



Winnipeg Regional Health Authority
Office régional de la santé de Winnipeg



Health



Co-occurring Mental Health and Substance Use Disorders Initiative

Winnipeg Region Co-occurring Disorders Initiative Leadership Team

CODI Action Plan

October 2003



Co-occurring Mental Health and Substance Use Disorders Initiative

Winnipeg Region Co-occurring Disorders Initiative Leadership Team Action Plan

PART 1: Introduction: Action Planning Format and Process Guidelines

Winnipeg Region Co-occurring Disorders Initiative Leadership Team Action Plan follows a format developed by the project consultant Dr. Kenneth Minkoff. This format (illustrated below) involves an organization of action objectives on four separate levels of system change. This format encourages the identification of change objectives at a SYSTEM level, a PROGRAM level, a CLINICAL PRACTICE level and a CLINICAL COMPETENCY level as follows:

1. System level

- Any action plan objectives that relate to general administrative policies and procedures, and to administrative functions. These include mission statements, quality improvement plans, management information and data collection, and all general policy statements that relate to the other columns.

2. Program level

- Any action plan objectives that relate to designing or meeting program standards: using the tools to evaluate dual diagnosis capability, and developing a committee to review specific program standards for that agency.
- Any action plan objectives that relate to inter-program or intra-program issues: interagency care coordination meetings or policies, program content issues (implementation of new model for intake, groups, treatment planning meetings, curricula for skills building).
- Any specific program policies that relate to clinical program design (e.g., new admission criteria, removal of access barriers)

3. Clinical Practice level:

- Any action plan objectives that relate to designing an implementing practice guidelines, either a whole set of practice guidelines, or individual clinical practices. Individual practices may include welcoming, screening, assessment, treatment planning, stage of change assessment, skills building, contingency management, group leadership, discharge planning, case management, psychopharmacology, etc. These are objectives that involve monitoring clinical records and clinician activities as documented in those records.

4. Clinical Competency level:

- Any action plan objective that relates to the identification of clinician competencies (general or specific), incorporation of those competencies into human resource functions, and development and implementation of training plans.

Implementation Action Planning Levels



Co-occurring Disorders Initiative Action Plan Template (K. Minkoff)

CO-OCCURRING DISORDERS ACTION PLAN			
Date:			
Program Name:			
System	Program	Clinical Practice	Clinical Competencies
<ol style="list-style-type: none"> 1. Philosophy: Consensus Building 2. Regulatory Review 3. Funding Incentives 4. MIS Enhancement 5. QI Project 6. Outcome Measures 	<ol style="list-style-type: none"> 1. Inter-program Care Coordination 2. Inter-program Procedures 3. Program Standards: 4. Programmatic Initiatives 	<ol style="list-style-type: none"> 1. Practice Guidelines 2. Specific Clinical Practice Initiatives <ul style="list-style-type: none"> ▪ Screening/Assessment ▪ Welcoming ▪ Stages of Change ▪ Treatment Planning ▪ Scope of Practice ▪ Integrated Case Management ▪ Psychopharmacology ▪ Treatment Matching ▪ Trauma Issues ▪ Discharge Planning ▪ Interagency Collaboration 	<ol style="list-style-type: none"> 1. General Competencies 2. Project Specific or Practice Specific Competencies <ul style="list-style-type: none"> ▪ Competency Assessment ▪ Training and Supervision Plan

Horizontal Linkage

This Action Planning format also encourages a “**horizontal linkage**” of objectives across the different strategic levels. The establishment of horizontal linkage between the four action levels is strategically important in bring about an overall shift in organizational culture (attitudes and behaviours). Broad shifts of this nature need to be facilitated by forces which both push and pull... where people are invited into change by appealing and encouraging statements of vision/mission at one end, and nudged toward change by formal expectations and structure at the other. Examples of horizontally linked objectives are shown below:

System	Program	Clinical Practice	Clinician Competency
<i>Realize a change on a CODECAT item</i>	<i>Expectation for completion of CODECAT's</i>	<i>Specific performance/ practice expectations drawn from CODECAT</i>	<i>Competency specific training events</i>
<i>Revised Mission Statement supporting welcoming philosophy</i>	<i>Incorporate Mission and welcoming philosophy into all program materials</i>	<i>Written guidelines for welcoming practices at all levels of service</i>	<i>Education and training expectations for staff re. program mission, philosophy and welcoming skills</i>

