ENHANCING CAPACITY FOR INTEGRATED SERVICES

AN EVALUATION OF MAINE'S COSII PROJECT

Produced by
Hornby Zeller Associates, Inc.

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Department of Health and Human Services

Maine People Living Safe, Healthy and Productive Lives

John E. Baldacci, Governor   Brenda M. Harvey, Commissioner

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COSII is a SAMHSA-funded, five-year initiative whose goal is to develop and support state and provider capacity to deliver integrated services for people with complex, co-occurring conditions, especially mental health and substance use issues.

The Office of Adult Mental Health Services, the Office of Substance Abuse, and Children's Behavioral Health Services all collaborate to push this initiative forward. However, all of the Department of Health and Human Services is involved in the work of integrating care for the people it serves.

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Executive Summary

In 2005, the State of Maine received a Co-Occurring State Incentive Grant (COSIG) from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). The Maine project, entitled the Co-occurring State Integration Initiative, or COSII, was designed to increase the level of integration of mental health and substance abuse treatment services for people with co-occurring disorders.

This report describes several positive changes resulting from the COSII initiative at three levels: changes in state infrastructure; changes in agencies delivering services; and changes in the people touched by the COSII initiative.

State Infrastructure Achievements

In Maine, mental health and substance abuse treatment services are managed by two separate offices within the Maine Department of Health and Human Services (DHHS): the Office of Adult Mental Health Services and the Office of Substance Abuse Services, each office with its own director and staff. The specific infrastructure integration goals of the initiative were to:

1) identify standardized screening and assessment protocols,
2) develop complementary licensing and credentialing standards,
3) increase network-building,
4) enhance financial planning for co-occurring disorders, and
5) enhance information-sharing to permit tracking services and outcomes of the target group across systems.

GOAL 1: Identify standardized screening and assessment protocols.

The purpose of this goal was to identify appropriate tools and ensure all agencies routinely screen and assess for both substance abuse and mental health disorders. COSII exceeded the goal of identifying standard screening protocols by identifying, testing and ultimately working with the state leaders to mandate the implementation of the AC-OK for screening clients universally, effective October 2009. The AC-OK is a single, brief, integrated instrument that screens for mental health, substance abuse, and trauma. In addition, the state built the results into its administrative reporting structure, moving the COSII initiative forward to sustainability.

Assessment was determined to be so multi-faceted and complex that the COSII project decided to address it through licensing regulations and contracts, and the development of clinical practice guidelines, instead of mandating a single standardized assessment protocol. COSII identified and published clinical guidelines for co-occurring assessments, and required agencies to perform integrated assessments for all clients, giving them the freedom to determine the best methods for implementing the guidelines.

GOAL 2: Develop complementary licensing and credentialing standards by developing licensing standards to include co-occurring disorders; develop staff competency standards.

The purpose of this goal was twofold: to consolidate expectations and performance standards to cover both mental health and substance use disorders, and to ensure a workforce prepared to expect and serve a COD population. Progress on revising state licensure regulations has been slow due to such issues as shifting priorities, staff shortages, and some level of resistance to the idea of integration. More success has been achieved in introducing co-occurring language into substance abuse regulations than into the mental health standards.

At the same time, COSII was able to make progress on the essence of this goal through other means. The Division of Licensure and Regulatory Services (DLRS) has shifted attention from modifying mental health and substance abuse treatment standards separately to creating a set of standards serving all of behavioral health. Also, revisions to Rider E of provider contracts require providers 1) to conduct integrated assessments and treatment, and 2) to be co-occurring capable by June 30, 2011.

The gulf between mental health and substance abuse has also been evident in the project's work to incorporate standards for integrated care into the requirements for professional credentials. The substance abuse board has been concerned with issues surrounding scope of practice for its licensees, while the social work (mental health) board has been concerned with the kinds of training needed to ensure that licensees are able to address substance abuse appropriately in practice. Neither issue has been resolved to date, due in part to pushback both from the licensing boards and from academic institutions. Although not intending to address this goal specifically, the clinical guidelines that were developed address this goal by including information on providing integrated treatment within the scope of a provider's specific license.

GOAL 3: Increase network building by appointing a State Commission on Co-occurring Disorders with permanent roles and specific boundary-spanning responsibility and providing enhanced training and consultation to providers.

The purpose of this goal was to support and sustain infrastructure change. During the course of the project, COSII itself played the role of the boundary-spanning commission. Its multiple workgroups and the Project Coordinator's participation in other initiatives created an awareness of COD issues across the relevant groups, and provided forums for addressing those issues.

While this goal was achieved during the initiative, sustainability of these efforts could be a concern. COSII staff are now attempting to form a new committee to oversee co-occurring disorders efforts by building on its own Workforce Development committee. At the same time, during the course of the project the Commissioner created an Office of Integrated Services, which is intended to focus on a wider array of issues than those handled by COSII alone, however COSII issues generally are handled by that Office. One of the major achievements was the issuance of an Integrated Services Policy which sets out an

integrated services framework for high-risk families and individuals, of which people with co-occurring disorders are a major but not exclusive group. This policy may be sufficient for the Office of Integrated Services to assimilate and sustain the work of COSII into its existing efforts.

GOAL 4: Enhance financial planning for co-occurring disorders by realigning MaineCare reimbursement with other goals for treating individuals with co-occurring disorders.

The purpose of this goal was to ensure that billing MaineCare for services is aligned with the reality of providing integrated care to consumers, and is reflective of integrated licensing and credentialing standards. Section 65 of the MaineCare regulations regarding behavioral health services was successfully re-written to include integrated co-occurring language. Similar language was also added in other sections, such as the V9 Extended Care definition, which includes the need to access co-occurring services as a reason to justify extended care.

In addition, the rates for mental health services and substance abuse services were aligned to a similar structure and almost equal rate, and a new billing code was added for integrated services. However, the integrated rate was not enhanced, resulting in a co-occurring rate that is the same as the mental health rate or substance abuse rate. If the provider uses the new code, it cannot bill for any other mental health or substance abuse service, effectively limiting the client's access to additional services, as well as the agency's ability to be further reimbursed. Because of these constraints, the code has not been adopted for general use.

GOAL 5: Enhance information sharing to permit tracking services and outcomes of the target group across systems.

The purpose of this goal was to create a mechanism to track individuals across the state's different data systems and promote measurement of the impact of integrated services. Developing an integrated data-reporting structure proved to be a challenging component of COSII. Because data are collected and stored in three separate systems which are unable to communicate with one another, gathering comprehensive data for co-occurring clients is especially difficult. The relevant three state data systems are: the Treatment Data System (TDS, substance abuse data); Enterprise Information System (EIS, mental health data for higher-need consumers); and Maine Claims Management System (MeCMS, MaineCare).

The project was successful in designing the kinds of reports needed for monitoring progress on co-occurring issues, including integrated reports about the numbers of people served, as well as their demographics, living arrangements, and educational and employment statuses from TDS and EIS through the COGNOS reporting software platform, and monthly data on co-occurring screening and prevalence related to MaineCare clients through APS HealthCare. For the longer-term viability of an integrated reporting system, HZA worked with COSII staff and APS HealthCare to design additional basic reports from its database. The standard reports are supposed to cover both screening and diagnosis results and service results. In addition, DHHS recently migrated the MaineCare data into the COGNOS structure and HZA worked with the Office of Quality Improvement Services to identify diagnostic and procedure

codes for both mental health and substance abuse that could be used to generate more detailed co-occurring reports in the future.

Agency Achievements

In addition to addressing infrastructure changes at the state level, the COSII project worked directly with 30 service-delivery agencies to increase their capacities to serve consumers with co-occurring disorders in accordance with best practices. The 30 agencies represent some of the largest and most sophisticated service providers in the state, as well as some of the smallest and most geographically remote agencies. To be a pilot site, each agency was required to develop an action plan for changing organizational and clinical practices that included specific goals, timeframes, and persons responsible for implementing and overseeing this change.

Agencies were also required to complete at least two change projects using the NIATx Process Improvement model, participate in regular pilot site meetings and regional discussions, enroll clients diagnosed with co-occurring substance abuse and mental health disorders to provide information on program services and outcomes, and track clients entering the agency as part of a federal data requirement. Additionally, agencies from the earlier cohorts provided mentorship to incoming COSII agencies and on a regional level.

The project's agency level achievements are best viewed through the results of the pre- and post-assessments conducted using the Self Assessment of Co-Occurring Capability instrument. Increased integration occurred in each of the domains (organizational structure, program structure, program milieu, clinical process: assessment, clinical process: treatment, continuity of care, staffing and training). Moreover, almost every agency that scored "not integrated" or "integrated very little" in a domain increased at least one of those scores to be greater than or equal to co-occurring capable in that area.

Consumer Outcomes

Through the work of the pilot agencies, the COSII project enrolled 1,174 consumers in the evaluation study, and conducted follow-up interviews with as many as could be contacted at three, six, and nine months past the baseline period to determine changes in the people's conditions and well-being.

Enrollees ranged in age from 18 to 82 at baseline, with an average age of 38 years, and were evenly split between males and females. The majority had earned at least a high school diploma or GED, and over one-third had attended at least some college. They were generally independent and had stable living arrangements. Most enrollees reported low levels of income, were relatively under-employed, and relied heavily on public benefits, (*e.g.,* unemployment or Social Security benefits). The baseline enrollee population was also highly involved with the criminal justice system through arrest or incarceration.

Mood disorders were the most prevalent mental health disorder for enrollees, followed by anxiety disorders and Post-Traumatic Stress Disorder specifically. Slightly more than half of the population had multiple diagnoses across the different disorder groups. Just over half

felt they presented a risk to themselves at baseline, while one-quarter felt they presented a risk to others. Less than half of the enrollees reported feeling in control of their life.

Enrollees were most likely to report that they used alcohol and marijuana in the month prior to enrollment, followed by abuse of opiates, cocaine, and other non-opioid prescriptions. Forty-three percent of enrollees exhibited symptoms of impairment from drugs and/or alcohol at baseline.

By the conclusion of the project, 227 clients had completed all three follow-up interviews; this represents 38 percent of those eligible to have completed all follow-up interviews. Overall, the outcomes for individuals enrolled in the COSII evaluation group are good. Enrollees generally reported improved quality of life (*e.g.*, living arrangements, employment), reduced involvement with law enforcement, decreased impairment due to substance use, and positive improvements in functioning and well-being.

Notably, employment significantly increased from baseline (21 percent) to nine-month follow-up (28 percent), a rate of change of 31 percent. In addition, the proportion of enrollees who reported a stable living situation (meaning they had been there for longer than three months) increased from 72 percent at baseline to 90 percent after nine months.

Involvement with law enforcement is another key indicator of quality of life. Arrest rates for enrollees decreased by 60 percent from the nine months prior to the baseline interview (25%) to the nine month follow-up interview (10%).

Most enrollees showed significant improvement nine months after enrolling in treatment at a COSII pilot site in terms of impairment due to alcohol and drug use. While impairment due to alcohol gradually decreased over time (from 17% to 14%), impairment due to other substances decreased sharply from baseline to six months (34% to 13%). Enrollees were more likely after nine months to report improved functioning in terms of being in control of their lives, experiencing reduced emotional symptoms, and posing a lower risk to themselves and to others. The proportion who reported being more in control of their lives *as a result of services* increased from 47 percent at baseline to 83 percent nine months after receiving services.

Service Use and Costs Post-Treatment

To assess the prevalence of Medicaid beneficiaries with co-occurring disorders in Maine, as well as their service utilization and the cost of delivering those services, a one-year retrospective observational study was performed using an administrative data extract obtained from MeCMS which contained all medical claims records from July 1, 2006 to June 30, 2009.

MaineCare claims attributable to mental health disorders far outnumbered claims attributable to substance use disorders and co-occurring disorders, accounting for approximately 85 percent of all behavioral health claims. Few claims were found to have both a mental health and substance use disorder. Claims with co-occurring disorders accounted for only 2.5 percent of all behavioral health claims. More than half of all

MaineCare beneficiaries had at least one claim attributable to a behavioral health disorder over the course of the three year study time frame. However, among beneficiaries receiving a diagnosis of at least one behavioral health disorder, three-quarters were diagnosed with mental health disorders only, followed by co-occurring disorders and substance use disorders only.

COSII enrollees used significantly fewer physical health care services than the comparison group, with significantly lower use of critical care services, emergency room services, inpatient services and emergency transportation services, and significantly higher use of laboratory services (*e.g.,* drug testing) which is likely attributable to increased participation in substance abuse counseling. Lower physical health care utilization among COSII enrollees following treatment generated a net savings of nearly $2.7 million dollars over the comparison group in physical health care costs alone.

COSII enrollees were significantly more likely than the comparison group to have accessed medication management services, individual substance abuse counseling, group counseling for substance abuse, community integration services, and skill-development services, while they were significantly less likely to have been admitted for inpatient psychiatric care and to have used detoxification centers or participated in mental health group therapy.

The observed differences in behavioral health and community support service utilization did not always correspond to significant cost reductions. Although COSII enrollees had fewer PNMI claims than the comparison group, the cost of the services paid out for the COSII enrollees were 50 percent higher than those paid on behalf of the comparison group. The difference is significant and likely due to extended lengths of stay among COSII enrollees as they persist in treatment, as opposed to shorter and more interrupted stays for those in the comparison group. At the same time, inpatient psychiatric hospitalization costs were $377 thousand lower for COSII enrollees, who tended to use that service less.

In total, the cost of providing mental health services, substance abuse services and community support services for the COSII group is more than the cost of providing mental health services for the comparison group. Nevertheless, the higher mental health and substance abuse costs are dwarfed by the savings in physical health services. Overall, service utilization costs for the COSII group was $2.1 million less than the comparison group over an equivalent time period.

Recommendations

Based on the findings of this report, HZA offers the following recommendations:

Infrastructure Recommendations

1) During the extension period, COSII staff should keep working towards an enhanced Medicaid rate for co-occurring services.

2) DHHS should maintain the focus on developing the core standards for mental health and substance abuse which include co-occurring principles, and use them as a basis for licensing reform.

3) COSII staff should continue to work with the Office of Quality Improvement Services to assure the timely development of reports related to co-occurring issues.

4) DHHS should begin to include physical health providers in its efforts to integrate screening, assessment and treatment.

5) DHHS should continue to work on the concept of integrating policy and programs between and among the Office of Adult Mental Health Services, the Office of Substance Abuse, and Children's Behavioral Health Services.

Agency Recommendations

6) The COSII team should continue educating providers about the co-occurring practices that are now permitted under licensing rules.

7) The COSII team should support agencies with integrated practices to provide internships.

8) The COSII team should consider providing higher-level training to professionals who already have a baseline understanding of co-occurring disorders, and include education for administrative personnel on how to support co-occurring disorders through policy and practice at their agency.

Background and Purpose

Project Goals

In 2005, the State of Maine received a Co-Occurring State Incentive Grant (COSIG) from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). As identified in the grant announcement, the national goals of the COSIG program are “to develop and enhance the infrastructure of States and their treatment service systems to increase their capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based treatment services to persons with co-occurring substance abuse and mental health disorders, and to their families.” The Maine project, entitled the Co-occurring State Integration Initiative, or COSII, was designed to achieve objectives at three levels:

- development of a statewide infrastructure for serving people with co-occurring disorders,
- enhancements of individual agency capacity, and
- improvements in consumer outcomes.

While states applying for COSIG funds were required to identify at least one area of the state infrastructure that was to be improved, Maine was highly ambitious in targeting all five of the federally suggested areas. The resulting goals were to:

1) identify standardized screening and assessment protocols,
2) develop complementary licensing and credentialing standards,
3) increase network-building,
4) enhance financial planning for co-occurring disorders, and
5) enhance information-sharing to permit tracking services and outcomes of the target group across systems.

Collectively, achievement of the five goals areas was intended to modify Maine’s philosophy, policy and practice in regard to co-occurring disorders (COD).

In addition to addressing infrastructure changes at the state level, the COSII project worked directly with 30 service-delivery agencies to increase their capacities to serve consumers with co-occurring disorders in accordance with best practices. While these efforts were originally intended to involve fewer agencies to test strategies for increasing capacity, the expansion to a larger number of service providers came to represent another approach to changing the state’s COD infrastructure.

Working with the pilot agencies also provided the opportunity to measure the impact of integrated service delivery on individual consumers. The evaluation of that impact included not only measurement of the benefits to the consumers, but also analysis of the services those consumers required after discharge and the costs associated with those services.

Project Activities

Mental health and substance abuse treatment services are managed by two separate offices within the Maine Department of Health and Human Services (DHHS): the Office of Adult Mental Health Services and the Office of Substance Abuse Services, each office with its own director and staff. This bifurcation was a symptom of the need for the project, and one of the challenges was to find ways, even for the conduct of the project itself, to bridge the two offices. That challenge was addressed by having a third party, the Co-Occurring Collaborative Serving Maine (CCSME) act as the lead contractor on the project. CCSME was responsible, with the consent of the two state offices, for hiring and supervising the Project Coordinator. Despite working for a contractor, the Project Coordinator was physically housed at the DHHS offices in Augusta, Maine.

In addition to the Project Coordinator, the project had an Executive Committee which included division directors or their designees, evaluators, members of the Commissioner's office and other key leaders. Together, the Project Coordinator and the Executive Committee structured the project's major activities around state and agency-level goals, because achievement of those would lead, according to the assumptions of the state's proposal, to improved consumer outcomes.

