

Green Country Behavioral Health Services, Inc.

FY2019 Annual Plan

PURPOSE

The Green Country Behavioral Health Services (GCBHS) Annual Plan establishes a planned, systematic, organization-wide approach to design and performance measurement, analysis and improvement for GCBHS services. The plan includes agency and departmental goals.

INTEGRATION OF PLAN WITH GCBHS MISSION, VISION, VALUES AND STRATEGIC PLAN

This annual plan assists GCBHS staff in working toward, and actively achieving, our agency mission.

MISSION STATEMENT

GCBHS strives to create a safe, supportive and welcoming environment where those we serve can gain skills and resources necessary to lead healthy, self-sufficient, productive lives.

VISION

Our vision is to be the team of excellence and leaders in the provision of quality services.

VALUES

Accountability	Highest Ethical Standards	Mutual Trust
Dedication	Integrity	Open, Honest Communication
Diversity	Loyalty	Professional Development
Excellence		Respect

PRIORITIES

GCBHS organizational priorities continue to be established around three major areas:

- growth and expansion of services to meet our ever-changing community needs;
- improved productivity and efficiency, and
- continuous quality improvement. These priorities guide our performance improvement efforts and help us achieve our strategic goals.

GCBHS staff are committed to increasing the value of our services by enhancing quality and strengthening our ability to deliver the most effective and efficient care to our clients and communities. We will do this in a variety of ways, which include:

- Design effective programs and processes that meet the needs of our clients and community, which are consistent with our mission, vision, values, goals and plans.
- Collect data to monitor the stability and efficiency of existing processes, identify opportunities for improvement, and make changes that will lead to improvement.
- Aggregate and analyze data on an on-going basis and to identify changes that will lead to improved performance and reduction in errors
- Achieve improved performance and sustain the improvement throughout the organization
- Promote collaboration at all levels of the organization, creating a foundation of mutual respect and a culture focused on performance
- Educate leaders and staff regarding responsibilities and effective participation in performance improvement activities.

SCOPE AND ORGANIZATION

Governance Board

Green Country Behavioral Health is a private, non-profit organization with a seven member Board of Directors that maintains fiduciary responsibility for the agency. The GCBHS Board meets statutory and agency regulations, as outlined in GCBHS Bylaws and the Oklahoma Open Meeting Law. We are fortunate to have seasoned board members who have served diligently for many years. However, we believe that fresh ideas, new schools of thought, and interested parties are critical for objectivity. Even though we have board members who rotate on and off of our board, we also enjoy new board members regularly.

GCBHS serves as Grantee for the Muskogee County Head Start/Early Head Start program. This program operates under joint governance with the Muskogee County Head Start Policy Council. As grantee, we are required to maintain a board of directors that includes members with specific expertise and experience. We have two GCBHS Board members with extensive financial background, one with early childhood development and education training and experience, and a practicing attorney. We have the guidance and expertise of law enforcement, with Muskogee's Police Chief serving on the GCBHS Board. Other individuals, with education, medical and faith-based backgrounds, also serve on the board, as well as service recipients and individuals representing Muskogee and McIntosh Counties.

The GCBHS Chief Executive Officer is hired by the Board of Directors to oversee the daily operations of the agency. The CEO works with an executive leadership team, which is comprised of Directors and Officers responsible for fiscal management, overall planning and direction, technology, and day to day operations of both GCBHS and Head Start.

Leadership Team

Our Leadership Team is comprised of professional staff with many years of experience in behavioral health care, early childhood education, fiscal operations, and administrative fields. Our philosophy revolves around our organization's tag line: *caring people, caring for others*. Our leadership perspective is clear: we serve our staff, our community, our clients and our industry. We are focused on providing a welcoming environment, free from judgment, and based upon a belief in recovery, early intervention and fully integrated care. Leadership Team meets weekly to plan for, and report on, business agenda items.

The GCBHS executive leadership team consists of the Chief Executive Officer, Chief Financial Officer, Compliance Officer, Head Start Director, Information Technology Director, and Clinical Director. All members of the leadership team, along with the Crisis Stabilization Unit Supervisor, report to the Chief Executive Officer. Attachment A is the most current organizational chart, listing agency positions. The tenure of leadership totals more than 130 years of combined experience with our organization. That history and expertise are invaluable to the success of our organization. **(See attachment A. Organizational Chart)**

Organizational Structure

The GCBHS organizational structure follows a typical hierarchal-based structure of leadership, supervisors, and direct care staff. Still, we work together to achieve program and agency goals. Each department/team acts as a self-directed group to achieve program goals, which ultimately support GCBHS agency goals. Departments are led by a supervisor, responsible for daily activities and supervision of identified staff. Ultimately, each leadership team member is responsible for guiding and mentoring various departments through direct contact with the supervisor and indirectly with staff.

FINANCIAL ACCOUNTABILITY PLAN

GCBHS Finance and other staff follow internal control policies approved annually by the agency's Board of Directors. Financial projections are conservative forecasts based upon the current fiscal year's revenue and expenses. We use an industry standard financial software package, proven to be trustworthy and reliable. This software is updated on a regular basis and informational staff trainings are provided as needed.

Certified public accountants with EideBailly, L.L.P. conduct an annual fiscal audit of Green Country Behavioral Health and Muskogee County Head Start. On an annual basis, the financial audit report is presented to the GCBHS Board of Directors and MCHS Policy Council for their approval. The final report is provided to the ODMHSAS auditing division, as well as the Department of Health & Human Services, Region VI office; The State Department of Education, Child Nutrition Division; and the Muskogee Community Action Foundation. It has been our experience, and it continues to be our expectation, that audit results show no issues of non-compliance and no material weaknesses.

ORGANIZATIONAL NEEDS ASSESSMENT/COMMUNITY PROFILE

The initial step toward our annual strategic plan, outlined in the next section, is identifying organizational and community needs and service or support gaps. The process is as follows:

- We collect information through stakeholder surveys for their valuable input.
- We review program outcomes, client charts, and agency outcome measurements through the GCBHS Performance Improvement (PI) Committee.

Client Satisfaction surveys are collected quarterly on all GCBHS programs, with the exception of our Crisis Stabilization Unit (CSU). Although CSU client satisfaction surveys are *compiled* quarterly, they are completed and collected at the time of discharge, so that any identified concerns may be addressed with the client personally, before he or she leaves the unit.

Head Start parents participate in a survey process twice annually and annual stakeholder surveys are completed by Board and Policy Council members, other community agency staff, and client family members. Additionally, our employees have input through on-going scheduled meetings, such as the GCBHS/Head Start monthly full-staff meeting, weekly clinical staffing, doctors' staffing and quarterly supervisors' meetings. Data collected from these sources is compiled and shared with the PI Committee, Leadership, and the Board of Directors. PI Committee members utilize this information for changes and/or improvements in our performance and to increase the quality of services to our clients.

GCBHS staff conduct strategic planning sessions annually, which include a SWOT assessment. A formal strategic planning meeting is conducted every three years. The most recent GCBHS strategic planning session was conducted on June 9, 2017. Our annual planning session for FY2019 was held in June 2018 during an off-site GCBHS Leadership Retreat. Combining these two events allowed all GCBHS leadership team members and supervisors to participate in strategic planning and develop this plan. The GCBHS Annual Plan is presented to the board for review and revisions, and to ODMHSAS. The plan is available to staff, as well as the public, through our external web page.

