

SAN MATEO COUNTY

BEHAVIORAL HEALTH AND RECOVERY SERVICES

*Improving Service Delivery to Persons with
Complex Conditions Through Systems Transformation*

CHARTER DOCUMENT

2010 Revision

I. OVERVIEW

San Mateo County residents with complex psychiatric and substance use conditions are frequently under-served and under-represented by behavioral and primary health systems of care. These individuals and their families are provided services that are often ineffective and costly. This results in over-utilization of criminal justice, health care, child protective, homeless shelter, crisis, and other services. It is an expectation that individuals in our public services sector have complex co-occurring mental health and substance use disorders—and all too often these disorders are exacerbated by other health and social problems. This Charter Document articulates the shared vision, goals, and activities for better serving this population.

II. SYSTEM VISION

With the help of a clear, multi-year plan laid out in this Charter Document and a team of diverse stakeholders with a commitment to meaningful collaboration, partnership and change, we believe this system transformation process will result in improved services and outcomes for clients with complex conditions.

Integrating mental health and substance abuse services is a challenging process. We approach this challenge as partners with a shared vision: to create a coordinated, community-based, effective and comprehensive system of service and supports delivery to promote lifelong recovery.

As a result of our efforts to enhance current systems and programs, we will:

- **affirm our commitment to a recovery/wellness and resilience orientation**
- **become increasingly competent and proficient in serving our diverse populations**
- **improve access, engagement, and outcomes for individuals and families with complex mental health and substance use conditions**

Therefore, we agree to:

- share a collective responsibility for individuals and families, with any combination of behavioral health needs, who present in any setting
- prioritize our resources to effectively meet the needs of these individuals and families
- create a framework for universal capability and mutual support

- establish a “welcoming”, “no wrong door” access system
- accurately assess the complex needs of individuals and their families regardless of their point of access
- seamlessly provide or link individuals to needed services and supports in treatment and the community

To implement our agreements, Behavioral Health and Recovery Services and key stakeholders have agreed to use the Comprehensive, Continuous, Integrated System of Care (CCISC) model for designing systems change. This model is based on clinical consensus best practice principles (Minkoff, 1998, 2000. Minkoff & Cline, 2004) that espouse an integrated mental health and substance abuse treatment philosophy.

Chief among these principles is the understanding that it is the expectation—not the exception, that our clients will have complex/multiple challenges and that any successful initiative to address individuals/families with complex needs must be grounded in hope, resilience, wellness and recovery and respect for the role of culture in the health and healing of individuals, families and communities.

All San Mateo BHRS programs are expected to incorporate the following CCISC principles in their service design and practices in order to increase the system’s capability to serve individuals with co-occurring disorders:

- A. Individuals with complex needs are welcomed and engaged.
- B. Cultural responsiveness and consumer and family participation are critical to all aspects of system design and development.
- C. Recovery-oriented, empowering, empathic, hopeful treatment relationships that provide integrated treatment and coordination of care are offered during each episode of care and, for the clients with the most complex problems, continuity of care must be assured across multiple treatment episodes.
- D. Primary locus of responsibility for provision of service (including continuous treatment relationships) can be determined using the four quadrant national consensus model for system level planning, based on high and low severity of psychiatric and substance use disorders. BHRS will organize and coordinate access to systems of care which are consistent with the four quadrant model of service provision.
- E. Individuals and families are engaged in client-centered partnerships balancing necessary care and support with opportunities to make empowered choices. This partnership will create a framework for contingent learning, with an emphasis on strength-based interventions and positive consequences for success. Programs will be developed/evolve to enhance individualized care grounded in clients/participants goals and needs, aspirations and assets
- F. When complex psychiatric and substance conditions co-exist, each disorder should be considered primary, and integrated treatment is critical.