For work on the state-level infrastructure goals, the Director and Executive Committee created multiple advisory, steering, and workgroup committees to conduct research, develop protocols and make recommendations on various strategies. Working with the Directors of the Offices of Substance Abuse and Mental Health, as well as with other COSII staff, the Project Coordinator managed all of the committees, each of which were charged with specific efforts or needs, such as clinical practice and workforce development. The results of the research and deliberations of each of these groups were brought back to the Executive Committee for final decision-making.

In addition to coordinating the work of the various committees, the Project Coordinator also promoted the integration of mental health and substance abuse services by bringing the co-occurring perspective to other state initiatives. Among the initiatives in which the Project Coordinator participated were Systems Transformation, Evidence-Based Practice Committee, STAR-SI, and Access to Recovery. She also attended some of the Integrated Management Team meetings.

The strategy for achieving agency-level change was twofold. First, the project provided small amounts of funds for substance abuse treatment and mental health agencies to serve as pilot sites, for eighteen months each, to implement changes which would result in co-occurring services. In its original grant proposal, DHHS had identified three agencies to serve as pilot sites in the first year and stated that three more agencies would be added for each of two additional periods, totaling nine agencies in all. However Dr. Kenneth Minkoff, COSII's consultant, encouraged the project's leaders to expand their concept of pilot agencies to include a larger number of agencies, even if the stipends COSII could pay would be less. COSII agreed, and after intensive work with the first set of three agencies, opened up the opportunity to all agencies on a first-come, first-served basis. Ultimately 27 additional

agencies were included, in three cohorts of 18 months each. A list of the 30 participating agencies and a sample of the language used in their contracts are included in Appendix A.

The second strategy COSII used to achieve agency-level change was to sponsor trainings. These sessions focused on various organizational and clinical topics and were open to all agencies, regardless of whether they were participating in the pilot program. The impact of the agency-level efforts was, therefore, intended to reach beyond even the expanded number of pilot providers.

Organization of the Report

This report represents a summary of the findings of the project evaluation at all three levels: state, agency and consumer. Following a description of the evaluation methodology, the third chapter describes the progress made towards the five state-level infrastructure goals. The fourth assesses the efforts made towards increasing co-occurring capability in the pilot agencies. The following two chapters examine first the consumer-level outcomes, and then the utilization of services after discharge and the costs associated with those services. The final chapter summarizes the findings and recommendations at all levels.

Evaluation Methodology

COSII retained Hornby Zeller Associates, Inc., (HZA) to conduct the evaluation. HZA had participated in the initial proposal writing and in the design of the evaluation, so the firm was familiar with the intent of the project from the outset.

The evaluation involves a variety of data collection and analysis methods, including interviews, document reviews, structured agency assessments, tracking of consumers during and after service delivery, and analysis of Medicaid claims data. Table 1 shows the relationship of each of these methods to the three levels of the evaluation.

Table 1
Project Goals by Evaluation Data Collection Method

	Interviews	Document Reviews	Agency Assessments	Consumer Tracking	Medicaid Claims
State Infrastructure Level	X	X			
Agency Capacity Level	X		X		
Consumer Outcome Level	X			X	X

Interviews

For the assessment of the state-level infrastructure changes, HZA conducted interviews with members of the COSII Executive Committee and with other personnel in the Department of Health and Human Services who were not directly involved in COSII, but were critical to the implementation of a system of integrated services. Interviews were conducted either in person or by phone, and all were semi-structured, meaning that HZA used a standard interview protocol, but the answers were intended to be discursive and respondents were encouraged to elaborate on their opinions and perspectives as much as they wished.

For the agency-level assessment, in the summer of 2010 HZA conducted 26 interviews with staff at past and current pilot agencies to gather the agencies' perceptions of the impact and value of participating in the COSII initiative. Agencies still in their 18-month pilot status were asked to share their most significant accomplishments, what important things they had learned, how efforts to serve consumers with COD will be sustained, and the barriers and challenges they faced or will need to overcome. Pilot sites from previous cohorts were also asked about accomplishments and lessons learned, as well as what integrated treatment looks like today at their agency, after the pilot has ended.

Document Reviews

Most of the documents reviewed for this evaluation related to the infrastructure changes COSII attempted to make. This included both existing documents and revised versions generated by the project itself. Examples of these included the policy on integrated services developed by DHHS, current licensing regulations and the proposed modifications, and a manual containing a set of clinical practice guidelines. Some documents were also reviewed as part of the assessment of the agencies. These included, among others, the Dual Diagnosis Capability in Mental Health and Addition Treatment (DDCAT) instrument developed by Mark McGovern and R.E. Drake.

Structured Agency Assessment

As shown in Table 1, the primary data sources informing the evaluation of agency-level accomplishments are the interviews with pilot agency personnel mentioned above and the results from the structured agency assessment that was conducted twice for each pilot agency by a COSII staff member.

COSII staff and HZA modified the DDCAT instrument for the agency assessment and developed Maine's Self Assessment of Co-Occurring Capability.[1] Whereas the DDCAT assumes the provider focuses on substance abuse treatment and is trying to encompass mental health, or vice versa, the COSII version of the tool encompasses both mental health and substance abuse criteria in a single tool. The COSII staff member assessed the capacity of each pilot agency for working with consumers with co-occurring disorders both before the pilot period began and after it had ended.

The Self Assessment uses eight domains (with each domain having a number of sub-domains) to assess an agency's level of dual diagnosis integration. The domains are:

- organizational structure,
- program structure,
- program milieu,
- clinical process: assessment,
- clinical process: treatment,
- continuity of care,
- staffing, and
- training.

Using a Paired Samples T-Test to look at the domains for both dually licensed agencies and agencies with either mental health or substance abuse licenses, HZA examined changes between the pre- and post- assessments. For agencies that had both mental health and substance abuse licenses, all domains were reviewed. However, for those with only one of the licenses, the treatment domain was not scored, since the single license may have

[1] The name of the tool reflects the idea that it would be used as a self assessment in the future. However, for this project the tool was administered by COSII staff.

hindered it from providing fully integrated treatment and a ceiling effect due to the naturally restricted scale would likely have obscured any significant improvements.

Consumer Tracking

Consumer-level outcomes were measured using structured interview instruments and a database developed by HZA for recording the responses. The goal was for pilot agencies to collectively enroll 300 consumers per year into the evaluation, and to track them for a period of nine months from the date of enrollment, regardless of their continued involvement in services. Once located, the consumers were interviewed about their current situation, with some agencies increasing their response rate by paying a small stipend for each interview. Each of the three pilot agencies in the first cohort reached the goal of enrolling at least 100 clients. Each of the 27 agencies in subsequent cohorts was asked to enroll at least 30 clients and all but two were able to do so.

To be eligible for the evaluation, a client must have had a co-occurring diagnosis and have had received at least four units of service prior to enrollment. The definition of “unit” depended on the service each agency provided. Overall, 1,174 clients were enrolled into the evaluation over the course of the project, meaning they were eligible and completed a baseline interview.

Analysis of Medicaid Claims Data

To assist in the analysis of the services each client received after discharge and the costs of those services, HZA obtained a data extract of Medicaid claims from the Office of MaineCare Services Claims Management System (MeCMS). The extract included all claims made between July 1, 2006 and June 30, 2009. HZA identified people from the first two pilot cohorts who were MaineCare recipients and created a matched group of people with co-occurring disorders who did not participate in the pilots. HZA then conducted an analysis of services used and the cost of claims made within 12 months after discharge from COSII to test the effects of involvement in integrated services on the later use and cost of services.

State Infrastructure Achievements

As noted above, COSII articulated five goals related to changing the state infrastructure for serving people with co-occurring disorders. Each of these goals is discussed below, starting with a general discussion of the goal's purpose, followed by a description of achievements and then an assessment of the achievements.

GOAL 1: Identify standardized screening and assessment protocols.

Purpose

Although screening and assessment are agency-level activities, identifying standardized tools is considered a state-level goal since the purpose was to have all agencies routinely screen and assess for both disorders. The concept arises from the notion that co-occurring disorders are an expectation rather than an exception for any person who has one or the other disorder. The wording of this goal was purposeful. It was not the initial intent to impose a common screening or assessment tool on all providers, but rather to identify appropriate tools and ensure that all providers screen for both mental health and substance use disorders.

The goal here was twofold: first, to ensure that all people entering an agency which traditionally provides either mental health or substance abuse treatment services get screened for both disorders; the second was to see if common, standardized tools could be used for this purpose. If the latter were possible, an ancillary benefit could be the ability to record the results on a statewide basis, enabling administrators to know how many individuals screened and assessed positively for both.

Achievements

One of the workgroups used by the project to advance its agenda was the Screening and Assessment Tools and Protocol workgroup. This was one of the earliest groups formed in the project; its charge was to identify tools that could be used for its namesake purpose.

Ultimately, the focus of the group was screening tools rather than assessment. The latter was determined to be so multi-faceted and complex that the project decided to address it through the development of Clinical Practice Guidelines instead. The workgroup did, however, believe that it was both possible and important for common screening tools to be used, or at least for agencies to have the option of selecting from a common menu of tools.

In the earlier years of the project, the workgroup recommended the Mental Health Screening Form III, the UNCOPE (for adults), and the CRAFFT (for adolescents) to the leaders of the Office of Substance Abuse and Office of Adult Mental Health Services for pilot testing among the participating agencies. The choices were based on each tool's established history, ease of use, cost (none) and universality.

The Office of Substance Abuse and Office of Adult Mental Health Services authorized these three tools to be tested in the thirteen pilot agencies active at that time in the project's life.

Collectively, these thirteen agencies (discussed in the next section of this report) completed a 90-day pilot during which these three standardized screening instruments were administered to incoming clients. HZA monitored the results and interviewed agency participants after the 90 days.

Agencies generally reported positive experiences with the screening instruments, but highlighted the frustration of using tools that did not necessarily fit their agency or program. For example, the UNCOPE was considered to be more beneficial for a program that provides outpatient mental health services than to a program providing residential services for people with a predetermined substance use disorder, yet the pilot encompassed both.

Given the results of the pilot project and their interest in identifying a single alternative instrument, the Directors of Office of Substance Abuse and Office of Adult Mental Health Services requested additional recommendations. After further research, COSII staff and Workgroup members then recommended implementation of the AC-OK (see Appendix B), a screening tool which was developed and tested by another researcher associated with COSIG in the state of Oklahoma. The AC-OK had the advantage of being a single, brief, integrated instrument that screens for mental health, substance abuse and trauma. With the growing recognition of the role of trauma in the life of co-occurring clients, the latter was considered an important benefit of the AC-OK.

A new pilot was conducted in 2008 with the then-current cohort of agencies using the instrument on incoming clients for a 90-day period. Agency representatives again highlighted the benefits of a comprehensive screening process but questioned whether one screening tool should be mandated of Maine's therapeutic agencies. There were particular objections among adolescent treatment providers who did not consistently find the tool relevant.

In this instance, the directors of the Office of Substance Abuse and of the Office of Adult Mental Health Services believed that the benefits of using a common screening tool outweighed the objections. They decided to handle the most serious agency concerns with a waiver process and required that all providers holding service delivery contracts with the state use the AC-OK for screening clients, effective October 2009. Those who wanted waivers had to meet three specific conditions:

1) they had to be willing to administer alternative tools (UNCOPE, CRAFFT, MENTAL HEALTH SCREENING FORM III);
2) they had to administer both the mental health and substance abuse tool for all clients; and
3) they had to demonstrate that use of the AC-OK would create a burden relative to an electronic medical record protocol already developed.

The tool was to be used at intake and was to be made available for Prior Authorization Reviews with APS Healthcare, which was now performing the prior authorization function as the state's Administrative Service Organization (ASO).

To help institutionalize the screening protocol, APS was asked to include information on the screening results in its database at the Continued Stay Review point of service delivery. While using the Continued Stay Review timeframe did not capture all people at the time of screening, DHHS believed that to do more would have been too costly and disruptive.

Moving from the question of screening tools to assessment tools, the Screening and Assessment Tools and Protocol workgroup determined that it was not prudent to attempt to identify one or even a few tools to be used by the multiplicity of providers, operating in vastly different residential and outpatient settings, for a myriad of consumer issues. Instead, the workgroup decided to develop principles that could be universally applicable in any clinical setting, and ultimately incorporated them in a manual. This work was performed by the Clinical Practices Committee and published as *"Maine Clinical Guidelines for Integrated Substance Use and Mental Health Care: A Resource Manual."*

In addition, both licensing regulations and contracts now require substance abuse and mental health agencies to assess for both mental health and substance abuse disorders.

Assessment

For both the screening and assessment tool, the initial goal was not necessarily to mandate unitary screening and assessment protocols (though ultimately this was the case for screening) but to "identify standardized…protocols." The original writers of the grant proposal purposely skirted the question of mandatory protocols because they were not convinced those would be in the state's best interest.

COSII exceeded the goal of identifying standard screening protocols by identifying, testing and ultimately working with the state leaders to mandate the AC-OK's use universally. In addition, the state built the results into the APS reporting structure. These steps moved the COSII initiative forward to sustainability. COSII also identified and published clinical guidelines for co-occurring assessments, and required agencies to perform integrated assessments for all clients, giving them the freedom to determine the best methods for implementing the guidelines. These were prudent steps consistent with the needs of providers and of consumers with co-occurring disorders.

GOAL 2: Develop complementary licensing and credentialing standards by developing licensing standards to include co-occurring disorders; develop staff competency standards.

Purpose

For agencies to provide integrated services, the expectations and performance standards for these agencies must be consolidated to cover both mental health and substance use disorders. At the beginning of this project the licensing rules bifurcated mental health and substance abuse treatment services, creating both duplicative and competitive expectations of agencies.

In addition, the workforce must be prepared to expect and to serve a COD population. Training and education in mental health or substance abuse individually does not adequately prepare a worker to treat a client presenting with co-occurring symptoms. While it is essential to have realistic licensure regulations, it is equally important to have workforce competent in co-occurring issues.

Achievements

Two COSII workgroups, the COD Licensing workgroup and the Workforce Development committee, have addressed these topics since the inception of the project. The charge of the former was to work with the Division of Licensure and Regulatory Services (DLRS) within DHHS to encourage integrated care through common licensing standards. The latter's task was to engage the professional licensure boards to ensure that integrated treatment is included in the standard professional scope of practice.

COSII approached the issue of standards from two directions: changes in regulations and changes in the terms of provider contracts. Moreover, the work on regulatory changes itself had three components. First, the COD Licensing Workgroup devoted substantial amounts of time to revising state licensure for both mental health and substance abuse providers. These efforts resulted in language requiring integrated treatment being revised in the substance abuse licensing regulations, although that has not yet occurred with the mental health licensing regulations.

The second approach taken to regulatory changes was to develop a strong working relationship with DLRS, including cross training of COSII and DLRS staff and DLRS staff attending COSII Regional Meetings. Through this process, licensors developed a strong understanding of co-occurring capability and were able to change their responses and expectations around requirements for compliance. This helped to diffuse provider anxiety about integrated practices based on prior penalizing experiences with DLRS surrounding the provision of integrated services.

The third approach taken to regulatory issues and one that continues is DLRS' "core alignment" effort. This is an attempt to integrate all behavioral health licensing regulations, including regulations for substance abuse services, adult mental health services and children's behavioral health services. The University of Southern Maine's Muskie School of Public Service has completed a crosswalk to identify policy, licensing regulations and contracting issues among these individual programs to help drive the core alignment process. This effort is likely to continue beyond the end of the project and, to that extent, represents COSII's success in getting DHHS to take integration issues into account on an ongoing basis.

Beyond its efforts with regulatory requirements, COSII has also focused attention on contract issues with its providers. As a result, DHHS has revised its contracts with provider agencies (specifically, through Rider E) to require providers 1) to conduct integrated assessments and treatment, and 2) to be co-occurring capable by June 30, 2011. This means that all agencies with behavioral health or substance abuse contracts should be "organized to welcome, identify, engage and serve individuals with co-occurring substance abuse and

mental health disorders and to incorporate attention to these issues in all aspects of program content and documentation. Such programs provide services that incorporate understanding of and approaches to substance abuse problems as they relate to and affect the mental health disorder."

In addition, the providers must perform an organizational assessment that identifies and tracks COD outcomes. It also ensures that people cannot be denied services based on their histories of mental illness, trauma, or a known substance use/abuse disorder, or for taking prescribed psychoactive medications or participating in medication-assisted treatment of their substance use.

The Workforce Development committee produced two documents defining staff competency standards. *"Core COD Competencies"* and *"Integrated Scope of Practice"* represent efforts to provide clarity when looking at COD workforce abilities and the relevant licensure requirements (see Appendix C). Of importance is that both documents are comprehensive in scope, not limiting themselves only to clinicians. By defining competencies for all levels of workers, the statements seek to create an entire system of care that is COD-informed from entrance to exit.

To gather more information on professional credentialing needs, the Workforce Development committee developed and conducted a survey examining educational and training opportunities for workers entering the behavioral health field. The survey was distributed to all Maine academic institutions that prepare students for this field, and was intended to determine whether educational programs include training in co-occurring disorders and related evidence-based practices. Survey responses generally demonstrated that academic programs are at least somewhat prepared in regard to co-occurring disorders and evidence- based practices. They also indicated that there are significant problems finding and maintaining qualified professionals to work in the field.

Although not intending to address this goal specifically, the Clinical Practices committee developed comprehensive clinical guidelines intended to guide integrated practice. These guidelines include information on providing integrated treatment within the scope of a provider's specific license. The *Clinical Practice Guidelines* represents the culmination of COSII's work from the clinical perspective and includes sections on:

- screening and assessment,
- treatment and recovery planning,
- recovery-oriented treatment,
- progress notes,
- crisis-prevention planning,
- relapse-prevention planning (recovery management planning),
- transition and discharge planning,
- client records,
- psychopharmacology services,
- continuity of care, and
- integrated mental health and substance use programming.

