Virtual Site Visits as a Methodology to Assess Health Organizations' Capacity to Provide Integrated Services for Individuals with Co-Occurring Disorders

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Background: Providing quality integrated services for individuals with co-occurring disorders (CODs) is a prioritized, yet elusive goal. Accordingly, the Northwest ATTC assisted substance use disorder (SUD) organizations to identify corresponding improvement goals via a validated organizational assessment, the Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index at outset of an intensive technical assistance project. Due to the COVID-19 pandemic, traditional in-person site visits for this DDCAT assessment were amended so all procedures instead occurred virtually.

Methods: The DDCAT, a benchmarking instrument comprised of seven subscales (i.e., structure, milieu, assessment, treatment, care continuity, staffing, training) for which an external rater scores each of 35 individual elements on a 5-point scale (1=addiction-only services, 3= dual diagnosis capable, 5=dual diagnosis-enhanced services), was completed with ten SUD programs. Designed to replicate on-site visits of traditional DDCAT assessments, Zoom-enabled virtual site visits included data gathering by Northwest ATTC staff/contractor via a site tour; interviews with leadership, clinical and support staff, and clients; ethnographic observations; and records review. The mean and distribution of the resulting DDCAT subscale scores were examined for representativeness, relative to published norms.

Results: Virtual site visits were successfully completed with all ten SUD organizations. Mean DDCAT subscale scores for this sample were slightly elevated (+.50-.75 SD) relative to published norms and with similar distribution, as might be expected of SUD organizations voluntarily participating in a project focused on organizational capacity to provide integrated COD services. Figure 1 shows the DDCAT average dimension scores relative to published norms from McGovern et al[1]. A post-event survey revealed 100% of participating SUD staff expressed satisfaction with their experience and indicated plans to use this information to change their practice.

Conducting DDCAT site visits virtually are comparable to published norms for on-site DDCAT site visits.
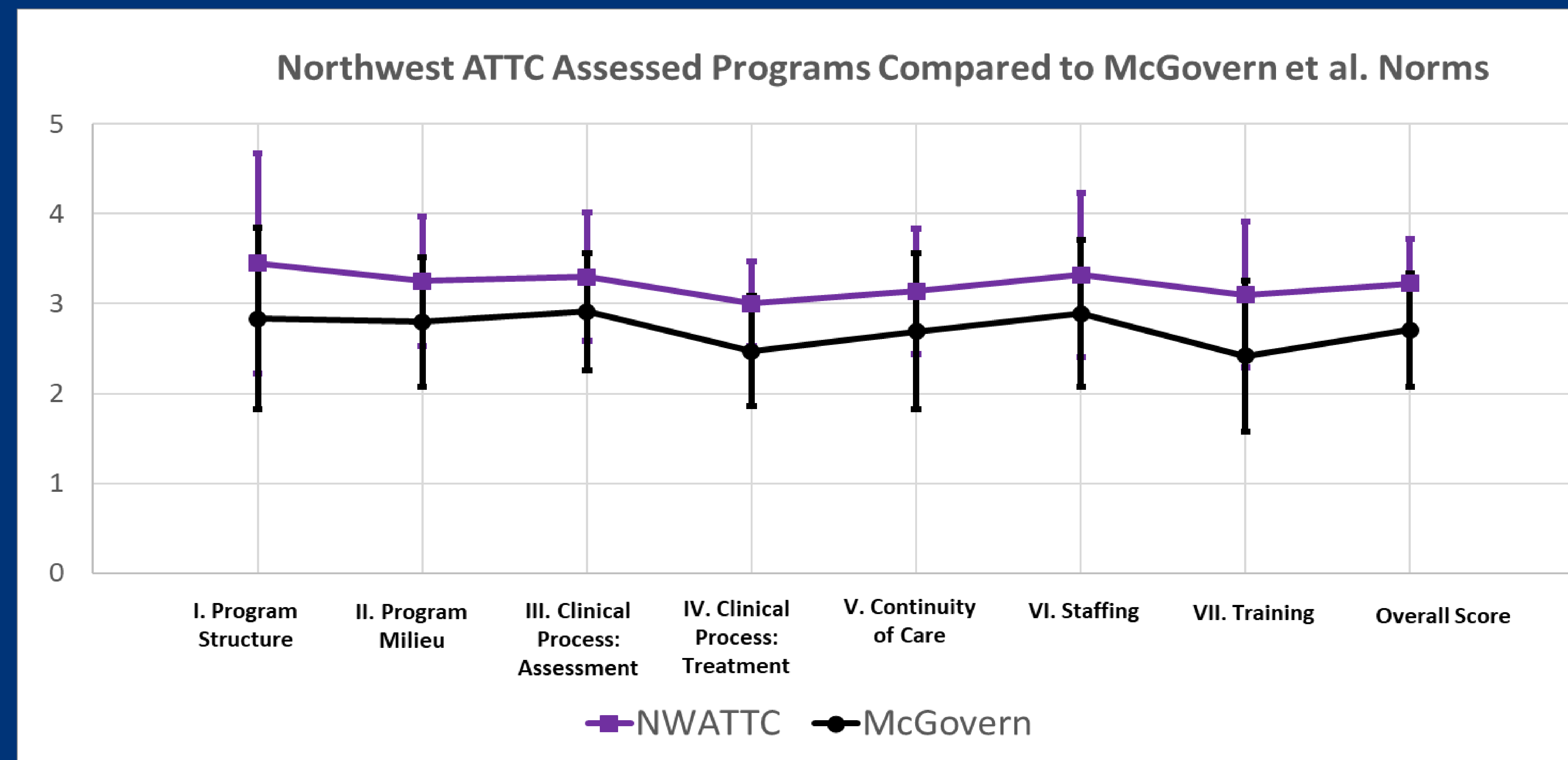