- G. Mental illness and substance use disorders are both examples of bio-psychosocial disorders that can be understood using a disease and recovery model. These disorders have parallel phases of recovery (acute stabilization, engagement and motivational enhancement, prolonged stabilization and relapse prevention, rehabilitation and growth) and stages of change. Treatment must be matched not only to the diagnosis, but also to the phase of recovery and the stage of change. Appropriately matched interventions may occur at almost any level of care.
- H. There is no single “correct” or “one size fits all” co-occurring disorders program or intervention. For each client, treatment matching and planning must consider level-of-need (the four quadrant model), diagnosis, disability, strengths/supports, problems/contingencies, phase of recovery, and stage of change. Consequently, each program may provide treatment programming that is uniquely tailored and matched to individual and family needs,
- I. Treatment and recovery outcomes must be individualized, recovery/resilience oriented, and culturally appropriate, and consider reduction in harm, movement through stages of change, a reduction in substance use or psychiatric symptoms, improvement in disease/disability management skills and treatment adherence.
- J. We are working together to develop a shared understanding and common language between all services within the BHRS system; this is critical to insure consistency and to achieve our vision and goals¹

IV. PROJECT CORE CHARACTERISTICS

Use of the CCISC in the first three years (2006-09) of the change process, will address quality management (QM) and improvement at all levels of San Mateo BHRS services, including management, clinical program leadership service providers, and clinicians. This project will have the following core characteristics:

- A. Representatives of all stakeholders in the San Mateo County behavioral health and primary care delivery system shall be included with the expectation of each component achieving, at a minimum, culturally competent, recovery oriented, complexity capable standards.
- B. The initial plan to become complexity capable shall be based upon existing operational resources and may be maximized by developing the capacity to provide reimbursable integrated treatment.

¹ . Historically there are concepts that have had different meanings depending upon the system and context of their use. Over time it is our intent to clarify terminology and concepts including but not limited to; “wellness”, “recovery”, “abstinence”, “harm reduction” “personal responsibility”, “cultural competency”, “treatment success”, and “continuity of care”.

- C. San Mateo BHRS will access resources for consultation, technical assistance, and training, and identify appropriate incentives for successful participation by programs and clinicians, as part of a QM process. We will promote and use the full range of culturally appropriate and recovery oriented evidence-based practices and clinical consensus best practice for individuals with psychiatric and/or substance disorders, including treatment matching. -Each program will develop the capacity to provide, link to, or appropriately coordinate matched services for each of their clients. Programs will do so within the context of their existing mission and resources.

- D. The principles and practices identified in this charter are integrated with other system collaborations and strategic planning initiatives (including MHSA, AOD Services, Children and Youth System of Care, Outreach and Prevention collaborations)

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COUNTY LEVEL, DIVISION LEVEL, and AGENCY LEVEL ACTIVITIES

In this section, progress concerning prior and newly identified actions will be discussed. Actions updated for 2010 will be clearly indicated, further defined, and delegated by the CCISC Steering Committee.

There will be collaborative activity between county, division, and agency personnel. Each division will create specific quality improvement activities to support CCISC collaborative quality improvement processes. Agencies will make a formal commitment, with the involvement of a board of directors, to grow to be recovery-oriented, complexity capable, cultural responsive, and to evaluate success in these endeavors through a quality management improvement process. Each agency will participate in increasing their ability to serve individuals with complex, co-occurring conditions over time.

The CCISC Steering Committee will examine methods to increase the breadth and depth of monitoring system, program and individual progress toward CCISC goals. In the first three years of introducing the model, it was critical to engage the system and its parts in the change initiative. As the co-occurring integrated system of care has moved from “inception” to an established quality improvement expectation, it is important to embrace this change process as an essential component of quality improvement efforts, and initiate appropriate monitoring and evaluation of these efforts.

1. Integration of Mental Health and Alcohol and other Drug Services:

Adopt this updated Charter Document as an official policy statement, and disseminate it in official material to its constituencies, including other agencies within each Department, MH Board and AOD Advisory Board, as well as all clinical and administrative staff. Its elements will be incorporated into official planning documents and other publications.

2010 - Since the adoption of this Charter Document in 2006, San Mateo County Mental Health and Alcohol and Other Drug Services have consolidated into Behavioral Health and Recovery Services, a single division of the Health System. As a result of this merge, the Mental Health and AOD Contractors' Associations joined forces in 2008. This formal integration has increased communication

between agencies and divisions, and assisted with access to and provision of behavioral health services

Progress in advancing the system transformation has occurred throughout all levels of the Behavioral Health System; however, progress is not uniform at systemic, programmatic and individual service levels. Efforts are needed to assess, support and assist groups and individuals working toward these goals.

Future efforts will continue to help focus service providers on the goals of the Charter Document, and encourage increased and sustained participation by providers in the CCISC process. For example: integration of the CCISC framework into contract language, as well as into policy guiding direct-service staff.

