CO-FIT100™

Version 1.0

CCISC OUTCOME FIDELITY AND IMPLEMENTATION TOOL

SYSTEMS MEASUREMENT TOOL FOR
THE COMPREHENSIVE CONTINUOUS INTEGRATED SYSTEMS OF CARE MODEL
FOR INTEGRATION OF PSYCHIATRIC AND SUBSTANCE DISORDER SERVICES

Innovative Strategies for
Behavioral Health Systems

Christie A. Cline, M.D., M.B.A., P.C.
President

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Co-occurring Disorders Services Enhancement Toolkit – Tool Number 10

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User's Guide

Introduction

The purpose of the CCISC Outcome Fidelity and Implementation Tool (**CO-FIT100™)** is to assist systems of care in monitoring and measuring success in implementation of the Comprehensive Continuous Integrated System of Care for individuals with co-occurring psychiatric and substance disorders (CCISC). The organization of the tool is based upon the recognition that the CCISC model is designed to create a system that meets the consumer-derived standards of Welcoming, Accessibility, Integration, Continuity, and Comprehensiveness, as defined in the SAMHSA Managed Care Initiative Co-occurring Disorder Consensus Panel Report (K. Minkoff, Panel Chair), entitled Co-occurring Psychiatric and Substance Disorders in Managed Care Systems: Standards of Care, Practice Guidelines, Workforce Competencies, and Training Curricula (1998). The tool will review success in meeting each of these standards, using a combination of specific outcome measures and implementation (process) measures based on the CCISC Model Description (Appendix A) and the Twelve Steps of CCISC Implementation (Appendix B).

The user is strongly advised to review Appendix A and Appendix B before proceeding to use the **CO-FIT100™**.

Definition of A System

For the purpose of the CCISC, and the use of the **CO-FIT100™**, a system is defined as any organized behavioral health delivery system, such as an entire state, a specific region within the state, a county, a network of agencies, or a single complex agency. Systems can also be defined by payor source, such as the Medicaid system, the state funded system, the county operated system, or by target population, such as the child and adolescent system. The use of the **CO-FIT100™** must be directed carefully to assessment of the specific system that is the target of systems change, and the boundaries between that system and other collaborative systems must be clearly demarcated. In some instances, a large system such as a state may be implementing CCISC statewide, but implementation is mediated through regional or county behavioral health systems. In such a situation, the state may require each subcomponent to use the **CO-FIT100™** to evaluate its own progress, and then create a state level composite by averaging scores on each item across the regions.

Scoring

Each item in the tool is rated using a five point Likert Scale, ranging from 5. Consistently or Completely Met; 4. Usually or Mostly Met; 3. Sometimes or Partially Met; 2. Occasionally or Slightly Met; 1. Rarely or Not at all Met. Some items may initially appear to be non-applicable, because the system may not specifically measure them. For example, the system may not measure consumer satisfaction with welcoming attitudes. In these instances, however, the correct score is 1. Not at all met. The reason for this is that an important purpose of the tool is to provide guidance for what systems should measure as part of the implementation process.

The **CO-FIT100™** has two key sections: the Implementation (process) section and the Outcome section, which includes sections on Welcoming, Accessibility, Integration, Continuity, and Comprehensiveness. Systems are likely to see progress in their implementation scores before seeing comparable progress in their outcome scores. There are 100 items that are to be scored, giving a scoring range of 100 to 500.

Methodology

The **CO-FIT100™** is intended for use as a tool to measure progress in system implementation of the CCISC model. As such, it is ideally scored first at the beginning of the change process, to measure the system baseline. Scores should be expected to be low in the beginning, and many items will remain low during the early phases of implementation. Ideally, the **CO-FIT100™** will be scored annually or semi-annually, either as a system self-audit involving providers and stakeholders, or through a formal systems audit conducted via system level quality improvement personnel. Systems should expect the process of implementation to proceed at the rate of 100 to 150 "points" per year in demonstrated progress on the **CO-FIT100™**.

The diversity of items affords an opportunity for the system to have flexibility in how it evolves during the process of implementation, and systems might expect to find different rates of progress in different areas of the tool, as well as in different subcomponents of the system. It is very important that within the larger system, the tool is used to measure progress in implementation for each organized subsystem (e.g., region, county, catchment area) that is delegated responsibility for its own implementation plan. The system can record scores for each subsystem, and then develop a composite overall system score. Similarly, a system may evaluate progress in subsystems defined by other means: Medicaid vs. block grant funding; child and adolescent vs. adult, etc.

The **CO-FIT100™** also provides flexibility for systems with regard to the number of items that are scored. A system might begin by scoring only the section on Implementation, or only the sections on Welcoming and Accessibility, or a combination of Implementation and Welcoming, in order to make the initial approach to systems change more manageable. Similarly, a system might select five or six items from each of the outcome scales, combined with the implementation items, to create a 50 item scale for initial evaluation. Thus, while full fidelity to the CCISC model involves assessment of all 100 items on the **CO-FIT100™,** initiating the change process with a subset of the items can be completely acceptable.