Our comprehensive needs assessment also includes data collected through client satisfaction surveys, staff surveys, stakeholder surveys, the ODMHSAS PICIS system, and word of mouth. Information is assembled and reviewed through the Performance Improvement Committee. A review of the previous year's annual management report (GCBHS Annual Report) is included in our information analysis. The

Annual Report is available to staff, the Board, the ODMHSAS and the general public, upon request and through our external web page.

Annual Objectives: Objectives are guideposts that define standards of what our organization should accomplish in areas such as service outcomes, customer service, stewardship, safety, etc. Department Supervisors, Performance Improvement Committee, and Leadership are able to evaluate performance on a regular basis, based on how well we are moving toward our objectives.

Goals: Organizational goals, both short-term and long-term, define the desired results that we hope to realize and achieve annually.

Strategies: Strategies are created by evaluation of decisions within the organization that will enable long-term objectives to be achieved. Strategies that help us identify the resources needed to implement the organizational objectives are as follows:

- Maintain quality standards
- Secure / maintain necessary resources
- Establish cost-effective operations
- Establish a continuous improvement plan for reviewing and evaluating progress
- Develop a system that documents processes, for staff training
- Include staff from all levels of the company; understanding and acceptance is developed through participation
- Establish a financial plan that ensures enough cash flow and revenue to grow the company effectively
- Include risk management to plan for downturns, should they occur
- Develop systems and policies that enhance our employees' abilities to perform their jobs effectively

PERFORMANCE IMPROVEMENT PROGRAM

GCBHS has a performance improvement program established to objectively and systematically monitor, evaluate and improve the quality of care we provide. The PI team reviews and monitors multiple facets of the organization, including fiscal management of the agency. The PI Chairperson, with input from the team, is responsible for drafting the Annual Plan. The annual plan guides our agency for each fiscal year. The plan includes agency goals, department goals, and outcomes management processes for each year.

The outcomes management for the agency will include, at a minimum:

1. Measure and monitor efficiency and effectiveness
2. Monitor client satisfaction;
3. Analyze patterns of service utilization;
4. Evaluate data and information received from all departments, programs, and teams;
5. Monitor and evaluate reports relating to client satisfaction, complaints, record reviews, and other information/reports identified throughout the year;
6. Implement, review, and monitor the organization's safety program;
7. Review and monitor on-going compliance with standards and regulations required by certifying bodies;
8. Provide analysis for data collection to be used for trending and identifying outcomes;
9. Review cases of critical incidents and sentinel events and offer input;
10. Make recommendations to improve the overall quality of services we provide; and

11. Give priority to improvements that affect behavioral outcomes, client/staff safety, and person-centered quality of care.

Performance Improvement Committee

The GCBHS Performance Improvement Team is the primary group which provides review and adaptation of functions and processes to increase the probability of achieving desired outcomes to better meet the needs of the people we serve and improve the overall quality of our programs and services.

This multi-disciplinary team consists of social workers, licensed professional counselors, case managers, peer recovery support specialists, nurses, as well as financial, medical records and data analyst staff, collaborating with the agency Medical Director as needed. Representatives from various departments attend this meeting as requested by the chairperson. Through collaboration across multiple disciplines and departments, the PI team will identify and prioritize areas for improvement based upon organizational goals and initiatives consistent with our mission, vision, and values. A written report with recommendations is submitted to leadership on a quarterly basis, at a minimum.

The Performance Improvement Chairperson

In FY2019, the PI team is chaired by the CEO, a licensed clinical social worker. The chairperson will act in a facilitative and consultative manner and assist the Committee in the implementation of policies, plans, and projects aimed at performance improvement or achieving and maintaining certifications.

GCBHS leadership ensures a concentrated effort is directed toward overall agency improvement. In addition, the chairperson will, in accordance with national outcomes expectations and enhanced tier payment system (ETPS) measures, provide the following:

- Guidance and consultation to department heads, staff, and leadership regarding current best practice information,
- Monitoring of reports and meeting minutes from all departments for the assessment of data and status of outcomes, and
- Reports to leadership noting status of improvement measures and outcomes.

Goals of Performance Improvement

1. Assess and improve clinical, managerial, and support processes to ensure efficiency and effectiveness throughout the organization.
2. Ensure the use of multidisciplinary approaches for improvement of client care. These include Co-occurring capability; the provision of trauma informed care; provision of culturally competent services; and assurance that services are client driven.
3. Manage improvement efforts within reasonable limitations of resources and restrictions of regulations and laws.
4. Review processes that are particularly important to ensure client safety.

Objectives of Performance Improvement

1. Provide ongoing information and suggestions to the organization's leadership and staff regarding outcomes and programmatic challenges.
2. Prioritize activities that are designed to improve client care.
3. Communicate to leadership and staff any issues of effectiveness, efficiency, and/or client satisfaction.
4. Make recommendations for inclusion in the annual management report.
5. Coordinate the collection, management, and analysis of all data needed for quality improvement and outcomes management.

Performance Improvement Activities

PI activities will consist of monitoring for efficiency and effectiveness, at a minimum, the following areas:

- Medical Services
- Clinical (including outpatient, CSU and discharge)
- The Clinical Privileging Process
- Human Resources (specific to turnover rates and retention)
- Information Technology (includes ALL technology – EMR, phones, etc.)
- Data Processing – for efficiency and effectiveness
- Utilization Management – of resources (primarily staff and space, but may include LOS norms)
- Identifying areas considered high volume, high risk, and problem prone
- Track adverse client events, analyze their causes, and implement preventive actions and mechanisms
- Annually review and make suggestions in regard to the agency’s training program for new and existing employees

Aggregation, Analysis and Monitoring of Data

The agency’s on-going collection and monitoring of data covers a multitude of variables including clinical, financial, operational, as well as client and staff satisfaction. Data collection activities will be based upon priorities established by the leadership team. Additional requirements for data collection imposed by funding sources and regulatory bodies will be included when necessary.

The collected data is used to monitor stability of existing programs and processes, identify opportunities for improvement, identify necessary changes, and/or demonstrate sustained improvement. Data will be collected within the agency’s limited resources.

Decisions will be made based upon data collected. Data will be aggregated and analyzed in such a way that current performance levels, patterns, and/or trends can be identified. The agency will utilize appropriate tools and techniques to analyze and display data. Outcomes management processes will include measures required by ODMHSAS and CMS and may also include measures from SAMHSA NOMS, NCQA and HEDIS as related to the services we provide. HEDIS is the Healthcare Effectiveness Data and Information Set, a tool to measure performance on important dimensions of care and service.

When appropriate, data will be trended and compared over time. External benchmarks may be used to establish baselines when available and appropriate to identify opportunities for improvement.

Analysis will be conducted when data indicates that levels of performance, patterns, or trends vary substantially from those expected and for those topics chosen by leadership as priorities for improvement.

