Behavioral Health Redesign Steering Committee (BHRSC)
November 15, 2012

Call to Order. Chair Gubbin called the meeting of the Behavioral Health Redesign Steering Committee to order at 12:00 P.M. in the Courthouse Conference Center, second floor, Rock County Courthouse-East.

Committee Members Present: Supervisor Billy Bob Grahn, Dr. Marko Pease, Tom Gubbin, Charles Jones (alt. for Neil Deupree), Deputy Chief John Olsen, Tim Perry, Linda Scott-Hoag, Julie Lenzendorf, Cristina Kroeze (alt. for Greg Ammon), Ryan Trautsch (alt. for Lance Horozewski, Cmdr. Erik Chellevold, Brian Gies, Sheila Deforest, and Melissa Meboe (alt. for Kate Flanagan).

Committee Members Absent: Dannie Evans, Judge James Daley, Laura Binkley, Faith Mattison, Denny Luster, and Brenda Clark.

Staff Members Present: Elizabeth Pohlman McQuillen, Criminal Justice System Planner/Analyst.

Others Present: Supervisor Steven Howland.

Approval of Agenda. Supervisor Grahn moved approval of the agenda as presented, second by Mr. Jones. ADOPTED.

Approval of the Minutes of November 15, 2012. Dr. Pease moved approval of the minutes as presented, second by Mr. Jones. ADOPTED.

Report on Zia Partners Phone Conference and Discussion regarding Site Visit. Chair Gubbin reported that the conference call was on Friday, November 9th and Ms. Flanagan gave the consultants an update on what has been happening with the Rock County behavioral health system since they last worked with us. Zia Partners gave an outline of what the site visit on December 4th would consist of, including a big group meeting with the BHRSC, several breakout groups, and a wrap up meeting with various stakeholders.

Information on CCISC. Chair Gubbin handed out sheets describing CCISC and told the group the information was for their review and that the consultants would talk more about it on December 4th.

Work on System Mapping—Human Services Department. Ms. Meboe lead the discussion and said Human Services is looking at a single point of entry into the system. Adults are screened after they call into a call line. She described the process of routing someone through the system and went over the handout of the process. Ms. Deforest asked when the screening started. She noted that her son got assessed but it took three weeks to get his result. Ms. Meboe said psychiatry services through the county are currently maxed out and unless the individual is getting out of the hospital or an ED and have no other options. Ms. Meboe added that the no show rate is 50%. Ms. Scott-Hoag said there is a gap in the system in giving reminders for appointments. Mr. Perry asked how many hours a week are spent on assessments. Ms. Meboe responded that 15 hours are spent on assessments. She said no shows were due to a variety of reasons including transportation issues, childcare, etc.

Ms. Meboe went over the handout on the children's system of care. She said right now there is no external way to get into the County's kid's system of care unless the child is already involved in county services—Juvenile Justice, CPS or Crisis. She added that Human Services is getting certified to provide CST teams, which would provide a wrap around family-centered approach. She also stated that there is a significant gap for kid's psychiatry services.

Citizen Participation and Announcements. None.

Time and Date for Future Meetings. The next BHRSC meeting with Zia Partners will be Tuesday, December 4, 2012, at 8:00 a.m. in the 2nd Floor Courthouse Conference Center. The next regular BHRSC meeting will be on Thursday, December 13, 2012, at Noon, in Room N1-N2, Fifth Floor, Courthouse East.

Adjournment. The meeting adjourned at 12:27 p.m. by acclamation.

Respectfully submitted,

Elizabeth Pohlman McQuillen
Criminal Justice System Planner/Analyst

NOT OFFICIAL UNTIL APPROVED BY COMMITTEE.

CCISC Description and Principles of Complexity Capability

Comprehensive Continuous Integrated System of Care

CCISC is both a framework for person- and family-driven system design and a process of getting there in partnership across the whole system.

