Comprehensive, Continuous, Integrated System of Care (CCISC) Model

The Comprehensive, Continuous, Integrated System of Care (CCISC) process (Minkoff & Cline, 2004, 2005) is a vision-driven system "transformation" process for re-designing behavioral health and other related service delivery systems to be organized AT EVERY LEVEL (policy, program, procedure, and practice)—within whatever resources are available —to be more about the needs of the individuals and families needing services, and the values that reflect welcoming, empowered, helpful partnerships throughout the system. The ultimate goal of CCISC is to help develop a system of care that is welcoming, recovery-oriented, integrated, trauma-informed, and culturally competent in order to most effectively meet the needs of individuals and families with multiple co-occurring conditions of all types (mental health, substance abuse, medical, cognitive, housing, legal, parenting, etc.) and help them to make progress to achieve the happiest, most hopeful, and productive lives they possibly can.

In a CCISC process, **every program and every person delivering clinical care engages in a quality improvement process—in partnership with each other, with system leadership, and with individuals and families who are receiving services—to become welcoming, recovery- or resiliency-oriented, and co-occurring capable. Further, every aspect of clinical service delivery is organized on the assumption that the next person or family entering service will have multiple co-occurring conditions, and will need to be welcomed for care, inspired with hope, and engaged in a partnership to address each and every one of those conditions in order to achieve the vision and hope of recovery.**

This model is based on the following eight clinical consensus best practice principles (Minkoff and Cline, 2004, 2005) which espouse an integrated recovery philosophy that makes sense from the perspective of both the mental health system and the substance disorder treatment system.

1. **Co-occurring issues and conditions are an expectation, not an exception.** This expectation must be included in every aspect of system planning, program design, clinical policy and procedure, and clinical competency, as well as incorporated in a welcoming manner in every clinical contact, to promote access to care and accurate screening and identification of individuals and families with multiple co-occurring issues.
2. **The foundation of a recovery partnership is an empathic, hopeful, integrated, strength-based relationship.** Within this partnership, integrated longitudinal strength-based assessment, intervention, support, and continuity of care promote step-by-step community-based learning for each issue or condition.
3. **All people with co-occurring conditions are not the same, so different parts of the system have responsibility to provide co-occurring capable services for different populations**. Assignment of responsibility for provision of such relationships can be

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determined using the four-quadrant national consensus model for system-level planning, based on high and low severity of the psychiatric and substance disorder.

4. **When co-occurring issues and conditions co-exist, each issue or condition is considered to be primary.** The best practice intervention is integrated dual or multiple primary treatment, in which each condition or issue receives appropriately matched intervention at the same time.
5. **Recovery involves moving through stages of change and phases of recovery for each co-occurring condition or issue**. Mental illness and substance dependence (as well as other conditions, such as medical disorders, trauma, and homelessness) are examples of chronic, biopsychosocial conditions that can be understood using a disease and recovery (or condition and recovery) model. Each condition has parallel phases of recovery (acute stabilization, engagement and motivational enhancement, prolonged stabilization and relapse prevention, rehabilitation and growth) and stages of change. For each condition or issue, interventions and outcomes must be matched to stage of change and phase of recovery.
6. **Progress occurs through adequately supported, adequately rewarded skill-based learning for each co-occurring condition or issue**. For each co-occurring condition or issue, treatment involves getting an accurate set of recommendations for that issue, and then learning the skills (self-management skills and skills for accessing professional, peer, or family support) in order to follow those recommendations successfully over time. In order to promote learning, the right balance of care or support with contingencies and expectations must be in place for each condition, and contingencies must be applied with recognition that reward is much more effective than negative consequences in promoting learning .
7. **Recovery plans, interventions, and outcomes must be individualized. Consequently, there is no one correct dual diagnosis program or intervention for everyone**. For each individual or family, integrated treatment interventions and outcomes must be individualized according to their hopeful goals, their specific diagnoses, conditions, or issues, and the phase of recovery, stage of change, strengths, skills, and available contingencies for each condition.
8. **CCISC is designed so that all policies, procedures, practices, programs, and clinicians become welcoming, recovery- or resiliency-oriented, and co-occurring capable.** Each program has a different job, and programs partner to help each other to be successful with their own complex populations. The goal is that each individual or family is routinely welcomed into empathic, hopeful, integrated relationships, in which each co-occurring issue or condition is identified, and engaged in a continuing process of adequately supported, adequately rewarded, strength-based, stage-matched, skill-based community-based learning for each condition, in order to help the individual or family make progress toward achieving their recovery goals.

