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)

Benchmarks were then set for each of the twelve measures based upon previous State performance data. The results of ETPS were immediately noticeable. In fiscal year (FY) 2009,[21] the initiative resulted in $6 million in payments to providers, increasing to $19.7 million in FY 2010. ETPS has continued this growth trend over the years with a payment of $51 million in FY 2023 (see Figure 3). The State has continued to experience improvement across the performance categories.

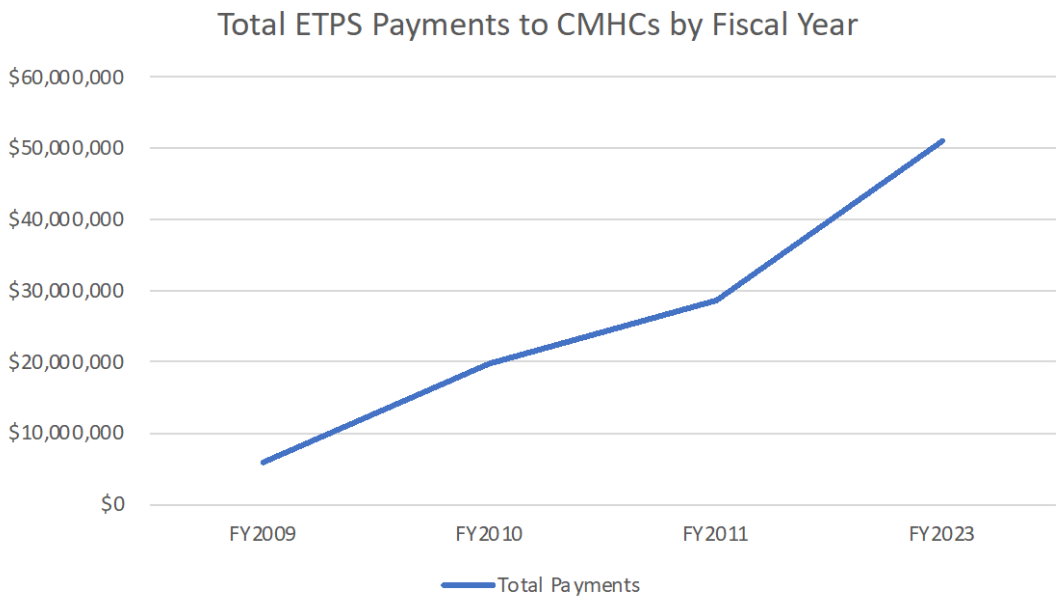


Figure 3. Total ETPS Payments to CHMCs by Fiscal Year

ODMHSAS has a strong history of relying on a comprehensive data infrastructure to measure and improve outcomes. The two recent areas of focus for Oklahoma's *Olmstead* compliance are

[20] Client Assessment Record (or CAR) is a tool provided to clinicians to evaluate the functioning level of a client based on knowledge of the client's behavior and adjustment to his/her community gained through the clinician's assessment and other information.

[21] The State's fiscal year runs from July 1 to June 30 of the following calendar year.

implementing and strengthening statewide a comprehensive crisis response system and a network of certified community behavioral health centers to maintain and support persons within the community. This plan has a significant focus on both continued expansion of services as well as further evaluation and goal setting for recently-implemented emerging national strategies in crisis and community-based care.

As part of that effort, the State has moved from delivering most community mental health services via a traditional CMHC model to a CCBHC model. Launched as a small demonstration program under Section 223 of the Protecting Access to Medicare Act (PAMA) of 2014, and greatly expanded via the Bipartisan Safer Communities Act in 2024, the CCBHC model is a significant upgrade in how mental health services are delivered, emphasizing important innovations including improved access, better medical services, greater use of peers, and more efficient payments. Oklahoma was one of eight (8) states selected by HHS in 2016 to participate in the original demonstration and one of only a few states that has transitioned all CMHCs to the improved approach. Indeed, it is believed that Oklahoma is one of only three (3) states in the country to have statewide CCBHC access.[22] Since the CCBHC model requires services that are consistent with ETPS goals, and provides more flexible payment for these services, CCBHCs are now an integral part of ETPS. ETPS improved access to services, follow up, and engagement, as providers were paid for the services that everyone agreed were most important. As a result, the State experienced a 39.2% increase in consumers served from January 2009 through March 2022. Oklahoma's ETPS model has received national acclaim and been presented at multiple national conferences, including NASMPHD.

Beginning in 2020, the State secured significant funding to further develop, improve, and expand its crisis continuum of care system. Building on the improved performance achieved under ETPS (both in terms of access to services and quality of care), the State is now investing in improved access to crisis supports that will provide more services to more Oklahomans.

On June 30, 2020, Oklahoma approved Medicaid expansion by passing the Oklahoma Medicaid Expansion Initiative (State Question 802). This major initiative, a break with traditional state policy, allows OHCA to use increased federal funding for a number of critical projects, including to pursue substance use disorder and serious mental illness waivers to expand access to prevention and treatment services.

---

[22] The State of Texas reports having at least one CCBHC in every county as of July 2022 (*see* https://www.hhs.texas.gov/providers/behavioral-health-services-providers/texas-certified-community-behavioral-health-clinics). The State of Missouri also reports having expanded CCBHC services to all of its counties (*see* https://dmh.mo.gov/certified-community-behavioral-health#:~:text=The%20Division%20of%20Behavioral%20Health,all%20of%20Missouri's%20114%20counties).

In December 2020, through the collective efforts of the OHCA and ODMHSAS, Oklahoma was granted a Section 1115 IMD Waiver by CMS, which permitted Oklahoma to receive Medicaid reimbursement for certain services provided to Oklahomans suffering from SMI. The IMD Waiver provides access to mental health and substance use treatment by allowing: (1) Medicaid coverage and reimbursement for services provided to eligible adults with SMI/SUD, ages 21-64, within IMDs; (2) individuals under the age of 21 to receive residential SUD services within an IMD as well as qualified residential treatment programs; and (3) medically necessary services covered under the waiver including (a) residential substance use disorder treatment; (b) facility-based crisis stabilization; and (c) inpatient treatment services within IMDs.

In May 2021, the Oklahoma legislature passed SB 1047 (2021), which appropriated significant funds generated from mental health state funding savings made possible by the Medicaid expansion toward a significant development of Oklahoma's crisis continuum. SB 1047 allocated funding to ODMHSAS to supplement program growth and apportioned allocations to several key programs, such as crisis intervention training for law enforcement and other connectivity programs between law enforcement and mental health providers, expansion of the State's mental health crisis centers and urgent care centers, and addition of more mobile crisis teams to respond to behavioral health crises across the State. In total, the legislative apportionment resulted in an effective increase of $17 million in funds for ODMHSAS to support the State's behavioral health crisis response services, including $7.5 million to increase the number of mental health urgent care and crisis stabilization centers across the State, $3 million to fund additional mobile crisis teams, $2 million for the establishment of ODMHSAS's mental health transportation program, and $2 million toward telehealth network expansion.

In September 2021, OHCA was among the first 20 states awarded a federal American Rescue Plan Act of 2021: Section 9813 State Planning Grant for Qualifying Community-Based Mobile Crisis Intervention Services. This grant is designed to help states implement community-based mobile crisis services.

The State's investment in improving the mental health and well-being of Oklahomans, combined with ODMHSAS' efforts to maximize available resources and implement best practices, resulted in a significant development and expansion of the State's core behavioral health services, including the crisis continuum of care, from 2006 to 2022. ODMHSAS remains committed to the fundamental principles of the 2006 Olmstead Plan and to providing behavioral health services to Oklahomans in the most integrated setting appropriate. But the new accomplishments, opportunities and priorities suggest it is timely for Oklahoma to renew its commitment to these principles, especially as they relate to crisis care.

Why is OMDHSAS updating the State's Olmstead Plan as it relates to Behavioral Health Crisis Services and Other Olmstead Responsive Services?

Oklahoma aims to set the standard for behavioral health systems that provide transformative, agile, and quality care. As a result, ODMHSAS has worked to assess the State's accomplishments and identify additional challenges related to the State's goal of fully integrating and including individuals with SMI within community settings. These challenges can be met in part through the expansion and improved integration of crisis services in which ODMHSAS is now

engaged. The State is making good progress in some areas, but there are opportunities for more positive changes that can be accomplished by further aligning improved crisis care and other community-based services, especially when fused with our traditional strength in measurement-based performance improvement (e.g., ETPS), with the *Olmstead* vision.

Figure 4. ODMHSAS Strategies, Initiatives, and Goals

The urgency of aligning Olmstead principles with crisis system development increased when DOJ announced in November 2022 that it was opening an investigation into Olmstead compliance related to adults with SMI in Oklahoma County focused on the availability of community-based mental health services. Although this investigation is local, it strengthened ODMHSAS' commitment to renewing its Olmstead Plan on a statewide basis and led to a review of the previous plan. Based on that review, ODMHSAS determined that: (1) the State's 2006 Olmstead Plan does not adequately reflect the significant progress that has been made or the wide array of services offered; (2) the Department's current strategies to ensure that services are provided to individuals with SMI in Oklahoma in the most appropriate integrated setting have significantly evolved since that time; (3) the Department's mission, vision, and goals are person-centered but may not have been explicitly linked to Olmstead/ADA principles and verbiage (even though the

Department's mission has consistently been to advance the original intent of Olmstead); and (4) the Department's strategic plans and goals are found in multiple documents, but have not recently been tied together in a single document. In other words, even though ODMHSAS' crisis services are shaped by national best practices, including the Roadmap to the Ideal Crisis System and the SAMHSA Crisis Toolkit, it may be useful to demonstrate this more clearly in a single document.

With that backdrop in mind, ODMHSAS is developing and publishing this Plan to document its comprehensive methodology for placing qualified individuals with SMI in less restrictive settings where possible and to increase visibility and accountability for ODMHSAS in carrying out its mission and vision.

It is important to note that the Plan is limited in scope to initiatives for which ODMHSAS can have a direct impact on systemic change. With that said, the work of ODMHSAS alone does not paint a complete and accurate picture of the efforts being undertaken by the State of Oklahoma to serve the behavioral health needs of individuals within the State. While ODMHSAS serves as the State's leader in the delivery and provision of public mental health services, it also coordinates with other State entities and private care providers to meet the mental health and behavioral needs of different subsets of the State's population. ODMHSAS will continue and expand its existing collaborations with state agencies and community-based organizations to further identify services and supports for individuals with behavioral health treatment needs, while welcoming new collaboration opportunities.