2. Integrated system planning process:

Create a Steering Committee responsible for the planning and implementation of CCISC. The Steering Committee will include representative participation from key stakeholders, including providers, consumers, family advocates, and collaborating system of care partners (e.g. San Mateo Medical Center, Probation, Child Welfare, and Homeless Services).

2010: The CCISC Steering Committee has met regularly since 2006. While participation and involvement has been strong, it is clear that processes to update and maintain membership need to be developed. As the CCISC becomes more integrated into BHRS, the Steering Committee will strategize ways in which to bring more partners to the table, including Primary Care Medical Providers, Probation and Child Welfare, among others. In order to engage those outside our system, flexible membership in the Steering Committee will be considered. The Steering Committee will also examine ways to promote understanding of this Charter Document and to promote it among agencies, so it has a sustained and increased presence among service providers.

3. Partnership and collaboration:

2010: Partnering has been determined to be an important strategy to increase engagement in systems change and to increase the promotion of integrated services. Partnering efforts have been underway fostered by change agents; as an example of partnering: BHRS staff have formed a case consult group in response to the complex needs of co-occurring individuals and families spanning multiple systems of care. Change agents have hosted two “Day of Partnering” events, widely attended by diverse provider groups, and are presently planning Day of Partnering III. Other opportunities for partnering will continue to be explored and pursued, particularly with the different workgroups, regional collaborative, and programs.

4. Promoting a shared vision:

Train stakeholders on the principles of the CCISC model, and the plan to achieve county-wide recovery oriented, culturally responsive, trauma-informed and co-occurring capable services and develop regular communication concerning ongoing project activities to all stakeholders.

2010: The Change Agent cadre has disseminated much information about CCISC among their programs, and these efforts can be broadened to the larger

community of stakeholders, including consumer, families, employers, and schools. The change agents have a website embedded in the larger BHRS platform, and an active list serve with over 150 members. Additionally, Change Agents are consistent contributors to Wellness Matters, and have been present at large gatherings (i.e. Trauma Conference and Recovery Happens events), to publicize CCISC. These publicity and marketing efforts need to have continued support and encouragement. Additional media outlets will be identified.

5. Development and implementation of practice guidelines:

Adopt a system-wide welcoming policy that is culturally appropriate, recovery and resiliency oriented, trauma-informed and provides hopeful engagement of clients and families in every setting, while removing arbitrary barriers to access.

2010: The BHRS Welcoming Policy was adopted in February '08 and has since been widely circulated, and in many setting has become integrated into service culture. Concentrated efforts are needed to assist staff at all levels to create strategies for implementing the policy at their worksite. Good examples of program Welcoming Policies can be promoted throughout the system as successful models for other programs to emulate. Questions were added to BHRS mental health Consumer Survey to assess “Welcoming” of co—occurring clients and families. Promising examples of where welcoming can be integrated include new employee orientation training and manuals, orientation materials for consumers, literature for consumers, program mission statements, and incorporating welcoming skills into workforce and development training for all levels of staff among others.

Alcohol and Other Drug Services developed Standards of Care in the fall of 2008. This collaborative effort was a valuable exercise; treatment providers throughout the county participated in researching and drafting the Standards which update and clarify basic principles of service provision, an important source for creating policy, and educating staff and the public. BHRS mental health division should integrate these substance provider standards along with similar standards used by mental health providers in a single BHRS policy that would help define job expectations, and clarify scope of practice issues within the system. This could be a helpful tool for educating the public and the community of providers regarding the provision of services in San Mateo County.

6. Development of co-occurring competencies for all persons engaged in consumer care:

Organize a universal competency development process to identify core scope of practice for single trained (AOD or MH) clinicians, and to assist all clinical staff to achieve core competency in working with clients and families with complex conditions.

2010: This action item was combined with #16 from the original Charter Document: “Participate in system-wide efforts to identify an integrated scope of practice for singly trained or licensed clinical staff regarding co-occurring disorders for development of appropriate attitudes and skills.” Training on Motivational Interviewing has been provided on numerous occasions to all levels of staff, however, this is an area which needs continual attention. The CODECAT EZ, which determines individual competencies, was released in winter 2009. Training on using this assessment tool has been initiated among Change Agents and Supervisors. This assessment tool identifies areas of provider competency

development that require additional training. The CODECAT EZ helps identify scope of practice determinants for clinicians trained in either AOD or MH; training recommendations can be taken to Workforce Development and Education Committee.

