Getting to “Capable” — Status of Long Island & New York State’s Outpatient Systems

Stanley Sacks, PHD – Director of CEIC at NDRI

presentation to — Nassau County's 2nd Annual Conference on Co-Occurring Disorders 2011 —
“Emerging Solutions to Integrating Care Throughout the Life Cycle”
December 2nd, 2011
What has CEIC learned?

CEIC Daily

no.203.078

We’re Co-occurring!

- Since 1977

New York State OMH & OASAS outpatient clinics are moving toward a COD capable status
What is CEIC’s purpose?

Fosters the implementation

of integrated care in screening, assessment, and evidence-based interventions

for New York State (NYS) residents with co-occurring conditions

and facilitates OMH and OASAS initiatives in this area
Implementation Approaches
(direct, “hands-on” & on-site)

Building COD Capability

- Leadership
- On-site assessment
- Site reports
- Provider forums
- Collaborations & informal networks
- Peer Recovery Workshops
- Ongoing support & consultation
- Tools (e.g. FIT & TIP 42)
Number of Direct Technical Assistance & Assessment Activities (DDCA[MH]T)

4-year total: 651

Year 1 (Nov ‘08 – Dec ‘09): 86
Year 2 (Nov ‘09 – Oct ‘10): 165
Year 3 (Nov ‘10 – Oct ‘11): 200
Year 4 (Nov ‘11 – Oct ‘12) – projected: 200
CEIC TA Services have been provided in about \( \frac{3}{4} \) of the state’s regions/counties.
Uses DDCA[MH]T
(Dual Disorder Capability in Addiction Treatment and Dual Disorder Capability in Mental Health Treatment)

Samples individual clinics within regions
Employs direct onsite observation
Scores and reports on 7 domains and overall
Makes specific recommendations to raise capability
447 assessments to date
<table>
<thead>
<tr>
<th>Dimensions of Capability</th>
<th>Levels of Capability</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SA/MH only</td>
</tr>
<tr>
<td>I Program Structure</td>
<td>Program mission, structure and financing, format for delivery of co-occurring services.</td>
</tr>
<tr>
<td>II Program Milieu</td>
<td>Physical, social and cultural environment for persons with mental health and substance use problems.</td>
</tr>
<tr>
<td>III Clinical Process: Assessment</td>
<td>Processes for access and entry into services, screening, assessment &amp; diagnosis.</td>
</tr>
<tr>
<td>IV Clinical Process: Treatment</td>
<td>Processes for treatment including pharmacological and psychosocial evidence-based formats.</td>
</tr>
<tr>
<td>V Continuity of Care</td>
<td>Discharge and continuity for both substance use and mental health services, peer recovery supports.</td>
</tr>
<tr>
<td>VI Staffing</td>
<td>Presence, role and integration of staff with mental health and addiction expertise, supervision process</td>
</tr>
<tr>
<td>VII Training</td>
<td>Proportion of staff trained and program’s training strategy for co-occurring disorder issues.</td>
</tr>
</tbody>
</table>
Improving Co-occurring Capability: Quick Guide

Recommendations: Getting to “Capable”

✓ Provide educational material for both disorders
✓ Develop a unique service statement
✓ Implement one of the state-recommended standardized screening instruments
✓ Use assessment data to inform the treatment plan
✓ Ensure inclusion of mental health and substance abuse content in all groups
✓ Allow co-occurring issues to flow freely in group and individual sessions
✓ Offer psycho-educational classes on mental health and substance abuse issues
✓ Provide dual recovery treatment groups
✓ Urge staff to enroll in FIT web-based learning
✓ Refer to and use TIP 42 and its associated training curriculum

Easy to employ and conserves resources
Scores based on DDCA[MH]T = Dual Diagnosis Capability in addiction [Mental Health] Treatment Index

Long Island Programs (N=122)

Program Structure
Program Milieu
Screening & Assessment
Treatment
Continuity of Care
Staffing
Training

Enhanced

Basic

Total Scores:

2.54
2.73
2.54
2.44
3.09
2.53
2.76
3.24
2.54
Scores based on DDCA[MH]T = Dual Diagnosis Capability in addiction [Mental Health] Treatment Index
Survey designed to obtain EBP integration by implementation stages (Fixsen et al.)