This Plan is not an attempt to document and describe all of the Department's efforts to comply with the spirit and underlying principles of *Olmstead*. Instead, this Plan focuses on targeted crisis services strategies that are directed at the reduction of institutionalization and supporting the successful transition of members from institutional settings into community-based living and service delivery. This focus aligns with major, current state and national efforts to improve crisis care and may be useful in documenting the breadth and depth of ODMHSAS efforts considering the current DOJ investigation.

This Plan is intended to be a living document, subject to input from all interested stakeholders and continuous improvement, consistent with the Department's mission and vision. The State of Oklahoma welcomes feedback as it continues to implement and update this Plan.

> **To provide feedback, please send an email to the following address: oklahomaolmstead@odmhsas.org. (Please keep in mind that we may not be able to respond to individual comments, but all feedback will be taken into consideration.)**

OKLAHOMA'S CRISIS CONTINUUM OF CARE:

A Strategic Olmstead Plan for the Provision of Behavioral Health Crisis Services and Other Olmstead Responsive Services

Relying upon national best standards and guidance, ODMHSAS has identified several priority areas within the behavioral health crisis service continuum and related recovery supports. In focusing on how to best approach these Priority Areas within this Plan, we are guided by the following principles:

- ***Person-Centered Approach***. Continue the Department's person-centered focus and approach to the provision of behavioral health crisis services. This includes listening to individuals to ascertain their preferences for services and their views about quality of life, ensuring that their rights are recognized, and incorporating this perspective throughout all phases of crisis care (assessment, planning, service delivery, and evaluation).

- ***Focused Policies and Procedures***. View the State's policies, procedures, laws, and funding mechanisms through the lens of Title II's integration mandate and the Supreme Court's *Olmstead* decision. This includes identifying where and how current systems unintentionally create barriers to integration or create disincentives to development and use of integrated settings. Wherever such barriers or disincentives exist, work to developing a concrete plan for change, through administrative alignment and collaboration, legislative action, policy and rule changes, and seeking additional funding opportunities and prioritization. Where appropriate, involve the Department's strategic partners and other State agencies and departments.

- ***Increased Leadership Opportunities***. Design and implement opportunities for people who are impacted by mental health and substance abuse issues to be involved in leadership capacities in the government programs that affect them. These opportunities can include both paid and volunteer positions. Provide support, training, and technical assistance to people with disabilities to exercise leadership, as this will lead to increased success and sustainability of the Plan over time.

- ***Quality of Life of Oklahomans***. Community-based placement is about services, programs, and activities being provided in the most integrated setting appropriate to the needs of qualified individuals and consistent with their personal choice. Continue efforts to educate Oklahomans about mental illness and to reduce stigma around treatment. Identify metrics to better measure and track quality of life outcomes for people who suffer

from mental health and substance abuse issues as part of the overall performance of the Olmstead Plan.

- ***Consumer Advocacy and Complaint Resolution Process***. Individuals who believe that they have not received services or supports in accordance with the principles set forth in this Plan will have a way to raise their concern and address the problem.

The following sections comprise Oklahoma's Plan. It is organized by Priority Areas, although we recognize that each of these Priority Areas is related and intertwined as part of the overall behavioral health crisis continuum.

Within each Priority Area, the Plan contains the following information:

- **Why is this a Priority Area?** This subsection describes how this topic plays into both the overall behavioral health crisis continuum and the State's obligations under Title II's integration mandate and the *Olmstead* decision.

- **What progress has ODMHSAS made as it relates to this Priority Area and what challenges does it face?** This subsection contains a description of Oklahoma's current system for providing community-based services and recovery supports within and beyond the crisis continuum as it relates to the specific topic. It also contains an assessment of the strengths and weaknesses of the current system.

- **What is ODMHSAS' action plan related to this Priority Area?** This subsection contains objectives related to how ODMHSAS intends to advance the State's goal of identifying and addressing gaps in its behavioral health crisis continuum to expand opportunities for individuals to receive community-based services and recovery supports and have the choice to live in the most integrated setting appropriate.

- **What strategic KPIs will ODMHSAS use to evaluate progress related to this Priority Area?** This subsection contains examples of Key Performance Indicators (KPIs) that ODMHSAS intends to review in connection with evaluating progress in this area.

It is the goal of the Department to set achievable, measurable objectives for each Priority Area and to make significant progress to implement each of them during the next year and to update this Plan annually or as otherwise needed. Unless stated otherwise, the Department's deadline to achieve and/or reevaluate each of the objectives set forth in this Plan is the end of the first full fiscal year after the issuance of this Plan.

OKLAHOMA'S CRISIS CONTINUUM OF CARE:

A Strategic Olmstead Plan for the Provision of Behavioral Health Crisis Services and Other Olmstead Responsive Services

OVERVIEW OF PRIORITY AREAS

#	Priority Area
1.	**988 HELPLINE, MOBILE CRISIS TEAMS, AND CRISIS TRANSPORTATION** Divert and transition individuals experiencing a behavioral health crisis from arrest and other encounters with the criminal justice system to appropriate behavioral health services where appropriate and consistent with public safety.
2.	**LAW ENFORCEMENT PARTNERSHIPS** Provide law enforcement officers who may be the first responders to a behavioral health crisis with appropriate training and support (including CIT training) to use best practices and improve outcomes.
3.	**COMMUNITY-BASED CRISIS CENTERS** Divert individuals experiencing a behavioral health crisis from inpatient hospitalization and emergency departments when appropriate by using outpatient and community-based interventions.
4.	**INPATIENT HOSPITALS** Continue to improve the processes by which the State diverts or transitions individuals from inpatient treatment for behavioral health services to community-based settings.
5.	**COMMUNITY-BASED CARE** Expand access to and the quality of community-based supports and other wrap-around services by a high-quality network of providers that allow individuals to receive outpatient services within their local community.
6.	**HOUSING SUPPORTS** Expand access to housing supports and services designed to assist individuals being served to live in the most integrated and least restrictive setting of their choice that is appropriate to their needs.

7.	**RECOVERY SUPPORTS AND SERVICES** Expand access to recovery supports and services designed to support community integration and that may prevent, or reduce the severity of, a behavioral health crisis and facilitate recovery.
8.	**COMMUNITY EDUCATION AND OUTREACH** Identify and expand opportunities to raise public awareness of mental health and wellness issues, provide education about available community-based resources, and reduce stigma toward help-seeking.
9.	**DATA MANAGEMENT** Continuously improve data collection, management, and reporting systems to develop an aggregate understanding of overall utilization patterns to drive decision-making regarding system investment, service delivery, and other policies.

PRIORITY AREA #1: 988 HELPLINE, MOBILE CRISIS TEAMS, AND CRISIS TRANSPORTATION

Divert and transition individuals experiencing a behavioral health crisis from arrest and other encounters with the criminal justice system to appropriate behavioral health services where appropriate and consistent with public safety.

Why is this a Priority Area?

DOJ has interpreted Title II of the ADA to require that people with behavioral health disabilities receive a health response in circumstances where others would receive a health response. For example, if a call center would dispatch an ambulance or a medic rather than law enforcement to respond to a person experiencing a heart attack or a diabetic crisis, equal opportunity would entail dispatching a health response in similar circumstances involving a person with a behavioral health disability.[23] As discussed above with regard to the SIM approach, this response could include a law enforcement officer with appropriate crisis intervention training or a mental health specialist or mobile crisis team in addition to, or in lieu of, law enforcement.

SAMHSA has noted that communities that have limited or no access to true "no wrong door" crisis services have a built-in gap in the crisis continuum of care. One of the core elements of a crisis system SAMHSA has identified is regional or statewide crisis call center(s) coordinating in real time with centrally-deployed 24/7 mobile crisis teams to respond to behavioral health emergencies in the community.[24] Organizations such as Vera Institute of Justice[25] and Fountain House[26] have published reports discussing the importance of a health-led crisis response, particularly in communities of color.

SAMHSA has further found that many communities have defaulted to law enforcement to operate as community-based mental health crisis response teams, with few options to connect individuals experiencing a mental health crisis to care in real-time.[27] As a result, SAMHSA notes, in many

---

[23] DOJ Guidance, at 3-4.

[24] SAMHSA Crisis Toolkit, at 10.

[25] *See* https://www.vera.org/civilian-crisis-response-toolkit.

[26] *See* https://fountainhouse.org/reports/from-harm-to-health.

[27] SAMHSA Crisis Toolkit, at 11.

parts of the country, those in need are often incarcerated for misdemeanor offenses or dropped off at hospital emergency departments that far too often report being ill-equipped to address a person in mental health crisis.[28] SAMHSA has identified the following unacceptable outcomes of this healthcare gap: (1) high rates of incarceration for individuals with mental health challenges; (2) crowding of emergency departments that experience lost opportunity costs with their beds; and (3) higher rates of referral to expensive and restrictive inpatient care with extended lengths of stay because lower levels of intervention that better align with person's needs are not available.[29]

An important, and often overlooked, aspect of the crisis continuum is how an individual is transported throughout the experience of a crisis episode – from how individuals enter the system from wherever they are in the community when a psychiatric crisis strikes, to the first point of in-person treatment, and to each subsequent destination within the crisis continuum (e.g., an inpatient psychiatric unit or back to their home, or to other locations for follow-up care appointments).[30] The GAP Committee reports that negative transport experiences "have a major bearing on how a person perceives the experience of care and of reaching out for help."[31] Given the long history of 911 serving as the number to call in a crisis, and law enforcement's primary role in response, police transport has become the predominant way individuals are moved in crisis. This is neither the least restrictive approach to transportation nor the best use of public safety resources.[32] As part of the State's crisis continuum, ODMHSAS is committed to providing welcoming, safe and supportive transportation whenever possible.

What progress has ODMHSAS made as it relates to Priority Area #1 and what challenges does it face?

Research shows that the criminal justice system does not adequately address the underlying needs of individuals with behavioral health problems and can often intensify the crisis and

---

[28] *Id*.

[29] *Id*.

[30] Roadmap to the Ideal Crisis System, at 121.

[31] *Id*.

