

FY 2005-06
San Francisco CBHS
Integration Implementation Plan
October 12, 2005

	<u>Page #</u>
<u>Introduction</u>	3
<u>Backdrop: The First Year</u>	3
I. <u>At the System-Level</u>	4
A. <u>Areas of Focus/Attention at CBHS Central Administration in 05-06</u>	4
1. <u><i>CBHS Executive Team will lead the integration process.</i></u>	4
2. <u><i>Strengthen Program Managers' involvement.</i></u>	6
3. <u><i>Begin to concretely apply the integration vision, and begin to re-configure services in the system towards integration.</i></u>	7
4. <u><i>Attend to changes needed in the CBHS central administration organizational structure.</i></u>	9
5. <u><i>Survey the satisfaction of providers with services provided by CBHS central administration.</i></u>	9
B. <u>Further Develop the Integration Advisory Committee</u>	9
1. <u><i>Ensure full representation in the Advisory Committee.</i></u>	9
2. <u><i>Engage in strategic conversations within the Advisory Committee.</i></u>	10
3. <u><i>Merge with the MHSA planning process.</i></u>	11
C. <u>Implement a System-wide Training Plan for the Year</u>	12
D. <u>Launch Four Key System Policies</u>	12
E. <u>Begin to Explore Meaningful Data Collection</u>	14
F. <u>Other System-level Initiatives for 05-06</u>	14
1. <u><i>"Tools of the Trade"</i></u>	14
2. <u><i>COFIT</i></u>	15
II. <u>QI Initiatives at the Program-Level</u>	15

A.	<u>Expand COMPASS & QI Action Planning towards Program Dual-Diagnosis Capability</u>	15
1.	<u>CBHS programs to do COMPASS.</u>	15
2.	<u>1380 Howard to provide support to programs on COMPASS/QI.</u>	15
3.	<u>Feedback, and involvement, from all programs will be sought – including Program Directors fully supporting their Change Agents.</u>	16
4.	<u>Programs will be recognized.</u>	16
5.	<u>ZiaLogic will provide technical assistance to programs on COMPASS/QI.</u>	16
6.	<u>A celebration will be held.</u>	17
B.	<u>Formalize the Partnerships between CBHS Programs and Central Administration around the Integration Consensus Statement</u>	17
C.	<u>Continue the Development of the Change Agents</u>	17
1.	<u>Continue to build the Change Agent group</u>	17
2.	<u>Get all Change Agents on the Yahoo list serve – SFChangeAgents@yahoogroups.com</u>	18
3.	<u>Pair-Up Change Agents across MH & SA.</u>	18
4.	<u>Involve the Change Agents in system policy development.</u>	18
5.	<u>Engage consumer and family participation with the Change Agents.</u>	18
III.	<u>Clinician/Counselor -Level Competencies</u>	19
1.	<u>CODECAT Clinician/Counselor Competence Self-Assessment Instrument.</u>	19
2.	<u>Other system-wide trainings directed at the clinician/counselor -practice-competence level.</u>	19
Conclusion:	<u>Quality and Participation Come Together</u>	20

FY 2005-06
San Francisco CBHS
Integration Implementation Plan
October 12, 2005

Introduction: *This is the plan of activities to implement the 2nd year (2005-06) of integration of mental health and substance abuse services in San Francisco Community Behavioral Health Services (CBHS). The CBHS Executive Team incorporated feedback from many quarters into this Plan, including from the CBHS Expanded Leadership Team, Integration Implementation Workgroup, Integration Advisory Committee, Change Agents, ZiaLogic behavioral health integration consultants, and from individuals throughout the CBHS system.*

Backdrop: The First Year

After a year of putting in place a *participative* and *all-sided* change *process* to advance behavioral health integration at the system-, program-, and clinician/counselor competency- levels, CBHS is poised in 05-06 to define what will be the *content* of change, in the areas of system policy development and actual improvement of services – with the aim of attaining *tangible gains* by year’s end.

In mid-2004, CBHS entered its 2nd phase of mental health and substance abuse services integration, engaged the assistance of ZiaLogic behavioral health consultants – Chris Cline, M.D. and Ken Minkoff, M.D., as well as David Mee-Lee, M.D. – and embarked on a quality improvement effort at the system, program, clinical practice, and clinician/counselor competency levels towards a Comprehensive Continuous Integrated System of Behavioral Healthcare. In a partnership between service providers, change agents from programs throughout the system, clients, and system administrators, the QI project has gained momentum towards moving mental health and substance abuse services into an integrated, and dual diagnosis capable system. This involves system, program, and clinician/counselor self-assessment leading to action planning in multiple areas (policies, program development, service delivery, training, etc.) to enhance the system’s success in helping all clients with mental health and substance abuse problems, and both.