In addition, the guidelines include discussions of special topics, including, among others, children and adolescents, motivational interviewing and medication-assisted treatment.

Assessment

If the standard of success here is achievement of the goal as it was initially articulated, one must conclude that progress on revising state licensure regulations for both the mental health and substance abuse fields has been slow in coming, and that more success has been achieved in introducing co-occurring language into substance abuse regulations than into the mental health standards. One of the reasons for the slow pace during the past year was simply priority: DLRS was preoccupied for several months with developing licensing regulations for the newly legislated medical marijuana dispensaries, and plans to return to the stated goal of developing a single set of core behavioral health standards by the fall of 2010. The medical marijuana law does not, however, explain the delays in developing co-occurring standards for mental health during previous years.

Whether the delays in revising the mental health regulations are attributed to staff shortages, some level of resistance to the idea of integration, or to some other cause, COSII was able to make progress on the substance of this goal through other means. First, DLRS has shifted at least part of its attention from modifying mental health and substance abuse treatment standards separately to the core alignment concept, which is really what is needed to get at the heart of creating a set of standards serving all of behavioral health. That is, therefore, a change in strategy rather than a change in the goal. The only caveat is that it is not clear whether there will be sufficient progress during the current administration, which ends in a few months, to achieve the core alignment.

The second significant success has been in the revisions to Rider E of the provider contracts. Not all states require their Medicaid providers even to have contracts; the fact that Maine does makes it possible to approach some issues not just from a licensing and regulatory angle but also from a contract angle. Again, the effort speaks to the substance of the goal if not to its literal meaning.

The schism between mental health and substance abuse has also been evident in the project's work to incorporate standards for integrated care into the requirements for professional credentials. The substance abuse board has been concerned with issues surrounding scope of practice for its licensees, *e.g.,* the extent to which licensees are permitted to address mental health issues. The social work (mental health) board has been concerned with the kinds of training needed to ensure that licensees are able to address substance abuse appropriately in practice. Neither issue has been resolved to date.

One reason for the limited progress in changing professional credentialing has been the pushback both from the licensing boards and from academic institutions. The licensing boards themselves do not believe changes to their existing requirements are necessary, while academic institutions do not want to add to their already lengthy list of graduation requirements within their programs. With no movement in sight, the documents created by the COSII project addressing COD competencies, scope of practice and the clinical

guidelines, are likely to become the *de facto* standards for agencies and clinicians delivering integrated services.

GOAL 3: Increase network building by appointing a State Commission on Co-occurring Disorders with permanent roles and specific boundary-spanning responsibility and providing enhanced training and consultation to providers.

Purpose

When attempting to change a system's infrastructure, multiple efforts and strategies must be in place to support and especially to sustain such change. One key mechanism is the development of committees that work toward project goals. Another is to create more permanent, boundary-spanning boards which are not COSII-driven from a project perspective, but relate to the integration effort's goals nonetheless.

Achievements

During the course of the project, COSII itself played the role of the boundary-spanning commission. Its multiple workgroups and the Project Coordinator's participation in other initiatives (such as Systems Transformation, the Evidence-Based Practice committee, STAR-SI, and Access to Recovery) created an awareness of COD issues across the relevant groups and provided forums for addressing those issues. To achieve the stated goal and to ensure the sustainability of the project's achievements, COSII staff are now attempting to form a new committee to oversee co-occurring disorders efforts by building on its own Workforce Development committee.

Assessment

COSII staff were highly active in building relationships with multiple DHHS offices and treatment providers throughout the initiative. While this goal was achieved during the initiative, sustainability of these efforts could be a concern.

As with the goal relating to regulatory change, however, there are sometimes multiple strategies available to achieve the same substantive end. During the course of the project, integrated services became a priority of the current administration for a wider array of issues than just those handled by COSII. The Commissioner created an Office of Integrated Services and COSII issues generally come under that Office.

One of the major achievements was the issuance of an Integrated Services Policy, which appears in Appendix D and sets out an integrated services framework for high-risk families and individuals, of which people with co-occurring disorders are a major but not exclusive group. This policy may be sufficient for the Office of Integrated Services to assimilate and sustain the work of COSII into its existing efforts. This office has adopted the lessons of integration from the COSII initiative and has expressed support for its mission. It may be prepared to carry on the work of COSII as a part of its overall mission of service integration.

To ensure a continuing focus on the specific COD population, COSII is trying to institutionalize its Workforce Development committee, which is still pursuing its agenda. Another mode of sustaining the project's efforts would be to develop a single permanent coordination position within DHHS to continue the work of the Project Coordinator. While it is generally agreed that this would be beneficial to the State's integration efforts, current budgetary limitations prevent this from being a viable option. Time may change that situation, and the no-cost extension of the COSII project will permit more time to work on this goal.

GOAL 4: Enhance financial planning for co-occurring disorders by realigning MaineCare reimbursement with other goals for treating individuals with co-occurring disorders.

Purpose

At the beginning of COSII, billing MaineCare for services was separated into substance abuse treatment and mental health treatment, without an option for integrated care. There was also a discrepancy in the amount that could be billed for each, with mental health commanding higher rates. As providers moved toward integrated care, this traditional billing structure became confusing, cumbersome and divorced from the reality of treatment. The project intended that MaineCare billing and reimbursement should also be reflective of licensing and credentialing standards, which were moving toward integration.

Achievements

Section 65 of the MaineCare regulations regarding behavioral health services was successfully re-written to include integrated co-occurring language. The following is drawn from the Definitions section:

65.02-12 **Co-occurring Capable** providers are organized to welcome, identify, engage, and serve members with co-occurring mental health and substance abuse disorders, and to incorporate attention to these issues in all aspects of Co-occurring Services including linkage with other providers, staff competency and training. Clinicians must practice within the scope of their individual license(s) and follow all applicable mental health and substance abuse regulations in regards to member records including, but not limited to Comprehensive Assessments, Individual Treatment Plans (ITP) and progress notes.

65.02-13 **Co-occurring Disorders** are any combination of a mental health and substance abuse diagnosis.

65.02-14 **Co-occurring Services** are integrated services provided to a member who has both a mental health and a substance abuse diagnosis. This includes persistent disorders of either type in remission; a substance related or induced mental health disorder and a diagnosis of Substance Abuse disorder that co-occurs with interacting symptoms of the other disorder.

When mental health and substance abuse diagnoses occur together, each is considered primary and is assessed, described and treated concurrently. Co-occurring Services consist of a range of integrated, appropriately matched interventions that may include Comprehensive Assessment, treatment and relapse prevention strategies that may be combined, when possible within the context of a single treatment relationship. Co-occurring services also include addressing family therapy or counseling issues involving mental health, substance abuse or other disorders where MaineCare services cover family therapy or counseling.

65.02-33 **Serious Emotional Disturbance** (SED) is when a member has a mental health and/or a co-occurring substance abuse diagnosis, emotional or behavioral diagnosis, under the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), that has lasted for or can be expected to last for at least one (1) year, and is at risk for more restrictive placement, including but not limited to, psychiatric hospitalization, as a result of this condition for which other less intensive levels of service have not been effective (e.g. traditional outpatient services).

Language was added in other sections, such as the V9 Extended Care definition which includes the need to access co-occurring services as a reason to justify extended care. Trauma-informed definitions and practices were added as well. Provider qualifications for both mental health and substance abuse agencies now include co-occurring language, as shown in the following sample:

Mental Health Agencies are providers licensed, contracted by DHHS pursuant to 34-B MRSA §1203-A, and enrolled as MaineCare Providers. In order for these agencies to provide adult mental health services or children's mental health services, including Trauma-Informed Care services, they must contract with DHHS, Office of Adult Mental Health Services or Office of Child and Family Services to provide covered adult mental health services or children's behavioral and mental health services, including services for members with co-occurring mental health and substance abuse diagnosis.

The definition of every relevant service now includes co-occurring language as shown in this requirement for the provision of Intensive Outpatient services:

The provider shall provide an intensive and structured service of alcohol and drug assessment, diagnosis, including co-occurring mental health and substance abuse diagnoses, and treatment services in a non-residential setting aimed at members who meet ASAM placement criteria level II.1 or level II.5.

The following is a partial definition of comprehensive assessment:

> A clinician must complete a Comprehensive Assessment that integrates co-occurring mental health and substance abuse issues within thirty (30) days of the day the member begins services.

More directly related to this goal, two objectives were achieved. The rates for mental health services and substance abuse services were aligned to a similar structure and almost equal rate, and a new billing code was added for co-occurring services. However, the integrated rate was not enhanced, *i.e.,* the mental health co-occurring rate is the same as the mental health rate. In addition, if the provider uses the new code, it cannot bill for any other mental health or substance abuse service on the same day. Because of these constraints, and their impact on future treatment options, the code has not been adopted for general use.

Assessment

As indicated by the regulatory language above, the framework for co-occurring definitions and billing has been well established in the MaineCare (Medicaid) Benefits Manual as a direct result of the COSII initiative. However, several issues hampered progress toward establishing a higher rate for co-occurring services. Higher rates had been sought on the theory that fewer services overall would be needed if the basic care could come from one clinician rather that two, allowing savings to be generated even though the individual service would be more expensive.

The first issue preventing a higher rate is the fact that the licensing regulations have not yet been integrated. Agencies are continuing to operate within one of the two structures, billing only within their approved licenses. Some agencies are dually licensed but generally choose to bill for either mental health services, substance abuse services, or both, rather than for integrated services.

Second, because MaineCare interpreted the goal as a cost-saving measure, the change to include an integrated billing code resulted in a rate set too low to reimburse adequately for fully integrated care. Integrated care is more intensive than either mental health or substance abuse treatment alone. Yet, the rate for integrated treatment is the same as the rate for either substance abuse or mental health treatment and adds the restriction that if the integrated code is used, no other treatment may be billed for that client (neither additional substance abuse nor mental health treatment). Without using the co-occurring code, if an agency chooses to bill for only substance abuse treatment, additional mental health treatment may also be billed (and vice-versa). This structure creates an incentive both to agencies and to consumers to bill separately for substance abuse and mental health services so that the agencies can maximize reimbursement and the consumers can maximize available treatment options.

A third issue affecting progress toward realigning MaineCare reimbursement specific to co-occurring disorders is that the entire MaineCare billing system is currently undergoing a revision. It does not make sense to push for revision of the current billing codes, but rather to focus on incorporating enhanced integrated codes into the new regulations. The project

leaders hope to continue pursuing the goal as the new MaineCare billing system is developed during the no-cost project extension period.

GOAL 5: Enhance information sharing to permit tracking services and outcomes of the target group across systems.

Purpose

Perhaps the most efficient manner in which to evaluate the impact of treatment services for the co-occurring population is by creating a mechanism to track individuals across the state's different data systems. Because data are collected and stored in three separate systems which are unable to communicate with one another, gathering comprehensive data for co-occurring clients is especially difficult. The relevant three state data systems are: the Treatment Data System (substance abuse); Enterprise Information System (mental health for high-end clients); and Maine Claims Management System (MaineCare). Achievement of this goal was intended to promote measurement of the impact of integrated services.

Achievements

Around the time COSII was starting, DHHS introduced the COGNOS reporting software as a platform for creating integrated reports. The project evaluator was retained to create these reports. For the first several years, the Maine Claims Management System was not included in COGNOS, meaning that the records of Medicaid clients could not be matched against records of clients of the other systems. HZA did succeed in generating integrated reports from the Treatment Data System and the Enterprise Information System, even though those systems have different structures and functions. The Treatment Data System records information at admission and discharge only for people seeking treatment from a state-funded substance abuse provider. The Enterprise Information System captures information at enrollment and quarterly thereafter for individuals receiving Community Support Services, Community Integration (CI), Intensive Community Integration (ICI), and Assertive Community Treatment (ACT), as opposed to basic community mental health. The integrated reports were able to capture clients who appeared in each system alone and to unduplicate those appearing in both. The reports generated information about the numbers of people served, as well as their demographics, living arrangements, as well as their educational and employment statuses.

During this period the state entered into a new ASO contract with APS HealthCare which included reporting responsibilities related to MaineCare Services. APS provides monthly data on co-occurring screening and prevalence. For the longer-term viability of an integrated reporting system, HZA worked with COSII staff and APS HealthCare to design additional basic reports from its database which, by definition, encompassed Medicaid-eligible people. The standard reports are supposed to cover both screening and diagnosis results, as well as service results. While some reports have been generated, APS HealthCare has not completed all of them, because changes are being made to the MaineCare system that will impact their content.

Simultaneous with the work being done by APS, DHHS had also migrated the MaineCare data into the COGNOS structure. HZA worked with the Office of Quality Improvement Services, which was developing the COGNOS cubes[2], to identify diagnostic and procedure codes for both mental health and substance abuse that could be used to generate more detailed co-occurring reports than was possible with the APS data. When completed, these were designed to supplement the co-occurring report, shown below, which was developed by the Office of Quality Improvement Services for its Data Infrastructure grant relating to co-occurring recipients.

Indicator	Definition	*Most Current Maine Data*		*Previous 2008 Maine Data*		*National Data or Trend Data*	
		Data	*Year*	*Data*	*Year*	*Data*	*Year*
Co-occurring Mental Health (MH) and Substance Abuse (SA) Disorders	**Adult Mental Health Service Recipients with Substance Abuse Condition**	22.0%	FY 2009	23.0%	FY 2008	23.0%	FY 2008
	Percent of adult mental health service recipients with co-occurring substance abuse condition. Source: Substance Abuse and Mental Health Services Administration Data Infrastructure Grant (DIG) 2009 Uniform Reporting System. (National figures for FY 2009 are not yet available).						
	Children Mental Health Service Recipients with Substance Abuse Condition	3.0%	FY 2009	6.5%	FY 2007	6.0%	FY 2008
	Percent of children mental health service recipients with co-occurring substance abuse condition. Source: Substance Abuse and Mental Health Services Administration Data Infrastructure Grant (DIG) 2009 Uniform Reporting System. (New methodology for FY 2009, national figures for FY 2009 are not yet available).						

Assessment

Developing an integrated data reporting structure proved to be a challenging component of COSII. While the project was successful in designing the kinds of reports needed for monitoring progress on co-occurring issues; it has not yet been successful in making sure those reports are actually created, periodically generated and utilized by managers.

Part of the issue is that the Medicaid system is a moving target. DHHS made a decision not to create a separate co-occurring cube, but rather to include the co-occurring report specifications into the mental health cube. Even that has been put on hold for the time being, however, because of recent enhancements to the capabilities of the MaineCare system. In theory, at least, the new system could generate these reports without the use of COGNOS, so additional justification is being required for the work of creating the mental health cube. While the outcome of that request is unknown, the basic issue is that the MaineCare system has many priorities for reporting, and without special attention, the needs of those handling COD issues are likely to fall far from the top.

[2]In this context, a cube is a structured extract of the larger database with embedded programming designed to produce a limited range of *ad hoc* reports.

Agency Achievements

One goal of the COSII initiative has been to increase co-occurring integration at the provider level. This section relies on agency-level assessments and interviews with key personnel at COSII pilot agencies to create a comprehensive picture of agency accomplishments in effectuating integrated services; it also identifies areas where more work remains to be done. This section first examines the agency-level accomplishments of the five-year project, and then provides a more detailed discussion of the key factors that have been found to impact agency-level success. These factors translate many of the state-level infrastructure changes discussed above to the agency level impact: billing and licensing, access to services, training and professional development, assessment, and treatment.

Achievements

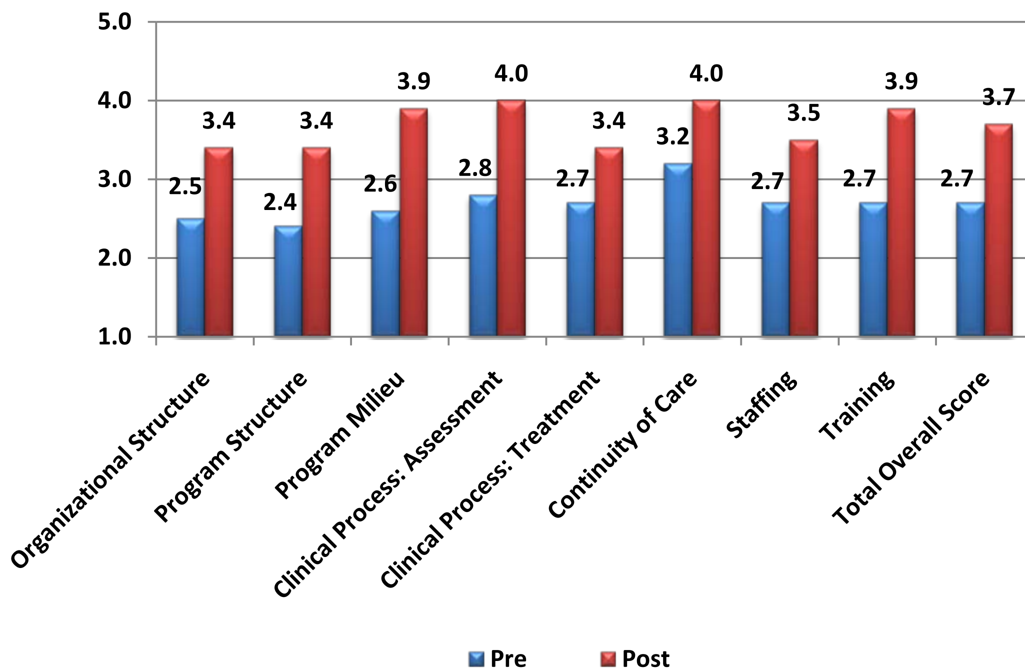
As noted at the outset of this report, 30 agencies participated as pilot for the COSII project. To be a pilot, each agency was required to develop an action plan for changing organizational and clinical practices that included specific goals, timeframes, and persons responsible for implementing and overseeing this change. Agencies were also required to complete at least two change projects using the NIATx Process Improvement model to aid in the movement toward becoming a co-occurring-enhanced agency. Each agency enrolled clients diagnosed with co-occurring substance abuse and mental health disorders to provide information on program services and outcomes and tracked clients entering the agency as part of a federal data requirement, examining rates of screening, assessment, and treatment for co-occurring disorders. Additionally, agencies from the earlier cohorts provided mentorship to incoming COSII agencies and on a regional level.