[32] According to a national survey of law enforcement officers throughout the country conducted by the Treatment Advocacy Center, mental health responses occupied more than 20% of officers' time and 10% of agencies' total budgets, while individuals transported to treatment facilities were only admitted for an evaluation a little over half the time. For more information, see Treatment Advocacy Center, "Road Runners: The Role and Impact of Law Enforcement in Transporting Individuals with Severe Mental Illness, A National Survey" (May 2019) (https://tac2.secure.nonprofitsoapbox.com/storage/documents/Road-Runners.pdf).

traumatize or retraumatize people, with little to no reduction in potential criminal conduct.[33] Thus, ODMHSAS seeks to identify opportunities to divert individuals from arrest and other encounters with the criminal justice system where appropriate and consistent with public safety. Specifically, drawing upon SAMHSA's guidance, Oklahoma has set out to create a crisis response system that more accurately reflects its "no wrong door" approach to the provision of crisis services, by increasing the frequency with which those responding to mental health emergencies are properly trained to provide an appropriate response and able to connect the individual with appropriate mental health care providers.[34] Increased service capacities through the growth of the CCBHC model, including walk-in appointments, team-based care approaches, case management, and use of peer recovery support specialists are connected to the reduction of crisis situations.

Crisis Response

In May 2021, through consultation with Dr. Mike Hogan (co-chair of the Crisis Now Task Force), participation in the Crisis Now community, and discussions with SAMHSA/Vibrant, ODMHSAS began to develop a new model for Oklahoma's Crisis Call Center network. Oklahoma's plan was to create an easy to remember helpline number (988) staffed by mental health professionals to answer calls around the clock from those experiencing a mental health crisis.

---

[33] "Guidance for Emergency Responses to People with Behavioral Health or Other Disabilities" (Washington, DC: U.S. Department of Justice and U.S. Department of Health & Human Services, 2023) (https://www.justice.gov/d9/2023-05/Sec.%2014%28a%29%20-%20DOJ%20and%20HHS%20Guidance%20on%20Emergency%20Responses%20to%20Individuals%20with%20Behavioral%20Health%20or%20Other%20Disabilities_FINAL.pdf), at 18 [hereinafter, "DOJ Guidance"].

[34] ODMHSAS, along with its partners, has developed and participated in many other programs and initiatives designed to promote a Smart on Crime approach to criminal justice challenges resulting from untreated mental health and substance use issues. The Smart on Crime concept addresses issues related to SMI and addiction at various diversion points. Some of the programs Oklahoma has adopted to promote criminal justice diversion include jail-based screening, drug courts, mental health courts, early diversion programs, and re-entry intensive care coordination teams (RICCT). ODMHSAS has recently partnered with the Oklahoma County District Court to establish the Oklahoma Court Ordered Outpatient Program (CO-OP) to provide additional treatment diversion opportunities for those charged with low level crimes. While these initiatives for individuals within the criminal justice system suffering with SMI are beyond the scope of *Olmstead*, ODMHSAS will continue to develop those programs and partnerships, and goals related to those efforts could be integrated into subsequent versions of this Plan. For example, ODMHSAS, OHCA, and other state agencies are reviewing the opportunity to develop a Section 1115 demonstration waiver to support re-entry services up to 90 days post discharge. The State was selected by the National Governor's Association in 2024 to participate in a policy academy to explore this waiver opportunity.

In connection with the 988 Helpline, Oklahoma also began to develop a new model for its mobile crisis teams. In May 2021, as a result of SB 1047,[35] ODMHSAS received approximately $3 million in legislative appropriations to fund an expansion of mobile crisis teams throughout the State. Oklahoma's plan was to create a statewide system of mobile crisis teams with the capability to respond locally within the community to deescalate crisis situations.

Oklahoma released its request for proposal (RFP) for the 988 Helpline in 2021, integrating best practices from SAMHSA and the Roadmap to the Ideal Crisis System. In March 2022, the RFP was awarded to Solari, with back up call center contracts also entered for overflow needs. Oklahoma's 988 network officially launched in partnership with Solari in July 2022.

Oklahoma released its Oklahoma 988 Mobile Crisis Team RFPs in 2022, integrating best practices from SAMHSA and the Roadmap to the Ideal Crisis System. In June 2022, contracts were awarded to multiple recipients, creating 24/7 statewide coverage, with multiple layers of teams. In July 2022, mobile crisis teams began to be deployed via community dispatch to individuals in crisis statewide, 24/7. Each mobile crisis team includes a licensed clinician and a certified peer recovery support specialist or case manager and utilizes best practices in behavioral health, including suicide prevention and intervention. ODMHSAS currently works with 15 partner organizations to provide statewide mobile crisis team coverage. Contractors providing mobile crisis teams are required to respond to emergencies within 60 minutes in urban areas and 2 hours in rural areas consistent with SAMHSA recommendations.[36]

Oklahoma's 988 Helpline operates 24 hours a day, 7 days per week with licensed behavioral health providers and certified mental health crisis specialists. The 988 Helpline provides connection and dispatch to local services and mobile crisis teams, including immediate communication and connection to 911 when a law enforcement presence is required for safety and local CCBHCs, if needed. The Helpline has also progressed from a call center to a "contact center," integrating responses via text and chat, providing access to younger individuals and others less likely to reach out by telephone. Further, the Helpline provides follow-up calls to 988 callers utilizing certified peer recovery support specialists to provide "support beyond the crisis."

The Oklahoma 988 Mental Health Lifeline and Crisis Continuum has seen tremendous outcomes when serving Oklahomans across the State. Solari publishes a public dashboard providing

---

[35] SB 1047 apportioned and allocated funding to ODMHSAS to supplement program growth. *See* http://www.oklegislature.gov/BillInfo.aspx?Bill=sb1047&Session=2100.

[36] *See* SAMHSA Webinar, FY 2022 Cooperative Agreements for Innovative Community Crisis Response Partnerships (June 15, 2022), at 10 (https://www.samhsa.gov/sites/default/files/sm-22-016-webinar.pdf).

visibility to important metrics related to Oklahoma's 988 system.[37] Initial goals focused on increasing awareness of the 988 Helpline. As call volume has continued to increase dramatically, Oklahoma is focused on improving answer rate, dispatch time, and marketing strategies. One positive trend the State has observed is that the primary reason for calls to 988 has shifted from self-harm/suicidal intentions to coordination of care. This suggests that more Oklahomans are using the Helpline before they get to a dangerous point. In FY 2023, the State's 988 call center established warm transfer protocols with all CCBHCs as part of its goals of creating immediate access to clinical appointments for high-priority populations (such as individuals expressing suicidal ideations). Call routing remains a nationwide challenge.[38]

Crisis Transportation Response

In April 2021, the Oklahoma legislature passed SB 3,[39] which provided ODMHSAS authority to provide private transportation, in lieu of law enforcement, for individuals in behavioral health crisis, whose transport needs were greater than 30 miles. And in May 2021, ODMHSAS received approximately $2 million in legislative appropriations to fund its statewide crisis transportation program. In November 2021, ODMHSAS launched a network comprised of four vendors providing 24/7, statewide crisis transportation services as an alternative to law enforcement when Oklahomans experience a psychiatric crisis called RideCARE. This model allows for private sector companies to provide transportation services to individuals experiencing a psychiatric crisis and lessen some of the burden on law enforcement officers and normalize and integrate the transport experience of the person in crisis. When transportation to a higher level of care is needed, third-party contractors provide free transportation to the nearest Urgent Recovery or Crisis Center. Existing partnerships with local law enforcement help with crisis transports where safety is a concern.

In its first year of operation, RideCARE conducted over 15,000 transportations, covering more than 1.5 million miles. In 2023, ODMHSAS supported legislation to remove the 30-mile requirement, authorizing ODMHSAS to provide transports to the nearest appropriate location with

---

[37] *See* https://public.tableau.com/app/profile/crisis.network/viz/OKPublicDashboard/OKDashboard.

[38] Efforts are underway to make "georouting" standard across all U.S. cellular phone carriers. *See* https://www.samhsa.gov/newsroom/press-announcements/20240925/wireless-calls-988-more-localized-response-georouting.

[39] SB 3 amended Oklahoma law to provide expanded transportation for the provision of mental health services. *See* http://www.oklegislature.gov/BillInfo.aspx?Bill=sb3&Session=2100.

no minimum mileage requirement. This legislation took effect in October 2023. CJI has specifically recognized and lauded Oklahoma's effort.[40]

911-988 Coordination

The current focus of ODMHSAS is to improve coordination between 911 and 988.[41] Consistent with national trends, ODMHSAS recognizes the importance of thoughtful, protocol-driven call transitions between 911 and 988 to reduce unnecessary interactions with law enforcement. In 2024, ODMHSAS commissioned Healthy Minds Policy Initiative (Healthy Minds) to develop a standard call center protocol example to support 911/988 coordination across the State. The implementation of this protocol will take time and the individual support of each local PSAP.

As described above, Oklahoma has made great strides in creating a crisis response system that aims to provide a health-first response in lieu of law enforcement. Thus, objectives for Priority 1 focus on further developing the crisis system and improving coordination between points of the system (ex. 911 and 988) in order to direct more Oklahomans to the available services.

What is ODMHSAS' action plan related to Priority Area #1?

Objective 1.1: Maintain a 988 in-state call answer rate of 90%,[42] with a continued wide variation of reasons for calling, including crisis and care coordination.

Objective 1.2: Increase the number of PSAPs using 988 transfer protocols by 100% in the first year.

Objective 1.3: Expand use of mobile crisis teams, which currently prioritize urgent/immediate responses to crisis situations, to include non-acute mobile response options for individuals who would like a scheduled on-site connection with a treatment provider within the client's preferred timeline.

---

[40] *See* CJI Analysis, at 12.

[41] Oklahoma has 911 systems operating in all 77 counties, including 126 local and county public safety answering points (PSAPs), eight (8) secondary PSAPs, and other standalone emergency communications centers. These PSAPs are not within ODMHSAS' control.

[42] This rate is based on data supplied by the national provider, including calls dropped before they are routed to the State, and satisfies best practices standards. Oklahoma has continuously maintained an in-state answer rate above 99% based on calls routed to Oklahoma's primary call center.

Objective 1.4: Develop workforce strategies for call center and crisis line training in partnership with vendors to support the number of trained individuals needed to maintain this service as well as ensuring high quality interactions with callers.

Objective 1.5: Increase State 911 PSAPs who receive behavioral health training by connecting them with training opportunities.

Objective 1.6: Increase coordination between 988 and 911 PSAPs by partnering with State leadership to fund a position which works within the 911 Management Authority.

