Stanford MEDICINE | Department of Psychiatry and Behavioral Sciences

Implementing Services and Managing Change: Organizational Measures of COD Capability

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Network Coordinating Office

MHTTC Mental Health Technology Transfer Center Network

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National Institute on Drug Abuse

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SAMHSA

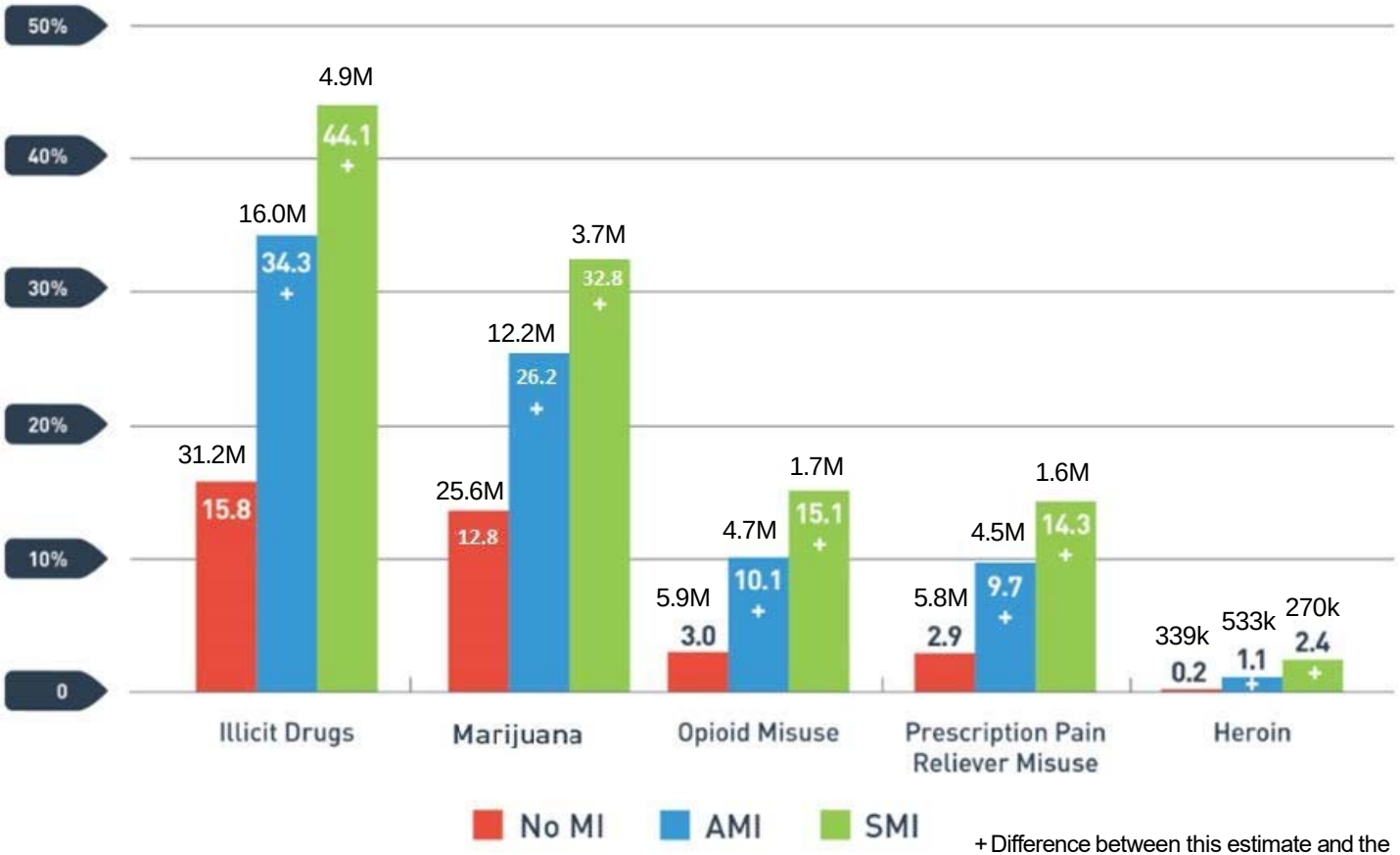
Programs, staff members, patients

KEY POINTS

- We continue to have a huge treatment gap between the people who need treatment for co-occurring substance use and mental health disorders (COD), and those who receive it.
- We have known for several decades that integrated services are more effective and produce better patient outcomes than fragmented or parallel services.
- This is, in part, an implementation problem – how to get systems and programs to increase the capability of mental health and addiction treatment providers to better serve their patients/clients.
- Measures of organizational capability can serve a key role in implementation efforts.

Co-Occurring Issues: Substance Use is More Frequent in Adults with Mental Illness

PAST YEAR, 2017, 18+



Special analysis of the 2017 NSDUH Report.

+ Difference between this estimate and the estimate for adults without mental illness (MI) is statistically significant at the .05 level.