The overall vision is to design the system at every level to be about the needs, hopes, and dreams of the people and families that are needing help with all types of co-occurring complex issues—including health, mental health, trauma, substance use, and cognitive conditions, as well as housing, legal, vocational, social and parenting issues.

The core of the vision is that ALL programs and ALL persons delivering care and support become welcoming, person-centered, resiliency-/recovery-oriented, hopeful, strength-based, trauma-informed, culturally fluent, and complexity-capable. In any community, all programs work in partnership to help achieve this vision, so that people with complex needs receive more integrated care within any door.

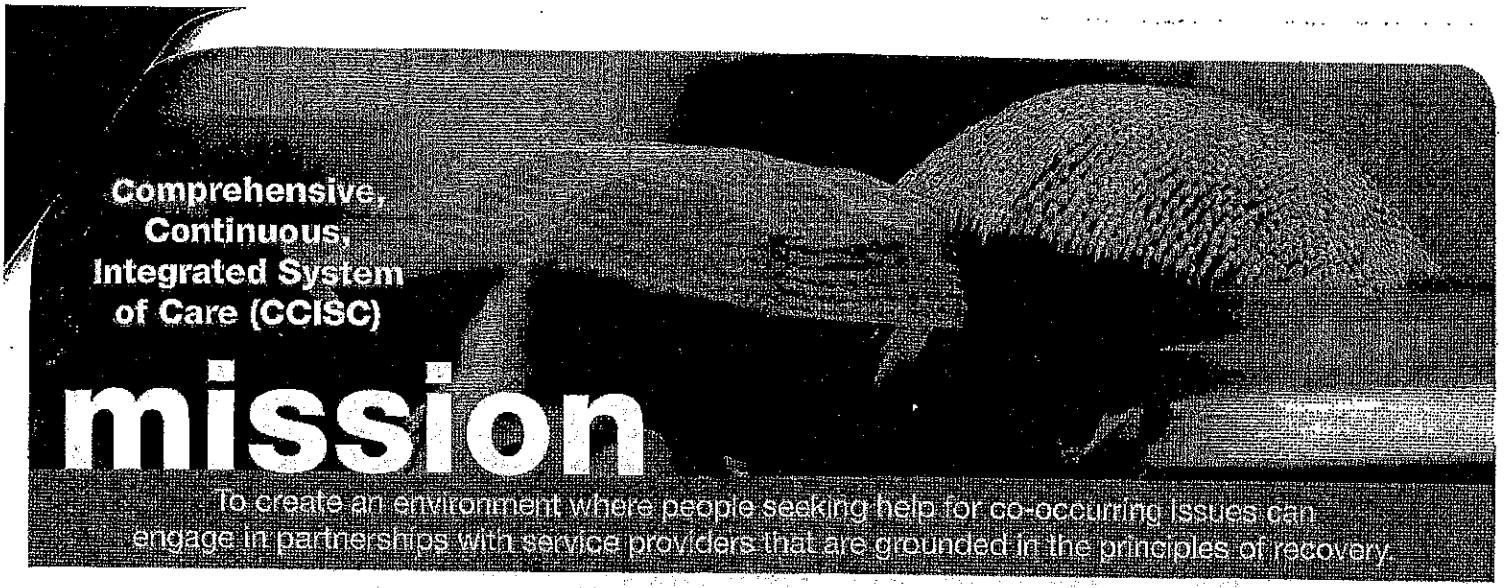
Making the vision a reality is based on implementing a set of evidence-based principles of service, each of which is associated with interventions and strategies that can be used in any setting, with any population, by any person providing care.

Making the vision a reality is also based on organizing a system-wide quality improvement partnership, in which all types of programs and providers are welcome to come together to move toward the common vision, and all levels of the system—state and county leaders, agency CEOs, program managers, front-line service and support staff, and people and families who are service recipients—come together in an empowered partnership for change.