Implementation (Process Measures)

All items are scored on the following Likert scale:

Not Applicable	Rarely	Occasionally	Sometimes	Often	Consistently
NA	1	2	3	4	5

1. The system has identified an empowered individual, team, or structure to oversee the change process.

   Score: ☐

2. The system has a defined mandate to implement the CCISC model, with widespread consensus support.

   Score: ☐

3. The system has identified and utilized a measure of system outcome, and developed a plan for regular monitoring and reporting of system outcome.

   Score: ☐

4. There is a written strategic plan that defines measurable objectives for a six, 12, 18 and 24 months time frame at the system, program, clinical practice, and clinician competency level.

   Score: ☐

5. The strategic plan identifies specific incentives/disincentives that the system will use to support attainment of the above objectives, and mechanisms for modifying these incentives at three to six month intervals as indicated.

   Score: ☐

6. Elements of the strategic plan are incorporated into routine quality improvement activities and progress in achieving the plan's objectives are routinely measured.

   Score: ☐

7. The system has developed consensus on the goal of attainment of universal dual diagnosis capability for all programs

   Score: ☐

8. Each program has identified an empowered structure to oversee its own change process and to be accountable for that process to the system.

   Score: ☐

9. The system has identified and utilized a process for assessing dual diagnosis capability at the program level.

   Score: ☐

10. This process is utilized to develop measurable action plans at the program level.

    Score: ☐

Continues on Next Page

Implementation (Process Measures) (continued)

All items are scored on the following Likert scale:

Not Applicable	Rarely	Occasionally	Sometimes	Often	Consistently
NA	1	2	3	4	5

11. There is measurable progress in achieving program action plan objectives at six month review, including continued assessment of dual diagnosis capability.

Score: ☐

12. The system has identified clinical practice guidelines to circulate for review, and selected specific measures of access and integration for initial implementation. These measures are modified semiannually.

Score: ☐

13. Each program has incorporated into its action plan a specific strategy for attainment of these measures of improved clinical practice.

Score: ☐

14. The system has identified and utilized an audit process for determining adherence to these guidelines or attainment of these measures.

Score: ☐

15. The system demonstrates measurable progress in attainment of these measures at six month review.

Score: ☐

16. The system has developed consensus on the goal of attainment of universal dual diagnosis capability for all clinicians.

Score: ☐

17. The system has identified and utilized a process for assessing clinician competency in relation to the principles of the model.

Score: ☐

18. The system has created and implemented a training plan for both clinical and systems change issues with measurable objectives for achieving competency.

Score: ☐

19. The system has identified trainers, supervisors, and/or clinical leaders responsible for implementation of competency in each program.

Score: ☐

Continues on Next Page

Implementation (Process Measures) (continued)

All items are scored on the following Likert scale:

Not Applicable	Rarely	Occasionally	Sometimes	Often	Consistently
NA	1	2	3	4	5

20. There is measurable progress in achieving competency among clinicians, and demonstrating this competency by formal assessment of clinicians, both in general, and in relation to specific program standards or clinical practices.

Score: ☐

Total Score 1 through 20 :

Notes:

Action Plan:

Welcoming

All items are scored on the following Likert scale:

Not Applicable	Rarely	Occasionally	Sometimes	Often	Consistently
NA	1	2	3	4	5

1. Consumer satisfaction surveys report high levels of satisfaction with “welcoming attitudes” at emergency access points in the service system.

   Score: ☐

2. Consumer satisfaction surveys report high levels of satisfaction with “welcoming attitudes” at routine access points in the system.

   Score: ☐

3. 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.

   Score: ☐

4. Program admission policies throughout the system are written to specifically welcome individuals with co-occurring disorders, and there is demonstrated adherence to these policies as documented by audit.

   Score: ☐

5. There are written protocols, policies, and procedures that define welcoming, empathic, and hopeful clinical practices for all clinicians in all settings (e.g., no use of disparaging language)

   Score: ☐

6. There are specific clinician competencies in all programs and settings that are written in human resource policies and that require welcoming attitudes, accepting values, and skills in conveying empathy and hope to individuals with co-occurring disorders.

   Score: ☐

Continues on Next Page

Welcoming (continued)

All items are scored on the following Likert scale:

Not Applicable	Rarely	Occasionally	Sometimes	Often	Consistently
NA	1	2	3	4	5

7. Clinicians demonstrate these required competencies in clinical practice and/or by formal assessment.

Score: ☐

Total Score 1 through 7:

Notes:

Action Plan:

Accessible

All items are scored on the following Likert scale:

Not Applicable	Rarely	Occasionally	Sometimes	Often	Consistently
NA	1	2	3	4	5

1. Consumer satisfaction surveys report high levels of satisfaction with "accessibility to evaluation and treatment" in emergency and crisis settings and at routine access points.