After a year of work, CBHS has succeeded in putting the following change processes into place:

- an internal CBHS Integration Implementation Workgroup
- an Integration Advisory Committee
- a group of Change Agents initiating QI efforts within CBHS programs
- a good number of CBHS programs embarking on integration quality improvement initiatives
- a vision of change for the system (Comprehensive, Continuous, Integrated System-of-Care), <http://www.zialogic.org/CCISC.htm>

- an Integration Consensus Statement articulating the blueprint for a system-wide partnership,
<http://www.dph.sf.ca.us/CBHS/CBHSIntegratStmnt.shtml>
- an effective communication tool, the "Tools of the Trade" newsletter, available online at
- a CBHS Integration Initiative website,
<http://www.dph.sf.ca.us/CBHS/default.htm>
- the full roll-out of the COMPASS and COFIT quality improvement toolkits
- a knowledgeable and experienced consulting team, Chris Cline, M.D., Ken Minkoff, M.D., and David Mee-Lee, M.D.
- a deeply-held model of participative implementation
- trainings of hundreds of staff and consumers throughout CBHS on the model and vision for integration, and on integrated treatment for co-occurring disorders

These bring CBHS to the threshold of the 2nd year of change. CBHS rolls out this Integration System Change Action Plan for 2005-06 to highlight the main thrusts of the next round of integration initiatives and projects at the System, Program Quality Improvement, and Clinician/Counselor -Competency levels.

I. At the System-Level

System-level integration initiatives that will be paid attention to in 05-06 are:

- working on key areas of attention at CBHS central administration (1380 Howard St.);
- continued partnership across the system through the Integration Advisory Committee;
- merging system transformation efforts between this behavioral health integration initiative and the Mental Health Services Act planning process;
- implementing a system-wide plan of trainings for the year;
- launching a key set of system policies; and
- beginning setting-up of meaningful data collection.

These 05-06 system-level initiatives are elaborated as follows.

A. Areas of Focus/Attention at CBHS Central Administration in 05-06

It is important for CBHS central administration to play a leadership role, as well as a supportive role to programs, in the integration initiative. The following are *5 key focuses for attention* at 1380 Howard St. for the coming year's integration effort:

- 1. CBHS Executive Team will lead the integration process.***

The CBHS Executive Team has the authority to set the strategic direction for integration, to direct a well-organized implementation plan, to approve new system-wide policies that promote integration, and to re-design and reorganize services, resources, and funding streams towards a Comprehensive, Continuous and Integrated System-of-Care. Integration calls for the exercise of such responsibilities at the highest level of the organization. The Executive Team intends to do no less.

The Executive Team has a special responsibility, and is in a unique position, to initiate and lead high-leverage changes at the system-level to effect wholesale transformation towards dual diagnosis capability, and “any door, the right door.” For example, the creative use of different mental health and substance abuse funding streams, and re-design of contracting mechanisms, to radically alter the ability at the program level to serve clients with mental health and substance abuse disorders and both, is a key system-level activity well-suited to the central role of the Executive Team.

At the same time, behavioral health integration in San Francisco will fundamentally *not* be *authority-driven* from the top, but *learning-driven* from all sides. A quote from Peter Senge’s book, “The Dance of Change” (1999), articulates this approach to change:

For a change initiative to succeed, Senge writes,

“...it would need to involve repeated opportunities for small actions that individuals could design, initiate, and implement themselves. First on a small scale, and then with increasingly larger numbers of people and activities, participants would articulate the goals they would like to achieve, experiment with new projects and initiatives, learn from their successes and mistakes, and talk with each other, candidly and openly, about the results. This would build commitment through participation and action. It would also naturally draw in new people who share similar values and aspirations.

This type of change process can become self-perpetuating...A learning-oriented strategy aims

to produce self-sustaining change in a way that continually accelerates its own growth and development.”

In accord with this type of change process, the CBHS Executive Team will develop multiple partnerships for action at the system-, program-, and frontline staff-levels (such as through the CBHS Integration Advisory Committee and the Change Agents), and will cultivate many drivers and leaders of change throughout the system.