Mc-Cance-Katz, E. M. (09/18) The National Survey on Drug Use and Health: 2017

SAMHSA
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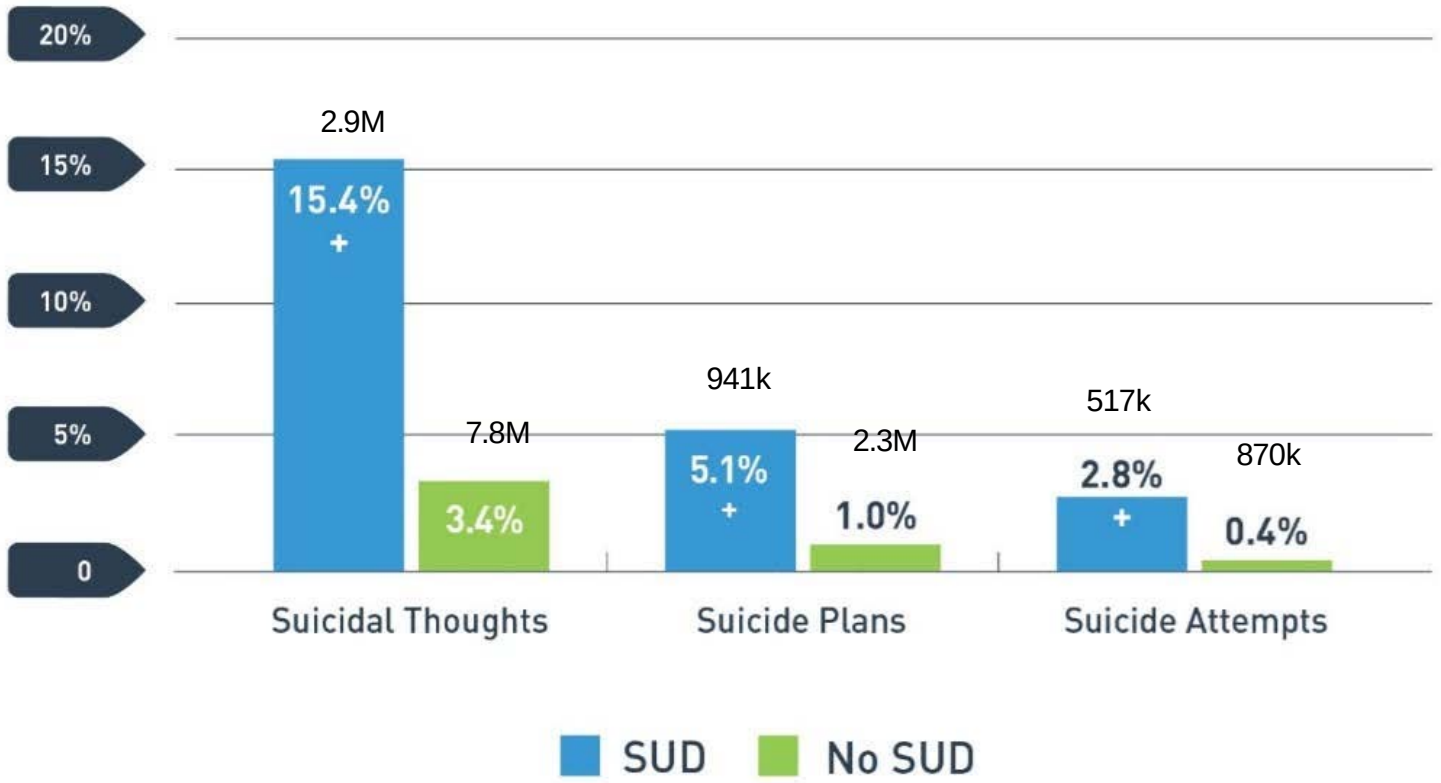
Suicidal Thoughts, Plans, and Attempts among Adults by Substance Use Disorder (SUD)

PAST YEAR, 2017, 18+



Special analysis

+ Difference between this estimate and the estimate for adults with no SUD is statistically significant at the .05 level.