Added items on COD in collaboration with CEIC (and NKI) to assess COD practices

Sent to all OASAS certified programs

Rated on a 5-point implementation scale
- 5. Sustainability
- 4. Innovation
- 3. Implementation
- 2. Installation
- 1. Exploration

Employs drop-down menu of additional questions to increase the accuracy of reporting

Response rate 96% of all licensed programs
# Local Services Plan (LSP) Survey Tool
(sample page)

## Screening and Assessment:

<table>
<thead>
<tr>
<th>A.</th>
<th>Screening for Co-Occurring Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.</td>
<td>Assessment for Co-Occurring Disorders</td>
</tr>
<tr>
<td>C.</td>
<td>Other (Specify):</td>
</tr>
</tbody>
</table>

## II. Clinical Practices and Interventions specific to treating patients with Co-occurring Disorders:

<table>
<thead>
<tr>
<th>M.</th>
<th>Motivational Interviewing (MI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>N.</td>
<td>Cognitive-Behavioral Therapy (CBT)</td>
</tr>
<tr>
<td>O.</td>
<td>Contingency Management (CM)</td>
</tr>
<tr>
<td>P.</td>
<td>Behavioral Couples Therapy (BCT)</td>
</tr>
<tr>
<td>Q.</td>
<td>Mutual Self-Help Groups</td>
</tr>
<tr>
<td>R.</td>
<td>Other (Specify):</td>
</tr>
</tbody>
</table>

## V. Achieving Integrated Care / Services for treating patients with Co-occurring disorders:

<table>
<thead>
<tr>
<th>S.</th>
<th>Achieving Integrated Care / Services for treating patients with Co-occurring disorders</th>
</tr>
</thead>
</table>
Evidence-Based Practices and Evidence-Based Interventions: Level of Implementation

Level of Implementation Scale:
5 = Sustainability
4 = Innovation
3 = Implementation
2 = Installation
1 = Exploration
0 = Not applicable (hasn’t moved to implement at all)
Screening, Assessment, Integrated Services Based on OASAS Survey (Level 5)

- Screening: 45%
- Routine Integrated Assessment: 45%
- Integrated COD Services: 35%
- Evidence Based Practices: 23%

Depicts sustained Level 5 programmatic use
Evidence-Based Treatment for COD Based on OASAS Survey (Level 5)

About ¼ regularly employ evidence-based interventions

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Motivational Interviewing</td>
<td>35%</td>
</tr>
<tr>
<td>Cognitive Behavioral Therapy</td>
<td>40%</td>
</tr>
<tr>
<td>Contingency Management</td>
<td>11%</td>
</tr>
<tr>
<td>Behavioral Couples Therapy</td>
<td>7%</td>
</tr>
<tr>
<td>Mutual Self-help</td>
<td>21%</td>
</tr>
</tbody>
</table>

Total: 23%
Comparative Survey Results

Findings from both surveys almost identical

CEIC  OASAS

<table>
<thead>
<tr>
<th>Service</th>
<th>CEIC</th>
<th>OASAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening</td>
<td>45%</td>
<td>45%</td>
</tr>
<tr>
<td>Routine Integrated Assessment</td>
<td>40%</td>
<td>45%</td>
</tr>
<tr>
<td>Integrated COD Services</td>
<td>32%</td>
<td>35%</td>
</tr>
<tr>
<td>Evidence Based Practices</td>
<td></td>
<td>23%</td>
</tr>
</tbody>
</table>
The strategic plan to reach & penetrate more than 1,000 out-patient substance abuse & mental health clinics over 4 years

Direct ("hands-on")
Technical Assistance

• DRCs
• Regional / County Networks
• Web-based tools (e.g. FIT & "Quick Guide")

Amplifies Direct TA & Promotes Sustainability
Evaluation Plan
How will we know the system status?

