Process Improvement Learning Collaborative Implementation Story

How we Learn, Share and Grow in Oklahoma

First year participants named as a part of the STAR-SI grant represented various provider types and served six percent of the total substance abuse population. Two providers had leadership dropped out shortly after the project began due to leadership changes. However, we were able to recruit one Community Mental Health Center (CMHC) to join the project in Year 1. We were very excited about the addition of a CMHC because Oklahoma is actively working toward an integrated services model at our substance abuse provider agencies and our CMHCs. This meant that Oklahoma didn't fit the exact STAR-SI model of change projects done at outpatient substance abuse facilities. With experience, we would see some difficulties as a result of this, but at the time we were blissfully ignorant.

Oklahoma spends the majority of our STAR-SI grant money providing training and collaboration opportunities for providers as an incentive to participate in the grants. These activities include monthly learning collaboratives, sending change leaders to the NIATx Change Leader Academy, and providing each STAR-SI provider agency the opportunity to send a person to the NIATx Summit. In Year 1, we even brought in a nationally known expert to train providers in a best practice that they felt would improve access and retention in their agencies.

At our first learning collaborative the STAR-SI Group decided to meet face-to-face monthly and hold monthly calls as well. This way we would be in contact with each other every two weeks. This proved to be too big of a challenge for busy providers. By the end of Year 1 we chose to drop the poorly attended call sessions.

One of the most productive exercises was a nominal group exercise in which providers were asked to identify existing state-level barriers to access and retention. This single activity gave the state change team insights into what the providers saw as barriers and irritations about our system. It also let the providers know that we were not asking them to make change without also being active in the change process as well. For Year 1, excessive paperwork was identified as the number one barrier to better access. However, we kept the entire list of provider concerns and found that we could make providers' lives easier by making minor changes to our way of doing business. Each month we reported on the changes made so providers could see the state's commitment to change and improvement.

To address the providers' concern about excessive paperwork, the state change team developed a Paperwork Reduction Team (PRT) that travels to individual provider facilities and reviews their intake forms to reduce paperwork. We provide expertise on client data gathering, Medicaid requirements, contract monitoring requirements, and certification requirements. The amount of paperwork varies considerably among providers, based on services provided, certification

requirements for providers (from outside entities), and the different programs for which they are funded. We were pleased that providers were able to reduce their paperwork to some degree. (See related story: Oklahoma State Change Story 1.)

We learned valuable lessons from these activities. After several PRT visits, we developed a list of common deletions and consolidations that we now share with all providers, making this an easy project to spread. We also discovered that a major factor in reducing intake paperwork is provider attitude. If a provider understands that intake consists of both paperwork and a process, the decrease in intake time was greater. Also, providers who were prepared to determine which forms were actually necessary made greater reductions. Using “right-time data gathering” reduces the time required to assess and admit a client.

We recruited Year 2 participants through an invitation letter that included a simple application process. Several Year 2 participants were state-operated CMHCs who joined the Department of Mental Health and Substance Abuse Services (DMHSAS) Executive Leadership Academy. These participants were a dynamic group of folks who were identified as leaders in their organizations and they made natural change leaders for STAR-SI projects. The second year of our STAR-SI project included five CMHCs (three state-operated and two contracted) and one substance abuse facility, for a total of six facilities.

Again, we spent part of our Year 2 kick-off meeting doing a nominal group exercise to identify a state change team project. The number one need providers expressed was more Addiction Severity Index (ASI) and ASAM training. Substance abuse treatment contracts require treatment professionals to be trained in certain clinical instruments before they can assess clients. DMHSAS was not providing timely training and this was causing problems with access. (Read the results of our change project in our “State Change Project” story.

We recruited Year 3 providers through an introductory letter describing the STAR-SI and we also drafted an incentive contract that we would offer to any provider who met certain performance and spread criteria. Unfortunately, this contract has been difficult to get through all of our state contracting criteria, so it is not in effect yet (although it may be retroactive when it is finally approved). Eight providers join our project in Year 3—seven substance abuse providers and one CMHC.

Instead of having a nominal group exercise and choosing a change project this year, the state change team decided to focus on making any adjustments to sustain the STAR-SI effort beyond the grant period. One of our first strategies involves implementing technology to reduce the time and expense required to attend all STAR-SI events. Utilizing technology virtual meetings is a gaining momentum as a way to meet the needs of a large rural state. Looming budget cuts make this change all the more necessary.

We have scheduled two of our four learning collaboratives as videoconferences, and the first one has already taken place. Making two meetings a year “non-travel” meetings translates into roughly $1,564 of travel savings and $2,040 of salary savings for the 12 facilities that do not have to drive to the meeting. This change makes an added difference because of these participants are also required to attend other DMHSAS meetings. We have seen a large increase in the number of virtual meetings over the past few months, so using the technology also spreads the change and increases the savings. This change has been very popular with the providers and we are looking at other ways to implement communication technology.

Overall, our learning collaboratives have been successful and useful. They are moderately well attended, even when they were monthly and all face-to-face. The initial numbers indicate that the new video conferencing will make a significant increase in our “attendance.”

Looking back there are decisions we made that with hindsight, we might change if given a second chance. In particular is the decision at the beginning of the project to allow each facility to choose the aim they wanted to change. Instead of choosing one aim and asking all providers to work on that one aim, we allowed providers to choose which aim they would work on. This has had mixed results.

On one hand, providers were invested in the changes they chose and really appreciated being allowed to choose the change they would make. Yet, without a single aim addressed by all providers, realizing a statewide change on an aim was difficult. Team cohesion suffered because everyone was working on different projects. Providers in Year 1 could not benefit from each other’s experiences, since they were all working on a different change. This problem has been resolved in Years 2 and 3, since more providers have joined and more changes have been made. However, it seems that starting out with the same aim could have helped build our collaboration quicker and stronger.