Incremental Steps

Action plan need to focus on moving organizations through small, readily achievable, incremental steps toward change. The first priority may be to establish a basic expectation at a program design level that service encounters with client must never be discourteous or abusive... as a step toward a more desirable expectation that they be universally welcoming and accepting. As the program moves forward to the point where it is able to demonstrate adherence to the basic expectation, the program would then need to secure (“backfill”) that change in clinical practice guidelines. Action plans are always evolving. They should represent a series of 6-month action priorities

Accountability

Action plans needs to include a designation of task responsibility and a timeline for each action item.

***Tips on the Development of Program Action Plans.** (K. Minkoff 02/03)

See APPENDIX

PART 2: Winnipeg Region Co-occurring Disorders Initiative Leadership Team Action Plan

Winnipeg Region Co-occurring Disorders Initiative Leadership Team Action Plan

Original Plan: October 2002.

Reviewed and revised in May- June, 2003

Last Revised: October 31, 2003.

Applicable: October 31, 2003 to April 30, 2004

WINNIPEG REGION CO-OCCURRING DISORDERS INITIATIVE (CODI) ACTION PLAN

Original: October 31, 2002
 Reviewed and revised in May-June, 2003
 Last revised: October 31, 2003
 Next review due in April/May 2004

System	Program	Clinical Practice	Clinical Competencies
<p>Philosophy & Consensus Building</p> <ul style="list-style-type: none"> • Leadership Team (LT) will define the decision making structure and communicate to Stakeholders (Completed June 2002) • LT will produce and distribute a Consensus Document to Stakeholders for their feedback. (Completed June 2002) • LT will finalize the consensus document and submit for formal signing by the sponsoring partner organizations (Completed October 2002) • LT will disseminate the finalized document to the field with the understanding that it becomes the foundation for developing expectations for provider performance. (Completed December 2002) • LT will establish a process for the Initiative stakeholders to adopt the Consensus Document. (Completed December 2002) • LT will establish a process to ensure that technical assistance to develop and implement action plans is available to partnering organizations (December 2003) • LT will identify strategies to anchor changes throughout the mental health and addiction service systems: <ul style="list-style-type: none"> ▫ Service purchase agreements (ongoing development, 2003) ▫ Performance deliverable reports (agreement established April 2003) ▫ Data capture initiative (ongoing development, 2003) 	<p>Philosophy & Consensus Building</p> <ul style="list-style-type: none"> • Conduct bi-annual meetings with Stakeholders (Initiated December 2002; Ongoing) • Disseminate a Core Documents Package (Part 1) among Stakeholder (November 2003) • Initiate a process, in accordance with the Strategic Priorities Framework of the Ongoing Training Plan, to include Level 3 agencies and programs within an expanded Stakeholders Group. (January 2004) 		