CCISC change agent teams represent the empowered collective front-line voice of both staff and service recipients throughout the system who are engaged formally as partners in this process, representing their organizations, communities, and other constituencies.

The CCISC principles are:

- Complexity is an expectation, not an exception. This expectation must be incorporated in a welcoming manner into everything we do.
- Recovery partnerships or service partnerships are empowered, empathic, hopeful, integrated, and strength-based, working with individuals and families step by step over time, building on their periods of strength and success, to address ALL their issues in order to achieve their vision of a happy, meaningful life.
- All people with co-occurring and complex issues are not the same. Different programs and different systems have responsibility for serving different sub-populations, but all programs are complexity-capable. Each program provides complexity-capable services to its own population, and helps other programs with their populations.
- All the co-occurring issues are primary, and integrated best-practice interventions for each issue at the same time are needed.
- Progress for any issue involves moving through stages of change; integrated interventions and outcomes should be stage-matched for each issue.
- Active change for each issue involves adequately supported, adequately rewarded skill-based learning, so that individuals and families develop and practice the skills they need to succeed for each issue, with big rounds of applause for each small step of progress.
- There is no one correct program or intervention for individuals or families with complex and co-occurring issues. For each person or family, the correct match is based on these principles.
- In CCISC, the principles inform every program, practice, policy, procedure, and person providing service, with every available dollar and resource, to design the system to be about the people who need us the most.



Comprehensive, Continuous, Integrated System of Care (CCISC)

mission

To create an environment where people seeking help for co-occurring issues can engage in partnerships with service providers that are grounded in the principles of recovery.

CCISC Annual Objectives

- **Establish the Steering Committee as the guiding force for CCISC.**
- Improve welcoming and service accessibility at BHD and its partner organizations.
- Empower service providers and people in recovery how to engage in recovery partnerships that are co-occurring capable person-centered, cultural competent, trauma-informed, family –involved and include peer to peer services.
- Train a corps of change agents, including people in recovery, committed to co-occurring, recovery-oriented capacity-building in their programs and across the system.
- Successfully implement NIATx projects to improve co-occurring capability/recovery-oriented services.
- Showcase successes in a variety of media/ venues to encourage broader involvement in the movement.
- Establish a cross-walk capability among service providers and systems to provide accurate and timely data to monitor progress at the individual and program levels.
- Improve effective utilization of available financial resources to support co-occurring/recovery-oriented services.
- Increase the involvement of other sectors in the CCISC process including criminal justice, primary health, Wraparound, corrections, and others.

Annual Process Indicators

1. **Steering Committee with broad representation is established.**
2. Number of BHD branches and contract agencies that undergo the CCISC assessment process, e.g. COMPASS-EZ and CODECAT-EZ.
3. Number of BHD branches and contract agencies that organize a Continuous Quality Improvement Process.
4. Number of change agents, including people in recovery, engaged in the CCISC process.
5. Number of NIATx process improvement projects implemented.
6. Number of NIATx projects showcased.
7. Establishment of co-occurring data capability at the individual, provider, and system levels.
8. Amount of funding expended on co-occurring/ recovery-oriented services.
9. Number of policy and procedure changes, including billing instructions, to support integrated recovery oriented services within each funding stream.
10. Demonstrated alignment with other initiatives such as trauma-informed and recovery-oriented services.
11. Involvement of a diversity of other sectors/ providers.

