

DRAFT
DETROIT-WAYNE COUNTY MENTAL HEALTH AND
SUBSTANCE ABUSE TRANSFORMATION PROJECT CHARTER
5/20/2008

TABLE OF CONTENTS

1. Overview
2. Historical Background and Context
3. System Vision
4. Project Core Characteristics
5. Clinical Model
6. Appendix A - Historical Background and Context
 - The Bureau of Substance Abuse Prevention Treatment & Recovery
 - CareLink
 - Detroit-Wayne County Mental Health Agency
 - Gateway Community Health
 - SEMCA
7. Systems Transformation for Consumers with Co-Occurring Mental and Substance Use Disorders, DRAFT ACTION STEPS, 2/8/2008
 - Action Steps at the D-WCCMHA/CA/MCPN Level
 - Action Steps for Service Providers

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I. OVERVIEW

Many individuals and families served in the Detroit-Wayne County system of care have co-occurring disorders. These persons present with co-occurring psychiatric and substance disorders, cultural or linguistic challenges, and/or age-specific special needs (e.g. children, youth, young adults, older adults) which are recognized as populations with poorer outcomes and higher costs in multiple clinical domains. This has resulted in over-utilization of resources including higher rates of psychiatric hospitalization, specialized residential and child caring institution days of care and out of home placements.

II. HISTORICAL BACKGROUND AND CONTEXT

For a brief history of previous efforts that have led to this system transformation initiative please see Appendix A.

III. SYSTEM VISION

Our overall goal as partners in the Detroit-Wayne County public mental health and substance abuse system, which includes the Detroit-Wayne Community Mental Health Agency (D-WCCMHA), the Managers of Comprehensive Provider Networks (MCPN's) Care Link and Gateway Community Health and their provider networks, the Coordinating Agencies (CA), Southeast Michigan Community Alliance (SEMCA) and the Bureau of Substance Abuse Prevention Treatment and Recovery (BSAPTR) and their provider networks, direct service providers, other system stakeholders, consumers, families, and people in recovery, is to design the system to be about the needs of the people and families who we serve. We desire to build upon strength and resilience and to inspire hope and sustained recovery for all individuals and families, particularly those with co-occurring issues and disorders. These individuals and families have complex and culturally diverse needs, and would otherwise have the poorest outcomes if not welcomed and engaged.

While each of the above-mentioned efforts has improved the quality and integrity of our services, we are striving to fully integrate our efforts as a system. Through partnering in a shared vision we will be able to create a coordinated and comprehensive system of service delivery.

Separate funding sources (Medicaid, Substance Abuse Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), Center for Substance Abuse Prevention (CSAP), State General Funds, PA 2 funds, Adult Benefit Waiver (ABW), MICHild, HUD, and Vocational Rehabilitation for example) in the mental health and substance abuse fields are a fact. Differing service requirements and limitations are also realities that affect our work. We recognize that we are faced with the challenge of working together to help each other use those limited resources to more effectively and efficiently help the high volume of individuals and families with complex needs in our service system.

Therefore, we agree to create a collaborative culture where all of our subsystems, funding streams and stakeholders join together in a partnership (not a merger) to own collective responsibility for individuals and families with any combination of mental health and substance abuse needs that present in any setting, and to collaboratively prioritize our resources to meet the needs of this population most effectively, and to create a framework for universal capability and mutual support.

Furthermore, we agree to create a truly welcoming “no wrong door” access and outreach system. Our clients, especially those with complex needs, will not always come to us for help, so we will have to reach out to them in a welcoming way. Both Mental Health and Substance Abuse access and outreach providers will have the ability to accurately assess the mental health and substance abuse needs of the individual served and their families. All systems will develop the ability to seamlessly provide or link all services in a fluid manner that does not place the burden on the individuals or families being served to navigate the different systems repetitively.