The internal *CBHS Integration Implementation Workgroup* at 1380 Howard St. will serve as the implementation arm of the Executive Team in designing and carrying out this participative vision for change.

2. *Strengthen Program Managers’ involvement.*

Strengthen the *capability of CBHS central administration staff* at 1380 Howard St. (especially program management and quality improvement staff) *to provide significant support and leadership* in the form of *policy clarification and technical assistance* to CBHS programs that are embarking on quality improvement towards dual-diagnosis capability.

- i. All CBHS central administration staff at 1380 Howard St. will be involved and empowered in the integration planning and implementation. Effective immediately, all CBHS Program Managers will include behavioral health integration planning and implementation as guiding principles in the way they carry out their duties.
- ii. Effective November 2005, a monthly meeting of all CBHS Program Managers will convene to *regularly bring together* all the CBHS Program Managers, *in one place at one time*, to discuss *overarching issues in leading, improving and integrating CBHS behavioral health services* – including in the many important areas of contracting, monitoring, auditing, setting of program objectives, oversight of contract and Civil Service programs, billing productivity, quality management and quality improvement, compliance, and performance review and outcomes

- iii. All CBHS central administration staff will have working knowledge of the CCISC vision, Integration Consensus Statement, COMPASS program self-assessment instrument, integration QI action planning at the program-level, and the integration implementation plan for the system as a whole (including the use of the COFIT).
- iv. Central administration staff will attend all trainings related to system integration, program dual diagnosis capability, and integrated treatment of co-occurring disorders, including sitting in on the extremely beneficial quarterly trainings of Change Agents by ZiaLogic, and going with ZiaLogic to site consultation visits of CBHS programs. By the end of FY 2005-06, all CBHS Program Managers will have accompanied ZiaLogic in at least one program consultation visit
- v. Organize technical assistance teams of mental health/substance abuse/adult & older adult/ and children-youth & families *program managers* to work in partnership together to provide support to, and monitor the progress of, CBHS programs in the integration effort.
- vi. Program Managers shall identify CBHS policies or regulations that are inconsistent with supporting the development of Dual Diagnosis Capability in the behavioral health programs, and provide feedback to CBHS administration regarding the need to modify those policies, with the assistance of ZiaLogic. The CBHS Executive Team will recognize Program Managers as *System Change Agents*, and encourage, heed, respect, value and incorporate input from them in implementing system change and quality improvement.

3. *Begin to concretely apply the integration vision, and begin to re-configure services in the system towards integration.*

Apply the integration vision across *all of the change initiatives and work projects within CBHS* (system, administrative, programmatic, and budgetary projects), across *mental health, substance abuse, adult, older adult, and children, youth &*

family settings, and in collaboration with *Community Programs* and the rest of *DPH*.

- i. This includes applying the behavioral health integration vision *in the local planning and implementation of the Mental Health Services Act*. (For example, the RFPs that will be sent out to recruit providers of MHSA services will include ability to access integrated mental health, substance abuse, and primary care services in the selection rating criteria.)
- ii. This includes applying the behavioral health integration vision in the reconfiguration and RFPing of the CBHS substance abuse outpatient programs in late 2005. (For example, the RFP language will include the substance abuse program's ability to access and partner with integrated mental health and primary care services in the selection rating criteria.)
- iii. This also includes positioning the behavioral health integration initiative more strongly and prominently in departmental *annual budget decision-making* so that there is consistent consideration of ramifications. Budget planning must support the development of dual capability in all programs and contracts, and make mental health resources available to support dual diagnosis capability development in addiction programs, and vice-versa.
- iv. CBHS, under the Executive Team's leadership and with technical assistance from ZiaLogic, will explore possible ways to make use of blended MH and SA funding streams, as well as dual-diagnosis contracting provisions, to create the greatest flexibility, incentive, and encouragement at the program level to serve individuals with co-occurring disorders.

*The CBHS behavioral health integration initiative is also expected to dovetail with a major DPH initiative about to be launched to substantially improve the integration of San Francisco's hospitals and community-based services, arising from the July 2005 report by Health Management Associates (HMA) on, "San Francisco Department of Public Health's

Effectiveness as an Integrated Health Care Delivery System and Provider of a Continuum of Long Term Care Service."

