ACMI Educational Webinar: Co-Occurring Help & Hope for Recovery

- Information presented is not medical advice
- Please mute all lines except presenters
- Submit questions in chat window
- Those requesting a Certificate of Attendance need to send an email to contact@acmionline.com with following information:
  - First name
  - Last name
  - Email address
- Diana Medina, Ph.D. |Copa Chief of Clinical Education will be sending the certificate

ZIA PARTNERS

Our Speakers- Co-Occurring Help & Hope for Recovery

- **Kenneth Minkoff, MD** is a board-certified psychiatrist with a certificate of additional qualifications in addiction psychiatry; a dedicated community psychiatrist, & currently is a clinical assistant professor of psychiatry at Harvard Medical School. He is recognized as one of nation's leading experts on integrated treatment of individuals with co-occurring psychiatric & substance disorders (ICOPSD) or "dual diagnosis", & on development of integrated systems of care for such individuals, through implementation of a national consensus best practice model for systems design: Comprehensive Continuous Integrated System of Care

- **Christie Cline, MD, MBA** is founder & President of ZiaPartners, Inc. Board-Certified Psychiatrist & also has a Masters in Business Administration from Georgetown University in Washington, DC, & graduated with distinction with a focus in organizational development & strategic planning. Dr. Cline is former medical director for Behavioral Health Services Division/New Mexico Department of Health & served as psychiatric lead for indigent safety-net system for seriously mentally ill people, homeless & victims of acute trauma & for public mental health & substance treatment system for & state between 1999 & 2003.

Changing the World: Inspiring Hope, Health & Recovery

Transforming systems at every level to be about the needs, hopes and dreams of the people and families with complex needs who come to our door

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The Complexity Challenge

- Individuals with complex multiple issues have the poorest outcomes in multiple domains.
  - Most likely to cost a lot of money, most likely to be homeless, most likely to die.
  - Often experienced as misfits rather than as priorities to serve.
- Is your system or organization designed to welcome people with complexity as a priority for care?

The Hope Challenge

- In order for our system to inspire people and families with serious challenges and multiple issues, we need to be in the hope business.
- Hope: Every person, including those with the greatest challenges, is inspired when they meet us with hope for achieving a happy, hopeful, productive, and meaningful life.

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Is your system/organization designed to inspire hope for people with complex needs?

Principle-driven
Adult and Child Systems of Care

ALL services are:

- Hopeful
- Person- or family-centered
- Empowering and strength-based
- Designed to help people achieve their most important and meaningful goals

Integrated Systems of Care

- Complexity is an expectation, not an exception.
- ALL services are designed to welcome, engage, inspire, and provide integrated services to individuals and families with multiple complex issues (MH, SUD, DD, BI, health, trauma, housing, legal, parenting, etc.)

Comprehensive, Continuous Integrated System of Care

CCISC

- All programs in the system become welcoming, hopeful, strength-based (recovery- or resiliency-oriented), trauma-informed, and complexity-capable.
- All persons delivering care become welcoming, hopeful, strength-based, trauma-informed, and complexity-capable.
- 12-Step Program of Recovery for Systems

Person-centered, Resiliency-/Recovery-oriented

Complexity Capability

Each program organizes itself,
within its mission and resources,
to deliver integrated, matched,
hopeful, strength-based,
best-practice interventions for multiple issues
to individuals and families with complex needs
who are coming to the door.

Person-centered, Resiliency-/Recovery-oriented

Complexity Competency

Each person providing clinical care is helped to develop core competency, within their job and level of training, licensure or certification, to become an inspiring and helpful partner with the people and families with complex needs that are likely to already be in their caseloads.

Person-centered, Resiliency-/Recovery-oriented

Complexity Capability

- **CCISC Program Self-assessment Tools: COMPASS-EZ™, COMPASS-ID™, COMPASS-PH/BH™, COMPASS-Prevention™**
- **CCISC System of Care Tools: SOCAT™, COMPASS-EXEC™**
- **12 Steps for Programs Developing Complexity Capability**

Person-centered, Resiliency-/Recovery-oriented

Complexity Competency

- CCISC Clinician Self-assessment Tool: CODECAT-EZ™
- 12 Steps for Staff Developing Complexity Competency

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Is this your vision?