As a result of this process, and the priorities that have been identified, the Detroit Wayne County partners have agreed to use the Comprehensive, Continuous, Integrated System of Care (CCISC) model for designing systems change. Using this model and within the context of existing resources, we aim to improve recovery orientation, recovery planning and recovery management, cultural competency, access, engagement, and outcomes for individuals and families with both mental health and substance use disorders (with or without co-occurring medical and developmental needs). (See Appendix A for description of model)

IV. PROJECT CORE CHARACTERISTICS

The D-WCCMHA, SEMCA, BSAPTR, Gateway, Care Link and key stakeholders (including providers, consumers, families, people in recovery, and organizations) have agreed to utilize CCISC principles to begin the development of a multi year quality improvement project that will result in a welcoming, accessible, integrated, continuous and comprehensive system of care, in accordance with the system's mission and vision, and in accordance with stakeholder priorities, and incorporating the universal attainment of culturally appropriate, recovery oriented service capability that addresses the co-occurring disorders of all individuals and families served. This document charters this quality improvement project and describes the first steps of concrete implementation at the Agency management level, the clinical program leadership level, the clinical practice level, and the clinician competency development level. This project will have the following core characteristics:

- A. Representatives of all stakeholders in the Detroit Wayne behavioral health system shall be included with the expectation of each component achieving, at a minimum, culturally competent, recovery oriented, Co-occurring Capability.
- B. The initial plan to achieve Co-occurring Capability shall be based upon existing operational resources by maximizing the capacity to provide reimbursable integrated treatment proactively within current resources, and within each single funding stream, contract, and service code. D-WCCMHA, along with its partners, will plan to access resources for consultation, technical assistance, and training, and to identify appropriate incentives for successful participation by programs and clinicians, as part of the QI process.
- C. The full range of culturally appropriate and recovery oriented evidence based best practices and clinical consensus best practices for individuals with psychiatric and/or substance disorders will be utilized within the Detroit-Wayne County system. The integration of appropriately matched best practice treatments for individuals with co-occurring disorders that receive services in the system will be promoted.
- D. In addition, this process will recognize and welcome the diversity of programs and services in the Detroit-Wayne system. The goal is not that all providers become the same but rather that each program develops the capacity to provide or link to (and coordinate with) properly matched services to its own complex populations. These programs will do so within the context of their existing mission and resources. In Wayne County, we have very diverse clients with diverse needs, and we will need diverse programs to meet those needs.

- E. This initiative will be aligned with all the major strategic priorities that are currently under way for the Agency, the CAs and the MCPNs. The Behavioral Health Transformation Quality Improvement Project will not only be aligned with organizational priorities but will infuse them all. Specifically, this means infusing welcoming, recovery oriented, cod capability into each of the above activities.

V. CLINICAL MODEL

This model is based on clinical consensus best practice principles (Minkoff, 1998, 2000) that espouse an integrated clinical treatment philosophy that makes sense from the perspective of both the mental health system and the substance disorder treatment system. Chief among these principles is that dual diagnosis (and in fact, multiple diagnosis); cultural diversity and the hope of recovery are expectations, not exceptions. These expectations must permeate every aspect of system planning, program design, clinical procedure, and clinician competency, and be incorporated in a welcoming manner into every clinical contact. Consequently, all programs must meet minimal standards of Dual Diagnosis Capability. This involves organizing infrastructure so as to provide properly matched and integrated services within the context of its resources and mission to individuals and families suffering from co-occurring disorders. Similarly, every clinician must become a dual diagnosis competent clinician, within the context of the design of the program in which s/he works, his or her specific job description and licensure, and the individuals or families with co-occurring disorders who are presently served. Additional important CCISC principles include:

- A. Welcoming and engaging individuals with complex needs is emphasized.
- B. Cultural competency and maximization of consumer and family participation are critical to system design and development at all levels of activity.
- C. The core of treatment success in any setting is the availability of culturally competent recovery-oriented, empowering, empathic, hopeful treatment relationships that provide integrated treatment and coordination of care during each episode of care, and, for the most complex patients, provide continuity of care across multiple treatment episodes.
- D. Assignment of responsibility for provision of such relationships can be determined using the four quadrant national consensus model for system level planning, based on high and low severity of the psychiatric and substance disorder.