Objective 1.7: Evaluate mobile crisis demand and response time per region quarterly to determine the need for additional mobile team investments.

Objective 1.8: Review data to formulate a plan in connection with the Care Coordination Team to connect with individuals who call 988 most frequently.

What strategic KPIs will ODMHSAS use to evaluate progress related to Priority Area #1?

Strategic KPIs ODMHSAS will use to evaluate progress in this Priority Area may include:

- Number of People Served
- 988 Crisis Line Answer Rate/Dashboards
- Number of PSAPs using 988 Transfer Protocols
- Statewide Service Utilization Rate
- Geographic Coverage

PRIORITY AREA #2: LAW ENFORCEMENT PARTNERSHIPS

Provide law enforcement officers who may be the first responders to a behavioral health crisis with appropriate training and support (including CIT training) to use best practices and improve outcomes.

Why is this a Priority Area?

Although one of the State's goals in developing its behavioral health crisis system is to shift more of the responsibility for crisis "first response" to behavioral health clinical crisis settings, law enforcement and other first responders will still be involved as an initial or early contact in many crisis situations. This is especially true for situations that may be deemed unsafe for civilian responders. In other instances, the behavioral health crisis may not be immediately apparent during a 911 call or law enforcement may encounter an individual experiencing a behavioral health crisis while on patrol. When law enforcement officers are among the primary responders to a behavioral health crisis, it is important that they are appropriately trained to use best practices in a coordinated and collaborative manner with other crisis providers and community stakeholders and provided other resources.[43]

This includes training to law enforcement and other first responders, such as Crisis Intervention Team (CIT)[44] training. CIT programs provide training to law enforcement officers with the goal of improving outcomes of law enforcement interactions with those experiencing behavioral health crises. DOJ has recognized that CIT-trained officers can provide a specialized police response to individuals experiencing a behavioral health crisis in situations where police presence is needed.[45] It also includes enhanced emphasis on telehealth, particularly in more rural areas where on-site service availability may be limited.[46] In its recent Behavioral Health Crisis Response Landscape Analysis, CJI noted that efforts to promote telehealth in law enforcement and other crisis response models, such as in Oklahoma, can be a key step towards giving law enforcement officers the resources they need, particularly in rural areas.[47]

---

[43] Roadmap to the Ideal Crisis System, at 94.
[44] CJI Analysis, at 1.
[45] DOJ Guidance, at 12.
[46] Roadmap to the Ideal Crisis System, at 50.
[47] CJI Analysis, at 12.

What progress has ODMHSAS made as it relates to Priority Area #2 and what challenges does it face?

In conjunction with the development and expansion of its crisis system, ODMHSAS has also worked to ensure that law enforcement officers (and other possible first responders) are better equipped to respond to mental health emergencies where police presence is needed.

As part of SB 1047, ODMHSAS received approximately $2 million in legislative appropriations in to make telehealth tablets available to all law enforcement officers in May 2021, and distribution was completed to all areas of the state by December 2021. ODMHSAS currently provides every law enforcement officer in the State with access to a telehealth tablet that has 24/7 access to a CCHBC to assist the officer with assessment, evaluation, and connection to treatment. ODMHSAS also continues to provide iPads/electronic tablets to first responders, consumers, and staff across Oklahoma. In 2022, a total of 269,468 calls, including 51,298 crisis calls, were made through the telehealth networks. Calls during this time achieved a 78% community stabilization rate, providing a least restrictive level of care suitable for individuals to address their crisis needs. Oklahoma's model of telehealth access, including crisis care, was studied through partnership with one of Oklahoma's CCBHCs and the National Association of State Mental Health Program Directors Research Institute (NRI), which found the model to be a direct contributor to a decrease in hospitalizations and reduction in law enforcement travel time and distance. It has also been highlighted as a best practice by the National Council for Mental Wellbeing.

ODMHSAS added a function to the law enforcement tablets which allows officers to receive mental health support for themselves (for example, to debrief after a traumatic call). The suicide rates for law enforcement are among the highest for any profession, with more officers dying by suicide than in the line of duty.[48] By providing a 24/7 telehealth connection for officers to engage personally with a mental health professional, officers are then better able to respond to crisis situations when they themselves are healthy.

ODMHSAS also provides CIT[49] training to law enforcement officers and others who are interested in receiving such training.[50] CIT programs provide training to law enforcement officers with the

---

[48] *See* https://www.cna.org/our-media/indepth/2024/04/suicide-data-for-public-safety-officers#:~:text=Police%20officers%20are%20at%20a,to%20evidence%20from%20prior%20research.

[49] Crisis Intervention Teams are specialized units of law enforcement officers who have received a nationally-recognized, 40-hour training to identify and de-escalate crisis situations. *See* CJI Analysis, at 1.

[50] While some advocates recommend that all officers receive CIT training, research has shown that training works best when officers voluntarily choose to participate. CIT International,

goal of improving outcomes of law enforcement interactions with those experiencing behavioral health crises. DOJ has recognized that CIT-trained officers can provide a specialized police response to individuals experiencing a behavioral health crisis in situations where police presence is needed.[51] ODMHSAS has launched a training course catalogue which is viewable on the Department's website. ODMHSAS has continuously updated CIT training information to include newly established crisis continuum resources such as 988, mobile crisis teams, and rapid law enforcement drop off at urgent recovery centers. Training includes information on how these newer resources provide key support to officers. ODMHSAS published a 988 law enforcement toolkit in January 2024 to provide a resource for officers to better understand the use of 988 and the telehealth tablets.

In FY 2022, ODMHSAS doubled CIT training to 499 officers in a single year. During FY 2023, ODMHSAS surpassed its goal of training an additional 500 law enforcement officers statewide, as 554 officers received CIT training. During FY 2023, ODMHSAS implemented CIT hubs in Oklahoma City, Tulsa, and Lawton, which provide local training opportunities in partnership with community-based providers. Through these CIT hubs, ODMHSAS is implementing a "train the trainer" model to increase reach. In FY 2024 to date, these numbers have continued to grow – expanding to ten (10) CIT training hubs and training a total of 513 individuals. Since the beginning of FY 2021, ODMHSAS has provided CIT training to 729 officers from Oklahoma County, including the Oklahoma City Police Department, Oklahoma County Sheriff's Office, and others.

What is ODMHSAS' action plan related to Priority Area #2?

Objective 2.1: Establish statewide regional CIT training hubs which provide local CIT training as needed to the community's law enforcement agencies to maintain at least 25% of the State's law enforcement workforce being CIT trained.

Objective 2.2: Provide an annual education for law enforcement on "person requiring treatment" criteria.

Objective 2.3: Survey police chiefs through the state association annually to inform decisions about continued or new training and support needs and receive feedback from law enforcement agencies on cultural assessments as to community awareness of available services, access to care, and the effectiveness of partnerships.

Inc., provides research and has issued a Position Paper supporting CIT as a voluntary specialist/general model, not as mandatory training. *See* https://citinternational.org/research.

[51] DOJ Guidance, at 12.

Objective 2.4: Update the eLearning library of CLEET trainings to ensure that content is up to date and reflective of current statutes and treatment resources.

Objective 2.5: Provide education and information to all criminal justice partners on level of care, access to care, and local resources for treatment needs.

Objective 2.6: Publish a decision tree to support the coordination between law enforcement and mobile crisis teams that balances safety and least restrictive environment in situations which may require either a co-response or local law enforcement first assuring safety prior to a mobile team responding.

Objective 2.7: Publish standardized call tree formats for treatment agencies answering law enforcement tablet calls to support consistency in answering processes.

What strategic KPIs will ODMHSAS use to evaluate progress related to Priority Area #2?

Strategic KPIs ODMHSAS will use to evaluate progress in this Priority Area may include:

- Number of People Served
- Number/Percentage of Officers Trained
- Number/Percentage of Trainings Completed
- Number of Collaborative Partnerships
- Statewide Service Utilization Rate

PRIORITY AREA #3: COMMUNITY-BASED CRISIS CENTERS

Divert individuals experiencing a behavioral health crisis from inpatient hospitalization and emergency departments when appropriate by using outpatient and community-based interventions.

Why is this a Priority Area?

The goal of crisis services is to stabilize individuals in the community without the need for hospitalization. Institutionalization can often be avoided all together if consumers have access to appropriate behavioral health urgent care, crisis stabilization, and other outpatient services. However, individuals in crisis can also benefit from diversion from emergency departments. Most emergency departments do not have access to psychiatric services and the physical environment is not conducive to caring for individuals experiencing a behavioral health crisis. As a result, patients can sometimes spend hours, or even days, waiting to be transferred to another facility where they can be provided any specialized care.[52]

Crisis facilities provide a less-restrictive alternative to emergency departments, inpatient hospitalization, and jail. The Roadmap to the Ideal Crisis System describes the need for a "crisis center or crisis hub," a secure physical location (crisis center) that provides a place for people in behavioral health crisis to go or be brought by law enforcement or other first responders that is an alternative to going to an emergency room or to jail.[53] According to the Roadmap, the ideal crisis system contains an entire system of behavioral health facilities that operate in tandem with, but are separate from, physical health facilities (like hospitals). These facilities can include behavioral health urgent care units, 23-hour evaluation beds, and extended observation programs and services.[54] Experience has shown that sometimes urgent crises (e.g., suicidality) can be addressed via a call. In other situations, a crisis can be stabilized during a mobile crisis visit. However, other crises require a brief or overnight visit to a facility to be safely resolved. Without community-based structured crisis centers, often hospitalization is often viewed as the only safe alternative.

---

[52] *See* Margaret E. Balfour and Chris A. Carson, "Crisis Receiving and Stabilization Facilities: Designing Systems for High-Acuity Populations," Psychiatric Clinics of North America, Volume 47, Issue 3, 2024, Pages 511-530 (https://doi.org/10.1016/j.psc.2024.04.022).

[53] Roadmap to the Ideal Crisis System, at 88.

[54] *Id.*, at 100-101, 104-107.

What progress has ODMHSAS made as it relates to Priority Area #3 and what challenges does it face?

Oklahoma has conceptualized its behavioral health crisis service model to include community-based structured crisis centers. These facilities are places of community-based stabilization and offer individuals in crisis “no wrong door” access to mental health and substance use care. These facilities operate similar to a hospital emergency department that accepts all walk-ins, ambulance, fire and police drop-offs, and any other behavioral health crisis referrals but they are focused on behavioral health crises and are generally community-based and not in a hospital.