Mc-Cance-Katz, E. M. (09/18) The National Survey on Drug Use and Health: 2017

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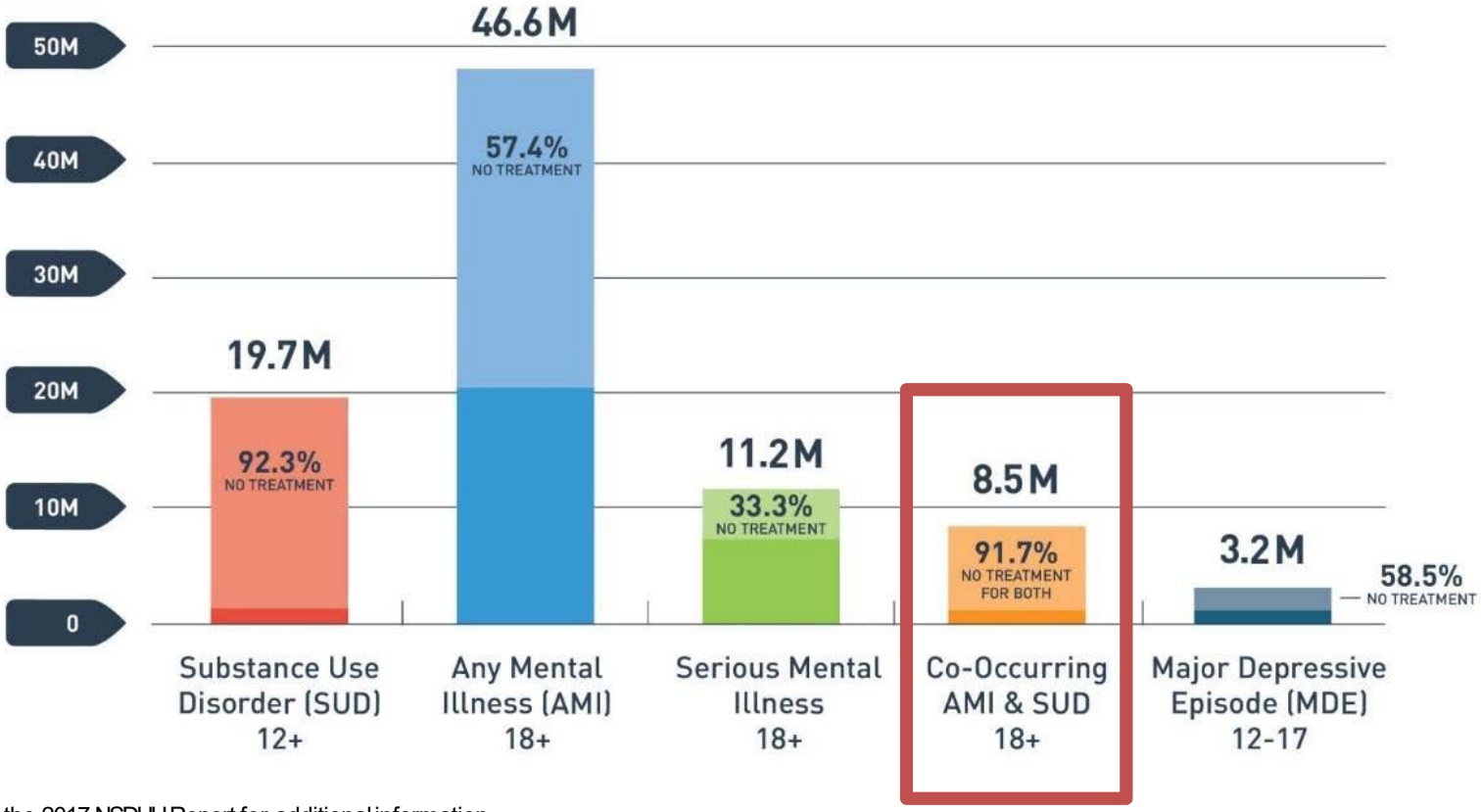
Despite Consequences and Disease Burden, Treatment Gaps Remain Vast

PAST YEAR, 2017



See the 2017 NSDUH Report for additional information.

Mc-Cance-Katz, E. M. (09/18) The National Survey on Drug Use and Health: 2017

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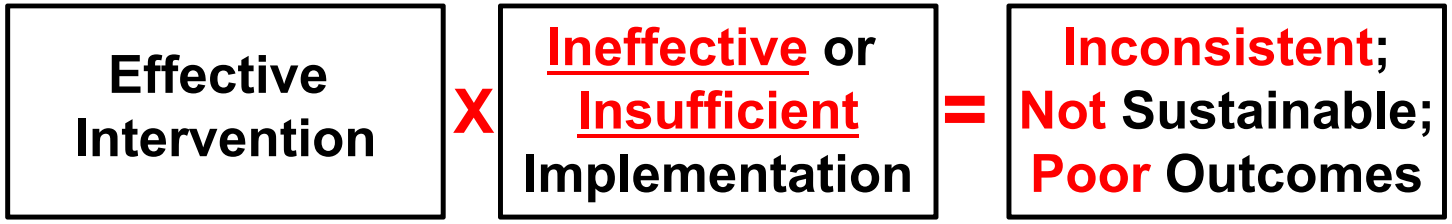
THE IMPLEMENTATION GAP



State Implementation & Scaling-up of Evidence-based Practices Center
http://sisep.fpg.unc.edu/

IMPLEMENTATION GAP: INTEGRATED COD SERVICES, "YEAH, WE DO THAT"

- "Integrated" lacks specificity and meaning without objective criteria
- Like other EBPs, integrated treatment for COD can be assessed by a fidelity-type scale
- Fidelity & capability scales have multiple uses:
  - Benchmarking by agencies themselves
  - Certification or funding decisions
  - Educated decision making by patients and families
  - Evaluating change efforts

Self-ratings of co-occurring capability are higher than independent ratings (Lee & Cameron, 2009)