   Score: ☐

2. Consumer satisfaction surveys report high levels of satisfaction with cultural competency and sensitivity in screening and engagement of individuals with co-occurring disorders at all access points.

   Score: ☐

3. There are no arbitrary barriers to initial emergency mental health evaluation based on substance levels.

   Score: ☐

4. There are no barriers to psychiatric inpatient admission based upon substance levels, substance diagnosis, or need for detoxification and there are no barriers to initial routine mental health evaluation based upon presence of substance disorder and/or length of sobriety

   Score: ☐

5. There are no barriers to initial routine substance evaluation or treatment based upon psychiatric diagnosis or medication.

   Score: ☐

6. There are no barriers to identification and registration of individuals as having co-occurring disorders at point of entry.

   Score: ☐

7. Individuals with co-occurring disorders are routinely counted and reported in system management information systems.

   Score: ☐

8. There is universal screening for comorbidity at all points of entry.

   Score: ☐

9. There is universal screening for trauma history at all points of entry.

   Score: ☐

Continues on Next Page

Accessible (continued)

All items are scored on the following Likert scale:

Not Applicable	Rarely	Occasionally	Sometimes	Often	Consistently
NA	1	2	3	4	5

10. There is a process for proactively engaging all screened in clients in an ongoing assessment and/or treatment relationship, regardless of diagnostic clarity or motivation to change, in some component of the treatment system

    Score: ☐

11. The percentage of individuals with co-occurring disorders identified in the service system is comparable to what would be expected based upon epidemiologic data.

    Score: ☐

12. There are mechanisms to provide integrated access and outreach for individuals with co-occurring disorders who may present in:

    a. criminal justice settings
    b. homeless shelter settings
    c. child protective and welfare settings
    d. elder service settings
    e. victim of abuse settings
    f. primary health care settings
    (Score this as a single item, averaging scores on a – f)

    Score: ☐

13. Utilization management criteria and level of care assessment procedures have specific provisions to promote access to all levels of care for individuals with co-occurring disorders.

    Score: ☐

14. Clinicians have required competencies in integrated culturally competent screening and engagement in services incorporated into human resource policies.

    Score: ☐

Continues on Next Page

Accessible (continued)

All items are scored on the following Likert scale:

Not Applicable	Rarely	Occasionally	Sometimes	Often	Consistently
NA	1	2	3	4	5

15. Clinicians demonstrate these required competencies in clinical practice and/or by formal assessment.

Score: [ ]

Total Score 1 through 15:

Notes:

Action Plan:

Integrated

All items are scored on the following Likert scale:

Not Applicable	Rarely	Occasionally	Sometimes	Often	Consistently
NA	1	2	3	4	5

1. Consumer satisfaction surveys report high levels of satisfaction with "integration of treatment provided by primary clinical relationships."

   Score: ☐

2. Consumer satisfaction surveys report high levels of satisfaction with "integration of services in treatment programs available in the service system."

   Score: ☐

3. In each single funding stream, there is specific contractual or reimbursement language requiring defined capability in provision of integrated services for individuals with co-occurring disorders receiving treatment under that funding stream or in that contracted setting.

   Score: ☐

4. Each reimbursable service code has specific language defining the nature of integrated services provided under that service code to individuals with co-occurring disorders.

   Score: ☐

5. There is a set of standards defining "Dual Diagnosis Capability" criteria in accordance with national guidelines as a requirement for all programs in the mental health system and there is a similar set of standards for all programs in the addiction system.

   Score: ☐

6. All programs in the mental health system have been found to meet DDC criteria by a process of formal program audit and certification and all programs in the addiction system have been found to meet DDC criteria by a process of formal chart audit and certification.

   Score: ☐

7. There is an organized process for monthly interprogram care coordination meetings to share responsibility and decision making for difficult cases that cross system boundaries.

   Score: ☐

8. There are mechanisms in the system for proactively planning for access to psychopharmacology services in addiction treatment settings.

   Score: ☐

Continues on Next Page

Integrated (continued)

All items are scored on the following Likert scale:

Not Applicable	Rarely	Occasionally	Sometimes	Often	Consistently
NA	1	2	3	4	5

9. There are mechanisms in the system for providing mental health evaluations on site at addiction settings.

   Score: ☐

10. There are mechanisms in the system for providing addiction evaluations on site in mental health treatment settings.

    Score: ☐

11. There are mechanisms in the system for providing access to psychotropic medication for individuals in addiction treatment settings, regardless of payer source.