The leaders of the COSII initiative also organized regular pilot site meetings, regional discussion and training forums, and stayed visible and available to all participants through regular site visits for each cohort. In SFY 2010 alone, CCSME provided 38.5 hours of workshop training to 250 people at 130 agencies, as well as 135.6 hours of technical assistance. All 30 agencies involved in the COSII initiative worked within their geographic regions and alongside statewide providers to not only provide integrated treatment and care, but also to increase awareness of issues facing clients with co-occurring disorders and reduce the stigma associated with living with substance abuse and mental illness.

The project's agency-level achievements are best viewed through the results of the pre- and post-assessments conducted using the Self Assessment of Co-Occurring Capability instrument. Each of the domains (organizational structure, program structure, program milieu, clinical process: assessment, clinical process: treatment, continuity of care, staffing and training) contains multiple questions. Scores on each of the questions are combined to reach a domain score between one and five. A score of three is considered not only acceptable but even desirable, because it means "co-occurring capable," that is, in relation to that domain, the agency has the capacity to provide integrated services, if not directly then through arrangements with other staff and providers. A score of five represents full integration. This highest level is not considered a requirement for co-occurring integration and is reserved for agencies that have highly intensive programs intended for individuals

with significant COD severity and treatment needs. A score of three represents the basic standard.

As demonstrated in Figure 1 below, the pre- and post- results of the agency assessment show that increased integration occurred in each of the major domains. Moreover, almost every agency that had a score less than or equal to two (that is, a score that indicates the area is “not integrated” or “integrated very little”) increased at least one of those scores to be greater than or equal to three – a score that indicates the agency is co-occurring capable in that area – in the post-participation scoring. There were only two instances where an individual agency’s score decreased, however these decreases were only by tenths of a percentage point. These results suggest that involvement with the COSII initiative as a pilot agency resulted in increased integration and capacity to provide treatment to the co-occurring disorders population. It further shows that on a statewide level, the pilot agencies reached the threshold of a score of three on each domain, representing co-occurring capability.



The 30 agencies represent some of the largest and most sophisticated service providers in the state, as well as some of the smallest and most geographically remote agencies. Regardless of their service delivery capacity, agencies involved with COSII report they are providing better treatment and care for clients with co-occurring disorders as a result of the initiative.

Indeed, during the final interviews, HZA asked participants to rate their agencies on a scale of 1 to 5, where 1 is "not integrated at all" and 5 is "fully integrated." Many of the respondents scored themselves very close to their final post-assessment score. At the same time, however, every agency interviewed recognized that working to integrate their services for people with co-occurring disorders did not end when their participation in the COSII initiative was complete. They articulated that the work was something that required continuous and sustained effort. Indeed, three agencies from the second round rated themselves as much more integrated when asked in the interviews than they did upon completing the pilot; progress had been made in the ensuing years. Being part of an earlier cohort, these agencies had more time to continue their work, which likely resulted in higher levels of integrated service provision.

Licensing rules and billing requirements were discussed as major issues holding agencies back from providing fully integrated treatment to their clients, and this issue is explored in more depth below. However, multiple agencies said that there were some issues that providers often assumed to be barriers, and therefore people were unsure how to work around these perceived roadblocks. As one interviewee stated, it was only through participating in the COSII initiative that the agency learned about its misconceptions regarding what a single license agency could and could not do. This interviewee felt the COSII initiative forced people to face the barriers they had previously been hiding behind: *"It is becoming less common to use 'scope of practice' as a reason why we cannot treat someone with co-occurring disorders."*

Likewise, all respondents felt there was a greater awareness of co-occurring disorders among community practitioners as a result of their participation with the COSII initiative. However a few interviewees noted that local physicians and hospital staff are sometimes not as attuned s they should be to recognizing and effectively treating clients with co-occurring disorders. They felt their work could be undermined by doctors who are quick to provide a prescription and dismiss a patient. This was viewed as a result of a general lack of training and expertise among medical professionals in the area of treating patients with multiple, co-occurring issues.

The feedback from each and every interview was that the agencies' involvement with this project was important to their work, and they believed it was changing the system of integrated treatment and positively affecting the way that clients were served in Maine. While many barriers still exist, perceived or otherwise, interviewees felt their agencies were better off as a result of becoming more aware of and educated about co-occurring disorders. As one director candidly said, *"This was a great success, they deserve the highest praise. The effort and success with policy change, from top down, showed a lot of intelligence and changed the MaineCare regulations."*

The following issues represent themes that emerged from interviews with administrators of the pilot site agencies at the end of their involvement with COSII. Many of them are reflective of the items assessed in the Self Assessment; however, only those that stood out in the interviews are addressed.

Access to Services

Overall, providers reported that the increased access to services for the population with co-occurring disorders was an extremely important outcome of the COSII initiative. In particular, the Co-Occurring Collaborative Serving Maine and the COSII team pushed the pilot agencies in all four cohorts to consider their levels of acceptance and understanding of clients with co-occurring illnesses. Agencies were asked to assess their staff knowledge as well as the characteristics of their environments.

All agencies interviewed reported that as a result of the training they received from the COSII initiative, they were much more welcoming toward and understanding of clients with complex needs. Many stated that they fully embraced the concept of "No Wrong Door," meaning that consumers should have access to any services that will help them meet their long-term treatment goals no matter where they begin the process. To this end, agencies worked with regional partners to refer clients to the best possible service provider to meet their individual needs.

Being involved with COSII also taught participating agencies the importance of having all staff, not just clinicians, be more welcoming and accepting of incoming clients' needs. This also included considering the important messages they were sending to their clients through the physical set-up of their environments, the language used in their literature, and the processes established for assessment and treatment.

The area *Program Milieu* on the assessment tool reiterates this focus by examining the organization's level of acceptance and expectations for clients with co-occurring disorders, the overall access to treatment they provide, as well as literature and educational materials for consumers. The majority of agencies showed an increase in this area. The average score in the pre-assessment was 2.6 and in the post-assessment 3.9, meaning the average score rose by 1.3 over the course of the COSII initiative. This result corresponds to the agency interviews where providers acknowledged that access has greatly improved since they became involved with the project.

Billing and Licensing

Areas of great concern to COSII agencies continue to be billing and licensing. Despite valuable work from the COSII initiative, Maine continues to have separate regulations for Mental Health and Substance Abuse services which complicate the documenting, billing and reimbursement requirements for agencies that are providing fully integrated treatment. Indeed, this was the area most consistently reported as needing further work in interviews and discussions with pilot sites. In addition, the pre- and post- assessment scores in the area of Organizational Structure, which includes licensing and billing, were on the lower end of all the domains, although the average result was over three, which reflected co-occurring capability. Agencies appear to be both aware of and frustrated with this barrier. Interviewees expressed frustration that they could not bill for substance abuse and mental health treatment on the same day, which made scheduling difficult and could be particularly troublesome for clients who had to arrange for transportation. Efforts are currently being

made to address the issue of billing for both substance abuse and mental health services on the same day, however.

Many people interviewed reported that agencies holding a license in either mental health or substance abuse services (*i.e.,* not dually licensed) bill for the "dominant" condition, rather than as a co-occurring condition under one or the other. Many also indicated that if they were in the position to choose which way to bill, they file claims using mental health coding, possibly because they perceive that mental health services are reimbursed at a higher rate. While this has been true in the past, the newly revised co-occurring disorder rates for individual outpatient therapy services and comprehensive assessments are the same as the rates for those services under mental health and substance abuse. Other restrictions do, however, apply to the co-occurring rate, so the providers are not entirely wrong in their belief that mental health rates offer a better alternative.

Respondents also reported that agencies are not using the COD billing codes when the actual service providers are detached from the billing departments, when providers do not understand the new updated billing codes, or when providers choose to be reimbursed at the highest rate available for serving a client's complex needs. Perhaps the most important factor that agencies must consider in determining whether to use the COD billing code is that no other treatment (*e.g.,* medication management) is covered for an individual when the co-occurring service billing code is used. Through the use of the substance abuse and/or mental health billing codes, clients are free to receive both "substance abuse" and "mental health" treatment in an integrated way, while agencies are free to provide (and bill for) both substance abuse and mental health treatment. Use of the co-occurring mental health code eliminates the possibility of clients receiving, and agencies billing for, additional services the client may need. Many people interviewed said that these billing concerns are contradictory to the goal of integrating treatment.

Training and Professional Development

In addition to the Project Coordinator, the Co-Occurring Collaborative Serving Maine has been actively involved in organizing and delivering multiple training efforts on a statewide and regional level. Co-sponsored by Office of Substance Abuse and Office of Adult Mental Health Services, these have included conferences, teleconferences and videoconferences, as well as cross training programs and on-line courses. Additionally, Regional Performance Partnerships have been held in several DHHS locations. These meetings included training on the topics of rapid cycle of change, screening and assessment, regulatory licensure and cultural competency. Training has been provided to providers and DHHS staff alike, and many people interviewed commented on the value of the training in furthering both organizational change and clinical practice improvements.

Additionally, COSII staff has actively worked with project consultants Dr. Kenneth Minkoff and Dr. Christie Cline to provide support and training for pilot agencies. By developing relationships with all of the pilot agencies, COSII staff has acted to support change on the agency level. The trainings provided by the COSII initiative were unanimously perceived as positive and of the highest quality. Interviewees praised the COSII staff for their expertise in integrated treatment and were happy about the resources provided by them. Interviewees

also reported that the COSII trainings enabled agencies to increase staff knowledge in the areas where they had the least exposure. For example, mental health providers had access to training in substance use issues, while substance abuse treatment providers learned about mental and intellectual disabilities. Many acknowledged that they felt more successful in treating clients when they were able to attend to the whole individual, rather than focus on only one area.

All interviewees spoke of the high quality technical assistance and guidance they received from the COSII leadership team. One director stated, *"They provided objective, valuable feedback. They gave us the encouragement we needed to create an action plan and stick to it to create change in our agency."* Another shared, *"They were always available and kept us informed and organized. Having the technical assistance was critical; the project was clear and we knew what was needed to be accomplished."*

The assessment scores for *Training* consistently remained largely the same for agencies in both pre- and post- assessments. However, on this domain there was large variance among the cohorts. For example, the Cohort 2 agencies generally rated high in the pre-assessment, with seven out of the ten agencies rating themselves at a 3 or 4 in the pre-assessment (four rated themselves at 4). In the post-assessment, half the scores remained the same. However, for Cohort 3, there was a different trend. More than half the agencies went from a score of 1 or 2 in the pre-assessment to a score of 3 or higher in the post-assessment. Two agencies increased dramatically from a score of 1 or 2 to a score of 5 (or fully integrated) during this cohort.

The assessment also measured what kinds of professional supports were provided to staff working with clients with co-occurring disorders. These supports include peer or alumni supports, supervision and consultation with clinicians to assist with integrating treatment in practice. In particular, *Staffing* looked at the team of professionals available to clients being served by the agency, and the certifications and credentials they held. Where possible, organizations looked for staff who had complementary skill sets that could provide comprehensive services. Many agencies mentioned that they had made an attempt to hire staff with a wider variety of licenses or certifications due to their increased awareness of the necessity of co-occurring treatment as a result of their COSII involvement. As with other areas of the Self Assessment, the assessment score for the area of *Staffing* increased for all but one agency, and one agency rated at five in the post- assessment.

Agency providers who were interviewed often expressed that social work programs placed too little emphasis on substance abuse training. A few interviewees discussed the importance of including co-occurring disorder subject matter in college-level coursework and training, and brought up the fact that students' internship placements greatly affected their future capacity to provide treatment effectively and comfortably to clients with co-occurring issues. That is, students who interned at host organizations that provided co-occurring treatment were more capable of providing similar treatment post-graduation.

Many interviewees stated that they would like to see co-occurring disorders training become mandatory for service providers and required for annual updates and professional development. However, while they appreciated the ongoing COSII trainings for new staff,

they also identified a need for a higher level of training; that is, an intermediate or advanced level of training for those who had already had basic co-occurring disorders training. They also expressed the need for more education targeted to the administrative and decision-making positions within their agencies.

Screening and Assessment

The majority of agencies noted that if they were not previously completing both mental health and substance abuse screenings, they had begun using an integrated screening tool as part of the COSII initiative. As noted in the chapter on infrastructure above, the screening tool selected and currently used by all but three programs is called the AC-OK. The capacity to screen for both disorders using a common tool across the state represents a major accomplishment. Also important is the question of *when* people get screened. All agencies noted that they had changed or refined the process of screening everyone at intake through their involvement in the COSII initiative. That is to say, they now screen at the outset for both disorders.

During the interviews, people often mentioned that having a more integrated screening tool was helpful in thinking about the client as a whole person who required both mental health and substance abuse services, as well as beginning to conceptualize what services would most appropriately meet their individual needs.

The agency assessments also examined the assessment process in place at each agency, particularly if a client's stage of change was screened, assessed, and documented for each disorder. It also measured the extent to which the assessment results informed and influenced the treatment services actually received by a client. The average score from *Clinical Process: Assessment* in the first assessment was 2.8 and the average score for the post-assessment was 4. As Table 2 demonstrates, however, the pre-assessment scores ranged from a low of 1.2 to a high of 4.7, while post-assessment scores ranged from 2.3 to 5. Obviously, assessment practices across all the agencies continue to be quite varied in terms of the level of integration.

Table 2
Clinical Process: Assessment

	Pre	Post
Average Score	2.8	4.0
Lowest Score	1.2	2.3
Highest Score	4.7	5.0
Range (Low to High)	3.5	2.7

Treatment

In the context of COSII, all agencies were asked to provide a welcoming environment, to screen for both disorders and to complete a comprehensive assessment with all clients in order to make available the most appropriate treatment possible with full respect to the

client's unique set of needs. Agencies were asked to consider the nature and stages of change for each disorder for each person served, and to develop concrete treatment plans based on the assessment. As summarized by one clinical director, *"Good integrated treatment starts at the first contact, believing in the 'No Wrong Door' philosophy. From there we complete a comprehensive assessment to look at all aspects of struggle for each individual, and then we look at the case plan and make sure it includes goals that tie in the substance use issues."*

The action plans that providers put in place often included screening for both mental health and substance use status, training for all staff in co-occurring disorders, and consistent recording of diagnosis and goal planning and progress. Many providers shared that they were now obtaining more accurate diagnoses for their clients as a result of the action plans and were thus able to respond appropriately when challenges arose, particularly as they related to substance abuse for the mental health providers. One person shared that the improvements implemented at the agency to better document dual diagnoses made it more effective in providing treatment, and also made the clinicians more aware of how intertwined substance abuse and mental illness are. Another director shared that a broad range of staff (from both substance abuse and mental health) now consult with each other on a regular basis, and felt that the agency was "almost fully integrated" in treatment provision.

For the assessment, treatment scores remained relatively consistent for many agencies over the pre- and post- assessments. The average score from *Clinical Process: Treatment* in the pre-assessment was 2.7 and the average post- score was 3.4. On a statewide basis, the agencies exceeded the benchmark score of three. Some agencies were constrained in scoring even higher due to licensing issues, while some expressed that they felt more constricted in what they could provide for co-occurring disorder treatment. In contrast, one of the directors from the final cohort said that integrated treatment could be provided if an agency committed to doing so, and that the perceived barriers were often very minor. She further stated, *"I think providers just get stuck in old ways of doing things; coupled with the separate licensing entities, this continues the divide. But we can do it if we work at it."*

Assessment

The strategy of expanding the pilot served to involve a wider array of agencies, both large and small, and reaching every part of the state. The pilot agencies engaged in an intensive process of agency assessment, goal-setting and procedural change. As the discussion above has highlighted, the COSII initiative has brought about remarkable changes at these agencies. For many, participation in this initiative was transformative. For example, some agencies changed their intake and screening procedures; some reorganized their staffs; some modified their hiring criteria; while others changed their assessment and treatment approaches, making sure to consider the stage of change for both mental health and substance use disorders separately.

In many ways, the COSII project brought the subject of mental health disorders among people abusing substances out of the darkness, just as it did in highlighting substance use disorders for people with mental illness. It caused agencies to re-examine their policies of

turning away people who wanted help but may have been abusing legal substances or using illegal ones. As the next section shows, these changes reflected positively in their impact on clients. The changes can be and were demonstrated at the person level.

In addition, involving agencies in the COSII initiative has improved and enhanced data collection, provided hands-on experience to clinicians, tested initiatives such as the screening tools, and provided the much-needed opportunity to increase professional capacity through ongoing networking and training sessions. The pilot agency process has proved invaluable to increasing integration at the service provider level, and thereby providing enhanced services to the co-occurring disordered population. Expanding the pilot process to a far broader group of agencies was an excellent step, and one that truly served to spread and enhance COSII's impact.

The pilot process employed by COSII has also created champions who remain working within the system, and who will continue to lobby for increased integration and practices that support those aims, as demonstrated in the changes made by the earlier pilot agencies even after COSII was completed. With more help at the infrastructure level, it appears that much of the work achieved by COSII can and will be sustained.

