Concurrent Capable Review Service for Programs using Compass EZ

Zone B Summary

Helping others achieve concurrent capability

Alberta Health Services

Addiction and Mental Health

Teams Reviewed

Between 2015 and 2017 ten Addiction and Mental Health teams in Alberta's Zone B went through a Concurrent Capable Review using the Compass EZ fidelity assessment tool

The following slides show summary of all the review results and zone recommendations

What happens during a review?

1. Manager requests review
2. Review session (2 – 2.5 hours)
   - Facilitate walk through sections
   - Notes and scores (1-5)
3. Clinical Consultant compiles Recommendations List
   - QI opportunities & resources
4. Follow-up meeting within one month
   - Review of QI opportunities
   - 2-3 QI opportunities chosen
   - QI change agents identified
5. Program/team makes planned improvements
6. Repeat review in 12-18 months

<u>The Goal:</u>

Welcoming, recovery-oriented & concurrent capable services for individuals and families in need

Compass EZ Sections

Using the Likert Scale

- Each item is rated
- There is no “0”
- Scoring by consensus

Likert scale

1 “Not at All” to 5 “Completely”

- Access
- Screening
- Assessment
- Person Centered Planning
- Discharge Planning
- Psychopharmacology
- Programming
- Staff Competencies & Training
- Quality Improvement
- Program Philosophy
- Program Policies
- Collaboration
- Relationships

BLACK =

Areas of strength

BLUE =

Areas of opportunity for QI project consideration

<Compass EZ Section>

Average Score (1-5)

1-5

Staff comments during the review

- BLACK Areas of strength
- BLUE Areas of opportunity – for QI project consideration

Access

Average Score (1-5)

4.2

Staff navigate clients to resources
Reception is key to client feeling welcome
and continue to come back
we have good team work

- "no wrong door" access
- Emphasize welcoming and engaging
- Individuals and families with concurrent disorders
- Regardless of active addiction, mental illness symptoms

Screening & Identification

intake and screening is not integrated

Piloting an integrated screening form

Some clients say they got fired from their physician

It would be good to have a form letter to refer

Some staff say just go to a doctor

- Guideline states all screened for
  - Medical disorder
  - Basic social needs
  - Immediate risk
  - concurrent addiction & mental health disorders
- Identify and document: Nicotine use, STI, Hep C, HIV, TB
- Protocol for access to primary care (PCN/GP)

Average Score (1-5)

2.7

Recovery Oriented Integrated Assessment

Average Score (1-5)

4

Do we need to use stage of change language?

Capturing client/family goals is done informally

Interested in integrated assessment

- Identify period of strength/stability
- Document:
  - addiction and mental illness symptoms
  - Each concurrent issue
  - Stage of change for each issue
- Document goals for a hopeful, meaningful, happy life, using persons own words

Program Collaboration and Partnership

Average Score (1-5)

3.7

Meet about concurrent clients as needed, could have more regular meetings

We collaborate with schools, parent link

We consult with each other

We consult using Tele-Health

- Program documentation guideline:
  - Care coordination
  - Collaborative service planning
- Collaborate with internal and external stakeholders
- Addiction Staff consult with mental health staff and vice versa
- Regularly scheduled AMH interagency case conference to address clients with complex needs

Integrated Person Centred Planning

Service plans:

- Clients hopeful goals
- Recent success and strengths
- List all concurrent issues
- Stage of charge for each issues
- Achievable steps
- Focus on building skills and supports
- Acknowledge small steps of progress

Different philosophy between addictions and mental health

Service plans may be more of a thought vs written

Relevant concurrent issue are brought up

Average Score (1-5)

3.6

Psychopharmcology

- Procedures, forms, material help clients:
  - Learn about medications
  - Communicate with physicians
  - Take meds as recommended
- Staff and physicians collaborate
- Program guideline :
  - Period of sobriety is not required
  - Access to medication assessment and prescription
  - medication prescribed despite continued use of substances
- Medications with addictive potential are prescribed as needed
- Medications used to treat addiction are prescribed

No specific guidelines

Very limited role with medication

Addictions is left out of process re doctors and meds

Dependent on professional designation

Staff don't influence prescribers

Average Score (1-5)

2.8

Integrated Treatment Recovery Programming

- Educational Materials available:
  - Concurrent disorders
  - Recovery
  - medications
- Group/Individual therapy
  - Basic education
  - Help with choices re concurrent disorder
  - Matched to stage of change
- Workbooks:
  - Build sobriety skills, manage trauma
- Access to concurrent disorders support:
  - Individual/group
  - peer support

We are interested in group therapy

Some groups running like Family Violence

No ready access to concurrent materials or manuals

Small rural town, groups are a challenge

offsite group peer support like NA/AA

Average Score (1-5)

2.8

Integrated Treatment – Recovery Relationships

Average Score (1-5)

4.4

Client centred

Continue to support client and make more appts

No contact 30 days, close file

- Service continues despite:
  - Client using substances
  - Client is not taking medications
  - Client is not following treatment plan
- Concurrent disorder is addressed
- Each client has a primary relationship with a clinician who documents service