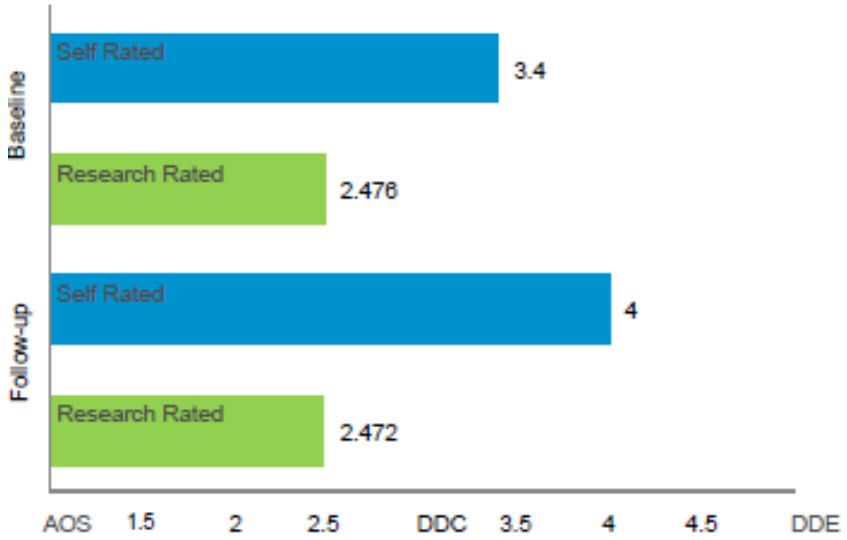


Fig 1: self vs independent DDCAT scores

FAMILY OF MEASURES OF FIDELITY/CAPABILITY TO TREAT PATIENTS WITH COD

- Dual Diagnosis Capability in Addiction Treatment (DDCAT)
  - McGovern et al., 2007
- Dual Diagnosis Capability in Mental Health Treatment (DDCMHT)
  - Gotham et al., 2013
- Behavioral Health Integration in Medical Care (BHIMC) (formerly Dual Diagnosis Capability in Healthcare Settings [DDCHCS])
  - McGovern et al., 2012
- Dual Diagnosis in Medically Integrated Care (DDMICe)
  - Sacks et al., unpublished

SCORING FOR DDCAT/DDCMHT/BHIMC DRAWS ON ASAM TAXONOMY OF DUAL DIAGNOSIS SERVICES (ASAM, 2001)

1	Addiction or Mental Health Only Services (A/MHOS) – serve clients with no or minimal COD; Minimal Integration (BHIMC)
2	
3	Dual Diagnosis Capable (DDC) – serve clients with low severity COD; Partial Integration (BHIMC)
4	
5	Dual Diagnosis Enhanced (DDE) – serve clients with more severe, unstable COD; Full Integration (BHIMC)

DDCAT/DDCMHT: 7 DIMENSIONS, 35 ITEMS

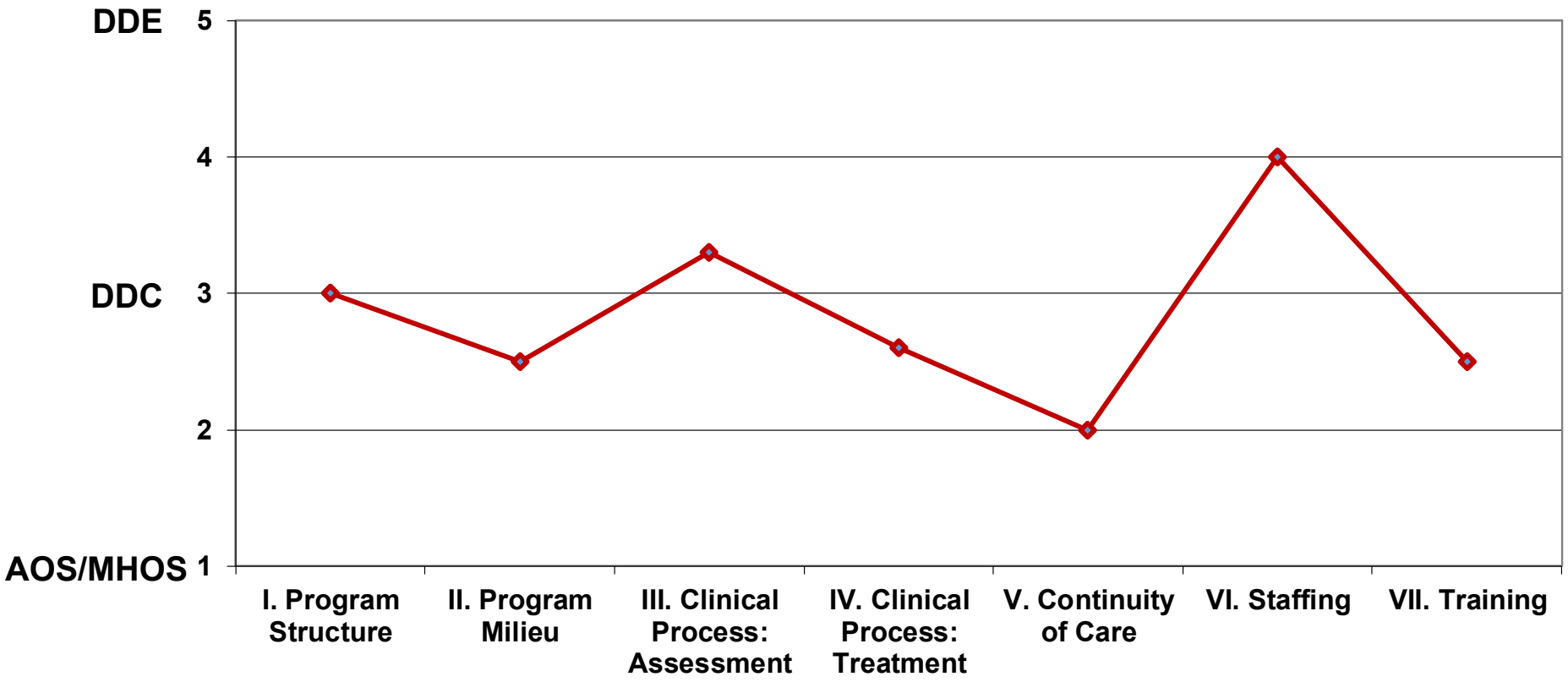
	Dimension	Content of items
I	Program Structure	Program mission, structure and financing, format for delivery of substance abuse services.
II	Program Milieu	Physical, social and cultural environment for persons with co-occurring disorders.
III	Clinical Process: Assessment	Processes for access and entry into services, screening, assessment & diagnosis.
IV	Clinical Process: Treatment	Processes for treatment including pharmacological and psychosocial evidence-based formats.
V	Continuity of Care	Discharge and continuity for both addiction and psychiatric services, peer recovery supports.
VI	Staffing	Presence, role and integration of staff with addiction treatment expertise, supervision process
VII	Training	Proportion of staff trained and program's training strategy for co-occurring disorder issues.