<p>PSYCH. HIGH SUBSTANCE HIGH</p> <p>SPMI or SED and Substance Dependence</p> <p>QUADRANT IV</p>	<p>PSYCH. LOW SUBSTANCE HIGH</p> <p>Psychiatrically Complicated and Substance Dependence</p> <p>QUADRANT III</p>
<p>PSYCH. HIGH SUBSTANCE LOW</p> <p>SPMI or SED and Substance Abuse</p> <p>QUADRANT II</p>	<p>PSYCH. LOW SUBSTANCE LOW</p> <p>Mild Psychopathology and Substance Abuse</p> <p>QUADRANT I</p>

- E. Within the empathic, hopeful, integrated learning relationship, individuals and families are engaged in client-centered partnerships which balance the provision of necessary care and support, with the development of opportunities to be empowered to make choices which create a framework for contingent learning, involving an emphasis on rewards for success (not just negative consequences). A comprehensive system of care will have a range of programs that provide this balance of care and expectation differently for different groups of consumers and families, according to their differing needs. When mental illnesses and substance disorders co-exist, each disorder should be considered primary, and integrated dual primary treatment is optimal.
- F. Mental illness and substance dependence are both examples of chronic, biopsychosocial 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. Consequently, there is no one correct dual diagnosis program or intervention. For each individual, the proper treatment must be matched according to quadrant, diagnosis, disability, strengths/supports, problems/contingencies, phase of recovery, stage of change, and assessment of level of care. In a CCISC, as noted above, all programs are dual diagnosis programs that at least meet minimum criteria of dual diagnosis capability, but each

program has a different “job”, that is matched, using the above model and treatment principles, to a specific cohort of patients. Similarly, outcomes must be also individualized, recovery oriented and culturally appropriate, including reduction in harm, movement through stages of change, changes in type, frequency and amounts of substance use or psychiatric symptoms, improvement in specific disease management skills and treatment adherence.

APPENDIX A

HISTORICAL BACKGROUND AND CONTEXT

The Bureau of Substance Abuse Prevention Treatment & Recovery (BSAPTR)

The Bureau of Substance Abuse Prevention Treatment & Recovery (BSAPTR) recognizes that a significant number of its clients in treatment have co-occurring diagnosis (over 80%). In an effort to increase the awareness among substance abuse clinicians and providers to the dual needs of clients, the BSAPTR in 2005, encouraged providers to develop competencies in the field of mental health. The BSAPTR also emphasized the need for clinicians to obtain mental health disease management certifications.

Also in 2005, the BSAPTR aggressively tried to identify all clients in treatment with mental health disorders in order to refer them to the appropriate mental health providers. The BSAPTR discovered that a majority of clients in treatment were not those with severe and persistent mental health illnesses. However, there were a significant number of clients with mild to moderate mental health disorder that could easily decompensate without appropriate mental treatment/services and follow-up. The BSAPTR also discovered that the numbers of co-occurring clients were significantly under reported by providers – translation, substance abuse clients were not adequately screened for mental health illness.

Between 2005 and present, nine substance abuse providers obtained certification to co-occurring providers. However, the number of dually diagnosed clients remained low.

Since 2006, the BSAPTR in collaboration with the D-WCCMHA and the State of Michigan's Community Mental Health Boards have sponsored trainings and seminars to address this issue. These efforts are ongoing.

Care Link

The Care Link Network in 2003/2004 signed a contract with Dr. Minkoff and Dr. Cline to provide training and consultation for our Network in their model of how to deal effectively with Co-occurring disorder (IDDT – Integrated Dual Diagnosis Treatment). Southwest Counseling Solutions had been working with Dr. Minkoff and Dr. Cline on this issue and had found their experience to be a very positive one. All of the Care Link partner agencies pooled their resources to hire Zialogic (the company formed by Dr. Minkoff and Dr. Cline) to do clinical training and consultation as well as systems transformation within our Network and our larger community of stakeholders. Our Network designed the charter document together. Each agency took this document back to their organization to indicate that there was “buy-in” at all levels for making the organization a “welcoming” place for consumers with co-occurring disorder.

The Care Link primary partner agencies developed action plans for their agencies, which described how they were going to institute the core concepts of the IDDT model. The agencies also administered readiness tools such as the COMPASS, CodeCat and GOI in their agencies.