    Score: ☐

12. There are procedures defining mechanisms and time frames for collaboration regarding treatment planning and discharge planning between mental health settings and addiction treatment settings.

    Score: ☐

13. Programs have policies for development and documentation of integrated treatment plans and progress notes.

    Score: ☐

14. There is a definition of expected scope of integrated practice for singly licensed mental health and substance abuse clinicians. This definition has been implemented and is supported by system policies and licensing standards.

    Score: ☐

15. All clinicians have competencies in integrated treatment planning and scope of practice defined in human resource policies.

    Score: ☐

Continues on Next Page

Integrated (continued)

All items are scored on the following Likert scale:

Not Applicable	Rarely	Occasionally	Sometimes	Often	Consistently
NA	1	2	3	4	5

16. Clinicians demonstrate required competencies in clinical practice and/or by formal assessment.

Score:

Total Score 1 through 16:

Notes:

Action Plan:

Continuity

All items are scored on the following Likert scale:

Not Applicable	Rarely	Occasionally	Sometimes	Often	Consistently
NA	1	2	3	4	5

1. There is a plan for identification of high priority clients using the four quadrant model. (See CCISC model description—Appendix A)

   Score: ☐

2. The system has a written plan that defines and monitors responsibility for continuous integrated treatment in particular agencies or programs for all Quadrant IV clients, and clients in other quadrants that are identified as system priorities.

   Score: ☐

3. Consumer satisfaction surveys report high levels of satisfaction with availability of continuity of integrated treatment for individuals with serious and persistent mental illness. (Quadrants II and IVA)

   Score: ☐

4. Consumer satisfaction surveys report high levels of satisfaction with availability of continuity of integrated treatment for individuals with psychiatrically complicated addictive disorders (Quadrants III and IV B)

   Score: ☐

5. Programs that have responsibility for continuing integrated mental health treatment do not discharge patients for substance use or medication non-compliance.

   Score: ☐

6. Programs that have responsibility for continuing integrated substance treatment do not discharge patients for substance use or medication non-compliance.

   Score: ☐

7. Patients are not discontinued from necessary non-addictive medication for stabilization of a known serious mental illness because of continuing substance use unless medically contraindicated.

   Score: ☐

8. There is at least one program that provides continuing proactive outreach to disengaged priority population individuals with co-occurring disorders who drop out of or who are non-adherent with traditional clinic based services.

   Score: ☐

Continues on Next Page

Continuity (continued)

All items are scored on the following Likert scale:

Not Applicable	Rarely	Occasionally	Sometimes	Often	Consistently
NA	1	2	3	4	5

9. Episode of care programs have policies that require making a connection with continuous integrated treatment at the point of discharge, whether discharge is planned or unplanned.

   Score: ☐

10. System chart audit demonstrates that such connections are made 90% of the time (appointment made; client has at least one follow up contact).

    Score: ☐

11. All clinicians have specific competencies concerning the four-quadrant model, matching of service responsibility, and maintaining continuity of care incorporated into human resource policies.

    Score: ☐

12. Clinicians demonstrate required competencies in clinical practice and/or by formal assessment.

    Score: ☐

Total Score 1 through 12:

Notes:

Action Plan:

Comprehensiveness

(Measures comprehensiveness of service array within each geographically defined service area or organized subsystem determined by payer or population).

All items are scored on the following Likert scale:

Not Applicable	Rarely	Occasionally	Sometimes	Often	Consistently
NA	1	2	3	4	5

1. Consumer satisfaction surveys document high levels of satisfaction with the comprehensive array of programs within the service system, and with the capacity of the system to provide an appropriate program for the widest range of consumers.

   Score: ☐

2. Consumer satisfaction surveys document high levels of satisfaction with the comprehensive array of interventions available to consumers with co-occurring disorders, so that consumers have access to individually matched interventions in their primary treatment settings.

   Score: ☐

3. The system has a written plan for assigning responsibility for providing defined integrated assessment and treatment programs to individuals who overlap with other systems outside the behavioral health system, and the plan has been implemented.

a. correctional system
b. homeless shelter system
c. child protective and welfare system
d. elder service system
e. victims of abuse system
f. primary health care system
(Score this as a single item, averaging scores on a – f)

Score: ☐

4. The system has defined standards for DDE programs in both mental health and addiction systems

   Score: ☐

5. The system has implemented DDE programming for at least 20% of clients in all program models in the mental health and addiction systems:

   Score: ☐

6. There are DDE services at all four levels of care in addiction treatment, including detox.

   Score: ☐

Continues on Next Page

Comprehensiveness (continued)

(Measures comprehensiveness of service array within each geographically defined service area or organized subsystem determined by payer or population).