The report found that San Francisco can better meet the needs of its citizens and gain significant financial benefits by not increasing the size of the Laguna Honda Hospital rebuild project (skilled nursing facility) and instead providing a mix of long term, skilled nursing, in-home and community-based services. Planning will proceed apace to develop integrated health, mental health, and substance abuse resources and supports to successfully maintain high-need clients in the community

4. *Attend to the changes needed in the CBHS central administration organizational structure.*

Make the necessary improvements in the *CBHS central administration organizational structure*, and in the coordination of work between CBHS divisions at 1380 Howard St., in order to better facilitate integrated systems-of-care planning, service implementation, quality management, performance review and monitoring, compliance, and culturally-competent, client-centered, and effective practices.

5. *Survey the satisfaction of providers with services provided by CBHS central administration.*

The CBHS QI Committee will implement a survey of provider satisfaction with regards to CBHS central administrative processes. This will be the first step taken by CBHS central administration towards modeling “welcoming”, by changing administrative processes that may be “unwelcoming” to CBHS programs by virtue of long tradition of existing divisional silos.

B. Further Develop the Integration Advisory Committee

The Integration Advisory Committee will continue to be developed as the central venue where the critical partnership towards integration gets forged between clients, providers, and CBHS central administration. Significant and important discussions on the integration of mental health and substance abuse services *must* take place in this Committee.

1. *Ensure full representation in the Advisory Committee.*

All of the significant stakeholders in the system have to be represented in the Advisory Committee.

- i. By December 2005, invitations to join the Committee will be sent to sectors in the system that are not yet represented.
- ii. *All members* of the Advisory Committee have to *be able to speak more than just for themselves*, and should be consulting, networking, exchanging information, and regularly discussing integration issues, with their constituents from throughout the system, in order to involve all stakeholders in the integration planning process.
- iii. The chairs of the various CBHS Integration Implementation Workgroup Committees will attend the regular monthly meetings of the Integration Advisory Committee, in order to regularly bring together all the integration planners. These CBHS workgroup committees are the Change Agents, Integration Training, Integration Quality Improvement, Policy Drafting, and Publicity committees. Representation from Change Agents at the Advisory Committee meetings is also very important.
- iv. The IAC monthly meetings will be periodically attended by senior leadership from Community Programs and Department of Public Health, in order to dovetail integration efforts within CBHS with the rest of DPH efforts to integrate primary care, prevention, behavioral health, and wrap-around adjunct services to the most marginalized populations.

2. *Engage in strategic conversations within the Advisory Committee.*

In an advisory capacity to the CBHS Executive Team, the Integration Advisory Committee will help *map the CBHS behavioral health service delivery system* to understand: the entry points into the system; the decision points for client triaging; the different levels of care, including all the different providers, and access to, and eligibilities for, their services; where there exists dual diagnosis capability, and where not; clinical and services pathways; where clients needing services

are not able to access them; and where there are gaps and flaws in the system.

The purpose of such an exercise is to glean opportunities for improvement, for re-design of services, for revision of policies and procedures, and for resource commitments – which will be expressed through a recommended action plan for future years to carry out the integration vision of “Any Door, the Right Door.” This will include beginning to measure the extent to which co-occurring clients currently experience barriers to access, and developing strategies to assist programs to increase their capacity to be welcoming.

This mapping exercise will take-off from, and join forces with, the system-transformation planning being conducted under the rubric of the MHSA.

It would be useful for the IAC, in conjunction with CBHS central administration, to do a baseline assessment of the system through identifying, compiling and using meaningful information/system data (some of which the system may not yet be regularly collecting). The identification of important system data that’s needed but not currently available will, by itself, be very useful. This will be tied initially to QI efforts to more accurately identify co-occurring clients, and to measure access and barriers to access in each program.

Recommendations resulting from these strategic discussions will be made by the IAC to the CBHS and DPH administrations.

3. *Merge with the MHSA planning process.*

“Integrated Services” is a very important component of the transformation vision under the Mental Health Services Act, and must serve as a key filter in the design of the county MHSA plan.

The Advisory Committee will be brought into the MHSA planning process, and their input will be incorporated on how Community Services and Support, Prevention/Early Intervention activities, and Innovative programming, can be designed in SF. Ways for the IAC and the MHSA implementation to cross-engage will be developed.