Consumer Outcomes

Through the work of the pilot agencies, the COSII project enrolled 1,174 in the evaluation study and conducted follow-up interviews with as many as could be contacted at three, six, and nine months past the baseline period to determine changes in the people's conditions and well-being. This section reports on the results of the consumer study.

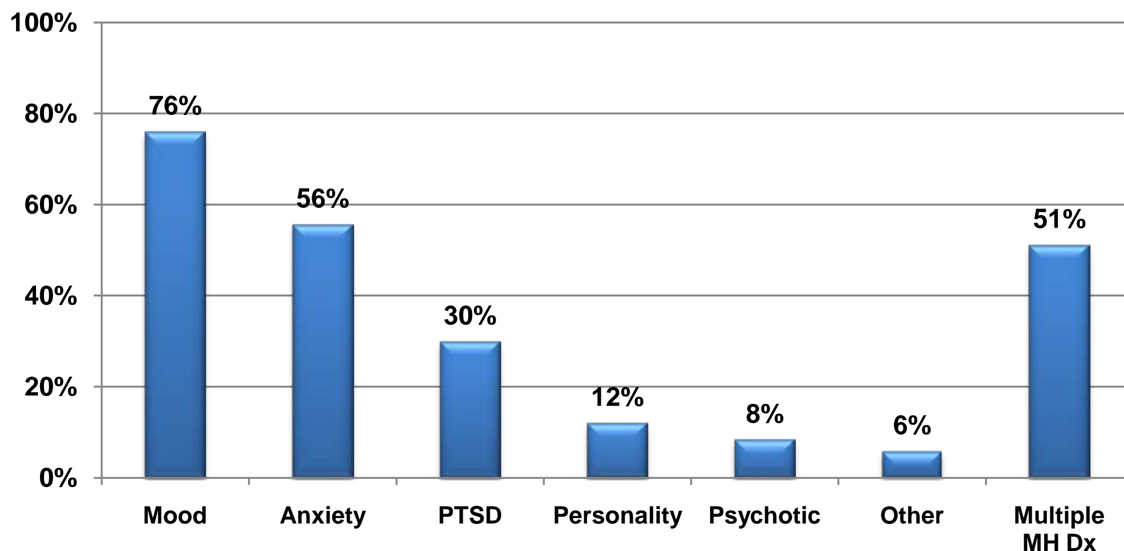
Enrollee Population at Baseline

Enrollees ranged in age from 18 to 82 at baseline, with an average age of 38 years, and were evenly split between males and females. The majority (77%) had earned at least a high school diploma or GED, and 37 percent had attended at least some college. They were generally independent, with 79 percent living independently by themselves or with others; three-quarters of enrollees had lived in their current setting for at least three months.

Most enrollees reported low levels of income, with 71 percent having a monthly income that was less than $1,000. They were also relatively under-employed, with only 29 percent employed at least part-time. Many relied heavily on public benefits, including 77 percent who received some form of public insurance (*e.g.,* unemployment or Social Security benefits). Twenty-two percent received another public benefit such as Temporary Assistance for Needy Families (TANF).

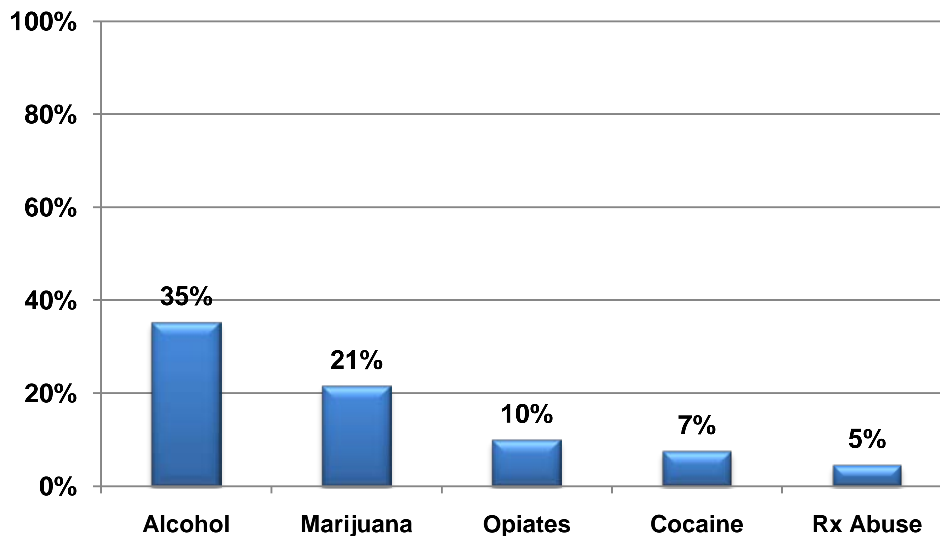
The baseline enrollee population was also highly involved with the criminal justice system. Seventy-five percent had been arrested at least once in their lifetimes, and 31 percent had been arrested within the past year. Fifty-nine percent had been incarcerated at some point, and 21 percent were currently on probation.

Figure 2.
Enrollee Mental Health Diagnoses



Mood disorders were the most prevalent mental health disorder for enrollees (76 percent), followed by anxiety disorders (56 percent) and Post-Traumatic Stress Disorder, or PTSD (30 percent, see Figure 2). Slightly more than half of the population had multiple diagnoses across the different disorder groups. Just over half (54 percent) felt they presented a risk to themselves at baseline, while one-quarter felt they presented a risk to others. Less than half of the enrollees (49 percent) reported feeling in control of their life.

As demonstrated in Figure 3, enrollees were most likely to report that they used alcohol (35%) and marijuana (22%) in the month prior to enrollment, followed by abuse of opiates (including heroin and prescription opioids such as OxyContin® or Percocet®), cocaine, and other non-opioid prescriptions (including depressants such as Xanax® and Valium® or stimulants like Ritalin®). Forty-three percent of enrollees exhibited symptoms of impairment from drugs and/or alcohol at baseline. Among those, 20 percent exhibited impairment due to drugs only, ten percent due to alcohol only, and 12 percent exhibited impairment from both alcohol and drugs.



Enrollee Outcomes at Nine-Month Follow-Up[3]

Each enrollee who received a baseline interview was eligible for follow-up interviews at three, six, and nine months after the baseline date. By the conclusion of the project, 227 clients from 14 agencies had completed all three follow-up interviews; this represents 38 percent of those eligible to have completed all follow-up interviews. The remaining enrollees

[3] Participants were also asked during each interview about services they had received. However, self-reported service data (*i.e.,* information based on a person's recollection) tend to be less accurate than medical claims data (*i.e.,* information about the services for which agencies were paid). Therefore, service utilization patterns for the COSII population are presented in the subsequent section.

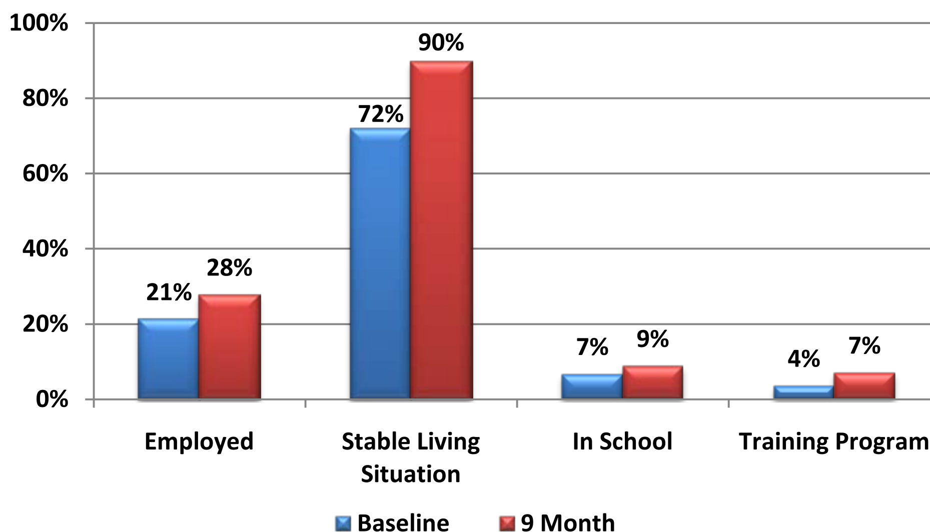
were largely unable to be located and most likely were no longer receiving treatment at the agency.

Enrollees who completed all three follow-up interviews were significantly different from the baseline population. It is important to note these differences when discussing longer-term client outcomes, because it is possible that the outcomes reported by the enrollees who persisted do not fully represent the experiences of the entire co-occurring disorders population. Notably, when compared to the baseline sample of evaluation participants, enrollees who completed all three follow-up interviews were:

- significantly older (by three years);
- engaged in treatment longer prior to enrollment (by five months);
- more likely to have a psychotic disorder;
- less likely to have a personality or anxiety disorder;
- more likely to receive public benefits (*e.g.,* SSI, TANF);
- less likely to be employed; and
- more likely to receive case management services.

Nevertheless, many of the enrollees reported positive outcomes nine months after receiving treatment at a COSII pilot site. In particular, enrollees generally reported improved quality of life (*e.g.*, living arrangements, employment), reduced involvement with law enforcement, decreased impairment due to substance use and positive improvements in functioning and well-being. Each of these areas is summarized in more detail below.

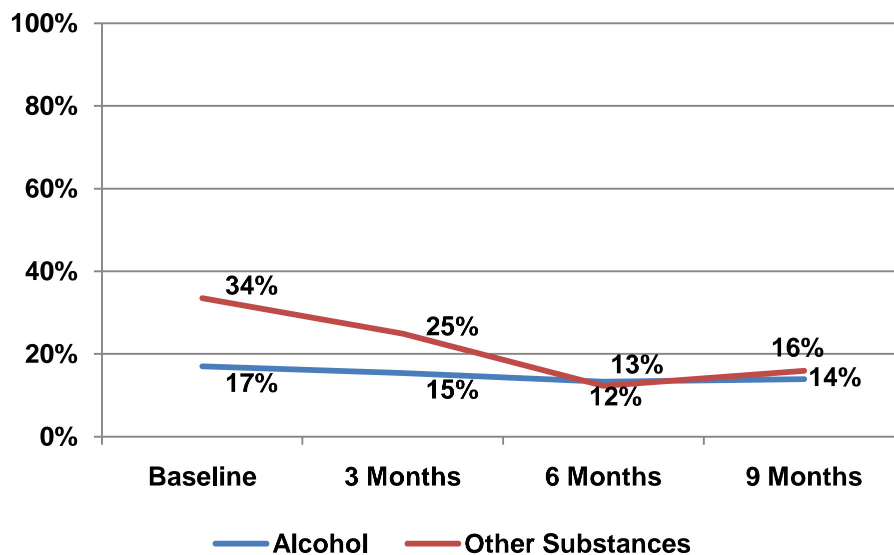
Quality of Life



An individual's living situation, employment and involvement with law enforcement all contribute to overall quality of life. As demonstrated by Figure 4, enrollees exhibited substantial improvements over time. Notably, employment significantly increased from baseline (21 percent) to nine-month follow-up (28 percent), a rate of change of 31 percent. In addition, the proportion of enrollees who reported a stable living situation (meaning they had been there for longer than three months) increased from 72 percent at baseline to 90 percent after nine months. With particular regard to living situations, enrollees were much less likely to report living in a residential or institutional setting after nine months (eight percent compared to 14 percent at baseline) although it should be noted that some COSII pilot sites were residential in nature.

Involvement with law enforcement is another key indicator of quality of life. In order to most accurately reflect the evaluation results, participants' arrest rates were calculated nine months prior to their enrollment in the COSII evaluation, and then compared to the overall rate of arrest during the entire nine-month period after enrollment. This analysis showed that arrest rates for enrollees decreased by 60 percent from the nine months prior to the baseline interview (25%) to the nine month follow-up interview (10%).

Impairment due to Alcohol and Drugs



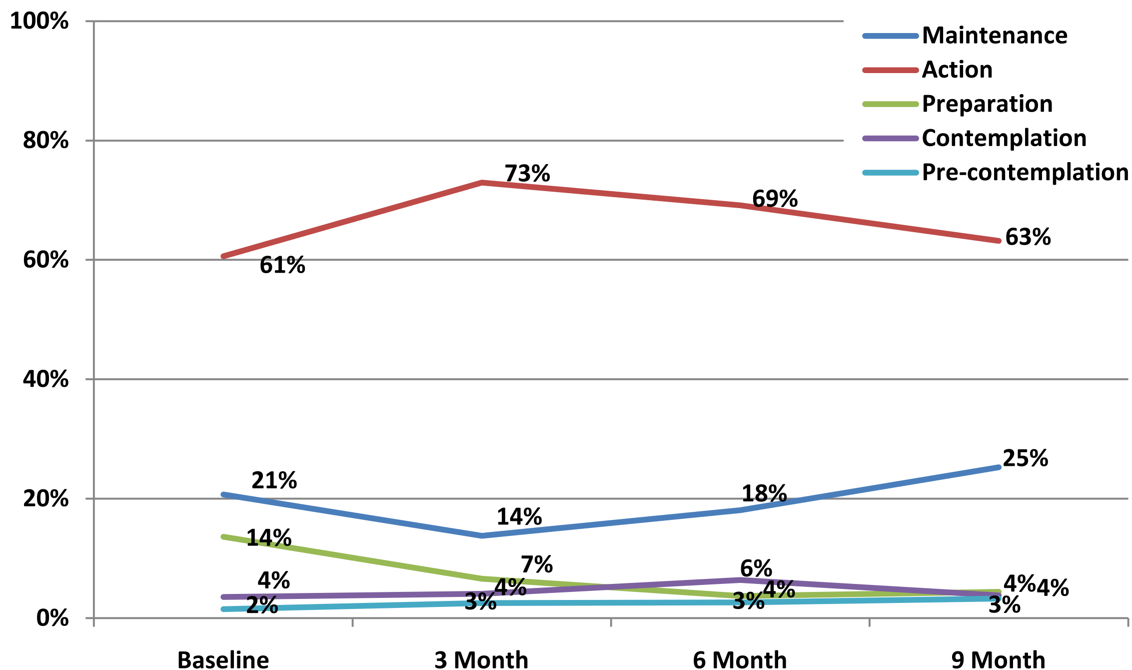
Most enrollees showed significant improvement nine months after enrolling in treatment at a COSII pilot site in terms of impairment due to alcohol and drug use (as shown in Figure 5). While impairment due to alcohol gradually decreased over time (from 17% to 14%), impairment due to other substances decreased sharply from baseline to six months (34% to 13%). Although impairment appears to increase slightly at nine months (to 16%), the overall rate of reported impairment is still much lower than at baseline. Moreover, this increase is not statistically significant, so without additional data it is unclear whether the rebound

actually indicates a reversal of the trend. It is important to note, however, that relapse is a normal part of the ongoing cycle of recovery.

Mental Health, Functioning and Well-being

The "Stages of Change" approach to substance abuse and mental health treatment centers on the concept that individuals undergo a step-by-step process to recovery that encompasses five basic stages: pre-contemplation, contemplation, preparation, action and maintenance.[4] At each interview point, the counselor responsible for administering the interview assessed the enrollee's current stage of change and recorded it.

Figure 6. Mental Health Stage of Change Over Time



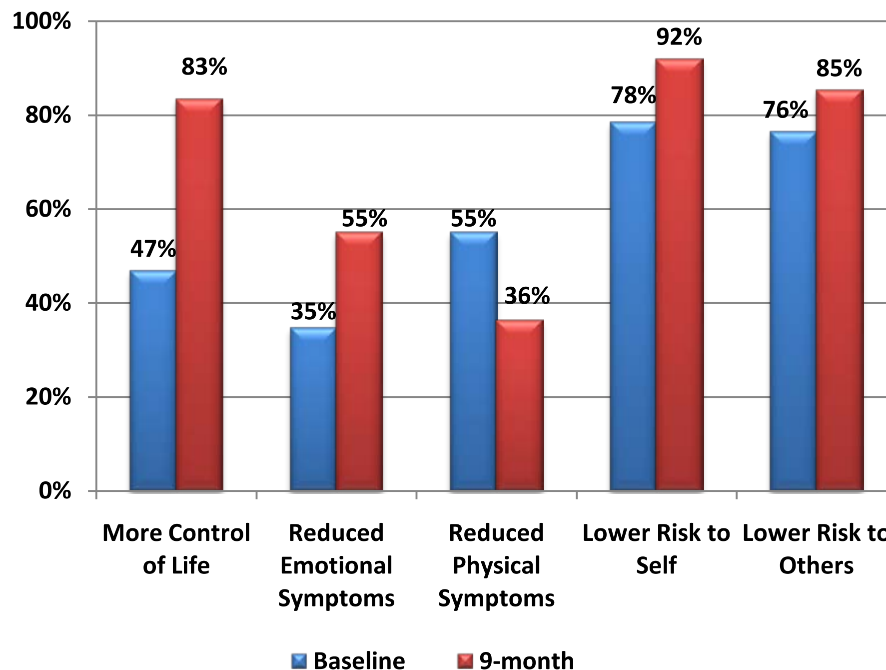
At baseline, 21 percent of enrollees were in the "maintenance" stage for mental health, while 61 percent were in the "action" stage (see Figure 6). Nine months after treatment, the majority were still either in the action (63%) or maintenance (25%) stages. Just over one-third demonstrated positive improvements, meaning they had moved from one stage to another (*e.g.,* from contemplation to action). Among the individuals who showed positive movement, more than half moved from action to maintenance. Notably, all individuals who had been in a pre-contemplation or contemplation stage showed positive movement, while those who showed negative movement most often went from maintenance to action (this is considered negative since additional work needs to be done in the action stage).