All items are scored on the following Likert scale:

Not Applicable	Rarely	Occasionally	Sometimes	Often	Consistently
NA	1	2	3	4	5

7. There is a DDE psychiatric inpatient unit. Score: ☐

8. There is a DDC or DDE crisis stabilization bed program. Score: ☐

9. There is a range of DDC case management programs at various levels of intensity for mental health clients. Score: ☐

10. There is a DDC case management program for non-SPMI addiction clients. Score: ☐

11. There is a range of DDC intensive outpatient or day treatment services for mental health clients. Score: ☐

12. There is at least one mental health day treatment or psychosocial rehabilitation program that has a DDE track. Score: ☐

13. All psychiatric residential support programs are DDC, with a range including wet (consumer choice), damp (abstinence encouraged), and dry (abstinence expected). Score: ☐

14. There is at least one DDE mental health residential support program that is wet, one that is damp, and one that is dry. Score: ☐

15. There is access to DDC opiate maintenance treatment. Score: ☐

16. The system has chosen a peer dual recovery model (Double Trouble in Recovery, Dual Recovery Anonymous, etc.), and implemented at least two meetings per week. Score: ☐

17. The system has implemented an individualized placement and support model program for psychiatric rehabilitation that works with dually diagnosed consumers in all stages of change. Score: ☐

Continues on Next Page

Comprehensiveness (continued)

(Measures comprehensiveness of service array within each geographically defined service area or organized subsystem determined by payer or population).

All items are scored on the following Likert scale:

Not Applicable	Rarely	Occasionally	Sometimes	Often	Consistently
NA	1	2	3	4	5

18. The system programs have implemented practice guidelines for service and program matching successfully, as determined by chart audit. Score: ☐

19. The system has adopted a formal integrated assessment process that captures the criteria for service matching: quadrant; diagnoses; strengths and disability; external problems, supports and contingencies; stage of change; recovery management and daily living skills; and level of care. Score: ☐

20. All programs routinely assess stage of change and incorporate stage-specific interventions into treatment plans. Score: ☐

21. All programs can provide motivational interventions and stage-specific groups (if groups are provided in the program.) Score: ☐

22. There is a program in the mental health system for contingency management of individuals with co-occurring disorders regarding substance use (e.g., using payeeship). Score: ☐

23. There is a program in the addiction system for contingency management of individuals involved in the corrections system regarding both disorders (integrated drug court, for example). Score: ☐

24. There is an integrated DDE program for women who are victims of trauma who have co-occurring disorders. Score: ☐

25. There are a range of DDC services for individuals who belong to significant linguistic or cultural minorities. Score: ☐

26. The system has identified individualized outcome criteria for people with co-occurring disorders, and measures success by incremental attainment of these criteria. Score: ☐

Continues on Next Page

Comprehensiveness (continued)

(Measures comprehensiveness of service array within each geographically defined service area or organized subsystem determined by payer or population).

All items are scored on the following Likert scale:

Not Applicable	Rarely	Occasionally	Sometimes	Often	Consistently
NA	1	2	3	4	5

27. Consumer satisfaction surveys report high satisfaction with provision of hope and support of small increments of success. **Score:** ☐

28. Utilization of individualized outcome criteria is documented via chart audit. **Score:** ☐

29. System management information systems report clinical outcome data using measurable criteria including: harm reduction, progress through stages of change, reduction in amount, frequency, or consistency of use; development of specific skills or recovery behaviors; adherence to treatment. **Score:** ☐

30. System can demonstrate that 80% of co-occurring disordered clients who are still unstable demonstrate measurable progress each six months. **Score:** ☐

Total Score 1 through 30:

Notes:

Action Plan:

Appendix A

COMPREHENSIVE, CONTINUOUS, INTEGRATED SYSTEM OF CARE MODEL DESCRIPTION

The Four Basic Characteristics of the CCISC

The Comprehensive, Continuous, Integrated System of Care (CCISC) model for organizing services for individuals with co-occurring psychiatric and substance disorders (ICOPSD) is designed to improve treatment capacity for these individuals in systems of any size and complexity, ranging from entire states, to regions or counties, networks of agencies, individual complex agencies, or even programs within agencies. The model has the following four basic characteristics:

1. System Level Change: The CCISC model is designed for implementation throughout an entire system of care, not just for implementation of individual program or training initiatives. All programs are designed to become dual diagnosis capable (or enhanced) programs, generally within the context of existing resources, with a specific assignment to provide services to a particular cohort of individuals with co-occurring disorders. Implementation of the model integrates the use of system change technology with clinical practice technology at the system level, program level, clinical practice level, and clinician competency level to create comprehensive system change.

2. Efficient Use of Existing Resources: The CCISC model is designed for implementation within the context of current service resources, however scarce, and emphasizes strategies to improve services to ICOPSD within the context of each funding stream, program contract, or service code, rather than *requiring* blending or braiding of funding streams or duplication of services. It provides a template for planning how to obtain and utilize additional resources should they become available, but does not require additional resources, other than resources for planning, technical assistance, and training.