7. Supporting active participation with incentives:

Encourage and create incentives for agency and program participation in 2006 in order to gradually increase expectations for providers to be welcoming, recovery oriented, trauma-informed and culturally competent, and to perform universal screening, identification, and data capture of co-occurring disorders; to engage in recovery oriented, stage specific person centered and family centered integrated assessment and recovery planning; and to move concretely toward attainment of complexity capability, as part of management performance expectations in future years.

Update 2010: The Steering Committee will continue to explore creative opportunities to promote agencies actively working on CCISC development. Examples may include: featuring agencies that have made substantial progress in Wellness Matters or other media.(e.g. websites) in order to provide inspiration and models for success for others to emulate.

8. Creating a funding plan within Utilization of existing resources:

Support flexibility and creative use of existing resources and services across systems that accurately match the needs of complex populations. Clarify how mental health and substance abuse programs can most efficiently use existing funding and maximize reimbursement opportunities to support the provision of integrated treatment, and how clinicians can document attention to integrated needs within each service code through issuing interpretive guidelines for existing regulations and policies.

2010 Update: Specialty Mental Health Medical Policy has been created and is intended to increase diagnosis of and billing for COD. Other efforts are currently underway to maximize resources: reviewing options to bill for co-occurring services via Care Advantage, considering options for billing for screening, and use of Drug Medi-Cal.

9. Address and Improve Systems Monitoring:

Facilitate the use of the Co-morbidity Program Audit and Self-Survey for Behavioral Health Services (COMPASS) throughout the county provider system and in contracted provider systems, to organize a baseline assessment of co-occurring capability throughout the system.

2010 Update: CCISC Program Reporting Form is currently being used to collect early engagement and activity: adopting a Welcoming Policy, completing COMPASS, counting COD consumers; identifying program Change Agents and creating an Action Plan. The results of this survey will be used in the current fiscal year's Outcome Based Management reports to determine quality improvement goals concerning improving care for consumers and families with co-occurring disorders (COD). Such efforts need to be expanded and utilized to measure other aspects of progress, such as competency development, and access to integrated services. Efficient collection of results continues to be a central concern, and will need ongoing review to strategize the best methods for disseminating and collecting results.

Companion or modified tools for recovery orientation, cultural competency at the system level will be introduced as they are developed

10. Tracking system level outcome measurements:

Utilize the CCISC Outcome Fidelity and Implementation Tool (**CO-FIT 100**) as a system tool for measuring progress with CCISC implementation. Steering Committee completed first Co-FIT Spring of 2007.

Steering Committee will complete the CO-Fit every other year. Will consider other systems (e.g. Youth and Adult SOC), which could further benefit from using this tool to help determine viable pathways for system integration.

Companion or modified tools for recovery orientation, cultural competency at the system level may be introduced as they are developed or become available.

11. Continuous quality improvement development:

Develop Quality Improvement Plans, and training activities based on COMPASS and Co-Fit 100 results, with measurable objectives at the department/division management, program services, clinical practice, clinician competency and client satisfaction/outcome levels.

2010 Update: Currently, individual agencies are completing CCISC Action Plans (Continuous Quality Improvement Plans) based on their COMPASS results. The expectation of the completion of such plans needs to be reinforced; compliance mechanisms and incentives for completion need to be developed.

12. Tracking clinical client outcomes and prevalence:

Develop a plan to collect information that will track clinical process and outcomes including provisions for the collection of tool scoring and QI plans as well as the collection of baseline and time sequenced data on the recognition of the prevalence of co-morbidity in the population served.

2010: San Mateo BHRS is engaged in system wide data improvement activities to support this process. The implementation of E-Clinical will assist in this regard as an integrated assessment, which will lead to more accurate data collection.

Beginning in FY 09/10, the outcomes of initial CCISC Program Reporting Form collection will be used in annual Outcome Based Management reports. This is a critical first step toward systemic data tracking for CCISC outcomes, which needs to be further developed.

13. Infrastructure and support for Change Agents:

Offer system wide consultation, training (including identification of a team of change agents or champions to assist with clinical practice development) and technical assistance to programs and clinicians participating in the initiative through a top-down, bottom-up partnership in which change agents in each program work in partnership with leadership to effect change.