Enrollees were also asked a series of questions about their own functioning and well-being and whether they had improved *as a result of services* they received from the COSII pilot agency. To show improvement for an outcome, the client must have the ability to change, as

[4] The COSII initiative embraced this model and it was employed at all pilot agencies.

defined in the interview. For example, a person who does not pose a risk to himself or herself is not able to "improve," as measured by the interview. Thus, two groups do not show improvement: those who truly did not improve (*i.e.,* started by posing a risk to him- or herself and stayed the same throughout all follow-ups) and those who were not able to demonstrate change (*i.e.,* started without posing a risk to him- or herself and stayed the same throughout all follow-ups.)

Enrollees were more likely after nine months to report improved functioning in terms of being in control of their lives, experiencing reduced emotional symptoms, and posing a lower risk to themselves and to others. Figure 7, below, demonstrates these findings. Notably, the proportion who reported being more in control of their lives *as a result of services* increased from 47 percent at baseline to 83 percent nine months after receiving services.



Assessment

Overall, the outcomes for individuals enrolled in the COSII evaluation group are good. Improvements are seen for almost all of the measures nine months after enrollment, most notably in reduction in arrest rates and improvement in employment rates. Individuals were also more likely to report higher levels of stability in their living arrangements. Consumer functioning on key indicators, such as the person's feeling in control of his or her life and behavior, also showed improvement nine months after baseline. Moreover, after nine months, most participants showed lowered impairment due to alcohol and drugs, while also being in an "acting" or "maintaining" stage of change for mental health.

These findings suggest that the changes made by COSII pilot sites to provide better integrated services to their clients with co-occurring disorders resulted in improved outcomes for this population over the duration of the evaluation study. What is not known from this element of the study is whether these findings can be generalized to the individuals who did not participate in each of the follow-up interviews. However, the next section on consumer services and costs suggests that the positive results, at least in avoiding emergency treatment and hospitalization, can be generalized to a much broader population of people with co-occurring disorders.

Service Use and Costs Post-Treatment

Up to now this report has focused on the agencies and individuals who have been touched directly by Maine's COSII initiative. The evaluation thus far has demonstrated significant impact on both the agencies and the individuals who have participated, as well as on some fundamental aspects of the state infrastructure. This chapter takes the question of impact one step further. First, it asks what the prevalence of co-occurring disorders is on the broader population of Maine residents who receive MaineCare benefits. Second, it looks at how those served by the pilot agencies fare one year after their enrollment in the study is completed compared to a matched group of people with co-occurring disorders. In other words, this chapter begins to examine the longer-term impacts of the initiative, both in terms of service use and costs.

Like many states, Maine often relies on external studies to draw inferences about the outcomes of various types of behavioral health interventions as they relate to different types of Medicaid beneficiary groups. Although there are broad federal guidelines, for the most part Medicaid policy and financing of public health services falls under the jurisdiction of each individual state. Consequently, differences in coverage, service array, service availability, population characteristics, and use of managed care make it difficult to extrapolate and apply findings from one state to another. As a result of this, little is known about the prevalence of Medicaid beneficiaries with co-occurring disorders in Maine, and even less is known about their service utilization or the cost of delivering those services. Hence, this section of the report is dedicated to exploring these questions:

- What is the prevalence of MaineCare beneficiaries with behavioral health disorders?[5]
- Among those with behavioral health disorders, what were their diagnoses? How many had co-occurring disorders?
- Was there a significant difference in service utilization patterns between COSII enrollees and other beneficiaries with co-occurring disorders?
- Did the difference in service utilization result in difference overall costs?

Methodology

To answer questions such as the ones posed above, a one-year, retrospective observational study was performed using an administrative data extract obtained from MeCMS which contained all medical claims records from July 1, 2006 to June 30, 2009.

Service utilization was measured for all COSII enrollees from the first two cohorts of pilot agencies for whom a minimum of one year had elapsed since their discharge from treatment. These agencies were selected to permit adequate time to elapse for a one-year follow-up study period. Table 3 provides a distribution of the sample from each COSII pilot agency in the first two cohorts.

[5] In this analysis, substance abuse is considered a category of behavioral health disorder.

Table 3 MaineCare Sample for COSII Pilot Agencies Included in Cost Study			
	Total MaineCare Beneficiaries	*Number Matched in MeCMS*	*Number Eligible (Time at Risk)*
Aroostook Mental Health Center	67	63	59
Crisis & Counseling	73	71	65
Maine Medical Center/Spring Harbor Hospital	54	51	49
Catholic Charities Maine Counseling	22	20	18
Maine General Health	17	14	14
Riverview Psychiatric Center	33	21	20
Wellspring, Inc.	26	24	20
Community Health & Counseling Services	0	0	0
Spurwink	0	0	0
Harbor Schools of Maine	0	0	0
Facing Change, PA	30	28	25
Youth and Family Services, Inc.	16	14	14
Common Ties Mental Health Coalition	37	35	34
Total	375	341	318

The observational study created a matched comparison group against which the impact of COSII enrollment on the service delivery system could be assessed. A matched comparison group increases the likelihood that observed differences in service utilization patterns are attributable to COSII enrollment, rather than to unknown factors or confounding effects. The comparison group for this study was developed by matching COSII enrollees with other beneficiaries using seven key variables including: date of entry (within one month of enrollment), most severe mental health diagnosis, number of mental health diagnoses, type of substance disorder (alcohol versus drug), county of residence, gender, and age group classification (5-year groups).

Information about the types of MaineCare claims and types of MaineCare beneficiaries is provided in Table 4 on the following page. Overall, a total of 46,670,219 claims were paid on behalf of 397,740 beneficiaries over the three-year time frame beginning July 1, 2006 and ending June 30, 2009. Based upon beneficiary diagnoses, claim types were first divided into two primary groups, physical health and behavioral health. Behavioral health claims were then divided into four mutually exclusive groups, as follows:

1) claims with one or more mental health disorders;
2) claims with one or more substance-related disorders;
3) claims with at least one mental health disorder and at least one substance-related disorder; and
4) claims relating only to nicotine dependence.

Incidence of Co-occurring Diagnosis

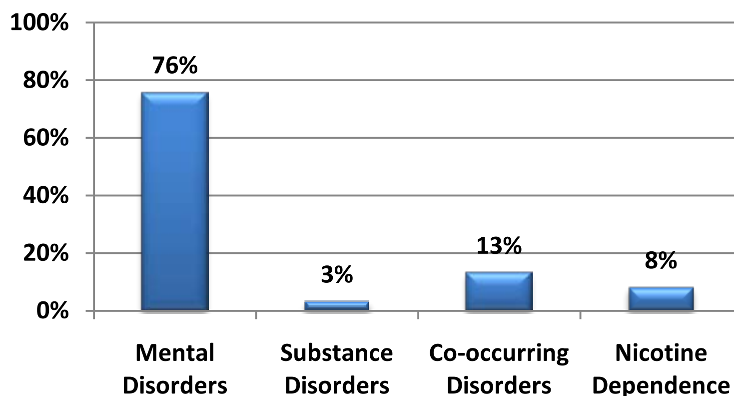
As shown below in Table 4, MaineCare claims attributable to mental health disorders far outnumber claims attributable to substance use disorders and co-occurring disorders. Claims attributable to mental health disorders make up approximately one out of every five claims (20.3%) in the aggregate, which accounts for approximately 85 percent of all behavioral health claims. Few claims were found to have both a mental health and substance use disorder. Claims with co-occurring disorders account for 2.5 percent of all behavioral health claims, and make up less than one percent of all claims.

Table 4
MaineCare Claims by Diagnostic Category

	Number	Percent
Physical Health	35,469,407	76.0%
Behavioral Health		
Mental Disorders	9,472,326	20.3%
Substance Disorders	925,725	2.0%
Co-occurring Disorders	275,513	0.6%
Nicotine Dependence	527,248	1.1%
Total	46,670,219	100.0%
Behavioral Health Only		
Mental Disorders	9,472,326	84.6%
Substance Disorders	925,725	8.3%
Co-occurring Disorders	275,513	2.5%
Nicotine Dependence	527,248	4.7%
Total Behavioral Health	11,200,812	100.0%

A slightly different picture begins to emerge when examining MaineCare beneficiaries, as opposed to examining the types of claims paid on their behalf. More than half of all MaineCare beneficiaries (203,537, or 51.2%) had at least one claim attributable to a behavioral health disorder over the course of the three year study time frame. However, among beneficiaries receiving a diagnosis of at least one behavioral health disorder, three-quarters were diagnosed with mental health disorders only (75.7%), followed by co-occurring disorders (13.1%) and substance use disorders only (3.1%, see Figure 8 on the following page). The prevalence of Medicaid beneficiaries with co-occurring disorders in this study falls well within the range of prevalence estimates cited elsewhere; between seven and seventeen percent (Coffey, 2004; Samnaliev & McGovern, 2007).

Figure 8.
MaineCare Claims by Diagnostic Category Among Individuals with a Behavioral Health Diagnosis



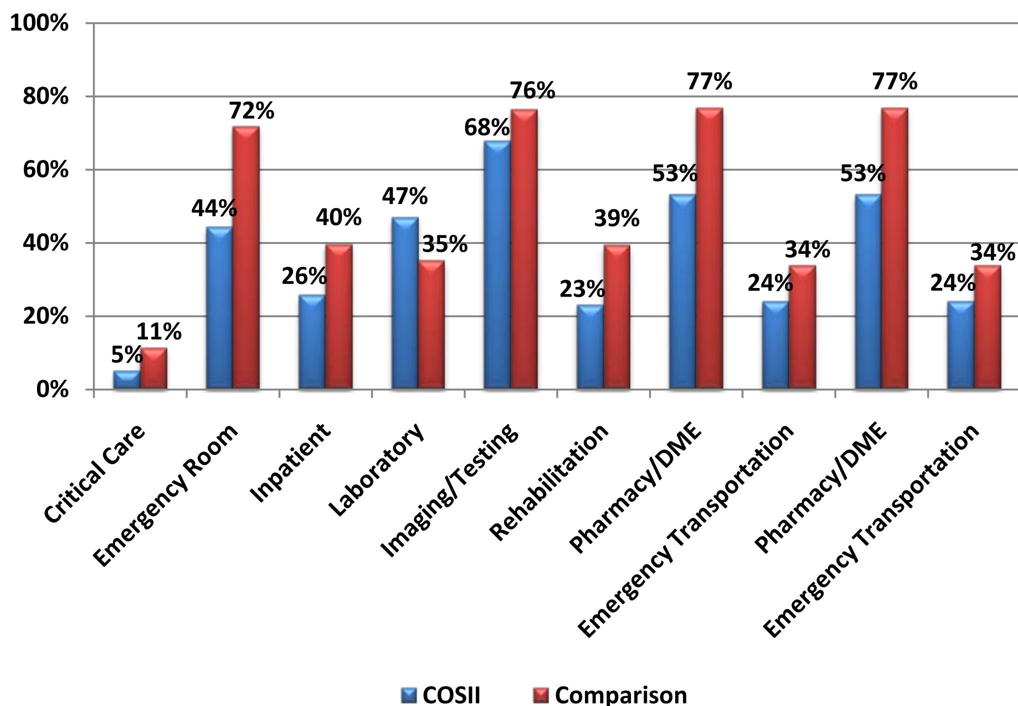
Client Level Service Utilization Patterns

Throughout this report, there has been evidence to support the conclusion that the COSII initiative generated improved outcomes for clients with co-occurring disorders across a number of important life domains (*e.g.,* drug and alcohol use, mental health well-being). Another critical outcome measure for this population is their service utilization patterns after being discharged from treatment.

It is well established in the literature that Medicaid beneficiaries with co-occurring mental health and substance use disorders access a wide range of services, and typically more expensive services, than other beneficiaries with behavioral health disorders (*i.e.,* beneficiaries with either mental health or substance use disorders only). Unfortunately, such findings are of limited empirical value. The conclusion that individuals with more complex problems access more services, or even more expensive services, remains strikingly self-evident. Another benefit of the COSII initiative is that it provides a unique opportunity to explore a different kind of question; that is, how do service utilization patterns among COSII enrollees compare to other beneficiaries with co-occurring disorders receiving "treatment as usual?" How, and to what extent, did COSII enrollment impact the service delivery system?

Information provided in Table E-1 in Appendix E includes 37 different types of services organized around four broad categories: physical health services, mental health services, substance-related services, and community support services. As shown in Figure 9 on the following page, COSII enrollees used significantly fewer physical health care services than the comparison group. Among the most expensive physical health services, COSII enrollees also had significantly lower use of critical care services (5% versus 11%), emergency room services (44% versus 72%), inpatient services (26% versus 40%), and emergency transportation services (24% versus 34%). Among the other physical health care services, COSII enrollees had significantly higher use of laboratory services (*e.g.,* drug testing) which, as will be discussed in more detail below, is likely attributable to their increased (or ongoing) participation in substance abuse counseling.

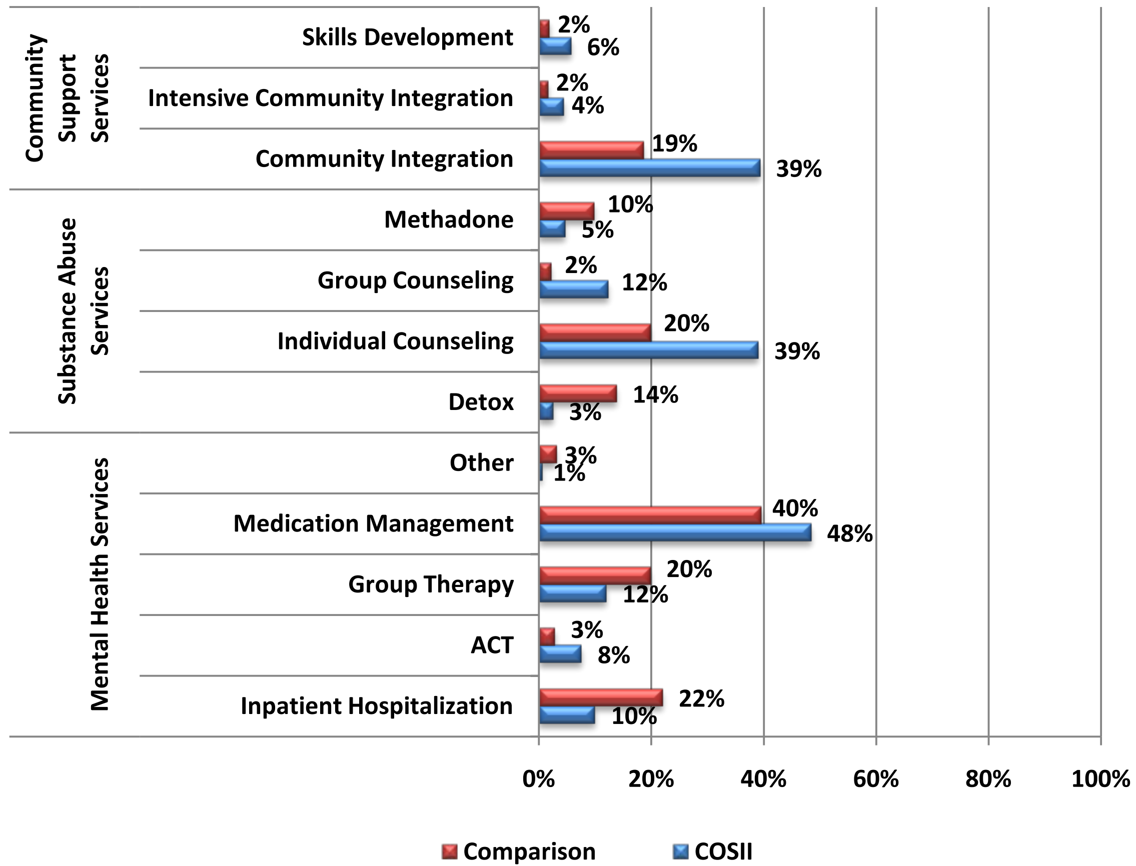
Figure 9.
Physical Health Services Utilization
COSII Enrollees and Comparison Group



Findings were more mixed with respect to behavioral health and community support service utilization. As Figure 10 on the following page demonstrates, COSII enrollees were significantly more likely than the comparison group to have accessed medication management services (48% versus 40%), individual substance abuse counseling (39% versus 20%), group counseling for substance abuse (12% versus 2%), community integration services (39% versus 19%), and skill-development services (6% versus 2%).

Conversely, COSII enrollees were significantly less likely to have been admitted for inpatient psychiatric care (10% versus 22%), and were also less likely to have used detoxification centers (3% versus 14%) or participated in mental health group therapy (12% versus 20%).

Figure 10.
Behavioral Health Services Utilization



Overall Cost of Services

The question that remains is whether or not these observed differences in service utilization translate into overall lower costs. Appendix E, Table E-2, includes each service type referenced above along with the total number of claims, and the cumulative cost of those claims, for both COSII enrollees and the matched comparison group of individuals with co-occurring disorders not enrolled in the COSII initiative.

As expected, lower physical health care utilization among COSII enrollees following treatment generated a net savings of nearly $2.7 million dollars over the comparison group in physical health care costs alone. Among the physical health service categories, significant cost differentials between the two groups pertain to hospital-based inpatient and outpatient services, and emergency room care (as shown in Table 5, on the following page). These three service types account for nearly two-thirds, or $1.8 million dollars, of the $2.7 million dollars in net physical health care savings.