3. Incorporation of Best Practices: The CCISC model is recognized by SAMHSA as a best practice for systems implementation for treatment of ICOPSD. An important aspect of CCISC implementation is the incorporation of evidence based and clinical consensus based best practices for the treatment of all types of ICOPSD throughout the service system.

Appendix A

COMPREHENSIVE, CONTINUOUS, INTEGRATED SYSTEM OF CARE MODEL DESCRIPTION (continued)

4. Integrated Treatment Philosophy: The CCISC model is based on implementation of principles of successful treatment intervention that are derived from available research and incorporated into an integrated treatment philosophy that utilizes a common language that makes sense from the perspective of both mental health and substance disorder treaters. This model can be used to develop a protocol for individualized treatment matching, that in turn permits matching of particular cohorts of individuals to the comprehensive array of dual diagnosis capable services within the system.

Appendix A

COMPREHENSIVE, CONTINUOUS, INTEGRATED SYSTEM OF CARE MODEL DESCRIPTION (continued)

The Eight Principles of Treatment for the CCISC

The eight research-derived and consensus-derived principles that guide the implementation of the CCISC are as follows:

1. *Dual diagnosis is an expectation, not an exception:* Epidemiologic data defining the high prevalence of comorbidity, along with clinical outcome data associating ICOPSD with poor outcomes and high costs in multiple systems, imply that the whole system, at every level, must be designed to use all of its resources in accordance with this expectation. This implies the need for an integrated system planning process, in which each funding stream, each program, all clinical practices, and all clinician competencies are designed proactively to address the individuals with co-occurring disorders who present in each component of the system already.

2. *All ICOPSD are not the same; the national consensus four quadrant model for categorizing co-occurring disorders (NASMHPD, 1998) can be used as a guide for service planning on the system level.* In this model, ICOPSD can be divided according to high and low severity for each disorder, into high-high (Quadrant IV), low MH – high CD (Quadrant III), high MH – low CD (Quadrant II), and low-low (Quadrant I). High MH individuals usually have SPMI and require continuing integrated care in the MH system. High CD individuals are appropriate for receiving episodes of addiction treatment in the CD system, with varying degrees of integration of mental health capability.

3. *Empathic, hopeful, integrated treatment relationships are one of the most important contributors to treatment success in any setting; provision of continuous integrated treatment relationships is an evidence based best practice for individuals with the most severe combinations of psychiatric and substance difficulties.* The system needs to prioritize a) the development of clear guidelines for how clinicians in any service setting can provide integrated treatment in the context of an appropriate scope of practice, and b) access to continuous integrated treatment of appropriate intensity and capability for individuals with the most complex difficulties.

Appendix A

COMPREHENSIVE, CONTINUOUS, INTEGRATED SYSTEM OF CARE MODEL DESCRIPTION (continued)

4. *Case management and care must be balanced with empathic detachment, expectation, contracting, consequences, and contingent learning for each client, and in each service setting.* Each individual client may require a different balance (based on level of functioning, available supports, external contingencies, etc.); and in a comprehensive service system, different programs are designed to provide this balance in different ways. Individuals who require high degrees of support or supervision can utilize contingency based learning strategies involving a variety of community based reinforcers to make incremental progress within the context of continuing treatment.

5. *When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated dual (or multiple) primary diagnosis-specific treatment is recommended.* The system needs to develop a variety of administrative, financial, and clinical structures to reinforce this clinical principle, and to develop specific practice guidelines emphasizing how to integrate diagnosis-specific best practice treatments for multiple disorders for clinically appropriate clients within each service setting

6. *Both mental illness and addiction can be treated within the philosophical framework of a "disease and recovery model" (Minkoff, 1989) with parallel phases of recovery (acute stabilization, motivational enhancement, active treatment, relapse prevention, and rehabilitation/recovery), in which interventions are not only diagnosis-specific, but also specific to phase of recovery and stage of change.* Literature in both the addiction field and the mental health field has emphasized the concept of stages of change or stages of treatment, and demonstrated the value of stagewise treatment (Drake et al, 2001.)

7. *There is no single correct intervention for ICOPSD; for each individual interventions must be individualized according to quadrant, diagnoses, level of functioning, external constraints or supports, phase of recovery/stage of change, and (in a managed care system) multidimensional assessment of level of care requirements.* This principle forms the basis for developing clinical practice guidelines for assessment and treatment matching. It also forms the basis for designing the template of the CCISC, in which each program is a dual diagnosis program, but all programs are not the same. Each program in the system is assigned a "job": to work with a particular cohort of ICOPSD, providing continuity or episode

interventions, at a particular level of care. Consequently, all programs become mobilized to develop cohort specific dual diagnosis services, thereby mobilizing treatment resources throughout the entire system.