1) Follow up DDCA[MH]T survey on representative sample (n=150)

2) Follow up on OASAS survey — planned for 2012

3) Analysis combining these data sources (as briefly illustrated here)

4) Focus groups

5) Case studies

6) Brief web-based survey
Comparison of initial (baseline) and follow-up DDCA[MH]T assessments

Scores based on DDCA[MH]T = Dual Diagnosis Capability in addiction [Mental Health] Treatment Index
There exists a clear and increasingly positive picture of the status of OMH and OASAS outpatient clinics regarding evidence based practices and interventions:
- 45% for screening
- 40% for assessment
- ⅓ for integrated services
- ¼ for evidence based interventions
- Total Capability score – 2.69

Transformation of the Service System may be said to occur when the majority of outpatient clinics are rated capable or above.

OMH and OASAS outpatient clinics are moving toward a COD capable status.
Conclusion

The project is significant in its:

- Promise of improving the health of NYS residents with co-occurring conditions
- Potential to reduce health disparities
- Ability to inform allocation of resources
- Capacity to effect system transformation in the delivery of services

Implications for health care reform:

- Development and field testing of new instruments with Mark McGovern to assess the degree of integration of primary care and guide the provision of technical assistance
## Development of a new instrument: Integration of primary care

### IV. CLINICAL PROCESS: TREATMENT

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>IVF. Psychosocial interventions to address medical problems (e.g. high risk behaviors for infectious disease, self-management groups).</td>
<td>Not present: Not addressed in program content.</td>
<td>Variable: Based on judgment by individual clinician; variable penetration into routine services.</td>
<td>Available but not routine: In program format as generalized intervention (e.g. chronic disease management) with penetration into routine services.</td>
<td>Routine but not systematic: Some specialized interventions by specifically trained clinicians in addition to routine generalized interventions.</td>
<td>Routine and systematic: Medical symptom management services; individual therapies focused on specific disorders (e.g. Hepatitis C, HIV, diabetes, renal failure, heart failure, atrial fibrillation, etc.)</td>
</tr>
<tr>
<td>IV.G. Content of medical interventions adapted to the behavioral health problem.</td>
<td>Medical intervention does not consider behavioral health disorders.</td>
<td>Medical intervention rarely or inadequately behavioral health disorders.</td>
<td>Medical intervention routinely considers to behavioral health disorders but lacks specificity</td>
<td>Medical intervention routinely considers behavioral health disorders in specific, but generic manner</td>
<td>Medical intervention routinely considers behavioral health disorder in a specific and individualized manner</td>
</tr>
<tr>
<td>IVH. Education about medical conditions, treatment, and interaction with behavioral health disorders.</td>
<td>Not offered.</td>
<td>Generic content, offered variably or by clinician judgment.</td>
<td>Generic content, routinely delivered in individual and/or group formats such as health &amp; wellness programs.</td>
<td>Specific content for a variety of specific medical problems for many program patients, offered in individual and/or group formats (e.g. HIV, HepC, Metabolic disease)</td>
<td>Specific content for specific medical problems for many program patients, routinely offered in individual and/or group formats (e.g. HIV, HepC, Metabolic disease)</td>
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Future Directions

1. Scaling up
2. Advancing to “Enhanced”
3. Embracing new populations & settings (e.g. adolescents and residential)
4. Integrating with primary care
5. Publishing
   - Describing the system
   - Evaluating the system
   - Predictors of progress
Stanley Sacks, PhD, Director
Center for the Integration of Research & Practice (CIRP) & Center for Excellence in Integrated Care (CEIC)
National Development & Research Institutes, Inc. (NDRI)
71 W 23rd Street, 8th Floor
New York, NY 10010
TF 877.888.6677 ◆ tel 212.845.4400 ◆ fax 212.845.4650
www.nyshealth-ceic.org ◆ www.ndri.org

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