The PI Team will conduct, at a minimum, a quarterly records review to assess:

- Quality of services delivered;
- Appropriateness of services;
- Patterns of service utilization;
- Treatment goals and objectives based on assessment findings and client input;
- Patterns of access to, and utilization of, specialty care;
- Services provided are related to goals and objectives;
- The care plan is reviewed and updated as prescribed by policy

Methods to assess data will include, but are not limited to, the following:

- Comparing data trends regarding processes and outcomes over time
- Intensive assessment when undesirable variation in performance occurs
- Single events and patterns/trends that significantly vary from those expected

Analysis of the program will begin with areas that are considered high volume, high risk, and problem prone or have occurred unexpectedly with serious consequences, which require a more in-depth analysis. Self-assessment measures, which may be linked to tier measures and NOMS, will be utilized to assist in determining progress toward agency and programmatic goals, when applicable. Some examples of areas that would require root-cause analysis include, but are not limited to, the following:

- Sentinel events
- Engagement
- Follow-up
- Crisis Services
- Medication errors
- Client injuries
- Staff injuries
- Accessibility
- Trauma Informed Services
- Co-Occurring capabilities
- Wellness Services

Planning Process for Performance Improvement

GCBHS recognizes that, in order to develop a strong organizational plan, input from persons served, service providers, employees, and the community is a necessary and valuable source of information. The following will be considered in developing performance improvement measures and organizational planning:

- Client surveys
- Employee Surveys
- Stakeholder Input
- Complaints & Grievances
- Critical Incident Reports
- Client Data (demographics and service utilization)
- Performance Improvement Reports
- Financial Reports
- Medication Reports
- Human Resource Reports
- Governing Authority
- Record Reviews
- Outcome Reports

Areas for Improvement

The PI Committee will also review areas for improvement agency wide. For FY2019, we will continue our focus on major areas identified for improvement: (1) increasing the number of clients receiving services; (2) establishing a plan for employee recruitment and retention; and (3) expanding our clinic office and parking space. We will also realize the goal of improving services in McIntosh County by establishing our new clinic in Checotah, Oklahoma.

Program Evaluation

Annual review of the PI program is completed in August and includes evaluation of the objectives, organization, and effectiveness of the activities to design, measure, assess, and improve the quality of services. This review results in a year-end report documenting data analysis, planning and outcomes. The report is reviewed in PI, shared with our Board of Directors, and provided to staff and the public through the agency website.

CLINICAL PRACTICE GUIDELINES

Clinical practice guidelines are used throughout the agency to monitor, evaluate and improve specific diagnoses, conditions, and/or symptoms and the overall clinical care provided by our organization.

Understanding that clinical supervision is a critical component of the provision of quality services, we require all clinical staff to have a clinical supervisor. Supervision occurs through a variety of ways, which include the following:

- Clinical Staffing, held at least twice monthly;
- Individual supervision which must occur, at a minimum, quarterly;
- Formal Clinical Supervision, to review treatment methods, EBP utilized, training needs, and strengths, must occur at least annually.

At any of the supervisions and staff meetings, the following may be reviewed/addressed:

- The appropriateness of selected treatment;
- Treatment effectiveness as reflected by the client meeting treatment plan goals;
- The provision of feedback that enhances clinical skill.

The supervisions may be documented in a variety of ways. The monthly clinical staff meetings are recorded by sign-in sheets; group and individual supervisions are documented on a supervision form.

INFORMATION MANAGEMENT

GCBHS adheres to the mandates of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), State Law 43A, the DMHSAS standards, as well as other regulating agencies. In addition, GCBHS follows those mandates requiring stricter regulation of information as prescribed by 42 CFR and 45CFR.

OPERATIONS

GCBHS provides services in three principal locations. Our McIntosh County clients receive local services in an outpatient facility, which we are in the process of moving to Checotah, Oklahoma. After providing services to McIntosh County in Eufaula for over 20 years, the change was made to relocate to Checotah. This move will be realized early in FY2019. We employ an average of five to ten staff of various credentials. McIntosh County has been a prime location and recipients of services here seem to be on a higher acuity level at all times. It is a very rural county and transportation is extremely limited. We have had difficulty finding employees who want to work in Eufaula; however, we believe staffing will be easier in Checotah, since this rural community is, at least, closer to Muskogee. Resources are few and the county census has a very low growth rate. Therefore, it is critical that McIntosh County staff are self-directed, enterprising, reliable, trustworthy, and goal-oriented, whether they currently work in Eufaula, or will work in our Checotah clinic, planned to open in FY2019.

In Muskogee County, we own and operate a 15 bed adult crisis stabilization unit for persons needing 24-hour restricted care. This is a locked facility, staffed every day and around the clock - 24/7/365. We employ nurses, bachelor and master level staff, licensed staff, psychiatric techs, PRSS techs, a cook, and administrative staff. We have an average of twenty-five to thirty staff at this location. This facility was remodeled specifically for the purpose of providing crisis care and we have operated this unit for over 15 years.

Our crisis unit staff are leaders in the provision of crisis care and discharge planning. Our average daily census is 10.64 and our average length of stay is 6.49 days. We provide stabilization to people from all over the state. Through a combination of effective treatment and comprehensive discharge planning, we have also reduced our recidivism rates.

Finally, GCBHS owns the Muskogee facility where our administrative offices are located and the majority of outpatient services are provided. There are approximately 80 employees housed at this location in central Muskogee. In addition to our services, we also have a fully licensed pharmacy available to our clients and the general public. At this same location, we collaborate with the Muskogee Health Center, an FQHC providing healthcare services to the public. Muskogee Health Center's medical staff provide services for our Medication Assisted Treatment Clinic, which continued to grow each month of the last fiscal year, and promises to maintain that growth.

GCBHS SERVICES

All GCBHS programs are designed and managed to provide a friendly, secure environment for adults, children and their families in need of assistance due to behavioral health and/or substance use issues. Individuals should expect and receive a helpful, compassionate, and welcoming response when seeking assistance from our agency. Services that are culturally relevant, trauma sensitive and evidenced based are paramount to our success. Furthermore, we understand that the people we serve are prone to have chronic conditions. We understand that brain health is interdependent upon all health. Physical conditions left untreated impact mental dispositions and recovery. We believe that treatment must include all health conditions and, although complex, we view treatment of all conditions as vital to our core service delivery. We know recovery is possible!

Our targeted population consists of persons presenting with behavioral health and/or substance use concerns. Services are available to all residents of Muskogee and McIntosh Counties, with priority given to children who are seriously emotionally disturbed and adults who are seriously mentally ill. Persons who live outside of our identified counties are also eligible for services at GCBHS, upon request. In the adult population, individuals with psychosis who have severe or moderate impairment and those persons being released from inpatient or crisis units are given priority.

In addition, persons presenting with substance use disorders will be given priority as follows:

- Pregnant, injecting drug users
- Pregnant, substance users
- Injecting drug users
- Women with dependent children
- Persons with HIV/AIDS or Hepatitis C

These services shall include the provision of HIV education, training and counseling services for drug dependent persons. This may be accomplished through staff providing basic education and/ or referring the person to agencies recognized for providing this education and/or services. Counseling may involve the person's significant other(s). Referrals to testing and counseling will also be provided to the person.

Outpatient services may include individual, group and/or family therapy. Psychological evaluations and testing may be administered at the agency's discretion, based upon staff availability, client status, and financial ability. Clinicians providing this service are licensed mental health professionals, as defined by state standards, with knowledge of co-occurring issues and education and/or training adequate to meet the needs of the target population.

Core Treatment Components include:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Support Systems

Core services include:

- Emergency Services (including emergency examinations for detention and Community Based Structured Crisis Care – CBSCC)
- Screening, intake, assessment, and referral
- Outreach
- Medication Clinic
- Case Management services
- Psychiatric Rehabilitation / Education, Skill Development, and relapse Prevention
- Outpatient Therapy services (individual, group, family, & marital)
- Co-Occurring Services
- Services to the Homeless
- Peer Recovery Support services
- Wellness Services and Related Activities
- Discharge Planning, Aftercare Engagement, and Follow-up

GCBHS staff members are trained in the role trauma plays in the process of recovery. Additional training in culturally competent approaches, client driven services, and co-occurring needs has been provided to all direct care staff. Behavioral health service plans and arrangements for integrated services will be documented in the client's record.

Program Components

GCBHS provides comprehensive, quality care utilizing evidenced-based practices. Our services have been streamlined to reduce, if not totally eliminate, barriers to access. First time users, as well as existing GCBHS clients, are afforded the opportunity for an array of service options to best meet their needs. We have a talented, diverse, well-trained team, ready to meet the needs of our clients and communities.