Annual Project Outcomes

- **Steering Committee holds ownership of incremental system outcomes.**
  Indicator: process evaluation, feedback from providers.
- Improved welcoming and service accessibility at BHD and its contract agencies.
  Indicators: provider self-assessment, feedback from people in recovery, and 'walk-through' assessment.
- Improved ability of service providers and people in recovery to engage in recovery partnerships that are co-occurring capable. *Indicators:* clinician self-assessment,
  feedback from people in recovery.
- Increased satisfaction with recovery expressed by people in recovery.
  Indicator: feedback from people in recovery.
- Increased provider, consumer, and change agent empowerment in a countywide quality improvement partnership.
  Indicator: feedback from providers.

annual

CCISC Long-Term (5 Year) Goals

1. Establish the Milwaukee County Behavioral Health Division and its contract agencies as an integrated service system capable of providing high quality recovery-oriented services that are co-occurring capable, person-centered, culturally competent, trauma-informed, family-involved and include peer to peer services.
2. Create momentum for progress that will attract other organizations and systems to align with the principles and practices established by BHD and its contract agencies:
   - private hospitals and service providers;
   - higher education and professional development programs; and
   - funders (local, state and federal), licensing, and certification.

Long-Term (5-year) Client/Community Outcomes

- People are satisfied with their recovery.
  Indicator: feedback from people in recovery.
- Children's services, primary health, housing, and criminal justice.
- Treatment resources support the delivery of services that are recovery-oriented, co-occurring capable, person-centered, trauma-informed, and family-involved, and includes peer to peer services.
  Indicator: funding allocations and service utilization data.
- Other community systems, e.g. law enforcement, homeless services, and health care, participate in and show evidence of positive impact of CCISC.
  Indicator: arrests, service utilization data.

long-term

This logic model is intended to serve as a starting point for planning and development of the CCISC process, which by definition, is a fluid and evolving process. Logic model elements are likely to be modified or enhanced as the process develops over time.

12 Steps for Agencies/Programs Developing Co-occurring Capability

Comprehensive Continuous Integrated System of Care (CCISC)

These steps are based on the principles for CCISC implementation (Minkoff and Cline, 2004), and can be initiated by any agency (for all of its programs, or by an individual program), within the scope of the agency/program mission and resources.

1. **Formal Announcement and Commitment** - Leadership officially announces its formal commitment to achieve co-occurring capability for all programs, and communicates to all staff about the CCISC implementation process.
2. **Continuous Quality Improvement (CQI) Team** - Leadership organizes a CQI team intended to represent all levels of the agency or program in partnership, and to meet regularly to oversee the change process.
3. **Change Agents** - The organization identifies a team of Change Agents that represents the voice of front-line clinicians (and, where appropriate, persons and families) in each program. Change Agents are represented on the CQI team and help clinicians achieve competency in the practice priorities listed below.
4. **Goal of Co-occurring Competency for All Staff** - The agency or program commits to the goal that all clinical staff will develop co-occurring competency at their level of training and/or licensure.
5. **Program Self-assessment** - Each program uses a structured tool (e.g., COMPASS-EZ™) to involve as many staff as possible in a program baseline conversation and self-assessment of co-occurring capability.
6. **Program CQI Action Plan** - Based on the results of the COMPASS-EZ™ survey, each program creates an achievable three- to six-month action plan, with measurable objectives, to make progress toward co-occurring capability. Initial action plan objectives are developed in the following areas.
7. **Welcoming and Access** - The program action plan addresses co-occurring welcoming policies, procedures, clinical practice, and staff competencies, and identifies access barriers that need to be removed.
8. **Screening** - The program creates a definition and process to implement universal integrated screening.
9. **Identification and Counting** - The program measures baseline data on the number of co-occurring persons and families it serves, and develops a CQI plan to improve recognition of the population.
10. **Empathic, Hopeful, Integrated, Strength-Based Assessment** - The program CQI plan helps clinicians to demonstrate integrated empathy and hope, and provides support for documentation of hopeful goals and periods of strength, including assessment of mental health baseline during previous periods of abstinence.
11. **Stage-matched Interventions** - The program focuses on identification and documentation of stages of change and stage-matched goals for each issue.
12. **Integrated Stage-matched Recovery Planning and Programming** - The program develops policies, procedures, and processes for improving integration and stage-matching in recovery plans, and works to improve the use of co-occurring issues skill manuals, stage-matched groups, and positive rewards, as part of routine recovery planning and interventions.