*Similar dimensions for BHIMC

METHODOLOGY: SITE VISIT SPECIFICS

- External raters make a ½ to full day site visit, collecting data about the program from a variety of sources:
  - Ethnographic observations of milieu and physical settings
  - Focused, but open-ended interviews of agency directors, clinical supervisors, clinicians, medication prescribers, support personnel, and clients
  - Review of documentation such as medical records, program policy and procedure manuals, brochures, daily patient schedules, telephone intake screening forms, etc.
- Unit of analysis: program
- “Triangulation” of data

DDCAT/DDCMHT PROFILE



DDCAT and DDCMHT TOOLKITS (2011)

- Applications for different purposes (e.g., system and regulatory agencies, treatment providers, health services researchers, families and individuals seeking services)
- Methodology & Training
- Scoring and Profile Interpretation
- Examples of enhancements - moving from AOS/MHOS to DDC, or DDC to DDE
- Site Visit FAQs
- Sample Forms, Screening & Motivation Tools

  - https://www.centerforebp.case.edu/resources/tools/ddcat-toolkit
  - https://www.centerforebp.case.edu/client-files/pdf/ddcmhttoolkit.pdf

EXAMPLE OF PROGRAM ENHANCEMENT

DDC PROGRAMS

Enhancing ID. Financial incentives.

Programs scoring at the DDE level can bill or receive reimbursement for addiction services. This may include mechanisms for billing Medicaid, Medicare, third party insurance, or via state contracts or voucher programs.

The Good Neighbor Clinic, an outpatient mental health treatment program, arranged for their onsite consulting psychologist, Dr. Heinrich, to be able to bill Medicaid/Medicare as well as receive payment for services to indigent patients (state funding) for his diagnostic and couples therapy services.

USING MEASURES OF COD CAPABILITY TO GUIDE AND MEASURE CHANGE - EXAMPLES

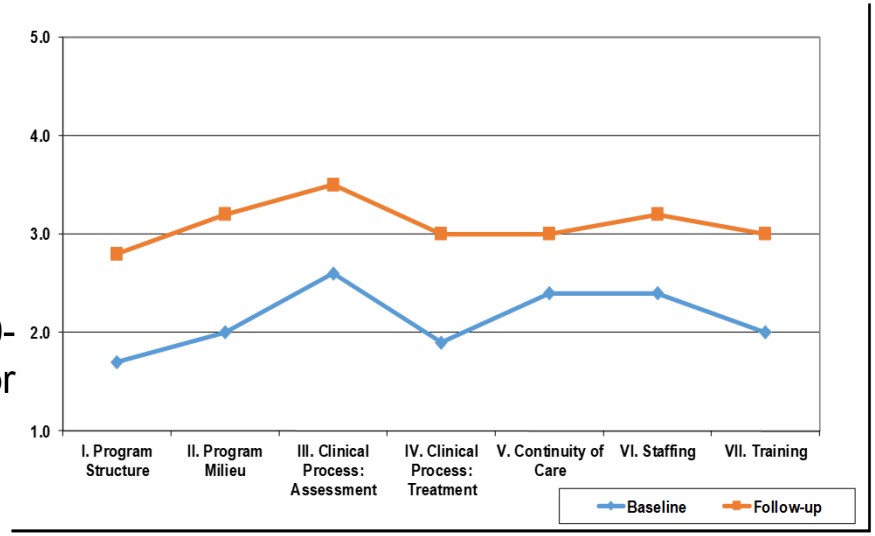
- Use of the DDCAT/DDCMHT/BHIMC as assessment method at baseline and as a measure of change over time
- Single agency quality improvement process
- Formal implementation and change plan development
- Large scale state system change
- Formal implementation science/health services research

MISSOURI PROVIDER: CASE STUDY

- Large Community Mental Health Center
- Provides array of psychiatric services, therapy and outpatient programs, crisis services for individuals and families, and substance abuse programs for adults and adolescents
- Interested in increasing capability of mental health teams to provide co-occurring services
- Year long project with change agent, implementation planning, and coaching by Mid-America ATTC