These facilities provide assessment and support and are staffed 24/7/365 with a multidisciplinary team. This team includes, but is not limited to, psychiatrists, nurses, licensed behavioral health practitioners and peers with lived experience similar to the population served. The facilities are designed to increase accessibility to the right services for Oklahomans experiencing a mental health crisis, where inpatient treatment may not be necessary.

Emergency rooms and areas used for pre-booking and holding persons prior to adjudication lack behavioral health expertise and result in increased rates of hospital placement and incarceration. As a more effective and integrated alternative, Oklahoma recognizes two types of community-based structured crisis centers. Urgent Recovery Centers (URCs) provide up to 23 hours of chair-based care with a full array of services available through walk-in or drop-off opportunities. Crisis Stabilization Units (CSUs) provide longer stays for those individuals in need of continued crisis stabilization after their URC stay but do not require inpatient hospitalization. Both URCs and CSUs are reimbursable under Oklahoma’s Medicaid state plan as well as ODMHSAS contracts to support services to individuals without third-party liability payment sources.

Oklahoma established the first URC/CSU (the Oklahoma County Crisis Intervention Center (OCCIC)) in Oklahoma City in 2013. The State-operated facility in Oklahoma County became a model for future expansion. Four (4) additional URCs and four (4) additional CSUs were established in the State between 2014 and 2018.

With the 2021 investment by the Oklahoma Legislature into the crisis continuum of care, ODMHSAS has continued to add new URCs and CSUs with the goal of achieving statewide coverage.

Additionally, in 2022, ODMHSAS passed an administrative rule requiring that by July 1, 2024, or within three years of initial certification, each CCHBC in the state must have at least one 24-hour outpatient clinic, URC, or crisis unit either in each county within the CCBHC catchment area with a population of 20,000 or more, or if the county population is less than 20,000, at least within the adjacent county.

As of June 2024, there were 26 URCs and 18 CSUs statewide, including OCCIC and the Oklahoma Crisis Recovery Unit (OCRU) operated by ODMHSAS in Oklahoma County and other facilities operated by a network of CCBHCs and other providers throughout the State. These facilities are operating across 20 counties and provide in-county access to URCs and CSUs for 68.8% of the State's population (based off 2020 census data).

What is ODMHSAS' action plan related to Priority Area #3?

Objective 3.1: Increase the percentage of Oklahomans who have access to 24/7 facility-based treatment services within their county of residence to at least 70% and supplement availability with services in adjacent counties where necessary.

Objective 3.2: Ensure that each individual discharged from any URC or CSU will be discharged by way of a warm hand-off to a service provider whenever possible and will receive a written discharge plan that, at a minimum, includes at least one post-discharge follow-up call and identifies available community-based resources and contacts for follow-ups with a provider of choice by reviewing current rules and policies for all URCs and CSUs for discharge planning processes and establishing monitoring procedures.

Objective 3.3: Review ETPS data and Medicaid claims data related to individuals not connecting with outpatient services after discharge and identify opportunities to enhance connectivity across the system at appropriate levels of service.

Objective 3.4: Conduct continuous quality improvement (CQI) reviews of readmissions to state-operated URCs and CSUs within 30 days to establish a baseline and benchmark provider performance of existing centers as to the root cause(s) of such readmissions. Use this data to assess whether additional strategies around length of stay and/or community supports can be provided to reduce the risk of readmission. Set a readmission benchmark goal, if determined appropriate.

Objective 3.5: Explore opportunities for third-party insurance coverage for crisis care to reduce dependence on State and Medicaid funding and expand the reach of available facility-based crisis resources.

Objective 3.6: Develop statewide admission and exclusionary criteria to ensure that facilities operate as 'no wrong door' options for crisis care, with exclusionary criteria reflecting medical emergency situations which cannot be cared for safely in the URC or CSU setting.

Objective 3.7: Create standardized outcomes metrics for URCs and CSUs which include community stabilization rates, law enforcement utilization, medical clearance requests, direct admissions to crisis centers, etc., to support system evaluation and improvement.

Objective 3.8: Present to hospitals, the Oklahoma Hospital Association, and CCBHCs a model of URC co-location in medical facilities such as emergency rooms to support rural access expansion as a cost-effective, sustainable model.

Objective 3.9: Pursue the renewal of Oklahoma's IMD waiver to continue Medicaid reimbursement for community-based crisis facilities that have a capacity exceeding sixteen (16) beds.

What strategic KPIs will ODMHSAS use to evaluate progress related to Priority Area #3?

Strategic KPIs ODMHSAS will use to evaluate progress in this Priority Area may include:

- Number/Percentage of People Served
- Evidence-Based Practice(s) Implemented
- ETPS Data
- Statewide Service Utilization Rate
- Statewide Readmission Rate
- Geographic Coverage

PRIORITY AREA #4: INPATIENT HOSPITALS

Continue to improve the processes by which the State diverts or transitions individuals from inpatient treatment for behavioral health services to community-based settings.

Why is this a Priority Area?

Although diversion away from emergency departments and inpatient hospitalization is a significant purpose of the crisis continuum, the GAP Committee recognized that community hospital emergency departments and medical units, ED-based psychiatric emergency services, community hospital psychiatric units and freestanding psychiatric inpatient facilities all represent critically important elements of an ideal crisis continuum.[55] Indeed, the Supreme Court in *Olmstead* recognized that institutional treatment is a necessary part of a state's overall response to mental health issues. There are some individuals who are unable to handle or benefit from community settings, and the State is permitted to rely upon the judgment of its treatment professionals in determining whether community-based placement is appropriate. Moreover, community-based treatment cannot be forced on patients who do not want it. But once those two criteria have been met, and both the treatment professional and the consumer are in agreement that community-based placement is preferred, ODMHSAS strives to identify the appropriate setting and wants to work with the consumer, the consumer's family, and all its community partners to place the consumer in the best possible position to succeed.

When hospitalization is necessary, ODMHSAS strives to minimize the disruptive effects of the institutionalization by ready access to inpatient care when needed and discharge planning which involve natural supports.

Community placement is a stated goal of *Olmstead*, and therefore, discharge planning for patients from inpatient settings is a focus of the State's efforts. It is estimated that about one-third of patients admitted to inpatient treatment for psychiatric services will be readmitted within one year.[56] According to a review of nearly 75 studies between 1946 and 2021, including 35 from the

[55] Roadmap to the Ideal Crisis System, at 115.

[56] Owusu, C. *et al*., "Readmission of Patients to Acute Psychiatric Hospitals: Influential Factors and Interventions to Reduce Psychiatric Readmission Rates," Published in HEALTHCARE, Vol. 10, 1808 (Sept. 2022), at 1 [hereinafter, the "Readmission Study"].

United States, hospital readmissions can be caused by many factors, including the length of the original hospital stay; previous clinical diagnosis of psychiatric disorders; alcohol, drug and substance abuse; non-adherence to antipsychotic medication; and suicidal ideation. [57] Additionally, engagement in community-based care post discharge can decrease readmission rates. However, it is important to acknowledge that consumer choice drives engagement in community-based services. Individuals may be discharged who are no longer in need of an institutional treatment setting but who choose not to engage with the services that may assist them to remain within the community.

According to the Roadmap to the Ideal Crisis System, inpatient hospitalization stays vary for individuals, but generally last for a brief period of two weeks up to a maximum of three months, during which time transition to continuing services at the right level of intensity can be arranged.[58] Indeed, the Readmission Study noted that many factors can contribute to higher risk of readmission, emphasizing the need for individualized treatment and care.[59] One of the Study's key recommendations is that adequate discharge planning is a critical component of reducing the risk of readmissions.

What progress has ODMHSAS made as it relates to Priority Area #4 and what challenges does it face?

ODMHSAS operates psychiatric hospital services for Oklahomans. These include four (4) facilities that provide acute inpatient psychiatric care for individuals who do not have access to other psychiatric inpatient care and longer-term care for individuals who are a danger to themselves or others and are unable to temporarily function in a community setting: Griffin Memorial Hospital, located in Norman, Oklahoma; Children's Recovery Center, in Norman, Oklahoma; Tulsa Center for Behavioral Health, in Tulsa, Oklahoma; and Transitions Recovery Center, in Vinita, Oklahoma. In addition, ODMHSAS operates the Oklahoma Forensic Center, located in Vinita, Oklahoma, which conducts forensic evaluations for the judicial system and provides inpatient care for persons found not guilty by reason of insanity.

One of the biggest challenges faced by ODMHSAS (and indeed, all providers of inpatient behavioral health services) is deciding when a patient is appropriate to discharge. Complicating matters is the fact that some of the factors that make it more likely that it becomes necessary for a patient to be readmitted for additional inpatient care, such as adherence to medication, lack of

[57] Readmission Study, at 12-16.

[58] Roadmap to the Ideal Crisis System, at 121.

[59] Readmission Study, at 13.

engagement in community-based services, and legal or other challenges, are not fully within the control of the State's treatment providers.

To address these challenges, ODMHSAS has initiated several procedures to improve discharge planning processes. For example, Griffin Memorial Hospital (GMH) created a Discharge Planning Evaluation Committee that meets weekly to discuss discharge planning for individuals with a length of stay greater than 30 days. Action steps created in this meeting to improve outcomes for the transitioning individual include, but are not limited to: implement additional psycho-social interventions; create solutions for complex conditions; resolve legal issues; engage intensive team solutions such as involving the Care Coordination Team with priority populations or to facilitate connection to CCBHCs; engage with housing resources and other supports; and assess the conditions and resources necessary for timely transition into community-based services.

In addition, on a monthly basis, each ODMHSAS facility provides written discharge updates for individuals with a length of stay in the top 80th percentile. Updates and barriers to discharge are then discussed in a monthly Clinical Services meeting offered to ODMHSAS clinical staff. This collaborative meeting allows for the analysis of common discharge patterns, the presentation of individual cases and to explore solutions as a group, identifying creative solutions for individual cases, implementing intensive solutions systemwide, and the sharing of resources.

Moreover, ODMHSAS has implemented several initiatives to assist with a smooth transition into community-based services. A MyCare iPad can be provided to individuals discharging from higher levels of care to access 24-hour community-based supportive services. The MyCare iPad is a solution for individuals with a history of non-compliance or poor impulse control or those who will continue transition into permanent housing arrangements after the initial transition into the community. While less restrictive options are considered first, a person with high recidivism can be provided an Order for Alternative Treatment for mandatory treatment in an outpatient program. Resource applications are completed and submitted to assist with short-term and long-term financial and medical resources.