8. *Clinical outcomes for ICOPSD must also be individualized, based on similar parameters for individualizing treatment interventions.* Abstinence and full mental illness recovery are usually long term goals, but short term clinical outcomes must be individualized, and may include reduction in symptoms or use of substances, increases in level of functioning, increases in disease management skills, movement through stages of change, reduction in “harm” (internal or external), reduction in service utilization, or movement to a lower level of care. Systems need to develop clinical practice parameters for treatment planning and outcome tracking that legitimize this variety of outcome measures to reinforce incremental treatment progress and promote the experience of treatment success.

Implementation of the CCISC requires utilization of system change strategies (e.g., continuous quality improvement), in the context of an organized process of strategic planning, to develop the specific elements of the CCISC. Minkoff (2001) has described a “12 Step Program for Implementation of a CCISC” that defines this process sequentially, and, in collaboration with Cline, has organized a CCISC Implementation Toolkit that promotes the successful accomplishment of many of the specific steps. Implementation of the CCISC occurs incrementally in complex systems, over a period of years, and is characterized by establishment of the following elements, which reflect fidelity to the model.

Appendix B

Twelve Steps for CCISC Implementation

1. **Integrated system planning process:** Implementation of the CCISC requires a system wide integrated strategic planning process that can address the need to create change at every level of the system, ranging from system philosophy, regulations, and funding, to program standards and design, to clinical practice and treatment interventions, to clinician competencies and training. The integrated system planning process must be empowered within the structure of the system, include all key funders, providers, and consumer/family stakeholders, have the authority to oversee continuing implementation of the other elements of the CCISC, utilize a structured process of system change (e.g., continuous quality improvement), and define measurable system outcomes for the CCISC in accordance with the elements listed herein. It is necessary to include consumer and family driven outcomes that measure satisfaction with the ability of the system to be welcoming, accessible and culturally competent, as well as integrated, continuous, and comprehensive, from the perspective of ICOPSD and their families.

2. **Formal consensus on CCISC model:** The system must develop a clear mechanism for articulating the CCISC model, including the principles of treatment and the goals of implementation, developing a formal process for obtaining consensus from all stakeholders, identifying barriers to implementation and an implementation plan, and disseminating this consensus to all providers and consumers within the system.

3. **Formal consensus on funding the CCISC model:** CCISC implementation involves a formal commitment that each funder will promote integrated treatment within the full range of services provided through its own funding stream, whether by contract or by billable service code, in accordance with the principles described in the model, and in accordance with the specific tools and standards described below. Blending or braiding funding streams to create innovative programs or interventions may also occur as a consequence of integrated systems planning, but this alone does not constitute fidelity to the model.

4. **Identification of priority populations, and locus of responsibility for each:** Using the national consensus four quadrant model, the system must develop a written plan for identifying priority populations within each quadrant, and locus of responsibility within the service system for welcoming access, assessment, stabilization, and integrated continuing care. Commonly, individuals in quadrant I are seen in outpatient and primary care settings, individuals in quadrant II and some in quadrant IV are followed within the mental health service system, individuals in quadrant III are engaged in both systems but served primarily in the substance system. Each system will usually have priority populations

Twelve Steps for CCISC Implementation (continued)

(commonly in quadrant IV) with no system or provider clearly responsible for engagement and/or treatment; the integrated system planning process needs to create a plan for how to address the needs of these populations, even though that plan may not be able to be immediately implemented.

5. Development and implementation of program standards: A crucial element of the CCISC model is the expectation that all programs in the service system must meet basic standards for Dual Diagnosis Capability, whether in the mental health system (DDC-MH) or the addiction system (DDC-CD). In addition, within each system of care, for each program category or level of care, there need to written standards for Dual Diagnosis Enhanced programs (DDE). There needs to be consensus that these standards will be developed, and that, over time, they will be built into funding and licensing expectations (see items 2 and 3 above), as well as a plan for stagewise implementation. Program competency assessment tools (e.g., COMPASS (Minkoff & Cline, 2001)) can be helpful in both development and implementation of DDC standards.

6. Structures for intersystem and interprogram care coordination: CCISC implementation involves creating routine structures and mechanisms for addiction programs and providers and mental health programs and providers, as well as representatives from other systems that may participate in this initiative (e.g., corrections) to participate in shared clinical planning for complex cases whose needs cross traditional system boundaries. Ideally, these meetings should have both administrative and clinical leadership, and should be designed not just to solve particular clinical problems, but also to foster a larger sense of shared clinical responsibility throughout the service system. A corollary of this process may include the development of specific policies and procedures formally defining the mechanisms by which mental health and addiction providers support one another and participate in collaborative treatment planning.