2010 Update: A strong Change Agent cadre has been developed. Presently, the challenge is to empower Change Agents to participate in the CCISC quality improvement process with ongoing attendance and visible representation in systems of care. Change Agent representation from any given agency can be rotated at monthly meetings.

The Change Agent Trauma-Informed Services Workgroup Learning Collaborative formed in 2008 as a response to the need and request of both MH and SA providers for trauma training and skills and has developed a 3 hour broad-based trauma presentation applicable to all levels of staff: 'Trauma 101: Understanding trauma for a trauma-informed system of care' In May 2009 a Trauma Conference featuring Stephanie Covington and gender specific trauma treatment was held at the South San Francisco Conference Center for 350 people. The Trauma Conference Coalition is currently planning the 2nd Annual Trauma Conference 'Practice is Progress: Expanding skills in trauma work' to accommodate 500 providers, consumers and family members on May 12th 2010.

Ongoing efforts are needed to support Change Agents with technical assistance and training to bring to their programs in collaboration with the Change Agent leadership team (CARE) and others Another goal for the current period is to encourage the involvement of Change Agents from other systems, such as Human Services, Primary Care, and Probation to represent principles and values of front line service delivery and service recipients in the system planning and implementation process. This might involve different recruitment strategies, which have yet to be identified and explored for their efficacy.

14. Promoting psychiatric medical staff participation as an essential component of the transformative quality improvement process:

Involve multidisciplinary leadership, including physicians, in the project from its inception, and develop a mechanism for clinical-and psychopharmacology practice guideline development for treating persons with complex conditions, and for providing the training necessary for clinicians, interns, and residents to develop the skills and competencies critical to supporting this initiative.

2010 Update: Steps have been taken to involve MD leadership as well as others, yet this is an area that needs further attention in order to communicate the systems perspective to physicians not yet involved in the CCISC process. To date, psychopharmacological guidelines have been distributed to BHRS physicians, the BHRS Medical Director is collaborating with AOD agencies to identify ways to integrate medicine into AOD treatment, and MDs have been provided ongoing training on co-occurring disorders and best medical practices for working with clients with COD. Will continue to assess primary care needs re: CCISC engagement through partnering with MD providers and leadership.

15. Increasing access to services:

Develop a process to review and update authorization and eligibility processes for individuals with co-occurring issues who do not necessarily meet specialty MH or AOD eligibility criteria to insure this population is adequately served.

2010 Update: This issue needs to be addressed. Change Agents have begun work with the BHRS Access Team, partnering to provide a Skills Based orientation group to potential system clients. Other areas of focus include: wet/damp/dry housing continuum based on the work of the Housing Change Agent Workgroup; and a formal process to establish a welcoming, integrated, urgent and routine access system. Additionally, a project is underway for entry re-design of BHRS

(Entry to Care). The Entry to Care Project incorporates use of collaboration in systems, consultation and other policies addressing complex needs of individuals.

[16 combined with #6]

17. Strengthen co-occurring disorder evaluation across systems:

Develop procedures for provision of on-site mental health screening, assessment, and consultation in AOD settings, and substance use disorder screening, assessment, and consultation in mental health settings.

2010 Update: Currently, an integrated co-occurring screen tool pilot is in process at several agencies and programs. It is intended that this screening pilot will be expanded, and data collected from this pilot will help determine routine system-wide screening tools and training for their use.

18. Diversifying Change Agent representation:

Identify clinical and administrative staff, as well as consumers and families when appropriate, to participate as change agents, to assume responsibility for implementation of training plans, and recovery oriented, culturally responsive, co-occurring capable action plans.

2010 Update: Administrative staff, including HSA and SSI, are currently receiving adapted communication skills training based on best clinical practice for COD. Individuals from the administrative staff as well as consumers and families will be encouraged to join the Change Agent group. Currently, new consumer workers and family partners are joining the Change Agent ranks, and recruitment/training of non-employee consumers and families will continue to be promoted.

19. Expanding community and clinic supports to include consumer, family and advocate recovery supports:

Establish a plan to facilitate the creation of recovery groups throughout the system in addition to increasing opportunities for consumers and family members throughout the behavioral health workforce.

The opening of SMCVOICES of Recovery Interim Center provides opportunity to envision a system for organized peer support. Increasing the diversity of the workforce by incorporating consumers and family members at all levels from entry level to leadership positions by providing management and leadership skills development opportunity is an integral goal of the BHRS Workforce Development Plan for 2010 and beyond.