In FY2019, the following agency goals will guide GCBHS program direction and provide a framework for departmental goals:

FY2019 AGENCY GOALS

Goal 1:

Reduce stigma associated with seeking help for mental health concerns, substance use, and domestic violence.

Objectives:

1. Provide public awareness and education through outreach and presentations.
2. Advocate for the services we provide through advertisement, forums, and employment fairs.
3. Develop and implement prevention and early intervention strategies.

Target date: On-going, Monitor Quarterly

Responsible Staff: Leadership Team, All Staff as Requested

Goal 2:

Provide fully integrated care for everyone we serve utilizing the Chronic Care Model for population based treatment.

Objectives:

1. Follow the “Health Home” model from the state for all persons served.
2. Implement the Chronic Care Model that will help reduce cost and improve outcomes for persons served by coordinating prevention and wellness services, acute care, and disease management.

Target Date: On-going, Monitor Semi-Annually

Responsible Staff: Clinical Staff, Leadership

Goal 3:

Continue to develop the agency’s wellness strategies which include staff and clients through activities, policies, and procedures that encompass healthy alternatives and directions.

Objectives:

1. Advertise the risks associated with tobacco use and encourage cessation through education.
2. Be proactive in our wellness activities, including nutrition and mindfulness activities.

Target Date: On-going, Monitor Quarterly

Responsible Staff: Wellness Champion, Leadership Team Support, All Staff

Goal 4:

Ensure that clinical staff is trained and utilizing only evidenced based practices and best practice methods.

Objectives:

1. Provide training to clinical staff regarding best practices and examine their knowledge about evidenced based interventions.

Target Date: June 2019, Review Monthly

Responsible Staff: Clinical Staff, Clinical Supervisors, Clinical Director

Goal 5:

Ensure that all agency employees have applicable education and understanding of problems related to co-occurring, trauma informed, client centered, culturally competent practices and holistic approaches for the people we serve.

Objective:

1. Provide education / training opportunities to staff.

Target Date: Staff Orientation, Annual training – March 2019, Review Quarterly

Responsible Staff: Leadership, Other identified staff

Goal 6:

Ensure that we have adequate staffing patterns to meet the needs of our communities and the people we serve.

Objectives:

1. Recruit and maintain licensed, quality staff for all agency departments and/or programs.
2. Provide supervision for licensed eligible staff to assist with licensure and certification requirements.
3. Review and compare salary scale to other similar businesses
4. Review and assess current employee benefits
5. Continue collaboration with area universities for internship opportunities.
6. Provide opportunities for staff to attend continuing education offerings to increase job skills and licensure requirements.

Target Date: On-going, review June 2019

Responsible Staff: HR Department, Leadership Team

Goal 7:

Utilize resources to better serve McIntosh County, expanding our reach in order to provide high quality, integrated behavioral health and substance use services to a greater number of people in need.

Objectives:

1. Create a safe, inviting clinic in Checotah through the purchase or lease of a building which is structurally sound, conveniently located, and suitable for clinic offices, waiting rooms and other amenities; plan and execute necessary modifications.
2. Ensure that the needs of current Eufaula clients are met by assisting with the transition.
3. Build new relationships by increased involvement in the Checotah community.
4. Be a community partner from the beginning; invite community to an open house when the clinic is complete.

Target Date: Opening: September 1, 2018, On-going

Responsible Staff: Leadership Team

Goal 8:

Continue to utilize all forms of technology to enhance services and improve staff and client safety.

Objective:

1. Utilize the most updated technology where possible for agency business.

Target Date: On-going, Review Semi-annually

Responsible Staff: Leadership, Primarily Information Technology Director

We moved our data base from GC data center to CREOKS data center (GoHealth). We upgraded our EMR in FY2019 and we switched our hosting from GC to an outside source – which will work better and work faster because they have the ability to correct issues immediately on their server, not ours, and the updates will be performed easier for the same reason. They also can detect data base errors faster because they monitor it from their end.

Goal 9:

Maintain strong financial stability.

Objective:

1. Increase Medicare and Medicaid billing opportunities
2. Increase grant funding
3. Maintain and continue federal Head Start grant program

Target Date: Review monthly; financial audit December 2018

Responsible Staff: Leadership, CFO

PROGRAM INFORMATION

All GCBHS clinical staff members are trained in the area of crisis intervention theories and application. Licensed staff throughout the organization has specific training in the applicable laws with regard to orders of detention. Persons meeting criteria for detention and those experiencing a mental health or substance dependence crisis will take precedence over any scheduled appointment, wherever the person presents.

ADULT SERVICES

Philosophy

GCBHS strives to create a safe, supportive and welcoming environment where those we serve can gain skills and resources necessary to lead healthy, self-sufficient, productive lives. We provide trauma informed, co-occurring capable, culturally competent, and recovery focused services that include the whole person so that health and wellness are considered integral aspects of our treatment focus. Staff is educated as to the dynamics trauma plays in the recovery process. Furthermore, staff understands how our interaction and reaction may impact a person's willingness to provide information and/or continue to seek service.

Admission Criteria

We provide mental health services to individuals who are at least 18 years of age and meet the criteria for services. Depending upon which contract source the person will be seen through, specific criteria must be met. Persons meeting financial thresholds for indigent care as well as those with SoonerCare must also meet standards to be identified as Seriously Mentally Ill (SMI). * All persons must have a clinical need, be able to benefit from services, and if no payer source- the person must meet indigent criteria as set forth by ODMHSAS.

*We also receive referrals for Employee Assistance counseling from a variety of organizations. A Memorandum of Understanding (MOU) or contract is established and approved by the Clinical Director. All contracts and or/ MOU's will be brought to the attention of the leadership team through our weekly meetings. This is strictly for informational purposes only. The leadership does not have any access to protected health information or services delivery; only organizations seeking our assistance and the details of the plans and arrangements we have with each organization. These services are offered as we have staff availability.

Exclusion Criteria

Individuals who cannot cognitively benefit from outpatient services or those individuals who do not meet eligibility requirements as set by ODMHSAS will be referred elsewhere for appropriate services. Additionally, we do not make decisions about admittance based upon their history of treatment or lack of participation.

Access to Service

We believe there is no "wrong door". We provide services in an atmosphere that fosters a sense of safety, trust, and hope. We believe that *Recovery is Possible!* Persons presenting for services will be seen that day by a clinician. Our staffing pattern is designed so that at least one staff person is available for walk-in screening. Furthermore, qualified staff is available to treat persons in crisis at all times.

Staff Credentials

All staff providing clinical service is credentialed through the ODMHSAS and meet the service guidelines as outlined in the ODMHSAS Service Manual. These staff members will have completed training and have the educational degrees to support their credentials as identified and documented within our clinical privileging process.

Adult Program Descriptions:

Screening, Assessment, Intake and Referral Services

Persons seeking services can make an appointment for screening or simply call or walk-in. The person calling will be asked a variety of questions to determine if they meet criteria for further assessment and will be given an appointment.

Those persons walking in or keeping a scheduled appointment will be asked to complete a basic questionnaire with information related to concerns in the following areas: substance use; gambling; trauma (current and/or historical); medical conditions; suicidal or homicidal thoughts or intentions. Persons indicating a desire to harm themselves or others will immediately be re-directed to a LBHP/LMHP or licensure candidates for crisis intervention. If individuals identify as being suicidal, Collaborative Assessment and Management for Suicidality (CAMS) services will be provided. Additionally, persons indicating a current or previous substance use or abuse concern will be screened and treatment decisions made based on the ASI (Addiction Severity Index) and The American Society of Addictive Medicine (ASAM) client placement criteria.