ZIA PARTNERS

12 Steps for Clinicians Developing Co-occurring Competency

Comprehensive Continuous Integrated System of Care (CCISC)

These steps are based on the principles of CCISC (Minkoff and Cline, 2004), and can be taken by any clinician within the scope of his or her existing job category.

1. **Welcoming** - Welcome the person who has co-occurring issues; thank him for coming, and let him know you are glad to get to know him as he is.
2. **Hope** - Ask the person about her goals for a happy life, and inspire hope that you will work to help her achieve that vision.
3. **Integration** - In the course of conversation, screen for issues in multiple life domains (mental health, substance abuse, trauma, court, etc.) and practice screening in the flow of the conversation.
4. **Empathy** - Ask the person to describe in detail his experience with each of the issues he is confronting, and empathize fully with what it feels like to be having such experiences.
5. **Strengths** - Ask the person to identify a period of recent success in relation to her issues, and describe in detail how she was successful and what she was experiencing (e.g., mental health issues during a period of sobriety—what they were and how they were managed).
6. **Quadrant** - Review the person's story and complex needs, and determine: Does he have co-occurring issues? (yes, no, maybe) What quadrant (1-4) is he in? (Practice distinguishing between abuse and dependence; SPMI and less serious mental health issues.)
7. **Integrated Primary Problem/Specific Treatment** - List the person's issue(s), and list a specific day-at-a-time set of recommendations to help her succeed. Discuss with the person how she attempts to follow each set of recommendations on a given day. Include recommendations in other areas, like medical issues, probation, etc.
8. **Stage of Change** - Identify the stage of change for each identified issue that may affect the person's goals for happiness. Write down, in the person's own words, a stage-matched goal for each issue. Practice establishing an empathic connection with persons in earlier stages of change.
9. **Skills and Supports** - For any identified issue during a period of success, identify in detail with the person the specific skills that he used to be successful, including asking for help or using supports.
10. **Skill-based Learning** - Use one manual for teaching co-occurring skills, and practice one exercise with a person that is connected to her life. For example, work with a person in an addiction setting on managing mental health symptoms on any day, or work with a mental health client on refusing drugs from a friend.
11. **Positive Rewards** - Identify small steps of progress for each issue, and provide strong positive reward for those small steps, such as a "round of applause for one day of sobriety."
12. **Recovery Support** - Identify a place where the person can receive recovery support for each problem—whether from peers, family, or others—and discuss in detail how he can improve asking for help.

369-B Third Street#223 | San Rafael, CA 94901 | info@ziapartners.com | www.ziapartners.com
Change Agent Connection: http://connection.ziapartners.com

RCHSD
MH/ADDA Division
Children's System

Internal Referrals from

Juvenile Justice or Child Protective Services or Crisis

↓

(interdivisional staffing)

Children and Family Integrated Services

- Coordinated Service Team (wraparound, family centered team)
- In home Family Treatment
- Crisis Stabilization (up to 90 days)
- Children's Long Term Support (medicaid waiver funding)

GAPS
- NO external referrals - can't serve families before JJ/CPS/crisis involvement
- NO psychiatry
- not enough resource for volume/need.

Serious mental illness
functional impairment
no options for care elsewhere
Risk....

Adults
Basic criteria for service

RCHSD
MH/AODA
Adults.

① Phone Screen
(Rock County Connections Line)

[pass screen based on above criteria?]

YES

NO — refer out

② Full Assessment Appointment within 2 weeks

Level of Care Decision
a. case management BCC/JCC
b. therapy (outpatient) BCC/JCC
c. CSP referral → refer to CSP supervisor
d. crisis stabilization
e&f. Referral to the community

GAPS....

* NO psychiatry available to outside referrals (only those coming in through our crisis system)

* only serving those who have demonstrated no other option, can't be selected as a preference/choice