If so, how do you get there?

How do we get there clinically?

Research-based principles of successful intervention that can be applied to any population in any program by any person delivering care.

As a system or organization, how do we get there?

Quality Improvement

- Recovery process for systems
- Horizontal and vertical quality improvement partnership
- Empowered Change Agents
- Anchoring value-driven change into the “bureaucracy”
- Serenity Prayer of System Change

System Design Components

Address using CCISC Principles/CQI Partnership

- Customer-oriented quality improvement redesign
- Welcoming integrated access & engagement
- Peer/family support expansion
- Integrated crisis system redesign
- Integrated SUD system redesign
- Integrated Adult and Child MH system redesign
- Utilization management redesign
- “Treatment & care coordination” redesign
- Managing “high utilizers”

System Design Components

- System of Care Partnerships
  - Primary health, MH, SUD
  - Elder Care, Cognitive Disability Services
  - Criminal justice/juvenile justice
  - Housing/homelessness – “wet”, “damp”, “dry”
  - Child/Family School, Social and Protective Services
  - Prevention/early intervention

Vision-driven Quality Improvement Challenge

- How well is your system, agency or program organized to empower staff as partners in vision-driven quality improvement?
- How well are you organized to build inspiration:
  - In the face of complex challenges in your program?
  - To provide services that effectively and efficiently match the complex challenges of your clients?

Principles Made Simple

Principle #1

Complexity is an expectation.

- Welcome people with complexity as priority customers.
- Remove access barriers that make it hard to be welcomed.
- See all the complex issues: integrated screening and documentation.

Principle #2

Service partnerships are empathic, hopeful, integrated, and strength-based.

- Hopeful goals for a happy life.
- Work with all your issues step by step over time to achieve success.
- Build on strengths used during periods of success.

Principle #3

All people with complex issues are not the same.

- Different programs have different jobs.
- All programs partner to help each other with their jobs, and their populations
- 4-Quadrant model (HI/HI, HI/LO, LO/HI, LO/LO) for MH/SA, MH-SA/PH or MH-SA/DD may help with service mapping and matching.

Principle #4

For people with complexity, all the co-occurring conditions are primary.

Integrated multiple primary condition-specific best practice interventions are needed, including - for illnesses - both medication (MAT) and psychosocial interventions.

NB: Conditions may include not only illnesses but psychosocial issues such as cultural/linguistic/immigration barriers, homelessness/housing, disability, justice involvement, educational needs, domestic violence, parenting challenges, cognitive/learning challenges, relationship issues, and so on.

Principle #5

Parallel process of hopeful progress for multiple conditions

- Recovery/resiliency/self-determination of the *person* with one or more conditions.
- Progress involves:
  - Addressing each condition over time.
  - Moving through stages of change for *each* condition.
- Integrated services involve stage-matched interventions for *each* condition.

Principle #5 (continued)

Stages of Change

Issue-specific, not person-specific.

- **Pre-contemplation:** You may think this is an issue, but I don't—and even if I do, I don't want to deal with it, so don't bug me.
- **Contemplation:** I'm willing to think with you and consider if I want to change, but have no interest in changing, at least not now.

Principle #5 (continued)

Stages of Change

- **Preparation:** I'm ready to start changing but I haven't started, and I need some help to know how to begin.
- **Early Action:** I've begun to make some changes, and need some help to continue, but I'm not committed to maintenance or to following all your recommendations.

Principle #5 (continued)

Stages of Change

- **Late Action:** I'm working toward maintenance, but I haven't gotten there, and I need some help to get there.
- **Maintenance:** I'm stable and trying to stay that way as life continues to throw challenges in my path.

Principle #6

Adequately supported, adequately rewarded, skill-based learning for each condition.

- Small steps of practical learning
- Self-management skills and “asking for help” skills
- Medication skills and psychosocial skills
- Rounds of applause for each small step of progress

Principle #7

There is no one correct intervention or program.

In CCISC,
every program, policy, practice, etc.,
is organized to match interventions
based on the principles.