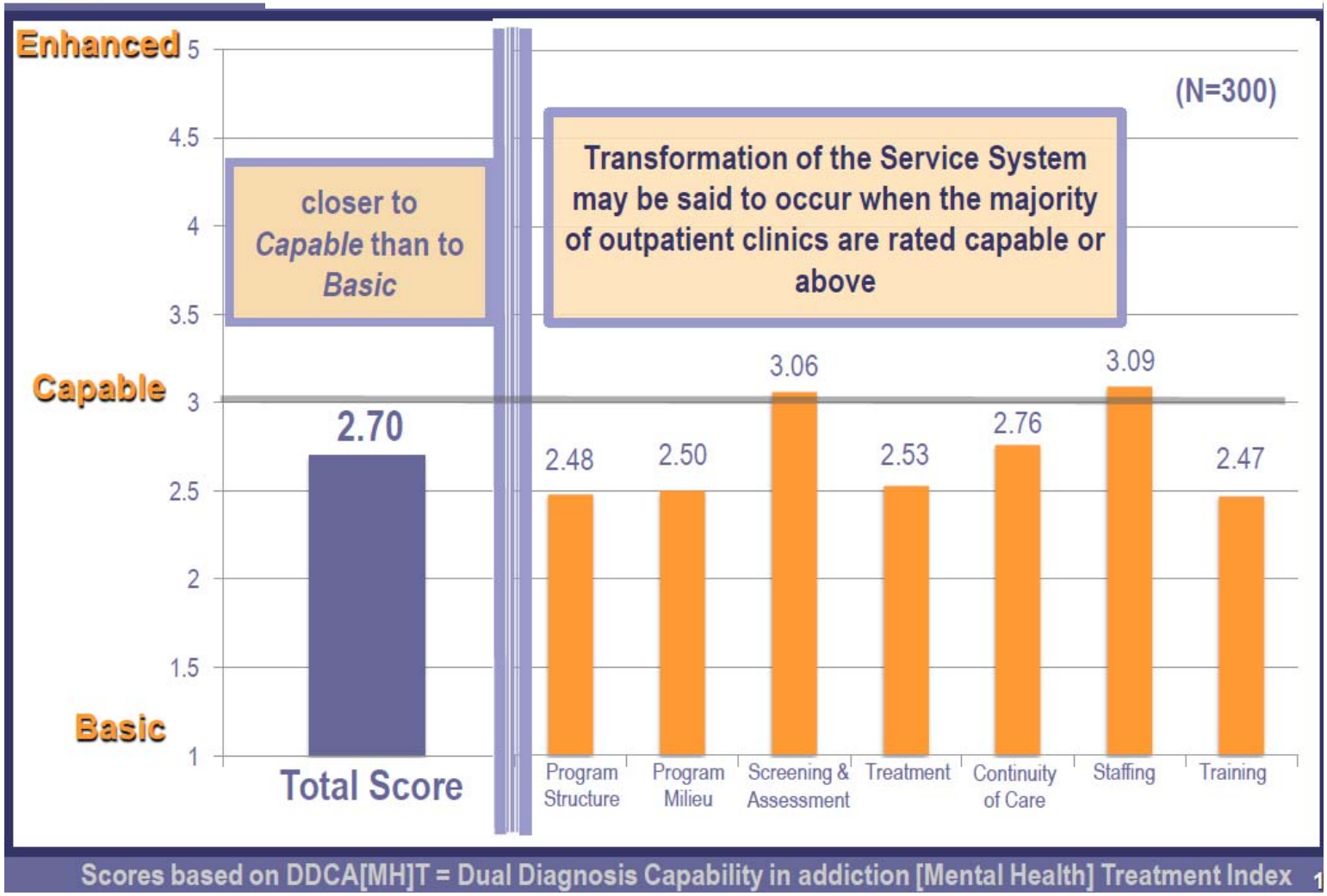
MISSOURI PROVIDER: CHANGES MADE TO COD SERVICES

- Program Structure: Changed mission statement to behavioral health
- Program Milieu: Literature on COD displayed; staff reflect new acceptance of COD
- Assessment: Implemented standardized SUD screener and assessment; charts reflect both diagnoses
- Treatment: Treatment plans routinely and substantively address both disorders; intake and 90-day review record readiness to change/treatment for both disorders; added COD family education group
- Continuity of Care: Discharge plans target both disorders
- Staffing: Added staff with addiction credential; documented regular clinical supervision pertaining to substance use
- Training: Basic training in COD required for new employee orientation