Additionally, a host of services are provided at the CCBHC level in order to secure solid discharge into the community, prevent future inpatient hospitalizations, and encourage continued stabilization. These resources include but are not limited to: incentivizing connections to CCBHC services within seven (7) days of hospital discharge; providing employment services, rehabilitation services, outreach services, medical services, and housing services; and providing access to a comprehensive crisis response system.

Finally, the State is in the process of investing in new hospitals to replace Griffin Memorial Hospital and the Tulsa Center for Behavioral Health. The Donahue, being constructed in Oklahoma City, will be a cutting-edge facility that will deliver innovative services tailored to both adults and

children, encompassing comprehensive care options and facilitating seamless referrals to outpatient services. The Oklahoma Psychiatric Care Center, being constructed in downtown Tulsa, represents a partnership between ODMHSAS, the Oklahoma State University Center for Health Sciences, the City and County of Tulsa, and numerous private donors and organizations that will expand and deepen experiential learning of medical students in Oklahoma. These new facilities are designed to expand ODMHSAS' psychiatric bed capacity and operational reach. Each will feature a 24-hour crisis response URC to ensure immediate access to vital services, including walk-in availability to stabilization services.

What is ODMHSAS' action plan related to Priority Area #4?

Objective 4.1: Ensure that each individual discharged from an inpatient stay at any state-operated facility will be discharged by way of a warm hand-off to a service provider whenever possible and will receive a written discharge plan that, at a minimum, identifies available community-based resources and contacts for follow-ups with a provider of choice by reviewing and updating policies and procedures and monitoring performance.

Objective 4.2: Provide annual discharge planning training for all state-operated facilities that focuses on CMS and SAMHSA-supported discharge resource strategies, including social determinants of health.

Objective 4.3: Provide intensive discharge planning by a facility-based discharge planning evaluation committee for any individual who has an inpatient stay longer than 30 days at any state-operated facility.

Objective 4.4: Provide intensive discharge planning by a central office care coordination team, and managed care organization care management teams for Medicaid members, with the authority to consult outside clinical resources where appropriate, for any individual who has an inpatient stay longer than 90 days at any state-operated facility.

Objective 4.5: Conduct continuous quality improvement (CQI) reviews of readmissions to state-operated inpatient hospitals within 30 days to establish a baseline as to the root cause(s) of such readmissions. Use this data to assess whether additional strategies around length of stay and/or community supports can be provided to reduce the risk of readmission. Set a readmission benchmark goal, if determined appropriate.

Objective 4.6: Open new inpatient hospitals in Oklahoma City and Tulsa by December 31, 2026. These hospitals will expand ODMHSAS' psychiatric bed capacity and operational reach as well as include URCs to ensure patients can receive immediate access to vital services, including walk-in availability to stabilization services designed to divert patients from inpatient treatment where appropriate.

Objective 4.7: Review the data to determine opportunities for expanded use of telehealth to increase care within state-operated hospitals as well as discharge support transitions.

Objective 4.8: Standardize operations across state-operated hospitals where appropriate and based on the population served.

What strategic KPIs will ODMHSAS use to evaluate progress related to Priority Area #4?

Strategic KPIs ODMHSAS will use to evaluate progress in this Priority Area may include:

- Number of People Served
- Number of Partnerships
- Number/Percentage of Trainings Completed
- Statewide Service Utilization Rate
- Statewide Readmission Rate
- Facility Launch Indexes

PRIORITY AREA #5: COMMUNITY-BASED CARE

Expand access to and the quality of community-based supports and other wrap-around services by a high-quality network of providers that allow individuals to receive outpatient services within their local community.

Why is this a Priority Area?

According to the Roadmap to the Ideal Crisis Network, Certified Community Behavioral Health Clinics, or CCBHCs, advance the crisis continuum of care and ensure sustainable financing; the model works because it provides a source of funding sufficient to cover the costs of implementing an advanced crisis system.[60]

CCBHCs are designed to provide a comprehensive range of mental health and substance use disorder services to vulnerable individuals. In return, CCBHCs receive an enhanced Medicaid reimbursement rate based on their costs of services to meet the needs of these populations.

CCBHCs represent an opportunity for states to improve the behavioral health of their citizens by providing community-based mental and substance use disorder services; advancing integration of behavioral health with physical health care; assimilating and utilizing evidence-based practices on a more consistent basis; and promoting improved access to high quality care. Care coordination is the linchpin holding these aspects of CCBHC care together and ensuring high quality care and improved outcomes. The CCBHC model results in increased access to services, innovative relationships with law enforcement, reduction in crisis hospitalizations, enhanced crisis services and increased use of evidenced-based practices.

The National Council for Mental Wellbeing issued a white paper in September 2024 evaluating the success of the CCBHC model and providing recommendations about how states can maximize the effectiveness of this "powerful resource" in crisis service delivery and ongoing care.[61] Oklahoma's role as a pioneer in several areas was recognized in this paper.[62] Since this is a rapidly evolving area, Oklahoma will continue to monitor data trends and national best

---

[60] Roadmap to the Ideal Crisis System, at 191.

[61] National Council for Mental Wellbeing, "The Role of Certified Community Behavioral Health Clinics in Crisis Services and Systems" (Washington, D.C., Sept. 2024), at 8 (https://www.thenationalcouncil.org/resources/role-of-ccbhcs-in-health-crisis-services/).

[62] *See id.*, at 48 (best practices for crisis receiving and stabilization services); 55 (supporting peer roles in treatment); 69 (legislative investment and system expansion).

practices, including this white paper and the anticipated update of the SAMHSA Crisis Toolkit in 2025.

What progress has ODMHSAS made as it relates to Priority Area #5 and what challenges does it face?

ODMHSAS has moved from the old Community Mental Health Center (CMHC) model to a CCBHC model. In 2017, Oklahoma was selected by SAMHSA to be among the first eight (8) states to participate in a CCBHC demonstration model. In 2019, Oklahoma approved a CCHBC State Plan for state certification of CCHBCs under Oklahoma Administrative Rules. Over the past several years, ODMHSAS has been able to work with its CCBHC network and other partners to make substantial progress on improving community services including the crisis continuum. This has been enhanced by Oklahoma's launch of the 988 Helpline and further enhanced by Oklahoma Medicaid expansion in July 2021. ODMHSAS is continuing to build and enhance its core community services as well as its crisis system.

ODMHSAS has partnered with 13 different CCHBCs providing coverage to every county in the State. ODMHSAS continues to assess the continued expansion needs statewide and individually for each community and is reviewing current operations compared to the adult crisis continuum vision to identify potential gaps in the provision of wrap-around services and other performance improvement needs. CCBHCs are monitored through both certification reviews and annual fidelity reviews to ensure their compliance with required services, operations, and community collaborations.

As part of the State's goal of reducing inpatient readmissions and provides services to consumers in the most integrated and least restrictive setting appropriate, and in connection with the conversion to the community-based CCBHC model, ODMHSAS initiated a "Most in Need" reporting process in 2019. Through this process, ODMHSAS seeks to identify those individuals who have had multiple psychiatric inpatient stays, crisis unit encounters, and/or mental health related emergency room visits, or received other substance abuse treatment within Medicaid and ODMHSAS providers. Once identified, a report is provided to CCBHCs showing which of these individuals, referred to as "special populations," are located within their catchment areas. To incentivize CCBHCs to reach out and engage these individuals, a higher rate is available if they provide outpatient services to those special populations. The CCBHCs' statement of work also requires them to coordinate services between themselves and other external facilities. The "Most in Need" report, commonly known as "MIN," is updated weekly.

In 2022, ODMHSAS formed a specialized Care Coordination Team (CCT) to assist in providing care and resources to these vulnerable individuals. The CCT monitors the MIN report via data collected from the ODMHSAS report system known as PICIS. The CCT has access to, and

requests as needed, more detailed consumer services history via the PICIS Helpdesk. The CCT receives daily notifications of MIN admission to elevated level of care episodes, informs providers, and assists with transitioning the care of those individuals to outpatient providers. The CCT also helps facilitate the transition of individuals being discharged from extended inpatient stays through the use of Flex Funds to provide financial assistance for transitional housing until benefits are in place. As the system has progressed, the CCT has continued to develop a list of primary contacts within the agency's safety net providers, allowing the CCT to reach out directly to a care coordination liaison to coordinate care. Care coordination may include assistance with resources, multi-agency collaboration, case staffings, and warm handoff referrals to the outpatient provider network.

As an additional step of the MIN process, the CCT has now created a "Top 25" list for each CCBHC by sorting the MIN list by the highest number of episodes for that provider. The CCT monitors this list even more closely, including obtaining monthly reports, checking in with providers, and facilitating staffings whenever possible at elevated level of care admits.

The goals of the CCT include supporting the service continuum to decrease frequency and duration of crisis and inpatient admissions through connecting individuals with community-based services providers and recovery support resources at high-risk treatment transitions.

What is ODMHSAS' action plan related to Priority Area #5?

Objective 5.1: Develop, in partnership with private practitioners and inpatient hospitals, a set of recommended protocols for crisis flow and connection to ongoing services that ensures, among other things, that high acuity patients have access to specialized crisis services and evaluates instances in which patients are taken directly to emergency departments or inpatient hospitals instead of URCs and crisis centers.

Objective 5.2: Explore opportunities and new models that will expand reimbursement for medical services within CCBHCs.

Objective 5.3: Provide a regular schedule of continuing medical education training opportunities to enhance psychiatric training for medical staff.

Objective 5.4: Review ETPS measures for opportunities to strengthen performance by raising benchmarks where appropriate.

Objective 5.5: Leverage the Medicaid managed care organizations to identify and stratify individuals in need of intensive care coordination and outpatient services to ensure successful transition to the community and prevent readmissions.

Objective 5.6: Leverage the statewide Health Information Exchange (HIE) to create real-time notifications to CCBHCs when their clients are admitted to and/or discharged from private ERs and hospitals.

Objective 5.7: Create and publish a guide of statewide resources available to providers and clients dealing with transportation or other barriers to accessing outpatient services prior to being connected with telehealth resources.

Objective 5.8: Continuously review interventions used for treatment of first episode psychosis for new evidence-based strategies.

Objective 5.9: Monitor CCBHCs to ensure they have made good faith efforts to establish partnerships with all psychiatric inpatient hospitals and emergency departments in their catchment areas to provide diversion from higher levels of care and discharge support.