Persons not indicating current suicidal intentions will be seen by a clinician for completion of the screening and begin gathering information critical for service plan development. Subsequent services are determined by evaluation and payer source. Those persons meeting indigent criteria or those persons receiving services through the State SoonerCare program will be screened with specific criteria.

Once an individual has been screened for services, they will be offered same day services for an intake, assessment and treatment plan however, if client is not able to stay then their treatment plan will be completed within 3 business days from initial engagement in services. The person centered treatment plan will address potential goals for employment, independent living, volunteer work, training, education, and recovery work to maintain current community tenure with services in the least restrictive setting.

Screening is available on a walk-in basis, Monday through Friday from 8:00 a.m. to 5:00 p.m. A 24-hour crisis line is available to assist persons who need immediate assistance after hours. Crisis intervention is available to individuals and/or families who may be experiencing a psychiatric and/or substance abuse crisis. Referrals to other community resources are provided to persons whose needs are not within our scope of practice or to those who do not meet our eligibility guidelines.

Outpatient Therapy

Outpatient services include individual, family and group therapy for adults with mental health and/or substance use/abuse issues. Outpatient services are primarily delivered in our offices; however, they may be provided in the client's home, when there is a clear indication based on the needs of the individual and approved by a supervisor. Our staff mostly employs Cognitive Behavioral Therapy (CBT), Cognitive Processing Therapy (CPT), and Motivational Interviewing (MI) as part of the evidence based treatment that we provide to our adult clients.

Persons are scheduled for individual therapy services through agreement between them and their therapist, Groups are arranged at various times throughout the week in an effort to meet the needs of our clients.

Emergency Services

Crisis intervention may be delivered in a variety of settings. Typically, crisis intervention is required due to sudden, unexpected events; however, we employ a practice that focuses on prevention rather than intervention. Clients are given resources and ideas to encourage skill development to plan for the unexpected in order to reduce stress and behaviors that escalate into crisis situations. If a crisis does occur, we have staff trained in diversion techniques designed to de-escalate the crisis.

The next step requires crisis intervention. Again, staff provides crisis intervention based on evidenced based principles of care. If a person meets criteria to have their rights removed on a detention status; a staff member qualified by education and law to do an examination will see the person and make a decision. If the person meets criteria for emergency detention then staff will arrange for placement at our crisis stabilization unit. If we do not have space at our unit we will access one of the other CBSCC's across the state until we can find space.

For the person who does not meet detention criteria upon examination, a plan for outpatient services will occur. Our community does not allow for outpatient detention; therefore, if the person refuses outpatient treatment we cannot do anything more. All of our staff has been trained to provide crisis diversion services to include crisis and safety plans. The LMHP is able to provide emergency evaluations and/or facilitate placement for an individual who is a danger to themselves or others into a higher level of care.

Lastly, our most restrictive level of crisis services is delivered through our Community Based Structured Crisis Center, “the Crisis Unit.” This is a 15 bed, 24-hour, locked facility providing non-medical services through voluntary treatment and to persons having been ordered there under detention status. We are heavily staffed with clinicians, nurses, psychiatric technicians, a cook, therapist, administrative assistant, and a supervisor. There is always a clinician, nurse, and a tech physically on duty there at all times. In addition, there is a licensed clinician either on duty or available to call at all times.

Case Management

Our case management services include advocacy, linkage, referral and monitoring on behalf of our clients. We aid clients in identifying community resources for employment, volunteer opportunities, medical services, housing, food, and clothing needs. We provide follow up for our clients within 24 hours of a missed appointment to help keep them engaged in services. This is completed by the outreach services department unless it is a crisis follow up then the crisis clinician will complete the follow up. Collaborations with other providers help our clients address their needs and also assist clients with resource development and community integration. Through supportive services we encourage our clients to utilize resources in their natural environment and create a support system independent of professional care.

Psychiatric Rehabilitation Services

This program allows for staff to provide clients with psycho-education and skill development techniques to assist with daily living needs for maintaining community tenure, relapse prevention and general coping skills. We offer skill building focused on independent living as well as education about mental illness, wellness principles, co-occurring principles including relapse prevention and recovery.

Medication Clinic Services

Medication clinic services are provided on a daily basis as scheduled. We also provide a “walk-in” clinic for those individuals who have missed their medication appointment or who are in need of emergency medication. Each client is seen by a nurse to review existing medication regimens, allergies, health conditions, family medical history, and current and/or historical substance use.

Wellness Activities and Support

We began offering health and wellness related services in FY2013. This is an area that has grown exponentially over the past couple of years. In anticipation of Health Home services, we have prepared staff to be comfortable with a holistic approach to care. Wellness services are delivered in both individual and group settings. Wellness topics include: tobacco cessation, nutrition, and exercise, and stress reduction, healthy coping mechanisms to address anxiety, and sleep disruption. All clients who use tobacco products are screened using the 5 A’s to encourage tobacco cessation through the Quit Line and/or through medication support. We have also added objectives to client’s individualized treatment plan to assist with smoking cessation. Clients are also encouraged to focus on taking charge of and managing their own health and recovery.

Service to Homeless Individuals

We work closely with the Gospel Rescue Mission in the provision of services to the homeless population. We provide referrals and linkage to housing resources for those individuals who indicate that they are currently without a safe place to stay. We assist clients in identifying community supports that can help with immediate housing needs. We also work closely with the Department of Veterans Affairs and Kibois in efforts to assist homeless veterans.

Peer Recovery Support Services

Our peer recovery support services are provided through our recovery support specialists (PRSS) who themselves have had a history of coping with a mental illness and recovery issues and are currently stable

and able to provide supportive care and mentoring to our clients. The PRSS story of recovery may help our clients to see how that recovery is possible and achievable. A PRSS will input the client's information for the triage specialist to complete the screening. If a client is in need of assistance with completing the screening paperwork, the PRSS will help the client. Once the screening has been completed, that clinician calls the PRSS to come to their office. The PRSS then takes the client on an agency tour, pointing out specific areas, such as the medication clinic area. This is a relaxed, purposeful means to begin the relationship building and allows the PRSS to better explain their role and accessibility. The PRSS also assists clients through the telemedicine process. A PRSS accompanies the medical clinic staff to our Eufaula clinic every other week.

Adult Services Program Goals

All of the program components of adult services are interrelated; therefore, the following goals are applicable across services delivered through Adult Services described above.

Measures of Efficiency

Goal 1:

Increase the number of consumers we serve in Muskogee County and McIntosh County over the next year.

Objectives:

1. Persons requesting services will have a comprehensive service plan completed within three business days from initial engagement of services.
2. A team approach has been implemented and same day services are being offered so that by the end of FY19, over 85% of client's treatment plans are completed within three business days from initial engagement.
3. Staff will be increased as needs arise to provide these services.
4. Schedules will be designed to allow for flexibility in timely service delivery.
5. All direct care staff will be trained in EBP to insure clients receive quality of care.

Target Date: On-going, Review Monthly

Responsible Staff: Adult Services Supervisor and Identified Direct Care Providers.

Measure of Effectiveness: Number of consumers served in Adult Services in FY2018

Goal 2:

Integrated care in the form of wellness activities and general health care will be included in service delivery.

Objectives:

1. Each service plan will include at least one wellness activity for persons served.
2. By the second quarter of FY19, two groups will be developed and implemented to assist clients in managing their physical health and mental health.
3. All direct care staff will be trained in Evidenced Based Practices to ensure clients are receiving quality of care.