The Care Link Network agencies have continued to move toward full readiness with regularly scheduled trainings. They have initiated dual diagnosis ACT Teams with substance abuse specialists. They have hired Board Certified Addictionologists for the medical staff. They have developed welcoming protocols from the front door to the Executive office and other initiatives as well. We continue to refine and develop programming to more successfully serve the large number of consumers of all ages that are diagnosed with a co-occurring disorder in the Care Link Network.

Detroit- Wayne County Community Mental Health Agency

The Detroit- Wayne County Community Mental Health Agency has actively supported funding and programming for individuals with co-occurring disorders. Agency research has shown that 57% of adults who were hospitalized have experienced a psychoactive substance use disorder within the month prior to hospitalization. Sixty-eight (68)% of the same group of individuals experienced a psychoactive substance use disorder during their lifetime.

The Agency was the grantee of Federal Block Grant Funds through the Michigan Department of Community Health, which supported dual-diagnosis emergency room screening, assessment and triage services and Intensive Outpatient and

Dual Diagnosis Assertive Community Treatment (ACT) services. The Agency contracted with 6 service providers to implement these specialized services in Detroit and Wayne County. All providers had contracts with both the Agency and with their local Coordinating Agencies.

Gateway Community Health

Gateway Community Health, Inc., MCPN for Detroit Wayne County Community Mental Health Agency is committed to the implementation of the CCISC Model and senior leadership has attended initial meetings with Dr. Kenneth Minkoff to begin taking the necessary steps to transform our network of providers within the context of their current strengths and structure.

To this end the following are activities that Gateway has engaged in with their provider network to move transformation forward: Gateway has received FY08 Block Grant funding to hire a Program Coordinator, an In-Service/Educator, a Psychiatrist, and four Peer Support Advocates. The Program Coordinator and Peer Support Advocates are hired at this time. The Gateway Program Coordinator has participated in the Ohio SAMI CCOE annual conference. Other Gateway staff and several Provider staff have attended Wayne State University's Project Care Evidence Based Practice Trainings and system development activities. Gateway has initiated an Evidence Based Practice Committee to foster program/staff development. At the Gateway provider network level the Arab American Chaldean Council, Detroit Central City, Community Care Services, and Detroit East are piloting IDDT programs. Other providers are piloting Family Psycho education and block grant funding has been obtained within the network for Supported Housing/Supported Employment/Supported Education/PMTO opportunities to be developed. Providers piloting IDDT programs have attended the Minkoff-Cline trainings for service providers. The agencies piloting the IDDT programs also have substance abuse licensing for their respective agencies. Lincoln Behavioral Services and few other agencies have hired Peer Support Specialist. Gateway will continue to work toward program/policy development through training/education/support to providers and the community and partners within their sphere of influence.

SEMCA

For the past four years, the Wayne County-based public substance abuse and mental health services systems have been exploring ways to effectively blend services so that clients who have co-occurring disorders can be appropriately screened and both conditions are treated. Despite planning, a true blended system has yet to emerge. Thus, SEMCA seeks contractors who can deliver an assessment that acts as a single point of entry for both substance abuse and mental health services within Wayne County (excluding the City of Detroit). SEMCA's Access Management System (AMS) has a screening tool and clinicians who can appropriately recognize and refer for both Substance Abuse (SA) and Mental Health (MH). SEMCA works closely with Detroit Wayne County

Community Mental Health Agency (DWCCMHA). This linkage will allow clients with co-occurring disorders to receive simultaneous or staggered services within both systems. SEMCA is seeking providers that possess the capability to provide treatment services to both populations (SA and MH). SEMCA is working with DWCCMHA and Wayne State University Project CARE with a provider that we mutually provide funding to on the IDDT (Integrated Dual Diagnosis Treatment) to pilot their program as an Evidenced Based Program (EBP) for persons with Co-Occurring Disorders. This program began April 27, 2005. Two of our mutual providers are using the CCISC Model for co-occurring disorders.