<p>Inter-program Coordination and Information Sharing</p> <ul style="list-style-type: none"> • LT will establish “release of information” guidelines dealing with each of the following situations: (December 2003) <ul style="list-style-type: none"> ▫ Case consultation and case conferencing, ▫ Using case information in the context of education and training, and ▫ Release of specific client/patient information on case by case basis • LT will disseminate these guidelines within 30 days of their approval by the sponsoring organizations. 	<p>Inter-program Coordination</p> <ul style="list-style-type: none"> • Set up regular meetings between MH and SA providers for looking at systems issues and eventually clinical case sharing. (Interagency Network established October 2002) • Develop mechanisms to achieve better coordination of services between the primary health care system and the addictions and mental health service systems. (Ongoing development) 		
<p>Training Plan</p> <ul style="list-style-type: none"> • LT will identify trainers (Completed April 2002) • LT will implement a training-of-trainers process. (Completed February 2003) • LT will establish an ongoing training plan to address the training of staff of participating stakeholder organizations and programs in the principles and practices of the Comprehensive Continuous Integrated System of Care model (CCISC). (Completed October 2003) • LT will adopt a set of clinical training guidelines for Dual Diagnosis Capable programs and communicate these to provider organizations and programs. (Completed October 2003) • LT will ensure the development and dissemination of training resource packages for each of the Clinical Training Guidelines (September 2004) 	<p>Training Plan</p> <ul style="list-style-type: none"> • Support the development of inter-disciplinary training and consultation teams. (October 2003) • Develop a dictionary of MH and SA terms: <ul style="list-style-type: none"> ▫ Substance Abuse Glossary completed, March 2003 ▫ CODI Glossary completed August 2003 	<p>Specific Clinical Practice Initiatives</p> <ul style="list-style-type: none"> • Develop training resource packages for key topics identified in the Clinical Training Guidelines and the Ongoing Training Plan Service Levels: (Progressive development ongoing; completion by December 2004) • Develop credit courses in co-occurring disorders for inclusion in the Counselling Certificate program at University of Manitoba (Development underway; scheduled for completion fall 2004) 	<p>Training and Supervision Plan.</p> <ul style="list-style-type: none"> • Develop a process to establish roles and expectations for trainers (October 2003) • Identify a core group of trainers available to provide consultation and training services to new agencies programs (November 2003) • Develop a process to coordinate and monitor the delivery of consultation and training services: <ul style="list-style-type: none"> ▫ Develop a process for trainers to report their activities to the Leadership Team. (November 2003)

<p>Screening, Identification and Tracking</p> <p>3. LT will communicate the expectation that participating stakeholder organizations and programs implement a system to ensure the identification of persons with co-occurring disorders and the reporting of same. (Completed, May 2003)</p> <p>4. LT will (by January 04) identify strategies to:</p> <ul style="list-style-type: none"> ▫ assist participating stakeholders, as needed, to establish the data system ▫ establish a communication system for reporting compiled and interpreted data results to participating stakeholder programs and, ▫ support stakeholder programs in their efforts to use the data to improve service responses to persons with co-occurring disorders 	<p>Screening, Identification and Tracking</p> <ul style="list-style-type: none"> • Provide technical assistance on screening, identification and tracking to participating agencies and programs (March 2004) 	<p>Screening, Identification and Tracking</p> <ul style="list-style-type: none"> • Develop guidelines for agency/program screening, identification and tracking (March 2004) 	
<p>Outcome Measures</p> <ul style="list-style-type: none"> • LT will utilize the following measures of <u>system level</u> outcome and will communicate these measures to stakeholders: <ul style="list-style-type: none"> ▪ System-Wide Service Array Planning <ul style="list-style-type: none"> ▫ Identification of populations falling into Quadrant Model cells and local programs serving those people by current program competency levels (DDC/DDE) (Preliminary List Completed March 2003) ▫ Development of a future service array plan that address gaps in current services. (2003/2004) ▪ Program / Agency CODI Action Plans <ul style="list-style-type: none"> ▫ Ensure that all addiction and mental health service programs which have adopted the Consensus Agreement have developed action plans. (Completed for all trainer programs, March 2003) ▪ Training Plan for Phase II <ul style="list-style-type: none"> ▫ Develop a training plan for Phase II (Strategic Priorities Framework Completed October 2003) • LT will utilize the following measures of <u>program level</u> outcome and will communicate these measures to stakeholders so that they can be addressed within their action plans: (Completed November 2003) 	<p>Outcome Measures</p> <ul style="list-style-type: none"> • Recommend responses to address system service array gaps (ongoing) 		<p>Competency Assessment Tools</p> <ul style="list-style-type: none"> • Ensure that all participating programs have completed the program competency and clinical competency self-assessment tools, and that the scores are reported, and fed back to the stakeholders (1st Report Completed February, 2003)