NYSHealth Center for Excellence in Integrated Care

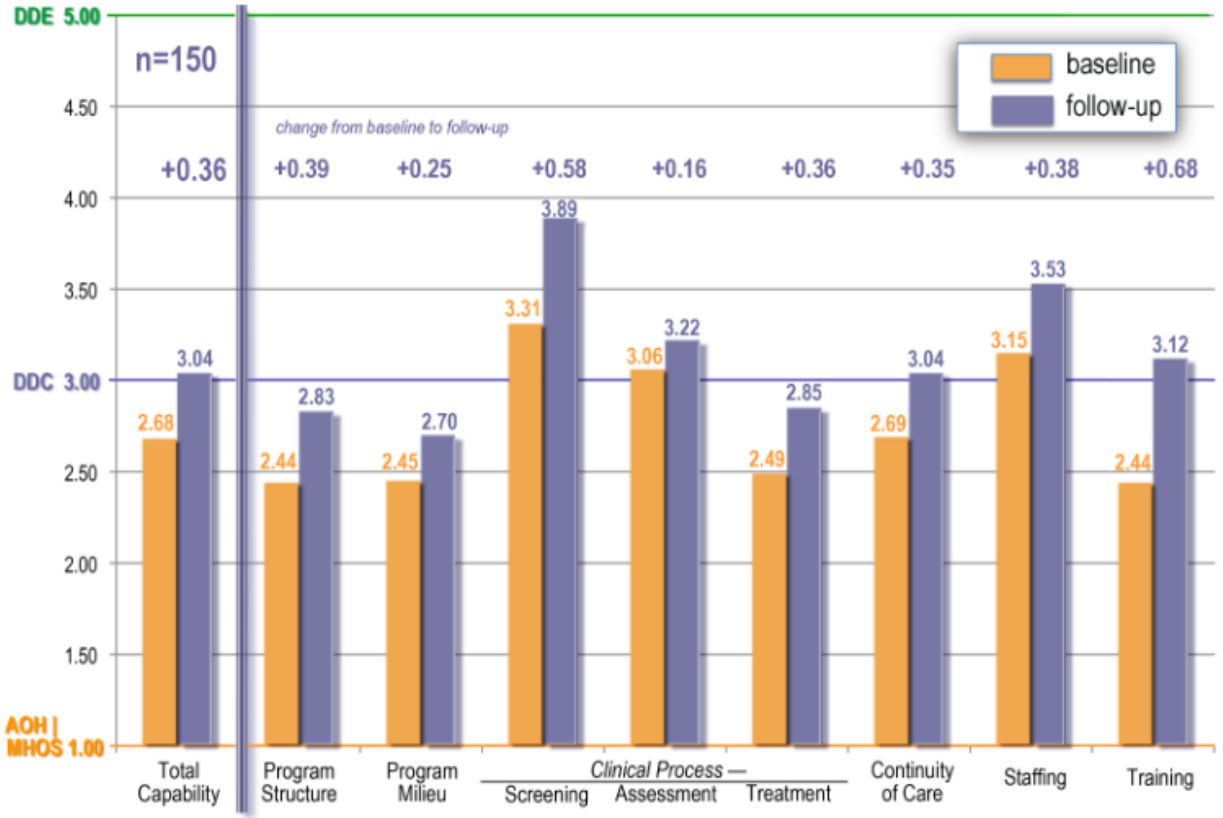
"Getting to Capable" - a Snapshot of New York State's Outpatient System – Sacks (2011)



Scores based on DDCA[MH]T = Dual Diagnosis Capability in addiction [Mental Health] Treatment Index

AFTER 1 YEAR, DOUBLED THE NUMBER OF AGENCIES AT CAPABLE LEVEL - SACKS ET AL.

Figure D2[a]— *Average baseline and follow-up* DDCA[MH]T *scores* **(n=150)** *by dimension and overall obtained from on-site assessments**



**The Screening item has been separated from the Assessment dimension and is presented separately.*

http://www.ndri-usa.org/CEIC%20Final%20Report.pdf

BHIMC: INCREASING INTEGRATED COD CAPABILITY IN MEDICAL SETTINGS

Chaple et al., 2016

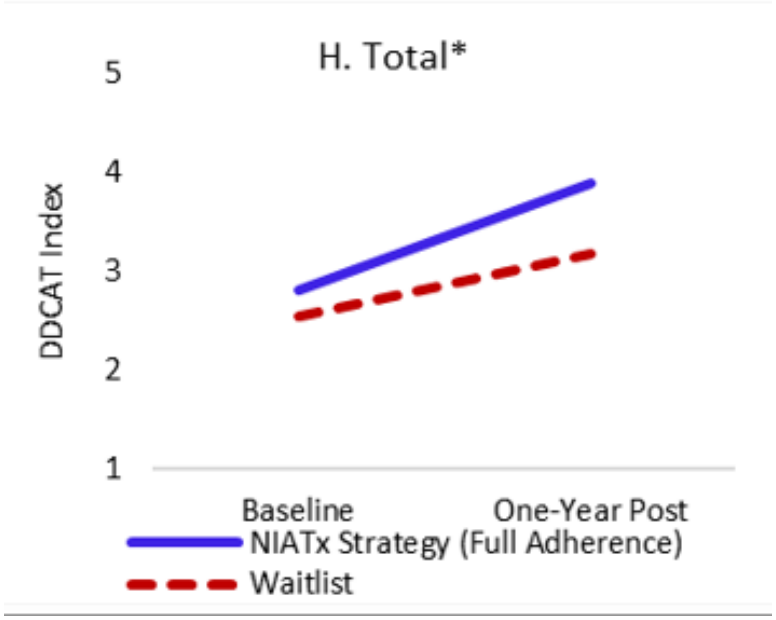
- 4 FQHCs in NJ
- Technical Assistance model
  - On-site baseline assessment
  - Assessment report
  - Implementation planning & guidance
  - Staff training
  - Follow-up (9-12 months)
- Average scores increased
- Shift to more addiction services