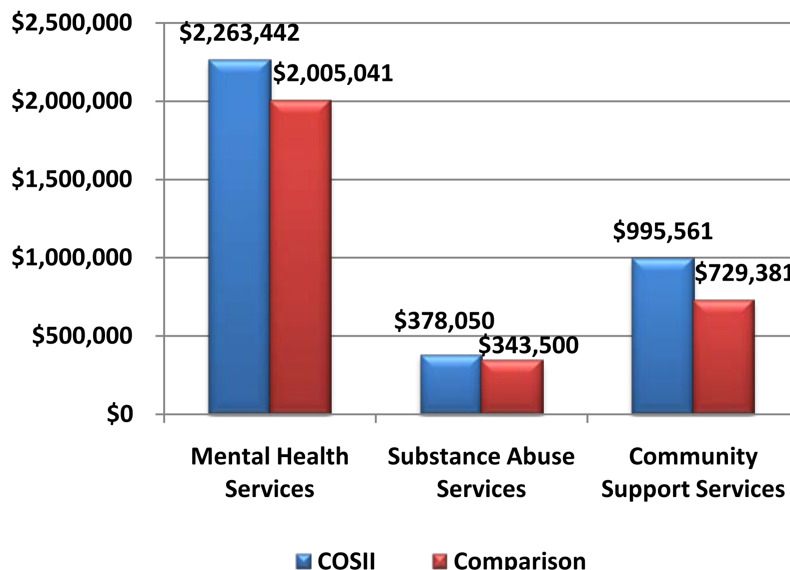
Table 5 Cost of Physical Health Care Services COSII Enrollees and Comparison Group			
	COSII Enrollees	Comparison Group	Cost Differential
Critical Care	$79,620	$174,361	($94,741)
Emergency Room	$1,154,726	$2,254,332	($1,099,606)
Inpatient	$906,596	$1,494,595	($587,999)
Surgical	$165,945	$255,671	($89,727)
Outpatient	$250,330	$394,638	($144,309)
Laboratory	$787,424	$1,183,797	($396,373)
Imaging/Testing	$292,367	$494,382	($202,015)
Rehabilitation	$57,615	$83,712	($26,097)
Pharmacy/DME	$100,618	$155,471	($54,854)
Emergency Transportation	$34,529	$37,048	($2,519)
Other	$6,830	$4,890	$1,941

With respect to behavioral health and community support services, the observed differences in service utilization do not always correspond to significant cost reductions (see Table 6 on the following page). For example, while an equal number of COSII enrollees and comparison group members utilized Private Non-Medical Institutions (PNMIs), there is a significant cost difference between the two groups. In this case, although COSII enrollees had fewer claims than the comparison group (a total of 1,177, compared to 1,566), the cost of the services paid out for the COSII enrollees totaled $986 thousand, compared to $635 thousand paid on behalf of the comparison group. The difference is significant and likely due to extended lengths of stay among COSII enrollees as they persist in treatment, opposed to shorter and more interrupted stays for those in the comparison group. However, in other cases, the different service utilization patterns between COSII enrollees and the comparison group did show lower associated costs. For example, inpatient psychiatric hospitalization costs were $377 thousand lower for COSII enrollees, who tended to use that service less.

Table 6 Cost of Mental Health Services COSII Enrollees and Comparison Group			
	COSII Group	Comparison Group	Cost Difference
Mental Health Services			
PNMI	$986,208	$635,273	$350,936
Inpatient	$287,783	$665,370	($377,587)
Crisis Intervention	$385,591	$293,679	$91,912
ACT	$274,463	$60,662	$213,800
Individual Therapy	$165,760	$168,249	($2,489)
Group Therapy	$15,243	$27,501	($12,258)
Medication Management	$115,374	$113,719	$1,655
Day Habilitation	$4,014	$17,403	($13,389)
Day Treatment	$17,350	$7,366	$9,984
Testing/Evaluation	$11,007	$12,901	($1,894)
Other	$649	$2,918	($2,270)
Total Mental Health Services	*$2,263,442*	*$2,005,041*	*$258,400*

Other significant and more expensive cost differentials for the COSII group include crisis intervention services (approximately $92K), Assertive Community Treatment (ACT) services (approximately $214K) and day treatment services (almost $10K). In total, the cost of providing mental health services for the COSII group is just over $258 thousand more than the cost of providing mental health services for the comparison group as demonstrated in Figure 11 below.

Figure 11
Cost of Behavioral Health Services Utilization
COSII Enrollees and Comparison Group



This same pattern holds true for the cost of delivering substance abuse services (approximately $35K) and community support services (approximately $266K; see Table E-2 in Appendix E for specific service costs). Nevertheless, the higher mental health and substance abuse costs are dwarfed by the savings in physical health services. Overall, service utilization costs for the COSII group was $2.1 million less than the comparison group over an equivalent time period.

Assessment

MaineCare claims for the treatment of co-occurring disorders account for 2.5 percent of all behavioral health claims and make up less than one percent of all claims. At 13 percent, the prevalence of Medicaid beneficiaries with co-occurring disorders in Maine falls well within the range of prevalence estimates cited elsewhere. This difference in proportion of claims compared to proportion of beneficiaries is likely due to billing practices in which providers submit only those diagnoses necessary to process the bill, and not all diagnoses with which the client has been diagnosed.

COSII consumer service utilization following treatment differs markedly from other beneficiaries with co-occurring disorders. COSII enrollees are less likely to use hospital-based services and more likely to use a wider array of behavioral health services and community-based supports. While the differences in service utilization among COSII enrollees did not always translate into cost savings in relation to specific types of services, the overall cost of providing services to the COSII group is less than the costs associated with the comparison group over an equivalent time period. This net savings is largely driven by lower physical health care services and costs among COSII enrollees following treatment.

Findings and Recommendations

Overall Findings

This report has described several positive changes resulting from the COSII initiative at three levels: changes in state infrastructure; changes in agencies delivering services; and changes in the people touched by the COSII initiative. While not all of the specific goals related to changing the state infrastructure were met, significant progress has been made towards the integration of services. Moreover, in some instances new strategies were found to pursue essentially the same goals. These include DSLR's core alignment process for licensing regulations, the modification of Rider E to provider contracts, and the creation of an Office of Integrated Services, which sees work on COD issues as part of its mandate.

At the agency level not only did the participating providers demonstrate significant improvements in their abilities to work with co-occurring disorders, the number of agencies involved was three times as large as initially planned. That in itself represents a significant change in the service delivery infrastructure. The improvements the agencies made were also reflected in improved outcomes for consumers.

Perhaps equally important, these changes have been shown to result in a long-term cost savings to the state in MaineCare expenditures. Combined, these conclusions should encourage state leaders to continue to promote the COSII initiative and to expand it to all substance abuse and mental health treatment providers. Further, the next step in integrated treatment is to include physical health care in all phases of assessment and treatment. The higher costs of physical health care for people with co-occurring disorders who are not treated in a co-occurring manner underscores the need for this next step in service integration. The lessons learned from the COSII initiative can help inform future treatment integration initiatives.

Recommendations

Based on the findings of this report, HZA offers the following recommendations:

Infrastructure Recommendations

1) **During the extension period, COSII staff should keep working towards an enhanced Medicaid rate for co-occurring services.**

It will make more sense for providers to use the co-occurring codes if they do not expect to lose revenue as a result. Since they are giving up some billing flexibility in using the code, the rate itself will have to be higher to justify its use to providers. With an enhanced rate for co-occurring services, more agencies are likely to provide those services and, as demonstrated in the previous chapter, that is likely to save far more in physical health claims to MaineCare than the enhanced rate would cost.

2) DHHS should maintain the focus on developing the core standards for mental health and substance abuse which include co-occurring principles , and use them as a basis for licensing reform.

Modifying substance abuse licensing standards to include mental health and modifying mental health to include substance abuse maintains the fundamental separation of the systems. DHHS has initiated the concept of Core Standards, something which got sidetracked with the medical marijuana work, but this should be the focus of future licensing development if true service integration is to be achieved.

3) COSII staff should continue to work with the Office of Quality Improvement Services to assure the timely development of reports related to co-occurring issues.

Both COGNOS and the standard reports built into the MaineCare system represent potential mechanisms for generating information for administrators need to track the success of their efforts with the co-occurring population. Whether one or the other is chosen, or both are utilized, the primary issue is to maintain some momentum from the project by ensuring that the reporting capacity is created very soon. While the enhancements now being made to the MaineCare system increase its capacity to generate the necessary information, quicker turnaround is almost certain to come from COGNOS.

4) DHHS should begin to include physical health providers in its efforts to integrate screening, assessment and treatment.

Taking the “no wrong door” philosophy seriously inevitably leads to the inclusion of physical health providers in the integration effort. Far more people, including those with mental health and substance abuse issues, see their doctors than visit behavioral health providers. Moreover, non-integrated services generate far more in the way of physical health costs than they do in the way of behavioral health costs. As some of the providers reported in the interviews for this evaluation, dealing with the whole person is simply more effective. This recommendation is especially important considering the expectation of increased coordination between physical health and behavioral health service providers in the recently passed healthcare reform bill.

5) DHHS should continue to work on the concept of integrating policy and programs between and among the Office of Adult Mental Health Services, the Office of Substance Abuse, and Children’s Behavioral Health Services.

To ensure continued consideration of COD issues in a truly integrated manner, the separate Offices of Adult Mental Health Services, Substance Abuse, and Children’s Behavioral Health Services should continue to strive for integrated policies and practices as they did in jointly requiring the AC-OK Screening Tool.

Agency Recommendations

6) **The COSII team should continue educating providers about the co-occurring practices that are now permitted under licensing rules.**

During the course of the COSII project the state eased up on various licensing requirements and now there are new requirements for integrated services. During the extension period, COSII staff should continue to encourage common understanding between the licensing authority and the provider agencies about what is permitted and required, and how integrated services can be delivered within the current regulatory and billing structure.

7) **The COSII team should support agencies with integrated practices to provide internships.**

Since it is difficult to obtain changes in social work curricula and professional licensing standards, as discussed above, the field will have to change at the provider level through student internships. While it is hard for agencies that have been strained by budget shortfalls to support student interns, even by providing time for supervision, this seems like a necessary and fruitful investment in moving the field toward co-occurring capability. During the extension period and beyond, the COSII team should consider how to work with the more advanced agencies to create internships for social work and counseling students.

8) **The COSII team should consider providing higher-level training to professionals who already have a baseline understanding of co-occurring disorders, and include education for administrative personnel on how to support co-occurring disorders through policy and practice at their agency.**

If more information is needed on what training topics to include, the COSII team might usefully conduct a brief survey or needs assessment of people who have already participated in training to determine what advanced topics they would like. Options should include both administrative and clinical subjects.

Appendix A: Pilot Sites and Sample Contract Language

Cohort 1:

- Aroostook Mental Health Center
- Crisis & Counseling
- Maine Medical Center / Spring Harbor Hospital

Cohort 2:

- Catholic Charities Maine Counseling
- Maine General Health
- Riverview Psychiatric Center
- Wellspring, Inc.
- Community Health & Counseling Services
- Spurwink
- Harbor Schools of Maine
- Facing Change, PA
- Youth and Family Services, Inc.
- Common Ties Mental Health Coalition

Cohort 3:

- Youth Alternatives Ingraham
- Life by Design
- Maine Pretrial Services, Inc.
- Day One
- Community Concepts
- Kennebec Valley Mental Health Center
- Crossroads for Women
- Health Access Network
- Mid-Coast Mental Health Center
- Community Counseling Center

Cohort 4:

- Northeast Occupational Exchange
- First Light Counseling Services, Inc.
- Counseling Services, Inc.
- Opportunity Housing, Inc.
- Eureka Counseling Services
- York County Shelters
- CAP Quality Care, Inc.

Total = 30 Agencies

MAINE COSII PILOT SITE CONTRACT LANGUAGE

Having agreed to serve as a Pilot Site of the Maine Co-occurring State Integration Initiative, (the COSIG Grant) ______ (agency) ____________ agrees to meet the performance requirements specified in the following four areas:

Meeting Requirements:

1. Become a regularly participating member of the bi-monthly COSII Regional Performance Improvement Partnership in your Region. Attend Pilot Site meetings on alternate months.

2. Encourage staff to experiment with new approaches to COD practice and be willing to share the results of your efforts with the Regional Performance Partners, the State, and the grant evaluators

3. Provide a representative to attend up to 2 meetings over the course of 18 months of the COSII Steering or other Work committee to provide feedback on the Regional Team and Pilot process

4. Provide peer mentoring to other agencies through the Regional Meeting process

Data Collection Requirements:

5. Screen 300 consumers, assess 200 consumers, treat 100 consumers per year for co-occurring disorders from an integrated perspective and provide substantiating data in quarterly reports.

6. Conduct 5 chart audits monthly using a tool provided in the COSII database

7. Enroll at least 30 consumers with co-occurring mental health and substance use conditions in the COSII database for one year providing specific follow-up data in 3-month intervals. (A consumer can be enrolled in the data set if he or she has received at least 4 units of service and can be contacted for follow up).

8. Provide agency prevalence data in quarterly reports on consumers who have co-occurring mental health and substance use disorders, consumer satisfaction data, chart audit data, and cost information as determined by the evaluator, Hornby Zeller Associates, and any other information that may be required by a national evaluator related to co-occurring clients.

Organizational Requirements:

9. Adopt a charter or policy statement that commits the entire agency, in particular executive management, to provide integrated treatment following the principles of the CCISC (Comprehensive Continuous Integrated System of Care) model.

10. Identify a team of "Champions" within the agency who will advocate and plan for the implementation process.

11. Complete the co-occurring agency audit tool, the COMPASS, in all programs.

12. Adopt the NIATx Rapid Cycle Change Process as a framework in which to embed the initiation of the implementation of co-occurring practices throughout the agency.

13. Develop an action plan for your agency for the term of the contract. Work with the Pilot Site Coordinator on a regular basis to revise and track progress on the implementation action plan

14. Choose at least one organizational function (such as Human Resources, MIS, Clinical policies and practices) and integrate co-occurring disorders (COD) policy in that area. Provide documentation of this implementation

15. Implement integrated Screening, Assessment and Treatment planning for co-occurring capable services

16. Identify one or more consumer "champions" to sit on agency and/ or grant committees to provide input into the COD implementation process

Reporting Requirements:

17. Document efforts to develop culturally and linguistically appropriate services for consumers with co-occurring conditions

18. Provide copies of new COD policies and procedures, minutes of meetings related to COD work, documents produced related to cultural competence, screening and assessment and changes in infrastructure areas and notes on team or champion meetings that speak to your implementation efforts and successes. Document your workforce dilemmas, as well as other barriers you experience in the implementation process.

19. Submit all quarterly reports within 30 days of the end of the quarter

Appendix B: AC-OK Screening Tool

AC-OK Screen for Co-Occurring Disorders
(Mental Health, Trauma Related Mental Health Issues & Substance Abuse)

First Name: ______________________________ **Last Name:** ______________________________________

Gender: ______ **Date of Birth:** ______________ **Date of Screening:** _________________

During the past year:

1. Have you experienced serious depression (felt sadness, hopelessness, loss of interest, change of appetite or sleep pattern, difficulty going about your daily activities)? ☐ Yes ☐ No
2. Have you experienced thoughts of harming yourself? ☐ Yes ☐ No
3. Have you experienced a period of time when your thinking speeds up and you have trouble keeping up with your thoughts? ☐ Yes ☐ No
4. Have you attempted suicide? ☐ Yes ☐ No
5. Have you had periods of time where you felt that you could not trust family or friends? ☐ Yes ☐ No
6. Have you been prescribed medication for any psychological or emotional problem? ☐ Yes ☐ No
7. Have you experienced hallucinations (heard or seen things others do not hear or see) ☐ Yes ☐ No

Mental Health **Questions 1-7** **Total Yes Answers:** ___________

8. Have you ever been hit, slapped, kicked, emotionally or sexually hurt, or threatened by someone? ☐ Yes ☐ No
9. Have you experienced a traumatic event and since had repeated nightmares/dreams and/or anxiety which interferes with you leading a normal life? ☐ Yes ☐ No

Trauma **Questions 8-9** **Total Yes Answers:** ___________

10. Have you been preoccupied with drinking alcohol and/or using other drugs? ☐ Yes ☐ No
11. Have you experienced problems caused by drinking alcohol and/or using other drugs, and you kept using? ☐ Yes ☐ No
12. Do you, at times, drink alcohol and/or use other drugs more than you intended? ☐ Yes ☐ No
13. Have you needed to drink more alcohol and/or use more drugs to get the same effect you used to get with less? ☐ Yes ☐ No
14. Do you, at times, drink alcohol and/or use other drugs to alter the way you feel? ☐ Yes ☐ No
15. Have you tried to stop drinking alcohol and/or using other drugs, but couldn't? ☐ Yes ☐ No

Substance Abuse **Questions 10-15** **Total Yes Answers:** ___________

Provider Signature: ____

AC-OK Adolescent Screen
(Mental Health, Trauma Related Mental Health Issues & Substance Abuse)

First Name: __________________________ Last Name: ______________________________

Gender: ____ Date of Birth: ______ Last grade completed: ____ Date of Screening: ______

During the past year have you:

1. Felt really sad, lonely, hopeless; stopped enjoying things, wanted to eat more or less, had problems sleeping, or doing what you need to at home or at school.? ☐ Yes ☐ No
2. Heard voices or seen things that others don't hear or see? ☐ Yes ☐ No
3. Burned or cut yourself? ☐ Yes ☐ No
4. Been prescribed medication for your feelings? ☐ Yes ☐ No
5. Tried to kill yourself? ☐ Yes ☐ No
6. Had thoughts about hurting yourself or wanting to die? ☐ Yes ☐ No

Mental Health Questions 1-6 Total Yes Answers: __________

7. Have you experienced a very bad thing happen (a traumatic event) where you continue to feel scared, worried, or nervous or even had nightmares that bothered you after it was all over? ☐ Yes ☐ No
8. Have you ever been afraid of your parent, caretaker or a family member? ☐ Yes ☐ No
9. Have you ever been hit, slapped, kicked, touched in a bad way, cursed at, yelled at or threatened by someone? ☐ Yes ☐ No

Trauma Questions 7-9 Total Yes Answers: __________

10. Been in trouble with the law, school, or parents, or lost friends because of your drinking alcohol or using other drugs, and continued to use? ☐ Yes ☐ No
11. Drunk alcohol or used other drugs to change the way you feel? ☐ Yes ☐ No
12. Drunk alcohol or used other drugs more than you meant to? ☐ Yes ☐ No
13. Changed your friends or planned your free time to include drinking alcohol or using other drugs? ☐ Yes ☐ No
14. Needed to drink more alcohol or use more drugs to get the same buzz or high as when you first started using? ☐ Yes ☐ No
15. Tried to stop drinking alcohol or using other drugs, but couldn't? ☐ Yes ☐ No

Substance Abuse Questions 10-15 Total Yes Answers ___________

Provider Signature: ____

Appendix C: Workforce Products

CO-OCCURRING COMPETENCIES

This document represents a consensus statement developed by the MAINE COSII Workforce Development Committee. It reflects current thinking about core skills important for the worker who provides services to people with co-occurring conditions. The scope of activity and functions of any specific practitioner depend on job description, role within the specific program, level of training, and the regulations governing practice. The competency levels reflect attention to all potential types of services provided in a program including those of support staff. They assume that each new level incorporates the competencies of the prior one.