SEMCA continues to provide Co-occurring Services through these three programs that have expertise in substance abuse and mental health diagnosis and treatment. These providers are network providers with Detroit Wayne County Mental Health Agency and two are working closely with Dr. Kenneth Minkoff on co-occurring disorders. Their clinical staff are cross-trained in both areas of substance abuse and mental health. SEMCA's co-occurring programs treat clients that are in quadrate I low psychiatric (milder psychopathology), low substance (abuse) and quadrate III high substance (dependence), low psychiatric (milder psychopathology) for Medicaid and Non-Medicaid clients. These three providers in SEMCA's network are dually diagnosed enhanced (DDE) programs. These providers are authorized for co-occurring clients through SEMCA's AMS department, and are monitored during annual site visits.

SEMCA has invested in training its workforce to be dually diagnosed capable (DDC). SEMCA requires that all providers address client's substance abuse and mental health diagnosis and needs. This requirement is included in all treatment provider contracts. SEMCA also has treatment policies that require coordination of care for co-occurring clients. Adherence is monitored during site visits. Those providers capable of handling client co-occurring needs maintain these clients in their programs. Those that cannot must coordinate care with providers who have both competencies. Providers must work with the mental health professional/agency and equally provide and exchange of information to meet the client's needs. SEMCA continues to provide training and is exploring train-the-trainer type trainings to educate the entire network of clinical therapists.

Systems Transformation for Consumers with Co-Occurring Mental and Substance Use Disorders

DRAFT ACTION STEPS 2/8/2008

Action steps at the D-WCCMHA/CA/ MCPN level

- A. D-WCCMHA along with CAs and MCPNs will create an empowered project leadership team (PLT) that is representative of all levels of the system and that is responsible to the Executive Leadership of the partners for the planning and implementation of this QI Project. The leadership team will include mechanisms for engaging participation from key stakeholders. We are considering building this out of the D-WCCMHA Quality Improvement Council or Improving Practices LT. This group will begin to review our current array of committees and workgroups so they are efficiently lined up with this process, and also begin to eliminate unnecessary or duplicative meetings.
- B. Consumers and family advocates and members of the recovery community will be empowered partners in this process at every level.
- C. In addition, each of the partners will organize similar levels of organized implementation internally within their own system infrastructure. That is, D-WCCMHA will sit in partnership with CAs and MCPNs to organize this process county wide, but will also organize an internal process within its own organizational structure, including involvement of contract monitors and auditors.
- D. In order for this to be successful, we recognize as partners that the contract between the County and the MCPNs/CAs has to be developed in a partnership context in which administrative rules can be developed that are aligned with the clinical policy direction of value driven transformation. This partnership must also be extended to our work with our providers.
- E. D-WCCMHA/CA/MCPN partners will each adopt this project charter as an official policy statement, and disseminate it in official material to its constituencies, including the Board of Directors, the Community Planning Council, Consumer Family Advocate Council and all clinical and administrative staff. Its elements will be incorporated into official planning documents and other publications. In addition, all stakeholders will receive basic training on the principles of the model,

and the plan to achieve universal recovery oriented, culturally competent and dual diagnosis capable services.

- F. D-WCCMHA, MCPNs, and CAs will each develop a mechanism for regular communication about ongoing project activities to all stakeholders.
- G. D-WCCMHA, CAs, and MCPNs will involve medical and psychiatric leadership in the project from the beginning by :
 - Ensuring that the QI Process has an organized way to include medical leadership at every level.
 - Developing a mechanism for implementation of psychopharmacology practice guidelines for co-occurring disorders.
 - Training psychiatric residents to have COD competency in line with this initiative.
 - Ensuring Physicians in the network are engaged in the process at all levels of care - state and community hospitals, residential and ambulatory settings.
- H. D-WCCMHA, CAs, and MCPNs will utilize the CO-FIT 100 as a system fidelity outcome tool for measuring progress in CCISC implementation to create a baseline score for 2008 for both adult and children's services, and then continue to use the tool at twelve-month intervals to measure progress in this initiative. D-WCCMHA and CAs may also identify or adapt tools that will be used to assess the system's progress in achieving recovery orientation and cultural competence.
- I. D-WCCMHA, CAs, and MCPNs will facilitate the use of the COMPASS throughout the provider system, to organize a baseline assessment of DDC throughout the system.
- J. Based on CO-FIT results, D-WCCMHA, CAs, and MCPNs will develop a mechanism for prioritization of project activities, and develop a concrete Quality Improvement Implementation Plan that specifies measurable objectives at the levels of management, program services, clinical practice development, and clinician competency and training.
- K. D-WCCMHA will work with its partners so that the contracted QI plan at the MCPN or CA level is unified under the general vision of transformation, as outlined in this charter, rather than having multiple disconnected projects.