Objective 5.10: Review data from recent CCBHC visits to establish minimum score standards for CCHBCs on fidelity reviews. Develop protocols for corrective measures to include plans of correction, provisional certifications, and certification revocation.

What strategic KPIs will ODMHSAS use to evaluate progress related to Priority Area #5?

Strategic KPIs ODMHSAS will use to evaluate progress in this Priority Area may include:

- Number of People Served
- Number of Collaborative Partnerships
- Number/Percentage of Trainings Completed
- ETPS Data
- Statewide Service Utilization Rate
- Evidence-Based Practice(s) Implemented

PRIORITY AREA #6: HOUSING SUPPORTS

Expand access to housing supports and services designed to assist individuals being served to live in the most integrated and least restrictive setting of their choice that is appropriate to their needs.

Why is this a Priority Area?

"Individuals experiencing homelessness are at increased risk for experiencing a behavioral health crisis by myriad risk factors, such as high rates of abuse and trauma, higher prevalence of suicidal ideation and attempts, and untreated physical health conditions, as well as increased likelihood of being arrested and incarcerated, which leads to a cycle of disconnection from the behavioral health system and recurrent homelessness." [63] According to SAMHSA, "[h]ousing is the cornerstone of recovery for people with behavioral health disorders who are homeless."[64]

According to the Roadmap to the Ideal Crisis System, residential crisis programs, designed and staffed to work with individuals in behavioral health crisis who do not need the full resources of a psychiatric inpatient unit or other secure treatment settings, "add considerable flexibility to the behavioral health crisis continuum, as they can respond to individuals in less restrictive, often more home like settings, at lower cost than a hospital."[65] These programs may be used both for hospital diversion (which reduces admissions) and hospital "step-down" (which can shorten length of stay).[66]

---

[63] Kevin Martone *et al*., "Technical Assistance Collaborative Paper No. 8: The Role of Supportive Housing, Case Management, and Employment Services in Reducing the Risk of Behavioral Health Crisis" (Alexandria, VA: National Association of State Mental Health Program Directors, 2022) (https://www.nasmhpd.org/sites/default/files/2022-11/Supportive-Housing-Case-Management-and-Employment-Services-in-Reducing-Risk-of-Behavioral-Health-Crisis_NASMHPD-8.pdf), at 5 [hereinafter, "TAC Paper No. 8"].

[64] "TIP 55: Behavioral Health Services for People Who Are Homeless, A Review of the Literature" (Rockville, MD: Substance Abuse & Mental Health Services Administration, 2015) (https://store.samhsa.gov/sites/default/files/sma13-4734_literature.pdf), at 1-60.

[65] Roadmap to the Ideal Crisis System, at 108.

[66] *Id*.

What progress has ODMHSAS made as it relates to Priority Area #6 and what challenges does it face?

When it comes to integration and choice, housing exists within a broad continuum of settings. Where a particular individual lives depends on many factors. Some of these factors are specific to an individual, such as individual preference, level of need and individual resources (income and support). Other factors, such as the availability of affordable housing options and supports, are the result of systemic influences. The State's goal is to identify and reduce barriers on both an individual and systemic level that prevent consumers from being able to live in the most integrated setting of their choosing that is appropriate to their needs.

ODMHSAS recognizes that it can play a role in ensuring that a range of housing options are available for individuals to access at various stages of treatment and recovery, and that those options reflect the needs and choices of the individuals being served and offer their ability to receive those services in the least restrictive community-based setting of their choice. However, ODMHSAS is limited in its ability to directly support the unhoused population and views its ability to make an impact most for those engaged in behavioral health services, including those experiencing, or immediately recovering from, a behavioral health crisis. In that role, ODMHSAS continues to invest in a continuum of housing support services, including flexible funds distributed through providers to assist in finding and securing personalized housing choices for persons served. In addition, ODMHSAS has continued to provide training for and to promote case management services to assess and assist persons served in identifying social support needs and linkage to individual goals and desires. Individuals with SMI receive a case management assessment by their CCBHC provider, and goals are set to meet the needs identified. When housing support is identified as a need, support in the community is provided at the level the individual needs, which may include advocacy with landlords, rehabilitation skill building around budgeting and money management, linkage with subsidies and supports, meal planning and preparation, and basic living skills.

Some of the strategies within ODMHSAS' continuum of supported housing services including the following:

- Building relationships with local landlords to support individuals remaining in homes
- Master Lease Agreements
- Providing funding for temporary accommodations while longer-term housing options are developed, for both those transitioning from higher levels of care to the community as well as individuals in outpatient services in need of temporary housing supports
- Implementing and coordinating grand staffings (interdisciplinary team staffings that can include multi-agency resource partnerships) for individuals with complex housing needs or other barriers.

- Statewide housing resource trainings for treatment agencies
- Temporary and permanent supported housing programs
- Transitional living programs
- Residential care facilities
- Rental assistance and discharge subsidies
- Case management supports to connect consumers to other housing resources
- Supported employment to connect individuals with additional resources for housing and other needs

ODMHSAS also provides specialized housing Flex Funds to CCBHCs, hospitals, and care coordinators to be used to assist individuals in being connected to the housing situation of their choice while receiving individualized supports by CCBHCs. These supports include, but are not limited to, case management work with landlords on behalf of those served, budgeting skills, meal planning and development, hygiene and cleanliness, and building natural supports in the community.

In late 2023, ODMHSAS engaged the Technical Assistance Collaborative (TAC) to conduct an assessment of the existing affordable housing and residential capacity for people with behavioral health conditions in order to identify system strengths, needs/gaps, and opportunities to increase the supply of housing and housing-related services and supports to meet the needs of ODMHSAS consumers. The final report was received by ODMHSAS on April 29, 2024 (the TAC Housing & Residential Services Assessment & Recommendations). The report identified both strengths and weaknesses of the system. ODMHSAS is currently evaluating this new report for potential plan updates within the year.

ODMHSAS will continue to work to provide Oklahomans who have suffered a behavioral health crisis with connections to safe, affordable, and appropriate housing.

What is ODMHSAS' action plan related to Priority Area #6?

Objective 6.1: Improve documentation and data collection on the use of housing Flex Funds to better understand how they can make the most impact for those with behavioral health treatment needs.

Objective 6.2: Expand contracts with housing providers around supported and transitional living programs.

Objective 6.3: Implement a pilot program with a community partner to create a master leasing arrangement.

Objective 6.4: Increase housing-specific flexible funding opportunities to providers from $750,000 annually to $1 million annually.

Objective 6.5: Facilitate an initial housing conversation between ODMHSAS staff and Oklahoma Housing Finance Authority (OHFA) regarding the potential for partnerships.

Objective 6.6: Facilitate local partnership development and strengthening between Norman and Oklahoma City public housing authorities with project-based vouchers and relevant CCHBC partners.

Objective 6.7: Explore the potential for new housing-related opportunities under Medicaid with the ODMHSAS Director of Medicaid Behavioral Health Policy and OHCA, including without limitation opportunities under Section 1115 and Section 1915(i), to fund certain housing supports for those leaving hospitals and crisis facilities.

Objective 6.8: Review other recommendations and develop a plan to implement appropriate strategies included in the TAC housing consultation report.

What strategic KPIs will ODMHSAS use to evaluate progress related to Priority Area #6?

Strategic KPIs ODMHSAS will use to evaluate progress in this Priority Area may include:

- Number of People Served
- Statewide Service Utilization Rate
- Number of Programs/Partnerships Created
- Geographic Coverage

PRIORITY AREA #7: RECOVERY SUPPORTS AND SERVICES

Expand access to recovery supports and services designed to support community integration and that may prevent, or reduce the severity of, a behavioral health crisis and facilitate recovery.

Why is this a Priority Area?

Recovery services that use evidence-based supports and best practices provide critical opportunities to support community integration, help reduce the severity of crises that do occur, and facilitate post-crisis recovery.[67]

- Supported employment services – especially research-validated Individual Placement and Support (IPS), which has been adapted for working with people who are experiencing homelessness and those who have been involved in the criminal justice system – have been shown to increase access to competitive employment and income; reduce symptoms of mental illness, inpatient hospitalizations, and psychiatric crisis visits; and improve self-esteem and overall quality of life.[68]

- Peer services, which involve the participation of peer specialists who have the expertise of lived experience in every program across the continuum of care, can be critical to the success of individuals.[69]

- Case management services that incorporate evidence-based and best practice interventions can function as a critical hub for engaging individuals, facilitating self-direction, and choice.[70]

Adults with SMI are more likely to be unemployed or underemployed, contributing to economic hardship that can further affect behavioral health.[71] The likelihood of a person with SMI having

---

[67] TAC Paper No. 8, at 3.

[68] *Id.*, at 6-7.

[69] Roadmap to the Ideal Crisis System, at 127.

[70] TAC Paper No. 8, at 3.

[71] *Id.*, at 6.

full-time employment is reported to be approximately 1 in 10.[72] In 2012, SAMHSA reported that only 16.9 percent of all people served by state mental health systems were employed.[73] Despite low employment rates, studies suggest that the majority of people with SMI are capable of, and interested in, working if connected with appropriate jobs and supports.[74] Thus, employment plays a critical role in promoting recovery, while also reducing social exclusion, isolation, and poverty.[75]

What progress has ODMHSAS made as it relates to Priority Area #7 and what challenges does it face?

Oklahoma adopted the SAMHSA-recognized IPS evidence-based supported employment and education model in 2016. Employment embodies recovery for people with a mental health or substance use issue. Assisting individuals to locate and maintain competitive employment enables them to improve their social integration and networks as well as their living situation, which can reduce crisis risk in addition to having positive impacts on other aspects of mental health. In recent years, ODMHSAS has expanded its employment services to include additional evidence-based practices and strategies.

- During FY 2023, ODMHSAS served 1,652 individuals through the IPS program.
- Of those individuals, 1,298 are competitively employed.
- Individuals work on average 30 hours per week and earn an average hourly wage of $12.66.

ODMHSAS is also focused on involving peer specialists with shared experience, who are trained, certified, living in recovery, and willing to use their experiences to help others, in providing support to those with behavioral needs. Peer support has been shown to:

- Improve quality of life
- Improve whole health including chronic conditions like diabetes
- Decrease hospitalizations, including readmission rates, and length of inpatient stays
- Reduce the overall cost of services[76]

---

[72] "Getting to Work: Promoting Employment of People with Mental Illness" (Washington, DC: Judge David L. Bazelon Center for Mental Health Law, 2014) (https://www.bazelon.org/wp-content/uploads/2017/01/Getting-to-Work.pdf), at 1.