Twelve Steps for CCISC Implementation

1. **Integrated system planning and implementation process.**
Implementation of the CCISC requires a system-wide integrated strategic planning process **and quality improvement partnership that creates an empowered partnership between all levels of the system, including consumers, families, and front line clinicians.** This partnership can address the need to create change at every level of the system, ranging from

system philosophy, regulations, and funding, to program standards and design, to clinical practice and treatment interventions, to clinician competencies and training. The integrated system planning process must be empowered within the structure of the system; include all key funders, providers, and consumer/family stakeholders; have the authority to oversee *continuing* implementation of the other elements of the CCISC; utilize a structured process of system change (e.g., continuous quality improvement); and define measurable system outcomes for the CCISC in accordance with the elements listed herein. It is necessary to include consumer- and family-driven outcomes that measure satisfaction with the ability of the system to be welcoming, ***recovery-oriented,*** accessible, ***trauma-informed,*** and culturally competent, as well as integrated, continuous, and comprehensive, from the perspective of individuals in service and their families. The COFIT-100™ (Zialogic, Albuquerque, NM) [30] has been developed to facilitate this outcome measurement process at the system level.

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

3. **Funding plan within existing resources.**
   CCISC implementation involves a formal commitment that each funder will promote ***recovery-oriented, co-occurring capable services*** within the full range of services provided through its own funding stream, whether by contract or by billable service code, in accordance with CCISC principles, and in accordance with the specific tools and standards described below. Blending or braiding funding streams to create innovative programs or interventions may also occur as a consequence of integrated systems planning, but this alone does not constitute fidelity to the model. ***CCISC supports developing the flexibility to use limited resources more creatively to design services across a whole system that are more accurately matched to the needs of complex populations, and supports using any available incentives to support providers engaged in the transformative quality improvement process.***

4. **Strategic prioritization and population based planning.**
   CCISC encourages alignment of all "initiatives" in a common transformation vision, and building energy for change from existing strategic opportunities or priorities, including funding increases or reductions. In addition, using the national consensus four-quadrant model, the system develops a written plan for identifying priority populations within each quadrant, and locus of responsibility within the service system for welcoming access, assessment, stabilization, and integrated continuing care. Commonly, individuals in quadrant I are seen in outpatient and primary care settings, individuals in quadrant II and quadrant IV are followed within the mental health service system, individuals in quadrant III are engaged in both systems but served primarily in the substance system. Each system will ***usually start the process*** with high-need high-cost priority populations (commonly in quadrant IV) that have no system or provider clearly responsible for engagement and/or treatment. As the CCISC process unfolds, the integrated system planning process is able to more easily create a plan for how to address the needs of these populations ***within existing resources.***

5. **Development and implementation of recovery oriented co-occurring capable programs.** A crucial element of the CCISC model is the expectation that all child and adult programs in the service system must meet basic standards for ***recovery-oriented co-occurring*** capability, whether in the mental health system or the addiction system. There needs to be consensus that ***each program can begin its own quality improvement process to achieve recovery-oriented co-occurring capability.*** As programs make progress, the system can develop co-occurring capability standards, and, over time, those standards can be built into funding and licensing requirements. (see items 2 and 3 above), as well as a plan for ***programs to make step by step progress toward implementation.*** COMPASS-EZ (ZiaPartners, 2009) is a program self-assessment tool for recovery-oriented co-occurring capability that can be helpful in initiating the program quality improvement process.

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

7. **Development and implementation of recovery-oriented co-occurring capable practice guidelines.**
CCISC implementation requires system-wide transformation of clinical practice in accordance with the above principles. This can be realized through dissemination and incremental developmental implementation via CQI processes of clinical consensus best-practice service planning guidelines that address assessment, treatment intervention, rehabilitation, program matching, psychopharmacology, and outcome. Obtaining input from and building consensus with clinicians prior to final dissemination is highly recommended. Existing documents **(**www.bhrm.org**)** are available to facilitate this process. Practice guideline implementation must be supported by regulatory changes (both to promote adherence to the guidelines and to eliminate regulatory barriers) and by clinical auditing and self-monitoring procedures to monitor compliance. ***Quality improvement processes*** to facilitate ***welcoming,*** access and identification, and to promote ***empathic, hopeful,*** integrated continuous ***relationships*** are a particular priority for implementation.