7. Development and implementation of practice guidelines: CCISC implementation requires system wide transformation of clinical practice in accordance with the principles of the model. This can be realized through dissemination of clinical consensus best practice service planning guidelines that address assessment, treatment intervention, rehabilitation, program matching, psychopharmacology, and outcome. Obtaining input from, and building consensus with clinicians prior to final dissemination is highly recommended. Existing documents (Minkoff, 1998; Arizona DHS, 2001) are available to facilitate this process. Practice guideline implementation must be supported by regulatory changes

Twelve Steps for CCISC Implementation (continued)

(both to promote adherence to the guidelines and to eliminate regulatory barriers) and by clinical auditing procedures to monitor compliance. Specific guidelines to facilitate access and identification and to promote integrated continuous treatment are a particular priority for implementation, (See items 8 and 9).

8. Facilitation of identification, welcoming, and accessibility: This requires several specific steps: 1. modification of MIS capability to facilitate and incentivize identification, reporting, and tracking of ICOPSD. 2. development of "no wrong door" policies and procedures that mandate a welcoming approach to ICOPSD in all system programs, eliminate arbitrary barriers to initial evaluation and engagement, and specify mechanisms for helping each client (regardless of presentation and motivation) to get connected to a suitable program as quickly as possible. 3. Establishing policies and procedures for universal screening for co-occurring disorders at initial contact throughout the system.

9. Implementation of continuous integrated treatment: Integrated treatment relationships are a vital component of the CCISC. Implementation requires developing the expectation that primary clinicians in every treatment setting are responsible for developing and implementing an integrated treatment plan in which the client is assisted to follow diagnosis specific and stage specific recommendations for each disorder simultaneously. This expectation must be supported by clear definition of the expected "scope of practice" for singly licensed clinicians regarding co-occurring disorder, and incorporated into standards of practice for reimbursable clinical interventions – in both mental health and substance settings – for individuals who have co-occurring disorders.

10. Development of basic dual diagnosis capable competencies for all clinicians: Creating the expectation of universal competency, including attitudes and values, as well as knowledge and skill, is a significant characteristic of the CCISC model. Available competency lists for co-occurring disorders can be used as a reference for beginning a process of consensus building regarding the competencies. Mechanisms must be developed to establish the competencies in existing human resource policies and job descriptions, to incorporate them into personnel evaluation, credentialing, and licensure, and to measure or monitor clinician attainment of competency. Competency assessment tools (e.g., CODECAT, Minkoff & Cline, 2001) can be utilized to facilitate this process.

11. Implementation of a system wide training plan: In the CCISC model, training must be ongoing, and tied to expectable competencies in the context of actual job performance. This requires an organized training plan to bring training and supervision to clinicians on site. The most common components of

such training plans involve curriculum development and dissemination, mechanism for training and deploying trainers, career ladders for advanced certification, and opportunities for experiential learning. Train-the-trainer curricula have been developed, or are being developed, in a variety of states, including Connecticut, New York, New Mexico, and Arizona.

12. Development of a plan for a comprehensive program array: The CCISC model requires development of a plan in which each existing program is assigned a specific role or area of competency with regard to provision of Dual Diagnosis Capable or Dual Diagnosis Enhanced service for people with co-occurring disorders, primarily within the context of available resources. This plan should also identify system gaps that require longer range planning and/or additional resources to address, and identify strategies for filling those gaps. Four important areas that must be addressed in each CCISC are:

- **a. Evidence based best practice:** There needs to be a specific plan for initiating at least one Continuous Treatment Team (or similar service) for the most seriously impaired individuals with SPMI and substance disorder. This can occur by building dual diagnosis enhancement into an existing intensive case management team.

- **b. Peer dual recovery supports:** The system must identify at least one dual recovery self-help program (e.g., Dual Recovery Anonymous, Double Trouble in Recovery) and establish a plan to facilitate the creation of these groups throughout the system.

- **c. Residential supports and services:** The system should begin to plan for a comprehensive range of programs that addresses a variety of residential needs, building initially upon the availability of existing resources through redesigning those services to be more explicitly focused on ICOPSD. This range of programs should include:

  1. DDC/DDE addiction residential treatment (e.g., modified therapeutic community programs).

  2. Abstinence-mandated (dry) supported housing for individuals with psychiatric disabilities.

  3. Abstinence-encouraged (damp) supported housing for individuals with psychiatric disabilities

  4. Consumer – choice (wet) supported housing for individuals with psychiatric disabilities at risk of homelessness

Appendix B

Twelve Steps for CCISC Implementation (continued)

d. Continuum of levels of care: All categories of service for ICOPSD should be available in a range of levels of care, including outpatient services of various levels of intensity; intensive outpatient or day treatment, residential treatment, and hospitalization.

CCISC implementation requires a plan that includes attention to each of these areas in a comprehensive service array.

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