[73] *Id.*, at 2.

[74] TAC Paper No. 8, at 6.

[75] *Id.*

[76] "Evidence for Peer Support" (Alexandria, VA: Mental Health America, 2019) (https://www.mhanational.org/sites/default/files/Evidence%20for%20Peer%20Support%20May%202019.pdf).

Peer Recovery Support Specialists are certified by ODMHSAS and services are compensable through both Medicaid and ODMHSAS contracts.

- ODMHSAS has increased the number of initial peer specialist certifications by 62% between 2019 (296) and 2023 (781).
- There are currently more than 1,200 actively certified peers in the State of Oklahoma. From July 1, 2023, through June 17, 2024, they provided nearly 230,000 services to over 57,000 clients.

Case Managers use a strengths-based approach to provide support to a wide range of needs including employment and housing. Case managers assist individuals in finding employment and housing opportunities of their choice, completing job and rental assistance applications, and linking with community resources and activities to build on a social support network.

What is ODMHSAS' action plan related to Priority Area #7?

Objective 7.1: Augment existing IPS services to implement a continuum of employment support strategies through ODMHSAS contractors, such as workshops, mock interviews, assistance with building resumes, and other job-related skills by strengthening the peer and case management workforce use in employment support tools and interventions.

Objective 7.2: Require CCBHCs to demonstrate they have made good faith efforts to establish partnerships with all shelters in their catchment areas to provide access to services.

Objective 7.3: Develop and expand a continuum of intensive community-based supports (to include peer recovery support services, PACT, critical time intervention, and the Clubhouse model) to support engagement with high-need individuals.

What strategic KPIs will ODMHSAS use to evaluate progress related to Priority Area #7?

Strategic KPIs ODMHSAS will use to evaluate progress in this Priority Area may include:

- Number of People Served
- Number of Collaborative Partnerships
- Statewide Service Utilization Rate
- Evidence-Based Practice(s) Implemented
- Geographic Coverage

PRIORITY AREA #8: COMMUNITY EDUCATION AND OUTREACH

Identify and expand opportunities to raise public awareness of mental health and wellness issues, provide education about available community-based resources, and reduce stigma toward help-seeking.

Why is this a Priority Area?

More individuals might opt for community-based services if they and their families could easily access information about services to support greater independence. Additionally, outreach activities can help to prevent an individual experiencing early crisis signs from progressing to an acute crisis event.

Community education and training is an important part of enhancing the effectiveness of the crisis continuum. This includes topics like how to recognize and respond to individuals with mental health needs (e.g., Mental Health First Aid), information about how to access 988 and the local crisis system, and encouraging individuals to seek help quickly from the crisis system if there is an emergency need for a family member or friend.[77] Individuals with disabilities and their families should have access to information about their disability and which services and supports are available to support community living.

What progress has ODMHSAS made as it relates to Priority Area #8 and what challenges does it face?

ODMHSAS supports a variety of community and local partnerships across the State with county/municipal governments, school districts, faith communities, and businesses. ODMHSAS has also engaged in multiple advertising campaigns designed to increase awareness of mental health issues and resources available in Oklahoma. This included a major campaign surrounding the 988 Helpline, including a nationally recognized media campaign.

What is ODMHSAS' action plan related to Priority Area #8?

Objective 8.1: Increase the number of business sectors developing policies and practices to train supervisors on Mental Health First Aid (MHFA) so they can assist employees experiencing a behavioral health crisis.

[77] Roadmap to the Ideal Crisis System, at 67.

Objective 8.2: Provide a regular schedule of crisis services training to enhance the knowledge of crisis best practices for the public and private provider network.

Objective 8.3: Implement three (3) workforce development strategies annually to support expansion of services across all levels. Strategies may include increased resources or contractual, administrative rule, or statutory amendments which allow expansion of state behavioral health workforce or improved workforce efficiencies.

Objective 8.4: Measure baseline and create role-specific marketing strategies to increase the number of behavioral health professionals in the field.

Objective 8.5: Review and expand opportunities for ODMHSAS to receive concerns or complaints directly from service recipients for each of the priority areas.

Objective 8.6: Provide a regular schedule of legal and ethics trainings to stakeholders beyond law enforcement, including at least one annual training on "person requiring treatment" criteria.

Objective 8.7: Review opportunities to increase public awareness and perception of service availability in their communities, driven by data identified in response to Priority Area #9.

Objective 8.8: Provide statewide training opportunities which target behavioral health providers, medical professionals, and preventionists to educate the field on Zero Suicide best practices and expand the use of Zero Suicide care pathways in behavioral health and medical treatment settings.

Objective 8.9: Provided targeted workforce trainings to support peer roles in crisis services.

What strategic KPIs will ODMHSAS use to evaluate progress related to Priority Area #8?

Strategic KPIs ODMHSAS will use to evaluate progress in this Priority Area may include:

- Number of People Served
- Number of Collaborative Partnerships
- Number of Trainings Completed
- Statewide Service Utilization Rate

PRIORITY AREA #9: DATA MANAGEMENT

Continuously improve data collection, management, and reporting systems to develop an aggregate understanding of overall utilization patterns to drive decision-making regarding system investment, service delivery, and other policies.

Why is this a Priority Area?

Behavioral health crisis systems (an integrated set of safety-net services) involve interacting programs which work to achieve optimal results, using best practices for performance management in dynamic systems, and as such, utilize shared performance data for customer-oriented continuous quality improvement (CQI).[78] The Roadmap to the Ideal Crisis System notes that it is important to have the ability to monitor and follow client-specific data through the system, both to identify instances where individuals fall through the cracks for individual cases and for aggregate understanding of overall utilization patterns.[79]

Using performance data to understand overall utilization patters and ensure individuals are matched with available services within a reasonable time frame is consistent with the *Olmstead* decision's requirement that a state's comprehensive plan must include "a waiting list that move[s] at a reasonable pace . . . ."[80]

What progress has ODMHSAS made as it relates to Priority Area #9 and what challenges does it face?

Decision Support Services (DSS) is the division within ODMHSAS responsible for collecting, analyzing, and reporting data on services. DSS maintains a robust database on services provided through the Department, including client characteristics, demographics, treatment needs and outcomes. Through analysis of this data, treatment effectiveness is determined at the client, agency, and system level. Results are used for quality improvement, program evaluation, advocacy, and federal and state reporting requirements. DSS has a stellar record using data for performance improvement and accountability. ODMHSAS is also an experienced user of national

---

[78] Roadmap to the Ideal Crisis System, at 31.

[79] Roadmap to the Ideal Crisis System, at 58.

[80] Olmstead, 527 U.S. at 584.

expertise for performance improvement, as the many references in this report to external resources and consultation indicate (GAP, SAMHSA, TAC, Dr. Mike Hogan, Healthy Minds, DOJ, and NASMHPD). ODMHSAS provides data analysis on its crisis continuum in various forms, including public reports, dashboards, and fact sheets.[81]

What is ODMHSAS' action plan related to Priority Area #9?

Objective 9.1: Annually review data reports to identify gaps with specific adult populations which are least likely to connect to outpatient services after receiving higher level of care. This includes, but is not limited to, evaluation of individuals discharging from inpatient settings and whether they connect to outpatient care by diagnosis, age, and gender.

Objective 9.2: Create and regularly review a data dashboard for each of the priority areas to review key performance indicators. Evaluate which, if any, of these dashboards should be made publicly available.

Objective 9.3: Partner with OHCA to evaluate the use of SoonerRide benefits for those with behavioral health treatment needs to determine opportunities for increased access to services through existing resources.

Objective 9.4: Review data sharing opportunities annually for updates and to determine if any additional agreements are needed.

Objective 9.5: Continue to conduct formal service gap analysis annually to support resource investment planning, including analysis of populations not accessing treatment resources.

Objective 9.6: Launch a new electronic health record (EHR) system across all State-operated facilities.

Objective 9.7: Obtain expert consultation to guide development of a data-based-performance-improvement (CQI) strategy and process for ongoing assessment and improvement of the crisis continuum, including recommendations published from the National Council for Mental Wellbeing whitepaper *Quality Measurement in Crisis Services*.

Objective 9.8: Support, train, and fully enforce new opportunities to improve coordination of care through data sharing. This includes but is not limited to the development of a new

[81] *See* https://oklahoma.gov/odmhsas/treatment/comprehensive-crisis-response.html and https://oklahoma.gov/odmhsas/research/statistics-and-data/dashboards.html.

statewide, ODMHSAS-endorsed consent template provided to state-operated and private treatment facilities.

What strategic KPIs will ODMHSAS use to evaluate progress related to Priority Area # 9?

Strategic KPIs ODMHSAS will use to evaluate progress in this Priority Area may include:

- Number of People Served
- Number of Collaborative Partnerships/Projects
- Statewide Service Utilization Rate
- Dashboards
- Project Completion Rate

CONCLUSION

ODMHSAS is proud of the progress the State has made in meeting the needs of Oklahomans experiencing behavioral health issues, in alignment with its responsibilities under *Olmstead*, but recognizes there is always room for improvement. ODMHSAS continues to study national trends, federal guidance, and best practices and strives to be a leader in implementing them where appropriate. With the adoption of this Olmstead Plan, ODMHSAS will continue to explore opportunities to expand on this important work.

ACKNOWLEDGEMENTS

ODMHSAS would like to thank the following for their assistance with the development and review of this Plan:

- Dr. Margie Balfour, M.D., Ph.D., Chief of Quality and Clinical Innovation at Connections Health Solutions and Associate Professor of Psychiatry at the University of Arizona; Co-author of the “Roadmap to the Ideal Crisis System: Essential Elements, Measurable Standards and Best Practices”

- Dr. Chris Carson, M.D., MBA, Co-founder and Chief Strategy Officer of Connections Health Solutions

- Dr. Joe Parks, M.D., Medical director for the National Council for Mental Wellbeing and Distinguished Research Professor of Science at Missouri Institute of Mental Health with the University of Missouri, St. Louis

- Dr. Michael Hogan, PhD, Former Commissioner, New York State Office of Mental Health; Former Director, Ohio Department of Mental Health; Former Commissioner, Connecticut Department of Mental Health; and Olmstead Special Master/Court Monitor, *U.S. v. Mississippi*