Padwa et al., 2015

- 10 primary care clinics in CA
- County funded
  - Funding
  - Training
  - Technical assistance
- Scores moved to *Partially Integrated* over 3 years
- Favored integration of mental health over addiction services

IMPLEMENTATION FACILITATION WITH NIATX MODEL RESULTS IN STEEPER INCREASE IN COD CAPABILITY THAN WAITLIST – Assefa & McGovern, 2018

- Rigorous implementation experiment, RCT and standardized measures
  - Larger study of 52 addiction treatment programs in Washington State.
- NIATx implementation facilitation
  - Process improvement strategies
  - Individual coaching
  - Peer sharing with other agencies
- Agencies with full adherence to NIATx had significantly higher COD Capability at 1 year



Assefa & McGovern. (2018). *Implementing integrated services into routine care for persons with co-occurring disorders*. AHSR.

SUMMARY

- Need system transformation to address COD treatment gap
- Use of COD capability tools at the program/agency level can accelerate transformation

- DDCAT and DDCMHT Toolkits
  - https://www.centerforebp.case.edu/resources/tools/ddcat-toolkit
  - https://www.centerforebp.case.edu/client-files/pdf/ddcmhttoolkit.pdf
- New versions of the DDCAT/DDCMHT & BHIMC version 3.3
  - Mark McGovern, mpmcg@stanford.edu

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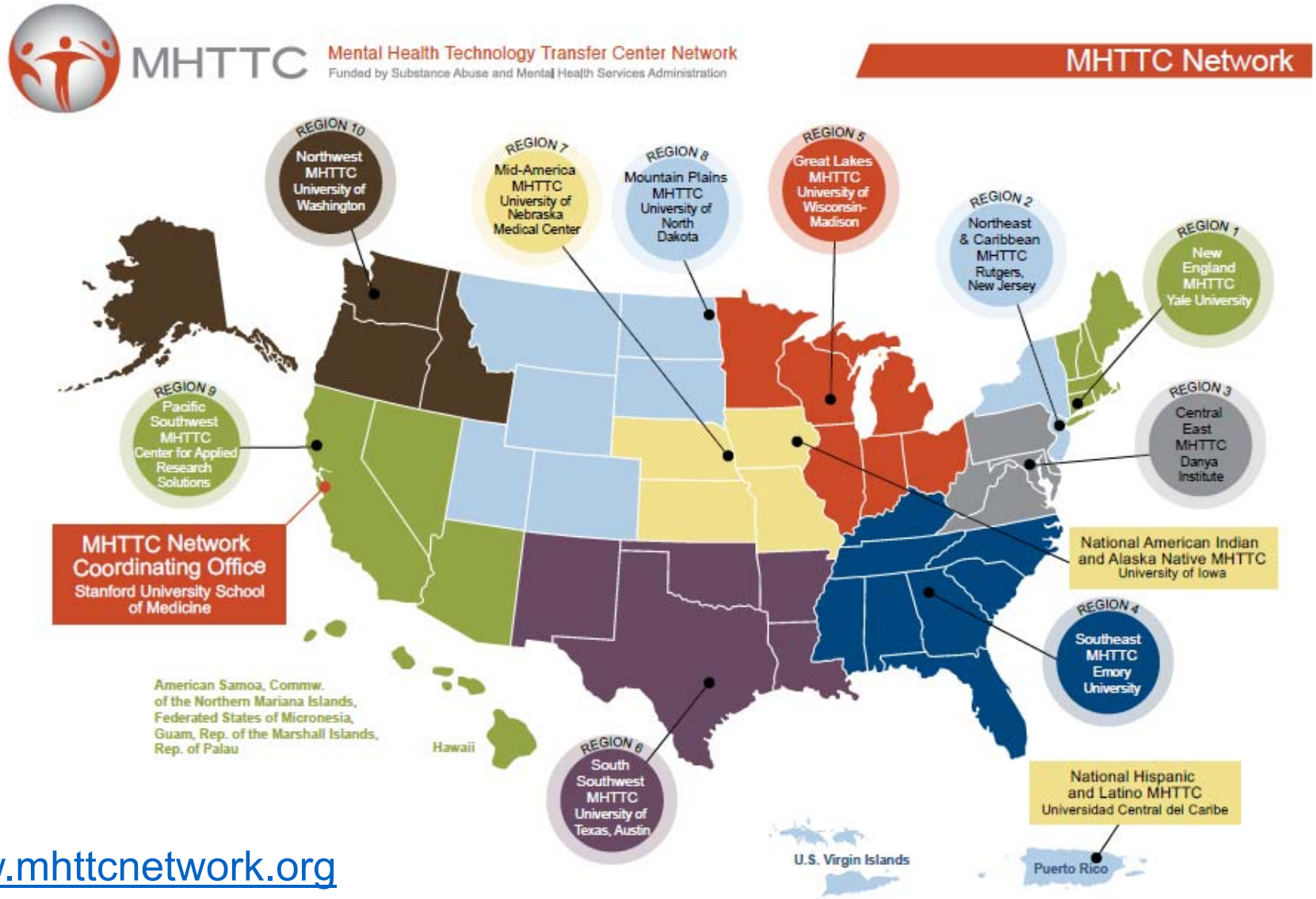

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