BASIC:

1. Convey a welcoming, empathic, hopeful attitude towards people with co-occurring conditions* and support a philosophy of dual recovery

2. Demonstrate awareness of and capacity to work with one's personal reactions, feelings and attitudes about people with co-occurring conditions

3. Be familiar with and willing to learn about multiple co-occurring conditions

4. Engage and welcome people in ways that convey respect for diversity; know how to access information/resources about diversity and to provide them in a culturally and linguistically appropriate way

INTERMEDIATE:

5. Recognize, with the person receiving services, possible high risk behaviors and feelings and support and engage the person respectfully to be able to maintain safety for self and others.

6. Understand the professional, legal and ethical requirements for work with people with co-occurring conditions

7. Identify basic symptoms of substance abuse and mental health disorders

8. Screen for co-occurring conditions, including history of trauma

9. Conduct or obtain a comprehensive, longitudinal, integrated, strength-based assessment of the person's supports and needs that incorporates an evaluation of both their stage of change and, using ASAM** criteria, their level of care.

10. Work with the person to design and implement individualized support plans based on an integrated assessment

11. Assist the person to make use of natural and community supports and resources to further their recovery

12. Provide resources and information to the person about co-occurring disorders and the skills most effective in managing their challenges

13. Demonstrate knowledge of and skills in using relevant evidence based practices such as Motivational Interviewing and Relapse Prevention strategies

14. Advocate for and facilitate timely referrals and monitor coordination of services to assure integrated continuity of care, including coordination with primary care providers

15. Partner with the person seeking co-occurring services in achieving their goals and in developing a clearer understanding of the dynamics impacting their current situation

16. Recognize the classes of psychotropic medications (including addiction medications), their actions, medical risks, side effects , and possible interactions with other substances

17. Understand and support Continuous Quality Improvement practices related to co-occurring conditions within organizations and service systems

ADVANCED:

18. Conduct a comprehensive, integrated, longitudinal, strength-based assessment of the person's supports and needs related to co-occurring conditions that evaluates stage of change and ASAM level of care; this assessment may include diagnoses of substance abuse disorders within a multi-axial mental health diagnosis

19. Work with the person to develop a long term, integrated, progressive treatment plan, as opposed to parallel treatment plans, that accurately reflects the person's goals and abilities. Revise the plan as the person makes progress on goals.

20. Demonstrate knowledge of defined, evidence- based practices for co-occurring disorder treatment; employ diverse theories, models and intervention methods, including relapse prevention approaches

* The term "co-occurring" in this document refers to mental health and substance use conditions. However, other complicating factors may include brain injury, conditions of aging, developmental disabilities, physical disabilities or illness and trauma.

** ASAM refers to American Society of Addiction Medicine standards.

INTEGRATED SCOPE OF PRACTICE FOR CO-OCCURRING DISORDERS

This document represents a consensus paper developed by the Maine COSII Workforce Development Committee on recommended scope of practice for certified and/or singly licensed practitioners who provide services for people with co-occurring conditions. It reflects current thinking on ways to address co-occurring conditions in an integrated way. The document outlines integrated services and activities that can and should be carried out by those with either mental health or substance abuse licensure and training. However, the requirements and scope of activity for any specific practitioner depend on job description, role within a specific program, level of training, and the regulations governing practice. Each level incorporates the skills included in the prior category.

All Practitioners at all Levels:

- Convey a welcoming, empathic attitude that supports a philosophy of dual recovery
- Administer a screen for co-occurring conditions
- Recognize, with the person receiving services, possible high risk behaviors and feelings and support and engage the person respectfully to be able to maintain safety for self and others.
- Engage people in ways that convey respect for diversity and cultural appropriateness
- Support the goals of a treatment or individual service plan
- Help the person to advocate with other providers regarding health care, substance abuse or mental health treatment needs
- Collaborate with other providers to assure integrated care
- Support the person in accessing community and family resources to enhance recovery
- Provide resources and information to the person about co-occurring disorders and the skills most effective in managing their challenges.

Intermediate Level Practitioners: (for instance: case managers, support workers, counselors, aides)

- Conduct or obtain a comprehensive, integrated, longitudinal, strength-based assessment of the person's supports and needs that incorporates an evaluation of both their stage of change and, using ASAM (American Society of Addiction Medicine) criteria, their level of care.
- Use relevant, evidence-based skills such as Motivational Interviewing to identify stage of change and enhance motivation
- Help the person to design and implement individualized support plans based on an integrated assessment and their individual desires
- Advocate for, make timely referrals, and coordinate services to assure integrated continuity of care

- Communicate and collaborate with Mental Health, Substance Abuse, or Primary Care providers
- Partner with the person seeking co-occurring services in achieving their goals and in developing a clearer understanding of the dynamics impacting their current situation
- Provide specific skills training including Relapse Prevention techniques
- Provide individual or group interventions that educate, enhance motivation, and help people manage their lives without using substances
- Recognize and educate the person about classes of psychotropic medications (including addiction medications) their actions, medical risks, benefits, side effects, and possible interactions with other drugs

Advanced Level Practitioners:

- Conduct a comprehensive, longitudinal, integrated, strength-based assessment of the person's supports and needs that incorporates an evaluation of both their stage of change and level of care using ASAM criteria. Provide a diagnosis in keeping with individual licensure.
- Work with the person individually to develop and implement a long-term, integrated treatment plan, as opposed to parallel treatment plans, that accurately reflects the person's goals and abilities. Under a single license, this plan can address each condition as it relates to or affects the other and must involve collaboration with a counselor licensed in the other discipline.
- Treat the person for co-occurring disorders individually or in groups using evidence-based theories, models and methods, including Relapse Prevention techniques. Under a single license, treatment can address each condition as it relates to and affects the other and must involve coordination/collaboration with a counselor licensed in the other discipline.
- Provide family counseling and encourage family and community involvement

Appendix D: Integrated Services Policy

Department of Health and Human Services
Office of the Commissioner
Policy and Procedure Statement

Policy # DHHS-30-07

Issue Date: May 22, 2007
Revised Date:

SUBJECT

Integrated Services Framework for High Risk Families/Individuals

POLICY STATEMENT

The Mission of the Department of Health and Human Services is to provide integrated health and human services to the people of Maine, to assist individuals in meeting their needs while respecting the rights and preferences of the individual and family within available resources.

RATIONALE

The Department recognizes that there are significant numbers of adults, adolescents and families with multiple, complex needs who want the Department's assistance in addressing those needs. Such complex needs are associated with poorer outcomes and higher costs when the service system is not organized to assess, respond and provide service in an integrated way. Integrated screening, response and service delivery within a well developed service continuum constitute current recognized best practice, and failure to offer such integrated services may place people at risk. Such a system can be developed through a process of continuous performance improvement and quality control measures that are aligned with the goals of the Department.

PROCEURE STATMENT

1. It is likely that people who come to the Department and its affiliated providers for help will have complex, multiple needs. This reality must be reflected in every aspect of system planning, program design, procedure and staff competency. It is critical that all access points into the service system convey a welcoming, no wrong door approach, regardless of the needs presented. It is critical that the response be coherent, individualized and integrated rather than fragmented and disjointed.
2. The success of service delivery in any setting lies in the availability of an integrated and coordinated continuum offering multiple levels of response. It also lies in developing professional relationships that support integrated and coordinated services. For individuals, with complex needs, there should be continuity in planning among all service providers. There also needs to be continuity of planning when there are repeated or multiple service episodes.

3. Within the context of any service relationship, the response must be based on the client's strengths, impairment or disability, needs and goals.
4. When the person's service needs include multiple factors and conditions, each should be considered equally important, and an integrated approach to behavioral and environmental support promoted. Integrated approaches must be matched to needs and strengths as well as to levels of motivation for change. Appropriately matched, integrated interventions should be available at all levels of service.
5. There is no one correct way of integrating services. For each individual or family, the integration of appropriate service must be matched according to need, diagnosis, disability, strengths/supports, problems/contingencies, motivation for change, and standardized assessment of need.
6. The measurement of outcomes must also be individualized, including such factors as reduction in risk, enhanced motivation for change, individual empowerment and recovery, improved health and well-being, lowered barriers to employment, income and housing stability and improved treatment adherence. In keeping with the mission of the Department, integrated services will lead to the increased capacity of the people of Maine to enjoy safe, healthy and productive lives in whatever way is optimal for each individual or family.

Statement of Intent:

In keeping with its mission, the Department requires, in all of its provider and managed care contracts, in all licensing and MaineCare regulation, and in all of its direct work with consumers, that complex conditions be anticipated and responded to in a welcoming manner, building toward an integrated system of access, assessment, payment and care.

This policy applies to all direct and contracted providers of the Department of Health and Human Services, including its managed care vendor, its providers who address homelessness, poverty, and behavioral health, and its welfare and healthcare workers. All providers are expected to develop comprehensive, integrated, collaborative and continuous strategies of service delivery within the scope of each program's mission, design, licensure and resources. The desired outcome of this framework is a system that eliminates fragmentation and enhances the coherence, coordination and ease of access to services.

This framework also reflects an expectation of how all DHHS employees, whether administrative, supportive or direct service providers, approach their work.

Definitions

Complex Conditions: People with complex needs or conditions may have any combination of functional, protective, or concrete service needs as well as any behavioral or medical healthcare need. Conditions that may co-occur include physical health problems, trauma, mental health diagnoses, brain injury, developmental disabilities, substance abuse disorders, financial, vocational or housing need, family and child support needs, crisis support needs, acute or chronic psychiatric conditions and need for protection from risk of harm.

Integrated Services: Any of a broad range of appropriately matched and integrated services may be combined to address multiple needs. Services are designed to assist individuals or families with multiple problems and to make progress toward identified goals and objectives in all domains where priority needs have been identified. The service response is coordinated, comprehensive, collaborative and continuous. Rather than the person needing to navigate a complex system, the system organizes itself around the person's complex array of needs.

Welcoming: Welcoming is a core principle that emphasizes that all people, and particularly those with complex needs, are a priority for access and engagement in the service system, and therefore should be specifically welcomed in every program and by every provider. Welcoming emphasizes that there is "no wrong door" in the service system, that no program refuses service based on the presence of multiple conditions alone, that all individuals are proactively assisted at any door to get connected to the services that best meet their needs. All programs have the capability to address the needs of individuals with complex conditions by providing integrated services within the scope of the program's mission, design, licensure, and resources. Those that they cannot provide directly, they assist in finding the appropriate sources of services.

VII. DISTRIBUTION

All Staff via e-mail and hard copy postings on designated bulletin boards. DHHS policies can also be found on the website.

Appendix E: Post-discharge Service Utilization

Table E-1
Percentages of Consumers Using Services
COSII Enrollees and Comparison Group

	COSII Group n=318	Comparison Group n=318	Sig
Physical Health Services			
Critical Care	5.0%	11.3%	***
Emergency Room	44.3%	71.7%	***
Inpatient	25.8%	39.6%	***
Surgical	39.9%	43.1%	
Outpatient	90.8%	93.1%	
Laboratory	46.9%	35.2%	***
Imaging/Testing	67.9%	76.4%	*
Rehabilitation	23.0%	39.3%	***
Pharmacy/DME	53.1%	76.7%	***
Emergency Transportation	23.9%	33.7%	**
Other	16.7%	18.6%	
Mental Health Services			
PNMI	9.8%	9.8%	
Inpatient	10.0%	22.0%	***
Crisis Intervention	21.4%	24.2%	
ACT	7.6%	2.8%	**
Individual Therapy	56.0%	57.6%	
Group Therapy	12.0%	19.8%	**
Medication Management	48.4%	39.6%	*
Day Habilitation	0.3%	0.3%	
Day Treatment	2.2%	1.3%	
Testing/Evaluation	13.8%	13.2%	
Other	0.6%	3.1%	*
Substance Abuse Services			
Residential	13.5%	11.0%	
Detox	2.5%	13.8%	***
IOP	5.4%	3.1%	
Individual Counseling	39.0%	19.8%	***
Group Counseling	12.3%	2.2%	***
Methadone	4.7%	9.8%	*
Other	2.5%	0.9%	
Community Support Services			
Community Integration	39.3%	18.6%	***
Intensive Community Integration	4.4%	1.6%	*
Intensive Case Management	1.6%	0.9%	
Targeted Case Management	15.1%	14.2%	
Skills Development	5.7%	1.9%	*
Home Health	5.0%	3.5%	
Transportation	56.3%	50.6%	
Other	1.3%	1.3%	

Table E-2
MaineCare Claims for Services
COSII Enrollees and Comparison Group

	COSII (n=318)		Comparison Group (n=318)		Outcome	
	Number of Claims	Cumulative Cost	Number of Claims	Cumulative Cost	Percent Difference	Cost Difference
Physical Health Services						
Critical Care	45	$79,620	77	$174,361	-71.1%	($94,741)
Emergency Room	1126	$1,154,726	2188	$2,254,332	-94.3%	($1,099,606)
Inpatient	389	$906,596	791	$1,494,595	-103.3%	($587,999)
Surgical	553	$165,945	707	$255,671	-27.8%	($89,727)
Outpatient	3539	$250,330	5080	$394,638	-43.5%	($144,309)
Laboratory	4398	$787,424	6678	$1,183,797	-51.8%	($396,373)
Imaging/Testing	1921	$292,367	2791	$494,382	-45.3%	($202,015)
Rehabilitation	456	$57,615	687	$83,712	-50.7%	($26,097)
Pharmacy/DME	1479	$100,618	2390	$155,471	-61.6%	($54,854)
Emergency Transportation	375	$34,529	407	$37,048	-8.5%	($2,519)
Other	114	$6,830	119	$4,890	-4.4%	$1,941
Mental Health Services						
PNMI	1177	$986,208	1566	$635,273	-33.1%	$350,936
Inpatient	79	$287,783	186	$665,370	-135.4%	($377,587)
Crisis Intervention	939	$385,591	601	$293,679	36.0%	$91,912
ACT	215	$274,463	46	$60,662	78.6%	$213,800
Individual Therapy	1667	$165,760	1726	$168,249	-3.5%	($2,489)
Group Therapy	248	$15,243	447	$27,501	-80.2%	($12,258)
Medication Management	995	$115,374	974	$113,719	2.1%	$1,655
Day Habilitation	27	$4,014	57	$17,403	-111.1%	($13,389)
Day Treatment	421	$17,350	147	$7,366	65.1%	$9,984
Testing/Evaluation	97	$11,007	108	$12,901	-11.3%	($1,894)
Other	4	$649	18	$2,918	-350.0%	($2,270)
Substance Abuse Services						
Residential	364	$194,891	432	$206,756	-18.7%	($11,865)
Detox	23	$9,146	76	$30,221	-230.4%	($21,075)
IOP	355	$36,895	150	$15,337	57.7%	$21,558
Individual Counseling	1080	$98,129	428	$36,067	60.4%	$62,062
Group Counseling	324	$17,297	102	$6,759	68.5%	$10,538
Methadone	252	$19,744	607	$47,956	-140.9%	($28,212)
Other	18	$1,948	3	$404	83.3%	$1,544
Community Support Services						
Community Integration	5121	$466,691	2144	$211,714	58.1%	$254,977
Intensive Community Integration	91	$83,506	23	$23,805	74.7%	$59,701
Intensive Case Management	12	$8,917	25	$18,578	-108.3%	($9,660)
Targeted Case Management	222	$77,400	304	$144,803	-36.9%	($67,403)
Skills Development	444	$195,506	166	$209,052	62.6%	($13,546)
Home Health	497	$49,860	183	$18,393	63.2%	$31,467
Transportation	10298	$107,974	7174	$96,910	30.3%	$11,064
Other	43	$5,707	40	$6,126	7.0%	($418)
Total	**39408**	**$7,473,654**	**39648**	**$9,610,821**	-0.6%	($2,137,167)

Department of Health
and Human Services
Maine People Living
Safe, Healthy and Productive Lives
John E. Baldacci, Governor
Brenda M. Harvey, Commissioner