Principles Made Simple

Summary

Welcoming, empathic, hopeful, continuous, integrated recovery and support partnerships

- Addressing multiple primary issues
- Providing adequately supported, adequately rewarded, strength-based, skill-based, stage-matched, community-based learning for each issue
- Moving toward goal of a happy, meaningful life

System Redesign Activities

System Redesign Activities

Customer-oriented QI Redesign

- QI is the fundamental organizational competency *not* QA/compliance monitoring.
- Customer experience informs system/program improvements. Emphasize customers with complex needs who may be “misfits”.
- Root cause analyses lead to *system* change.
- Customer-oriented QI processes & incentives are embedded in performance contracts.

System Redesign Activities

Welcoming Integrated Access

- Remove arbitrary access barriers.
- Every door is the right door for system entry.
- Everyone –especially those with the greatest challenges – is inspired with hope
- Easier access for those in crisis or with complexity.
- Each part of the system is a priority partner for access to other services.
- Improve data recognizing prevalence of complexity.

System Redesign Activities

Crisis System Redesign

- Welcoming safety net for high-risk clients of all ages/issues.
- Accountable system of crisis services, with oversight, quality improvement, service continuum, and best practice interventions (e.g. “no force first”, peers, MAT initiation)
- Design crisis response so it is easy to ask for help sooner - before needing commitment
- Integrated continuum of crisis intervention (not “one and done”) with multiple levels of co-occurring capable services
- Flexible continuity of care for those in crisis

SUD System Redesign

- Inverted public health triangle – most people get served early, in primary care or generic settings.
- Holistic trauma informed prevention & recovery capital in the community
- SBIRT (and MAT) in PH and partner systems (schools, child welfare, CJ)
- Crisis settings welcome SUD, start MAT, and engage high risk individuals
- Co-occurring capability in specialty MH and PH settings (oncology, HIV, OB)

Specialty SUD services are co-occurring capable and "deinstitutionalized"

- Continuity of rx, care coordination, **MAT**, and continuing recovery support
- Lengths of stay in higher levels of care are short and flexible: **Case rates**.
- Expansion of housing continuum that includes dry, damp, and wet.

System Redesign Activities

Treatment & Care Coordination Redesign

- Person/family-centered vs. slot-centered
- Recovery-oriented and strength-based partnerships
- All services/EBPs complexity capable—no parallel care
- Flexibility in service intensity provided within a continuing partnership.
- Treatment (especially addiction rx) moves from episodes of “acute” care to continuing rx and recovery support.
- Team-based vs. individual practice
- Teams move from *caseloads* to *population management.*

System Redesign Activities

Utilization Management Redesign

- All LOC criteria are designed with the expectation of complexity.
- Develop criteria that support continuity of care rather than distinct episodes.
- Create an integrated continuum rather than parallel continua.
- Integrated framework for LOC tools (LOCUS, ASAM).

System Redesign Activities

Managing "High Utilizers"

- Identify high-risk/high-volume/high-cost/ poor-outcome cohorts.
- Assume system misdesign.
- Develop wraparound services to *fit* the individuals—not the other way around.

System Redesign Activities

System of Care Partnerships

(Primary Health, Justice, Child Protection, Housing)

- Create formal expectations for local system (county) population management collaborations.
- Complexity capability is an expectation in all settings.
- Welcome the partners as priority clients.
- Each partner helps the other with complexity through cross-consultation and in-reach.
- Develop a systemwide trauma-informed prevention collaborative and co-occurring ROSC
- Contract incentives for QI and partnership.

System Redesign Activities

Housing System Redesign

- Wet/damp/dry housing
- Housing First
- Supported sober living
- Design housing programs to fit clients, rather than the other way around.

Stage-matched (for Substance Use) Options for Supportive Housing

- Individuals have a choice of housing options that includes
  - Abstinence-expected (dry)
  - Abstinence-encouraged (damp)
  - Full consumer choice of substance use (wet)

System Redesign Activities

Peer/Family Support Expansion

- Peer support is a core component of service delivery.
- MH, SA, PH, and DD systems all have peer/family support features that align.
- Peer/family support training and certification are integrated, and peer support specialists are co-occurring competent.

Thank You