New resources and services funded by the MHSA will be made to serve as linchpins of a larger system reconfiguration, towards a more comprehensive, continuous, and integrated system-of-care.

C. Implement a System-wide Training Plan for the Year

Implement a *one-year plan of selected system-wide trainings* to improve the knowledge, skills, values, attitudes, participation, and contributions of hundreds of CBHS providers, management and line staff, clinical and counseling staff, and consumers and families; and to take care of the unfolding training needs of the CBHS integration implementation plan for 05-06.

Organize the following *2005-06 system-wide trainings*, using ZiaLogic and Dr. Mee-Lee:

- i. “How to Survive and Thrive in Integration” (*Oct 05*)
- ii. “Partnering between a Mental Health Agency and a Substance Abuse Agency to Enhance each other’s Dual-Diagnosis Capabilities” (*Dec 2005 – with Change Agents*)
- iii. “Motivational Interviewing” (*late 2005/early 2006*)
- iv. “Use of the CODECAT– Clinician/Counselor-Level Self-Assessment” (*March 2006*)
- v. Full day training for front line clinicians/counselors by Ken Minkoff, M.D. on basic principles, assessment and treatment matching.
- vi. Training on “Welcoming” for frontline and reception staff at CBHS programs
- vii. *And other selected system-wide trainings to be identified*

D. Launch Four Key System Policies

The time has come to form an *Integration Policy Drafting Workgroups* to work on the following *four (4) key instructions/policies* for the system overall (in the following order):

- i. A CBHS *Welcoming Policy*, which will clearly articulate what CBHS programs are expected to do in the areas of welcoming and provision of assessment and access to services for all clients coming through their doors, whether singly- or dually- diagnosed, irrespective of whether they are a mental health or a substance abuse program.
- ii. A CBHS policy on *Universal Integrated Screening and data collection*, which outlines the minimum requirements, for MH and SA programs, to implement universal screening for the presence of co-occurring substance abuse and mental health disorders for all of their clients (including co-occurring families).
- iii. *A Definition of Dual-Diagnosis Capability*, which clearly articulates (without yet creating standards) what CBHS expects, as well as encourages, programs to do towards Dual Diagnosis Capability. The emphasis of this DDC policy is not so much on the promotion of a fixed definition of DDC, but rather on the promotion of a variety of QI approaches for programs to take step-by-step towards DDC – such as, an honest program self-assessment, and a quality improvement plan designed with participation of program staff.
- iv. Issuance of a CBHS memo describing the provision of, and billing for, specialty mental health services to address the treatment and service needs of clients with co-occurring disorders (*similar to San Diego County's billing policy and procedure*). The purpose of such a policy memo is to provide instructions on how to maximize the flexible, but appropriate, use of Medi-Cal, as well as other funding streams (including grants and General Fund), toward the integrated treatment of people with co-occurring disorders within CBHS.

Ultimately, CBHS will provide clarification on overall billing system and procedures, and even on the possible use of blended MH and SA funding streams with appropriate contracting mechanisms, and with clear instructions for clinicians and counselors, to be able to solve funding and billing

barriers that prevent the provision of the most appropriate screening, triaging, assessment, and service-provision to clients with co-occurring disorders. Integrated contracting for the provision of *both* mental health and substance abuse services, by one and the same program, will be explored.

These above seminal policies and instructions constitute a significant step forward towards making operational the vision of dual-diagnosis capability for CBHS programs, as well as in identifying, wrestling with, *and solving* some of the knotty problems that prevent CBHS from being the best it can be in serving clients.

The Integration Policy Drafting Workgroups will have client and provider input/representation.

E. Begin to Explore Meaningful Data Collection

For this year, the Integration QI Committee will organize a process to examine and generate data on the *size of the co-occurring disorders client population* in CBHS. This will be through a project to improve the consistency of the data-entering of appropriate substance abuse diagnosis into BIS/InSyst. The purpose is to get a baseline picture and awareness of the extent and types of co-occurring disorders prevailing in the CBHS client population.

The challenge for future years is to design data collection towards the purpose of adequate screening and assessment, informed and guided treatment planning, and establishment of baseline for service-delivery improvement. An evolving strategy for data collection in the future will include:

- studying the appropriate matching of treatment for each of the sub-groups of individuals with combined mental health and substance abuse disorders (4 Quadrants),
- looking into the extent to which service planning and delivery are appropriately addressing the co-occurring disorders of clients, and
- institutionalizing performance outcome measurement.