- L. In each existing or new program, quality improvement activity, or other activity, D-WCCMHA, CAs, and MCPNs will incorporate development of recovery orientation, cultural competency, and dual diagnosis capability as a core feature of infrastructure development.
- M. D-WCCMHA, CAs, and MCPNs will initially encourage agencies, programs and clinicians to participate voluntarily in this project in 2008, and will gradually increase expectations for providers to be welcoming, recovery oriented, 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 Dual Diagnosis Capability, as part of management expectations in future years.
- N. D-WCCMHA and CAs will develop an inclusive process (with the MCPNs) to develop and then a plan to issue interpretive guidelines of existing regulations to clarify how mental health and substance abuse programs can most efficiently use their existing funding streams to support the provision of appropriate integrated treatment, and how clinicians can appropriately document attention to integrated needs within each service code. All funders, including MCPN'S, would then be responsible for transmitting these guidelines into their own provider contracts and business operations.
- O. D-WCCMHA, CAs, and MCPNs will use the Workforce Development Committee of the Community Planning Process to organize a universal competency development process to identify core scopes of practice for single trained clinicians and to assist all clinical staff to achieve core competency (welcoming, recovery oriented, co-occurring capability) in working with their clients and families with core needs. This includes the training of psychiatric residents to have COD competency in line with this initiative. The County level Workforce Development activity will be aligned with a state level (ODCP) workforce development process regarding substance provider competency and credentialing, in which SEMCA is currently represented.
- P. D-WCCMHA, CAs, and MCPNs will be developing a plan to collect information related to this initiative that will track clinical process and outcomes. This plan will begin with provisions for the collection of tool scoring and QI plans as well as the collection of basic data on the prevalence of co morbidity and diversity in the population. MCPN'S will be responsible for collecting tools, scores and action plans from all of their major contracted providers, and incorporating this activity into their QI plans. MCPN'S will align their data collection and

screening/data QI activities with this process so that providers can report on a common set of data elements.

- Q. D-WCCMHA, the MCPN's and CAs will develop mechanisms to offer system wide consultation, training (including identifying a team of change agents or champions to assist with clinical practice development) and technical assistance to programs and clinicians participating in the initiative. This will include ZiaPartners (Minkoff/Cline), AHP (Housing, employment), Patrick Boyle (IDDT), etc, as well as developing internal capacity via the Office of EB Medicine. The Agency will be primarily responsible for coordinating and contracting with this at the system level, but the MCPN's and CA's will coordinate the implementation of this at their network level. It is recommended that the funders also identify change agents from internal contract management and/or QI staff to work in partnership with clinicians
- R. D-WCCMHA and CAs will develop a process to look at our authorization and eligibility processes for individuals and families with co-occurring issues who do not initially clearly meet Priority MH, SA or other eligibility criteria to facilitate welcoming, engagement, and accurate identification of their needs. This process will involve the MCPNs and Pioneer (and SA access points) as partners. This system will engage in a process to define the populations that will be eligible for public mental health and addiction services, both in terms of acute crisis response, and in terms of continuity of care.

In addition, D-WCCMHA will convene a workgroup with all partners to address the issue of integrated access and outreach and an integrated safety net for individuals who present with urgent and emergent needs throughout the system. This workgroup will also address the issue of the use of mandating that the blood alcohol level be below .08 as a criterion for emergency evaluation, medical clearance or psychiatric admission.