Target Date: On-going

Responsible Staff: Direct Care Staff and Adult Services Supervisor.

Goal 3:

Every adult endorsing suicidal ideations or past history of attempts will be screened using the Columbia Suicide Severity Rating Scale (CSSRS) and from those screened we will identify individuals who need Collaborative Assessment and Management of Suicidality (CAMS) treatment services and could be managed on an outpatient basis instead of within a CBSCC.

Objectives:

1. A protocol for crisis intervention will be developed and all staff will implement the procedures when assisting clients with suicidality.
2. By the end of the third quarter of FY19, all eligible case managers, LBHP and Candidates will be trained in the use of CAMS.
3. Direct Care staff will provide CAMS treatment and documentation tools to address the treatment needs of individuals identified by the CSSRS.

Target Date: On-going, Reviewed Quarterly.

Responsible Staff: Identified Direct Care Providers and Adult Services Supervisor.

Goal 4:

All clients using tobacco products will be provided education and referrals to the Quit Line for wellness options and resources to assist smoking cessation.

Objectives:

1. GCBHS Staff will increase the number of Quit Line referrals to 20% of all population of clients we serve.
2. Clients using tobacco products and accessing the medication clinic will receive the 5A's assessment.
3. A smoking cessation objective or an education on the benefits of smoking cessation objective will be added to 100% of treatment plans of clients who identify they smoke.

Target Date: On-going, Reviewed Quarterly

Responsible Staff: Identified direct care providers, and Adult Services Supervisor.

Client Satisfaction:

Responses from our client satisfaction surveys provide valuable information regarding our services; quality, delivery, and impact. Persons served were able to handle day-to-day living better because of the services at GCBHS.

Client satisfaction surveys will show that 99% of those served were involved in decisions about their treatment.

Client satisfaction surveys will show that clients agree or strongly agree that the services they received had a positive impact on their lives.

Client satisfaction surveys will show that clients agree or strongly agree that they were treated with respect by our staff.

CHILDREN AND FAMILY SERVICES

Program Description

The Children's department provides services for children from birth to age 21 and their families. We provide consumers with an array of services that include some or all of the following: individual and family therapy, individual rehabilitative counseling, crisis services, case management and group therapy. Consumers who seek our services include individuals with social, emotional and behavioral issues that

cause distress and role disruption. Services are provided at our offices in Muskogee and McIntosh Counties and within area schools. We receive referrals through the school system, Systems of Care, the Department of Human Services, physicians, and from individuals who walk in and request a screening.

Our hours of operation are Monday through Friday, from 8:00 a.m. to 5:00 p.m. Appointments may be scheduled after 5:00 p.m. on weekdays, based upon needs of the individual served. We have a crisis mobile response team that is available every day, 24 hours a day. Our staff includes individuals who qualify as either a behavioral health rehabilitative specialist, licensed mental health professional, case manager, embedded care coordinator, or behavioral health aide.

Philosophy of the Program

The philosophy of the Children's outpatient treatment program is to improve the quality of the child's life within the current family system. We believe that the first contact is paramount in establishing a partnership with the consumer. We believe there is "no wrong door" and our goal is to provide services in a welcoming environment that fosters a sense of safety, trust, and hope. We believe in providing recovery oriented, trauma informed, and co-occurring services, beginning with Screening, Assessment and Referral.

Staff Criteria and Specialized Training Required

A licensed mental health provider must have a master's degree in a mental health or related field and be licensed in the state of Oklahoma as either an LPC, LADC or LCSW. A candidate for LPC, LADC or LCSW is a provider with a master's degree in a mental health or related field who has been approved for supervision. A behavioral health Rehabilitative Specialist/Case Manager is someone who has a bachelor's degree at a minimum and has passed the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) rehabilitation specialist certification. Case management certification requires individuals to meet ODMHSAS criteria through education and/or experience. Individuals must take a test and attend additional training, depending on their educational level, to become a behavioral health case manager. A behavioral health aide is someone who meets the criteria outlined by ODMHSAS and has been certified through their training to become a behavioral health aide.

Admission Criteria

- Primary Axis I mental health diagnosis or co-occurring diagnoses
- Cognitive capacity to benefit from therapy and willingness to participate
- Guardian provides consent for treatment
- Children from birth to age 21 and their families
- Those children who are age 16-24 will also be evaluated for the Transitions program, which is part of our Systems of Care in Muskogee and McIntosh Counties. This program provides specific help to teenagers and young adults who need support as they make the transition to adulthood.
- Presence of any social, emotional, or behavioral problem that is causing difficulty for the child in a variety of settings
- Children who are deemed at risk by any referring agent including family, school, physician, and / or mental health facility
- Children from birth to age 18 discharged from an inpatient setting, in need of follow-up care
- Individuals qualify for services if they have Medicaid or meet the income guidelines

Exclusion Criteria

Persons who cannot cognitively benefit from and participate in treatment or who would be better served by a specialist will be referred for services elsewhere within the community.

Program Modalities

We serve children through various modalities, including individual rehabilitation, individual and interactive therapy, behavioral health aide supportive services, individual, group, and family therapy. We refer, link, and advocate for children and families through case management services and provide outreach, prevention groups, wellness groups and crisis intervention, as needed.

We serve Muskogee County Head Start by performing mental health observations for Head Start classrooms, individual observations for children in Head Start classrooms, and provide them with information and resources on specific mental health issues for teachers and family partners to utilize with the parent. In addition to this, we coordinate mental health curriculum for Head Start classrooms to incorporate into everyday activities and provide quarterly parent trainings on strengthening and creating a supportive environment in the home setting.

We serve children who have experienced ongoing abuse, trauma, or neglect through specifically designed sensory interventions addressing their developmental needs. These children are identified through exhibited social, emotional, or behavioral problems, as well as through parental interviews confirming the presence of chronic abuse, trauma, or neglect present in the child's life. We also collaborate with Systems of Care and Health Homes in both counties to provide mental health services to children and families that have been identified as being at risk. All treatment modalities are aimed at improving client's individual functioning, functioning within school and/or daycare and functioning within the family unit through individual rehabilitation, individual or interactive therapy, family therapy, and community integration through the use of case management and medication clinic services, as needed.

Measures of Effectiveness

Goal 1:

The number of school suspensions and absenteeism will be reduced by 50%.

Objective:

1. Children's Services will broaden their partnership with Muskogee Public Schools to include an embedded clinician in selected schools in the districts that have the highest number of at-risk students.

Goal 2:

95% of children who meet criteria will be enrolled into Health Home Services.

Objective:

1. Staff will place clients at the most appropriate level of care in order for them to receive Health Homes Services.

Measures of Efficiency

Goal 1:

The number of days children and adolescents spend in higher level of care will be reduced by 50%; recidivism will also be reduced by 50%.

Objective:

1. Children's Services will continue to incorporate Community Based Authorization as a way to keep children and adolescents in the community at the lowest level of care possible. Families will be given the assistance needed to prepare for the client's discharge from inpatient care and reduce

recidivism. Children's Services will also create a Care as Needed (CAN) Unit for children and youth who can benefit from intensive outpatient services in order to reduce inpatient care.

Goal 2:

In an effort to promote growth within Children's Services, we will increase the number of clients we serve by 25%.

Objective:

1. Children's Services will collaborate with five or more community partners to help increase client count. Children's Services will also incorporate a Day Program during the summer months to help promote wellness and increase client count.

Goal 3:

In an effort to provide services to children in a timely manner, we will assign each client to a clinician within two weeks of completion of their intake.