Figure 1. Profile of DDCAT dimension scores for the 10 addiction treatment programs at 10 organizations for each DDCAT dimension and the total overall DDCAT Score, superimposed over the means and standard deviations from McGovern et al.'s (2014) survey of 180 addiction treatment programs. As shown in the figure, programs surveyed by NWATTC generally had subscale scores that were slightly above the subscale means in McGovern et al. yet still within the bounds of comparable norms.

1.McGovern PhD, Aurora L. Matzkin MA & Julienne Giard MSW (2007) Assessing the Dual Diagnosis Capability of Addiction Treatment Services: The Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index, Journal of Dual Diagnosis, 3:2, 111-123, DOI: 10.1300/J374v03n02_13

Discussion: The baseline DDCAT scores in this sample were slightly elevated from the McGovern et al[1] published norms, which likely reflects a self-selection bias, as these programs were committing to a year-long technical assistance project aimed towards enhancing integration. Notably, a possible historical influence is increased recognition that integration of MH and SUD services now receives. The experience and data gathered herein demonstrate the feasibility of administering the DDCAT index virtually. However, salient adaptations to the DDCAT process include:

- Virtual site visits require extensive preparation and planning around securing the documents (policy and procedure manuals, schedules, confidentiality releases) for review prior to the site visit.
- Technology is essential, a Dropbox site was used to facilitate this process. Equipment, computer skills and Internet connections are integral.
- An on-site DDCAT site visit is 4-6 hours in duration, whereas a virtual site visit required 6-8 hours.
- Preparation for virtual site visits require detailed communication between site evaluators, evaluation program staff, and site contacts in order to outline expectations for how site visit procedures would be organized and conducted.

Conclusions: Virtual site visits represent an innovative strategy to assess organizational capacity to provide integrated services. This work documents feasibility in procedures, and representativeness of the resulting DDCAT data. Virtual site visit methodology carries potential to reduce costs and increase both reach and availability of such organizational assessments.