Integrated Treatment - Recovery Program Policies

Average Score (1-5)

4.4

Practices - no formal guidelines
Service plans are not integrated
Individual differences with clinicians
Harm reduction policy
Positive approach

- Program guidelines state service continues despite:
  - Addiction behaviour
  - Mental health symptoms
  - Not following treatment plan
- Service plans:
  - celebrate small success on any issue (social services/justice)
- Support is given to clients when struggling with an issues, ie relapsing

Integrated Discharge/Transition Planning

Average Score (1-5)

2.5

Community clinicians do not do discharge planning

Discharge planning is a learning opportunity

Need consistency in discharge planning from treatment centres

Discharge planning exists; Strive to give warm handoff

No stage matching or family involvement

Closure summary used

- Each discharge plan:
  - provides for continuing integrated care with a clinician or team
- Discharge plan guidelines, practices and forms:
  - Identify stage matched continuing care needs for each concurrent issue

General Staff Competencies and Training

Average Score (1-5)

3.3

Big need for team training

We don't use concurrent capable tools

Case conference and supervision is competency development plan

Concurrent capable competencies are evaluated annually

- Documentation guideline re concurrent disorders
- Interview tools and job descriptions include:
  - Recovery oriented and concurrent capable competencies
- Written plan for recovery oriented, concurrent capable competency development :
  - Supervision
  - Training activities
- Annual staff reviews include concurrent capable competencies

Specific Staff Competencies

Average Score (1-5)

4.3

Cultural diversity is a gap

Not in our mandate to provide family psychoed

Can do family support no family therapy

Transitional youth

Staff demonstrate competency with:

- Clients with different language and background
- Clients with intellectual disabilities
- Families, Seniors, Children and Youth

Quality Improvement and Data

Average Score (1-5)

1.7

Change agents and process identified

Numerous patient surveys have been done

Each therapist/counsellor collects information on concurrent disorder

We don't have integrated data system

Empowered partnership is done somewhat

Advisory group in place

- Culture of empowered partnership
- Leadership, supervisors, front line staff clients work together
- Vision of recovery-oriented concurrent capable services
- Meets regularly: supervisors, front line staff, and individuals and families
- Guide, track, progress toward being recovery-oriented and concurrent capable.
- Information systems collect accurate data on how many concurrent disorder.

Program Philosophy

- Program environment is welcoming:
  - Engagement of clients and family
  - With addiction and mental illness
- Program brochures:
  - offer hope for recovery
  - welcome clients and family
- Written vision, team charter or goal statement:
  - The goal of becoming welcoming, recovery oriented, and concurrent capable
- Written program descriptions specifically say:
  - Individuals and families with concurrent disorders
  - are welcomed
  - use their strengths to achieve their goals

We use an orientation letter

Our posters build on strengths

Addictions has brochures; Mental health has limited brochures

Program description does not include concurrent disorders

No printed info on concurrent disorders

Need a pamphlet for the clinic

Issues re welcoming space

Average Score (1-5)

2.7

Program Policies

Average Score (1-5)

2.5

cannot access each others notes

Single health record needed to support integrated addiction and mental health notes in one file

Separate data and charts

Need integrated data system

- Program confidentiality or release of information policy
- Clinical record keeping policies support integrated documentation

Summary of strengths

- All are welcomed and engaged
- Both substance use and mental illness symptoms are assessed on intake
- Service plans are developed for each client and concurrent disorder is addressed
- Service continues despite clients stage of change
- A written plan for recovery oriented, concurrent capable competency development
- Annual staff reviews include concurrent capable competencies
- Staff demonstrate competency with diverse client populations
- Collaboration between Addiction staff and mental health staff

Summary of opportunities

- ❑ Use a standard screen
- ❑ Identify nicotine use, high risk infections
- ❑ Protocol for access to primary care (PCN/GP)
- ❑ Identify stage of change for each concurrent issue: assessment, care planning & discharge
- ❑ Discharge planning
- ❑ Interventions available: group therapy, peer support, medication teaching, educational materials and workbooks
- ❑ Regular interagency complex case conference
- ❑ Principles of care and an advisory group
- ❑ Program guideline
- ❑ Concurrent capable interview tools and job descriptions
- ❑ IT system to support integrated documentation

Zone Recommendations

- Adopt or develop a standard screening tool
- Develop process to identify nicotine use and high risk infections
- Develop a process for ensuring each client access to primary care
- Adopt stage of change language for client care
- Develop a process for discharge/transition planning
- Accessible concurrent capable client education, medication teaching and workbooks
- Develop group therapy and peer support service

Zone Recommendations

- Form an advisory group with community agencies, family, clients, staff, and supervisors
- Develop a principles of care or service charter
- Develop program guidelines ensuring welcoming, recovery oriented, concurrent capable service
- Develop concurrent capable interview tools and job descriptions
- Host a regular interagency complex case conference meeting