<ul style="list-style-type: none"> ▪ Welcoming <ul style="list-style-type: none"> ▫ The system has adopted and disseminated a consensus mission statement or philosophy that encompasses welcoming, accessible, integrated, continuous, and comprehensive treatment principles, emphasizing empathic hopeful integrated treatment relationships, and using an integrated recovery model. ▪ Accessibility <ul style="list-style-type: none"> ▫ Individuals with co-occurring disorders are routinely counted and reported in system management information systems. ▫ There is universal screening for co-occurring disorders at all points of entry. ▪ Integration <ul style="list-style-type: none"> ▫ There is an organized process for inter-program care coordination cross system boundaries. • LT will develop a system change audit tool and a supporting data collection process to enable it to measure progress attained on these dimensions. (January 2004) • LT will develop a system for collecting, compiling and reporting agency/ program results on the COMPASS, CODECAT and COFIT tools on an annual basis, as well as a process for providing feedback to the participating programs. (January 2004) 			
<p>Information Awareness and Access</p> <ul style="list-style-type: none"> • LT will establish a promotional plan to ensure that service providers and the general public are aware of, and have access to, CODI information resources as follows: <ul style="list-style-type: none"> ▫ Addictions Foundation of Manitoba will establish a CODI resource section within its main website (January 04) and will update it on a regular basis ▫ Winnipeg Regional Health Authority and Manitoba Health will establish a links to the AFM CODI web resource pages within their home sites. (March 04) 	<p>Information Awareness and Access</p> <ul style="list-style-type: none"> • Development of mechanisms for broadly communicating the accomplishments of the Initiative to stakeholders (Ongoing development 2003/4) <ul style="list-style-type: none"> ▫ Progress Reports to 2002/3 Stakeholder Groups (December 2002; February 2003 completed ... fall of 03 planned) ▫ CODI Update newsletters (Editions December 2002 and April 2003) ▫ AFM CODI Webpage (January 2004) • Dissemination of information on the Initiative and the CCISC model to all primary care physicians (2003/04) 		

APPENDIX

Tips on the Development of Program Action Plans. (K. Minkoff 02/03)

It would be best to focus on a few very concrete objectives:

1. Develop a written welcoming mission statement and/or philosophy
2. Implement routine screening for co-occurring disorders, and collecting data on who is screened
3. Including a field for documenting stage of change for each substance use problem in the assessment
4. Including stage specific attention to substance use in treatment planning
5. Beginning one group to help patients make better choices and decisions regarding their substance use.

...[Each item should have very tiny steps to achievement...]

1. With regard to welcoming:

- Develop a committee to draft a welcoming mission statement.
- Develop a plan with program manager for adopting it.
- Circulate to staff for input, along with education about the CODI initiative and the consensus document.
- Revise as needed, and then adopt.

...[This could take several months. Each step has dates, and responsible people.]

- Once the mission statement is adopted, there should be a plan for disseminating it to staff and posting it for patients to see.
- Develop a committee to make the physical environment more welcoming with posters etc, and to find some materials for patients regarding substance use.
- Make a list of referral information, with help from the trainer group.
- Identify a clinical practice: a welcoming message to Patients... “We are glad you are here. We want to help you to be safe, and be stable in the community. You deserve to feel good about yourself and your life. We want to help you decide how your substance use is or is not helpful to you in achieving your goals, and make the best decisions you can about what to do.”
- Set up a training in the welcoming practice. Perhaps invite trainers from other inpatient units to join you.

...[Again, this might all take several months]

2. With regard to screening:

- Set up a committee to review the screening tool.
 - Circulate screening instruments to the committee, and check on what other units are doing. The committee should pick a simple screening process.
 - Circulate to staff for comment.
 - Revise as needed.
 - Incorporate in forms.
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- Committee writes a policy for how to document who screens in, both in the chart, and on a simple data form (or existing data form) that is collected by someone who usually collects data.
 - Once this is all set up, there is a training on using the screening form, and learning the policy for screening.

- Data is regularly reported back to staff.
- 3. With regard to stage of change:**
- The same or different committee could look at the assessment form, and find a place to add documentation of stage of change for each problem.
 - Same process as above. ... This leads to stage of change training for staff
- 4. With regard to treatment plan:**
- Policy written by treatment plan trainers that identified substance use issues should be listed in the Rx plan, along with stage of change, and the goal of moving the patient to the next stage.
 - Same process to obtain approval... This leads to training in motivational interviewing and skill building. (sample treatment plans may be used here).
- 5. With regard to group program.**
- Invite someone to come to talk to committee who designs programming and present their group format.
 - Develop a plan for new group implementation.
 - Same process... This leads to training in how to run the group.

...[These things should not be happening all at once. There is too much to keep track of. You might have different tasks beginning at 3 month intervals.]