Objective:

1. Children's Services will hire two BHS's and two therapists in order to better manage the increase in clients that we have been receiving.

Customer Satisfaction

Client satisfaction will be evaluated through quarterly client satisfaction surveys.

1. 90% of clients completing satisfaction surveys will report that they agree, if not strongly agree, that they would refer a friend or family member to Children's Services if they were having a problem.
2. 95% of clients completing satisfaction surveys will report that they agree, if not strongly agree, that the Children's Services staff seemed to respect them as a person.

Access

After hour appointments are available upon request at the discretion of the agency and the clinician. The 24-hour mobile response team is also available for anyone in need after hours or on weekends/holidays. Families may walk in for crisis intervention or screening any time during regular business hours and will be seen the same day. Persons served will not be limited to accessing services due to homelessness, his/her past or present mental health or co-occurring disorder issues, the presumption of their inability to benefit from treatment, any substances presently or historically used, or their level of success in prior treatment.

Mobile Crisis Services

Crisis services are provided 24/7/365 by a Licensed Mental Health Professional (LMHP). Staff is trained to provide crisis diversion services to include crisis and safety plans. The LMHP is able to provide emergency evaluations and/or facilitate placement for an individual who is a danger to themselves or others and needs a higher level of care. If a child meets criteria for a higher level of care, staff will try and locate an opening.

Many hospitals require their staff to complete an assessment before admittance; therefore, we have collaborated with several facilities to do this evaluation via tele-health to alleviate having families, and

law enforcement, driving to another city and being turned away. Tele-health services allow for hospital staff to interview the child, family and even our staff if necessary for admittance criteria.

Case Management Services

Case management services include advocacy, linkage, referral and monitoring on behalf of our clients, which are delivered from a strengths-based perspective with emphasis on recovery. We assist clients in identifying community resources, including: educational resources, employment, medical services, housing, food, clothing resources and volunteer opportunities. We provide follow up for our clients within 24 hours of a missed appointment to help keep our clients engaged in services. We provide continuity of care by collaborating with other providers to address the needs and preferences of the client.

Psychiatric Rehabilitation Services

This service is designed to help families learn and develop skills for daily living activities. Problem solving as a family unit to reduce crisis situations and increase community tenure is taught through rehabilitation.

Medication Clinic Services

Medication clinic services are provided on a daily basis including a “walk in” clinic for those individuals who miss their medication appointment or who are in need of emergency medication. Each client is seen by a registered nurse to review previous medication regimens, allergies, health conditions, family medical history, and any previous substance use or abuse.

Wellness Activities and Support

Our agency provides wellness services within individual and group sessions. Wellness topics include: tobacco cessation, nutrition, exercise, stress reduction, and healthy coping mechanisms to address anxiety and sleep disruption. All clients who use tobacco products are screened within our medication clinic using the 5 A’s to encourage tobacco cessation through the Quit Line and/or through medication support. Clients are also encouraged to focus on taking charge of and managing their own health and recovery.

Service to Homeless Individuals

We provide referrals and linkage to housing resources for those individuals and their families who indicate that they are currently without a safe place to stay. We also help our clients identify community supports that can help with immediate housing needs.

Peer Support Services

Our peer support services are provided through Behavioral Health Aides (BHA) who themselves have had a history of mental illness and recovery issues or they have cared for a family member who has had mental health issues. Our BHA provides supportive care and mentoring to our clients and their families.

Transitions Program

Systems of Care Transitions program serves clients ages 16 to 25. Persons served within this program may be enrolled in a school setting, not engaged in school due to behaviors, having dropped out, or having graduated, or are being seen for reasons ranging from social, emotional, or behavioral reasons, to substance use/abuse/dependence and academic difficulties. Clients are referred to the program through the school systems, outpatient facilities, private facilities, or any other service provider, such as the Department of Human Services or the Office of Juvenile Affairs. These clients are deemed at-risk by the system and are found to be in need of assistance in their lives to maintain within their natural environment. Services are provided Monday through Friday with varying hours based on client needs (may be from 8:00 a.m. until 8:00 p.m. and on weekends.)

Any needs after hours are routed through an agency cell phone carried by staff or routed to the crisis stabilization unit for further assessment, if needed. The Wellness, Recovery, Action, Plan (WRAP) philosophy is an integral aspect of this program.

Program Philosophy

It is the philosophy of the Transitions Program to meet clients where they are and assist them in getting stabilized within the community by locating resources including: educational, housing, medical, financial, and transportation. The aim of this program is to equip these clients with the tools they need in order to live independently as they transition into adulthood.

Admission Criteria

- People referred to the program must be from 16 to 25 years of age. Their families may also be offered services if deemed appropriate. They will be impacted by problems with social, emotional, behavioral, academic, financial, and/or substance related problems.
- Clients need to be involved with at least two systems (such as DHS, behavioral health, medical, education, etc.) in order to be admitted into this program.

Exclusionary Criteria

If the community team does not accept the referral, the individual will not be in the program. Persons outside of the age parameters may receive services elsewhere throughout the agency.

Access

The Transitions Program is accessed through a referral from the local Systems of Care Team. However, any person meeting age criteria may be evaluated for this service.

SYSTEMS OF CARE PROGRAM

Program Description

Systems of Care (SOC) serves clients ages two to 17 who are at-risk of being placed out of their home for reasons ranging from social, emotional, or behavioral reasons to substance use/abuse/dependence and academic difficulties. Clients are referred to the program through the school systems, outpatient facilities, private facilities, or any other service provider such as the Department of Human Services or the Office of Juvenile Affairs. These clients are deemed at-risk by the system and are found to be in need of assistance. Services are provided Monday through Friday with varying hours based on client needs (may be from 8:00 a.m. until 8:00 p.m. and on weekends). Any needs after hours are routed through an agency cell phone carried by staff or the crisis stabilization unit for further assessment.

Program Philosophy

SOC utilizes the wrap-around approach (WRAP) to encircle clients with informal supports in order to assist them in maintaining within their community setting, versus placement outside of the home or in a higher level of care. The program is strictly strengths-based, family and child centered, and community based. It is SOC's philosophy to bring the services to the family to strengthen and empower them to maintain without continual community supports.

Persons served within this program will be provided the following services as needed: individual and group services that are either therapeutic or educational in nature; case management services to help them maintain with the community setting; crisis intervention or assessment; family support; and medication clinic.

Admission Criteria

- Clients who are referred to the program may fall between the ages of 2 and 17. Their families may also be offered services if deemed appropriate.
- Clients may be impacted by problems with social, emotional, behavioral, academic, financial, or substance related problems.
- Clients may need to be involved with at least two systems (such as DHS, behavioral health, medical, education, etc.) in order to “qualify” for admission to this program.

Exclusionary Criteria

- Persons not meeting the age requirements
- Community team does not accept referral

Access

Those persons referred through the local community team are eligible for this program.

Program Goal

All program components of children’s services are interrelated; therefore, the following goal is applicable across services delivered through Children’s Services described above.

Goal 1:

We will strive to increase the number of clients enrolled in Systems of Care so that we may engage as many children and families in our counties as possible, utilize our assessments and SOC tools to enrich our client’s lives, and build staff’s knowledge in working with the clients we serve.

Objectives:

1. Increase staff’s development in working with children from birth to five years of age by attending at least three trainings specific to the age group, per staff member.
2. Increase transition age youth enrolled in Health Homes and/or Systems of Care by 5% by attending outreach opportunities with community partners.
3. Show improvement in meeting Systems of Care milestones (OHIO Scales, Functional Assessments, Crisis Plans, Strengths/Needs Lists, Strengths, Needs, and Cultural Discoveries, and Service Event Forms) according to state guidelines by 10%.
4. Increase the amount of clients in McIntosh County by 5% through outreach opportunities with community partners.