- S. D-WCCMHA, CAs, and MCPNs will develop a system level welcoming policy statement.
- T. D-WCCMHA, CA, and MCPNs will develop a process to create a system wide policy for integrated screening, and then create a process to define welcoming, recovery oriented, integrated assessment in which individuals and families have an opportunity to provide a history, to tell their stories, and to identify their most hopeful goals. Part of this process is to revamp documentation to eliminate unnecessary paperwork and to make it easier for clinicians to document this type of assessment efficiently.

D-WCCMHA, MCPNs, and CAs will work with the Research Advisory Committee to organize an evaluation and research component for the system level transformation, beyond just EBP implementation.

- U. D-WCCMHA, MCPNs, and CAs will organize a strategy for engaging AFC providers of specialized residential services to create a framework for them joining in this process, and for continually improving the welcoming, recovery oriented, and capability of all contracted housing services over time. This will be coordinated with AHP as part of supported housing implementation.
- V. D-WCCMHA and the MCPN's will organize a process with the community psychiatric units, the screening centers, and the state facilities to discuss involvement of the inpatient level of care in this process. Part of the discussion will be the development of language related to the CCISC process to be incorporated in the quality improvement indicators in the hospital contracts with D-WCCMHA and the MCPN's.

DRAFTAction steps for Service Providers

In the first year of implementation, all participating agencies, programs and clinicians agree to the following priorities for clinical practice development. Non-provider stakeholders can agree to participate in those elements of this list that are appropriate for them.

1. Each participating agency will adopt this charter as an official document, and circulate to all staff and stakeholders, and provide training on the basic principles and the implementation process.
2. Each participating agency will make a formal commitment, with Board approval if needed, to achieve recovery oriented capability, cultural competency, and dual diagnosis capability as a component of short and long range strategic planning and quality improvement priorities over time.
3. Each participating agency will organize its own systematic CQI process to achieve the goals identified in the previous paragraph
4. Each agency will have each program use the COMPASS to do a self assessment of its current DDC, and to develop a QI action plan based on the improvement opportunities identified in the tool process.
5. The QI plan for each agency will be matched to the developmental capacity of the agency for each program and will have measurable attainable objectives at 3-6 months intervals. Each plan will be individualized but will address the elements listed in the priorities below.
6. Participate in agency wide efforts to improve welcoming access for individuals with co-occurring disorders by adopting agency specific welcoming policies, materials, and expected staff competencies.
7. Participate in system wide efforts to improve welcoming, culturally appropriate, and recovery oriented hopeful engagement of clients in every setting, and to remove arbitrary barriers to access based on co morbidity.

8. Participate in system wide efforts to improve identification and reporting of individuals with co-occurring disorders by incorporating agency-specific and program specific improvements in screening and data capture in the action planning process
9. Participate in agency wide efforts to enhance efficiency of utilization of existing funding streams for integrated treatment by adopting specific policies, procedures, and training activities to ensure agency wide implementation of regulatory clarifications and interpretive guidelines regarding reimbursement and documentation of integrated treatment within any single funding stream, so that these new procedures can be reflected in existing treatment plans, progress notes, and billing documentation.
10. Assign appropriate clinical leadership to participate in inter-program and/or interagency care coordination meetings, or cross system interagency partnership activities, as they are developed and organized.
11. Identify staff, consumers, and families to participate in the agency quality improvement efforts to develop Dual Diagnosis Capability
12. Establish the goal that over time all clinicians will develop core competency in providing culturally competent, recovery oriented and person/family centered appropriate services to the individuals with single or co-occurring disorders in their case loads.
13. Participate as appropriate in system wide efforts to identify an integrated scope of practice for all singly trained or licensed clinical direct service staff regarding co-occurring disorders, to develop required attitudes, values, knowledge, and skills in relation to this scope of practice for all, and adopt the goal of dual diagnosis competency for all clinicians as part of the agency's long range plan.
14. After the first year, participate in clinical direct service staff competency self survey using the CODECAT at twelve month intervals, and use the findings to develop a program specific training plan. Other clinician tools?

15. Identify appropriate clinical and administrative staff, as well as consumers and families where appropriate, to participate as clinical change agents or champions this initiative, to assume responsibility for implementation of the program's training plan, and to participate in the implementation of the agency or program's Recovery Oriented, Cultural Competency, Dual Diagnosis Capability action plan.