F. Other System-level Initiatives for 05-06

1. “Tools of the Trade”

Continue with the publication of the “Tools of the Trade” CBHS integration newsletter, and ensure that it reaches the

hands of everyone throughout the system, and of all stakeholders. Continue to expand the e-mailing list, and overall distribution, of the newsletter. Explore other avenues to publicize the integration effort, including through Mitch Katz' monthly "Fast Facts."

2. COFIT

The COFIT system-level self-assessment instrument will be conducted in early 2006 to establish the first valid baseline score for the CBHS system, and to begin to use this tool to measure the progress of the integration initiative. Members of the CBHS Executive Management Team, Integration Advisory Committee, and Integration Implementation Workgroup will complete this COFIT together.

II. QI Initiatives at the Program-Level

"We don't have to wait for the system to get its act together before we can start doing something," is a mantra frequently intoned at the monthly meetings of the Integration Change Agents – which is a group of about 50 staff members from about 40 CBHS programs throughout the system, who are leading QI change efforts at their own programs.

The hope underlying their efforts is that the leadership they demonstrate at the program-level will some day merge with leadership emerging at the system-level to create a powerful force for change.

A. Expand COMPASS & QI Action Planning towards Program Dual-Diagnosis Capability

1. *CBHS programs to do COMPASS.*

CBHS programs, on a voluntary basis (except for Civil Service programs, which are required), will do the COMPASS program self-assessment, and QI action planning towards Dual Diagnosis Capability, by December 31, 2005. For the next FY 06-07, the use of COMPASS and program QI action planning towards Dual Diagnosis Capability will be incorporated as a requirement in all CBHS contracts.

2. *1380 Howard to provide support to programs on COMPASS/QI.*

CBHS central administration will provide technical assistance and support to, and keep central track of the progress of, all of the CBHS programs that are doing the COMPASS and program quality improvement.

COMPASS program scores do not have to be reported to 1380 Howard St., but the conducting of the COMPASS self-assessment, and the development, content, and outcomes of program QI action plans will be tracked by CBHS central administration.

It will be thoroughly emphasized that support coming from 1380 Howard St., at this time, is technical assistance, and *not compliance monitoring*.

3. *Feedback, and involvement, from all programs will be sought – including Program Directors fully supporting their Change Agents.*

Program Directors will fully support their Change Agents by being fully knowledgeable of, and directly involved with, the integration QI initiatives being launched within their programs.

Also, Program Monitors at 1380 Howard and all CBHS Program Directors will engage with each other throughout the system in one-to-one conversations for the purpose of exchanging feedback and giving input on how the integration effort at the program- and system-level is going. These discussions will be completed by early 2006.

Through these conversations, all CBHS Program Directors, including those who have not yet become engaged in the integration process, will have an opportunity to touch bases with their Program Managers and provide input/feedback regarding their concerns.

4. *Programs will be recognized.*

The quality improvement efforts of individual CBHS programs will be publicly appreciated, and CBHS central administration will explore ways to reward these efforts, such as by factoring in efforts of programs toward Dual-Diagnosis Capability in selection criteria for contract awards and RFPs.

5. *ZiaLogic will provide technical assistance to programs on COMPASS/QI.*

ZiaLogic will give technical assistance to programs by reviewing and giving feedback on a number of QI program action plans at their quarterly consultation visit in March 2006.

A plan will be created for ZiaLogic to provide technical assistance directly to some CBHS programs through site consultations arranged during their quarterly visit with CBHS.

ZiaLogic will also provide further clarification to providers to ensure the fitness of use of the COMPASS tool for CYF and substance abuse providers.

6. *A celebration will be held.*

A celebration of efforts and achievements will be held in early 2006 for all the CBHS programs that have developed a COMPASS QI action plan toward dual-diagnosis capability.

B. Formalize the Partnerships between CBHS Programs and Central Administration around the Integration Consensus Statement

By the end of September 2005, all CBHS contract programs that are willing to enter into the Consensus Statement agreement will have formally affixed signature onto the document. CBHS central administration will collect all signed Consensus Statements, and maintain a list of the programs that are formally participating in the Consensus-related activities (COMPASS, QI action planning, training, CODECAT, etc.), and will publish such list at the CBHS Integration website, as well as in “Tools of the Trade”.