Target Date: On-going

Responsible Staff: Direct Care Staff, Children Services Supervisor, Director of Clinical Services

HEALTH HOMES

GCBHS has both an adult and a children’s Health Home. A Health Home is a place where someone can go throughout their lifetime to receive comprehensive “health” services. The Health Home team coordinates both mental health care and physical health care to the people being served in this program.

Health Homes is a model designed around the best practice model of chronic care. It is a population based treatment model. Outcomes are measured for the entire population of persons in the program rather than individuals. The treatment goals of each individual make up the overall target goals. While each service plan is individualized, there must be a focus on overall wellness. This is how we “manage” the

population. Services are provided not by the traditional method where a clinician would have their own caseload and only provide services to those people, but where the “team” provides an array of services needed at any given time.

Overall, the program focuses on providing the following services:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Support Systems

Goal 1:

Increase Health and Wellness for Muskogee Adult Health Home consumers by encouraging healthier options and activities to manage chronic health conditions.

Objectives:

1. At least 10% of clients attending the Chronic Disease Self-Management group will self-report having a healthier and more confident level of managing their own chronic health conditions.
2. At least 10% of clients attending the Tobacco Cessation Wellness Group will strongly agree that they have more confidence in their ability to live a tobacco-free lifestyle.
3. Through education and self-monitoring activities, Health Home staff will reduce the number of Health Home clients with high blood pressure by 5%.

Target Date: June 2018, ongoing weekly and monthly reports.

Responsible Staff: Wellness Champion, Case Managers/Care Coordinators, Peer Recovery Support Specialist, and Adult Health Home Supervisor.

Goal 2:

Increase the number of Muskogee Adult Health Home consumers over the next year.

Objectives:

1. Health Home staff will provide outreach to 100% of eligible participants within 48 Hours of initial agency contact
2. Increase enrollment into Health Home by 30% this fiscal year.

Target Date: June 2018, ongoing weekly and monthly reports.

Responsible Staff: Wellness Champion, Case Managers/Care Coordinators, Peer Recovery Support Specialist, and Adult Health Home Supervisor.

CRISIS STABILIZATION UNIT

Program Description

The Crisis Stabilization Unit is a Community Based Structured Care Center (CBSCC) that provides crisis intervention, medication stabilization, and non-medical detoxification. Services include evaluation, stabilization, group, family, and recreational sessions, case management, discharge planning, referrals, and follow-up services. The unit is accessible 24 hours a day and offers both voluntary and involuntary

treatment based on emergency detention status. Evaluations, assessments, and referrals to appropriate treatment facilities are provided 24 hours a day.

Philosophy of the Program

We believe that clients receiving crisis intervention services are best served in the community where they reside. Family and/or other support systems are a vital part of this care. Individuals experiencing a mental health crisis, alcohol and/or drug problem(s), or those in need of medication stabilization due to decompensating and/or negative side effects are eligible for this program. Treatment is short-term with an average stay of three to five days. The structured milieu is focused on helping the person return to a pre-crisis state by providing therapeutic intervention, case management, and rehabilitative services. Discharge planning includes referrals to less restrictive settings in the community.

Staff Criteria and Specialized Training Required

CSU is staffed 24 hours a day with a Registered Nurse (RN) or Licensed Practical Nurse (LPN) a clinician (Bachelor's level, and/or Master's level), psychiatric technicians, and other support staff. CSU clinicians meet the guidelines outlined by ODMHSAS for Case Management certification and can assist clients with needs they may have while on the unit, including discharge planning. The licensed clinicians have been trained to provide Collaborative Assessment and Management of Suicidality (CAMS) so that clients can begin a treatment modality that can be continued on an outpatient basis to help them remain in the community. Additionally, clients are screened for Trauma (PCL-5), and Suicidality (Columbia Screener). The Crisis Stabilization Unit's medical consultation services are provided by a team of medical professionals contracted through Strength of Mind Psychiatric Services.

Admission Criteria

- Persons must be 18 years of age or older;
- Must be medically stable;
- Not currently incarcerated.

Exclusion Criteria

- Persons not medically stable;
- Those who present as violent or with conditions that require a higher level of care;
- Anyone under the age of 18;
- Persons currently incarcerated or currently residing at a nursing home.

Program Modalities

CSU is a 15,000 square foot facility with the capability of serving 15 adults. CSU is conveniently located just outside Muskogee City limits and offers clients ample space for outdoor recreation. The facility offers a common dayroom, dining room, and recreation area that staff and clients utilize for a variety of daily sessions. The daily schedule at CSU includes Doctor Staffing via telemedicine; six group sessions including therapy, rehab, recreation, arts and crafts, relaxation, medication education, and health/wellness; two community meetings; three meals and two snacks; phone hours/visitation; and free time. Additionally, vegetables and flowers are grown, with gardens tended by the clients.

Access

The Crisis Unit is open 24 hours/day and 7 days/week. The crisis line is also available 24/7 for consumers to speak with a clinician or to obtain information regarding agency services. Persons served will not be limited to accessing services due to homelessness, past or present mental health or co-occurring disorder

issues, the presumption of an inability to benefit from treatment, any substances presently or historically used, or their level of success in prior treatment. Assessments and referrals to appropriate treatment facilities are provided 24 hours a day for those who are 18 years of age or older.

The overriding goal for every client served at the Crisis Unit is to “Stabilize the Current Crisis Situation” and/or to “Complete Detoxification and/or address Substance Abuse Issues”.

Goal 1:

To provide the highest quality of care to the greatest number of clients on the most efficient budget.

Measures of Effectiveness

1. All consumers will display at least a 5-point increase in Level of Functioning, prior to discharge, to ensure they are ready to transition to outpatient services.
2. In providing prompt, effective, and quality services, less than 20% of CSU consumers who live in the GCBHS catchment area will return to the unit for re-admission within six months.
3. In an effort to provide prompt, effective services, Seeking Safety curriculum will be used as a mode of treatment for 90% of Consumers.
4. Consumers will be strongly encouraged, upon discharge, to enroll in the smoking cessation program.

Measures of Efficiency

1. To ensure a continuity of services, 95% of consumers who live in the GCBHS catchment area that are discharged from CSU will receive a documented follow-up contact within 7 days of discharge.
2. In an effort to provide care to the greatest number of consumers, CSU consumers will maintain 5-7 days as the average length of stay.
3. CSU will maintain level operating expenses during the fiscal year without compromising client care.
4. CSU will maintain a daily average census of 12.5 consumers.
5. Staff will increase the use of funding sources that benefit clients outside of GCBHS to further enable clients’ ability to remain independent. Staff will seek additional federal, state and local funding to support the expansion of services to individuals served by GCBHS.

Customer Satisfaction

Client satisfaction will be evaluated through client satisfaction surveys completed at the time of discharge.

1. Consumers will at least agree, if not strongly agree, 95% of the time that they are able to handle day-to-day living better because of the services they received at CSU.
2. Consumers will report on 95% of satisfaction surveys that they agree, if not strongly agree, that they would refer a friend or family member to CSU if they were having a problem.
3. Consumers will report they agree, if not strongly agree, that the staff seemed to respect them as a person on 95% of satisfaction surveys.

4. 95% of clients will report that they agree, if not strongly agree, that the therapeutic services received had a positive effect on their lives.
5. Clients will agree or strongly agree on 95% of Satisfaction Surveys that they were actively involved in decisions about their treatment.