8. **Facilitation of welcoming, access, integrated screening and identification of multiple co-occurring conditions.**
This requires a quality improvement partnership that

   - Addresses welcoming and “no wrong door” access in all programs
   - Eliminates arbitrary barriers to initial access and evaluation

- Improves clinical and administrative practices of screening, clinical documentation, MIS reporting, and appropriate next-step intervention for individuals and families with co-occurring conditions.

9. **Implementation and documentation of integrated services.**
Integrated treatment relationships are a vital component of the CCISC. Implementation requires ***creating a quality improvement process in which clinicians and managers work in partnership on the process of developing and documenting*** an integrated treatment ***or recovery*** plan in which the client ***or family*** is assisted to make progress toward hopeful goals by following issue-specific and stage-specific recommendations for each ***issue*** simultaneously. This expectation must be supported by clear definition of the expected "scope of practice" for singly licensed clinicians regarding co-occurring disorder [35, 36], and incorporated into standards of practice for reimbursable clinical interventions—in both mental health and substance settings—for individuals who have co-occurring conditions.

10. **Development of recovery-oriented co-occurring competencies for all clinicians.**
Creating the expectation that all clinicians can make progress to develop universal competency, including attitudes and values, as well as knowledge and skill, is a significant characteristic of the CCISC process. Available competency lists for co-occurring conditions, such as the 12 Steps for Clinicians, can be used as a reference for beginning a process of consensus-building regarding the competencies. Mechanisms can be developed to establish competencies in existing human resource policies and job descriptions, to incorporate them into personnel evaluation, credentialing, and licensure, and to measure and support clinician attainment of competency. Competency self-assessment tools (e.g., ***CODECAT-EZ™ ZiaPartners, 2009***) can be utilized to facilitate this process.

11. **Implementation of a change agent team.**
In the CCISC quality improvement process, both program capability development and clinician competency development occur through a top-down, bottom-up partnership, in which front-line clinicians and consumer/family change agents in each program work in partnership with leadership to effect the change. Further, the change agents in a system ideally become an empowered team to represent the principles and values of front-line service delivery and service recipients in the system planning and implementation process. ZiaPartners has developed a Change Agent Curriculum Manual for Michigan and provided initial training to hundreds of change agents statewide to initiate this process**.**

12. **Development of a plan for a comprehensive program array.**
The CCISC model requires development of a strategic plan in which each existing program begins to define and implement a specific role or area of competency with regard to provision of ***recovery-oriented co-occurring-capable*** service for people with co-occurring conditions, within the context of available resources. This plan should also identify system gaps that require longer-range planning and/or additional resources to address, and identify strategies for filling those gaps. Four important areas that must be addressed in each CCISC process are:

- **Evidence-based best practice:** There needs to be a specific plan for identification of any evidence-based best practice for any mental illness (e.g., Individualized Placement and Support for vocational rehabilitation) or substance disorder (e.g., buprenorphine maintenance), or an evidence-based best-practice program model for a particular co-

occurring disorder population (e.g., Integrated Dual Disorder Treatment for SPMI adults in continuing mental health care) that may be needed but not yet be present in the system, and planning for the most efficient methods to promote implementation in such a way that facilitates access to co-occurring clients that might be appropriately matched to that intervention.

- **Peer dual recovery supports:** The system can identify at least one dual recovery self-help program (e.g., Dual Recovery Anonymous has been identified in Michigan) and establish a plan to facilitate the creation of these groups throughout the system. The system can also facilitate the development of other peer supports, such as recovery coaching, peer outreach and peer counseling.
- **Residential supports and services:** The system should begin to plan for a comprehensive range of programs that addresses a variety of residential needs, building initially upon the availability of existing resources through redesigning those services *with the recognition that co-occurring conditions are an expectation.* This range of programs should include:
  - DDC/DDE addiction residential treatment (e.g., modified therapeutic community programs) [41]
  - Abstinence-mandated (dry) supported housing for individuals with psychiatric disabilities
  - Abstinence-encouraged (damp) supported housing for individuals with psychiatric disabilities
  - Consumer-choice (wet) supported housing for individuals with psychiatric disabilities at risk of homelessness. [42]
- **Continuum of levels of care:** All categories of service should be available in a range of levels of care, including outpatient services of various levels of intensity, intensive outpatient or day treatment, residential treatment, hospital diversion programming, and hospitalization. This can often be operationalized in managed care payment arrangements and may involve more sophisticated levels of care assessment capacity.

CCISC implementation is an ongoing quality improvement process that encourages the development of a <u>plan</u> that includes attention to each of these areas in a comprehensive service array.