Efforts will be made by CBHS central administration to identify key groups or categories of providers who may not yet have signed on to the Consensus Statement, and, with the assistance of the consultants, develop plans to engage such providers further and facilitate their participation during the coming year.

C. Continue the Development of the Change Agents

1. *Continue to build the Change Agent group.*

Continue the monthly meetings of the Change Agents, as well as their quarterly trainings with ZiaLogic. Recruit other interested Change Agents from programs willing to make the commitment to COMPASS quality improvement towards Dual Diagnosis

Capability. Strengthen the leadership within the Change Agents by relinquishing the chairing of their monthly meetings over to them.

2. *Get all Change Agents on the Yahoo list-serve - SFChangeAgents@yahoogroups.com*

By August 2005, provide assistance to every Change Agent to get onto the Yahoo list serve to better facilitate conversations/exchanges among the Change Agents as they set about to take leadership in improving their programs.

3. *Pair-Up Change Agents across MH & SA.*

By August 2005, partner two Change Agents with one another, one from a Substance Abuse program and the other from a Mental Health program (preferably whose programs are geographically close to each other) to work together to explore program coordination of services for joint clients, cross-training of each other's staff to improve services, and cross program boundaries in other various ways.

4. *Involve the Change Agents in system policy development.*

- i. Strengthen Change Agents' representation and participation at the Integration Advisory Committee.
- ii. Use the monthly Change Agents meetings to come up with ideas and recommendations for needed system-level changes and improvements.
- iii. Have Change Agents' representation in the newly-formed Integration Policies Drafting Workgroup.

5. *Engage consumer and family participation with the Change Agents.*

Include family members and clients to contribute toward the training of the Change Agents, such as by inviting clients to be interviewed for training purposes.

III. Clinician/Counselor-Level Competencies

The CBHS integration effort ultimately has to bear in mind this goal: we need to help our front-line clinicians and counselors to provide better services.

Where the rubber meets the road – where all integration efforts at the system and program levels have their day of reckoning – is where the individual client meets his or her CBHS clinician/counselor. The destination of all integration efforts is to provide the CBHS clinician/counselor with a consistent set of instructions fully backed by the system; coordinated and integrated services and resources in hand; and the requisite welcoming attitudes, values, and co-occurring disorders knowledge & skills to be able to help the client *really well*.

It is important that strong and visible commitments to change occurred first at the system and program levels, so that a partnership with CBHS front-line staff (clinicians, counselors, reception staff, etc.) can be forged, based on trust earned over time that real changes will surely take place, due to sustained and concerted efforts at all levels – system-, program- and clinician/counselor-competence.

1. *CODECAT Clinician/Counselor-Competence Self-Assessment Instrument.*

It is within this context that the CODECAT clinician/counselor self-assessment instrument will be rolled out through a big training at ZiaLogic's quarterly visit in March 2006. CBHS central administration will issue a guideline on the voluntary and encouraged use of the CODECAT throughout the system. This will set the basis for hundreds of CBHS clinicians/counselors, on their own accord, to begin examining and improving their individual knowledge, values, skills, and attitudes.

The utilization of the CODECAT will be incorporated into program-specific action plans, and tied to each program's efforts to identify core competencies and scopes of practice for each clinician/counselor in the program, and to facilitate the ongoing development and implementation of each program's training plan in accordance with these competency expectations and with action plan activities.

2. *Other system-wide trainings directed at the clinician/counselor -practice-competence level.*

The following big trainings, directed at the clinician/counselor practice-competence level, will also be conducted by ZiaLogic

and Dr. Mee-Lee, as part of the one-year plan of system-wide trainings for 05-06:

- i. “Motivational Interviewing” (*late 2005/early 2006*)
- ii. A full day training for front line clinicians and counselors by Ken Minkoff, M.D. on basic principles, assessment and treatment matching
- iii. *And other clinical-level trainings to be identified.*

Conclusion: Quality and Participation Come Together

The integration of mental health and substance abuse services calls for everyone’s involvement in CBHS – administration, providers, clinicians, counselors, front-line staff, and clients. Furthermore, quality improvement absolutely requires motivation, decision-making power, creativity, and ability to direct services, pushed to the very front of the line (where clinicians/counselors and clients meet), with program and system infrastructures transformed towards the purpose of being in the absolute service of client-centered care.

In this spirit, CBHS central administration invites program directors, clinical supervisors, and front-line staff to a 2nd year of partnership for change.