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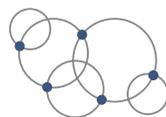
Addiction Technology Transfer Center Network  
Funded by Substance Abuse and Mental Health Services Administration



# ATTC WHITE PAPER:

INTEGRATING SUBSTANCE USE DISORDER AND HEALTH  
CARE SERVICES IN AN ERA OF HEALTH REFORM

MARCH 2015



**ATTC**

Advancing the Integration  
of Substance Use Disorder  
Services and Health Care

Prepared by:

ATTC Technology Transfer Workgroup: Stanley Sacks, PhD, and Heather J. Gotham, PhD, (Co-Chairs) with  
Kim Johnson, PhD, Howard Padwa, PhD, Deena Murphy, PhD, and Laurie Krom, MS



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Corresponding Author: Heather J. Gotham, PhD, School of Nursing and Health Studies, University of Missouri-Kansas City, [gothamhj@umkc.edu](mailto:gothamhj@umkc.edu)

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# Executive Summary

*Integrating Substance Use Disorder and Health Care Services in an Era of Health Care Reform* is the first in a series of white papers produced as part of the Addiction Technology Transfer Center (ATTC) Network's initiative, "Advancing the Integration of Substance Use Disorder Services and Health Care." The main goals of this white paper are to emphasize the need for better integration of substance use disorder (SUD) and health care services and describe an array of effective models, interventions and implementation strategies for treating SUDs in health care settings, highlighting efforts of the ATTC Network. The target audience for this document includes all those concerned with the integration of SUD and health care: the SUD, mental health, and health care workforces; policy makers; state officials; health and behavioral health treatment administrators; physicians, nurses, social workers, psychologists, and peer workers; and third party payers.

The ATTC Network is the Substance Abuse and Mental Health Services Administration's (SAMHSA) most experienced program to provide workforce development and to promote the adoption and implementation of research-based interventions in the SUD field. The ATTC Network employs a full array of technology transfer techniques, including product development, academic education, training, technical assistance and skills building, online and distance learning, coaching and implementation support/guidance, to help individuals, organizations and systems prepare for, make, and sustain change.

Comprised of ten Regional Centers that align with the ten Department of Health and Human Services (HHS) regions, four National Focus Area Centers and a Network Coordinating Office, the ATTC Network has both a national reach and a targeted regional/state emphasis. At the national level, the Network collaborates and partners with many national SUD and behavioral health care organizations to produce

projects that have an impact nationwide. At the regional/state level, ATTCs reach deep into local communities and are able to customize services to meet the needs of a particular area.

ATTC expertise in implementation science/technology transfer strategies combined with the complimentary national and regional reach of the various Centers situates the ATTC Network in an ideal place to promote and facilitate efforts to integrate SUD services and health care. A number of ATTCs have already begun such work, examples of which are provided throughout the paper. For a comprehensive list of the Network's integration projects, please visit: <http://www.attcnetwork.org/advancingintegration/index.aspx>.

This paper is divided into five sections. Section 1 discusses two major influences on integration, a growing body of research evidence for the effectiveness of integration and health care reform, including the Affordable Care Act (ACA). Health care reform and the ACA are destined to have a powerful influence on the delivery of health care services nationwide, including treatment for SUDs and the training of the SUD workforce. Sections 2 and 3 respectively examine a variety of effective models of integration and evidence-based clinical interventions that can be utilized in health care settings. Section 4 describes strategies for implementing integrated care in health care environments. Each section reviews key research in support of integration and illustrates selected ATTC activities in that area. Section 5 provides a summary and conclusions. The paper can serve as a resource for those who are pursuing the integration of SUD and health care services.

## 1. Integration in the Era of Health Care Reform

The Substance Abuse and Mental Health Services (SAMHSA) – Health Resources and Services Administration (HRSA) Center for Integrated Health Solutions defines integrated

care as “the systematic coordination of general and behavioral health care. Integrating mental health, substance abuse, and primary care services [that] produces the best outcomes and proves the most effective approach to caring for people with multiple health care needs” (2015). The momentum for the integration of SUD and health care services is being driven by (a) a growing body of research evidence showing better patient outcomes from integrated services, and (b) policy changes resulting from health care reform.

Research increasingly shows that integrating SUD and health care services improves patient outcomes. Successful integration efforts indicate that SUDs are common and should be addressed in the same way as other common diseases, via screening, a focus on harm reduction and symptom relief, use of evidence-based practices, and, as needed, chronic disease management. The benefits of integrated care extend to patients, caregivers, providers, and the health care system. The integration of SUD services and primary care can lead to improved physical and mental health (Madras et al., 2009), reduce levels of substance use (Gryczynski et al., 2011; Madras et al., 2009), and result in cost savings for health care (Babor et al., 2007).

“The Affordable Care Act and its implementing regulations, building on the Mental Health Parity and Addiction Equity Act, will expand coverage of mental health and substance use disorder benefits and federal parity protections in three distinct ways: 1) by including mental health and substance use disorder benefits in the Essential Health Benefits; 2) by applying federal parity protections to mental health and substance use disorder benefits in the individual and small group markets; and 3) by providing more Americans with access to quality health care that includes coverage for mental health and substance use disorder services” (Beronio, Po, Skopec, & Glied, 2013). It includes coverage for SUDs in recognition of their prevalence and role in causing or contributing to other serious health conditions (Buck, 2011; McLellan, 2014). Through the Triple Aim of improving the

*SAMHSA’s ATTC Network is the “go to” resource as states, providers, and the SUD treatment workforce embark on change under the ACA. The Network has the standing, resources, processes, and experience to train the SUD workforce and guide the integration of SUD services with mental health and primary health care services.*

patient experience of care, improving the health of the population, and decreasing the per capita cost of care (Berwick, Nolan, & Whittington, 2008), the ACA incentivizes coordinated and integrated care with the use of evidence-based practices that lead to improved clinical outcomes.

For the SUD treatment and recovery services fields, health care reform is projected to change the number and characteristics of the patient population receiving services, the structure and nature of providers and services, and to promote the integration of SUD and primary care services (Patient Protection and Affordable Care Act, 2013). Unfortunately, early signs suggest that the integration of SUD treatment services is not receiving adequate attention in health care settings. (Lardiere, Jones, & Perez, 2011; NORC, 2011; Sacks & Chaple, 2013; SAMHSA, 2010a, b).

A variety of challenges may impede the progress of integration, including needs to define and develop appropriate services; cultivate staff support; identify strategies for implementing change; train the SUD, mental health, and medical workforces; bring payers to the table; and transcend the currently bifurcated systems of SUD and mental health care. On the other hand, as integration moves forward, it creates opportunities for the current SUD workforce to work in new settings. This paper outlines recommendations for areas of change needed for the SUD treatment community to be prepared to integrate services.

## 2. Models of Integrated Care

Several reports suggest that health care programs can be categorized by the level of collaboration/integration in their clinical service models (Collins, Hewson, Munger, & Wade, 2010). Thus, the organization of service programs can be arrayed descriptively across levels of integration, suggesting points on a continuum from less to more integration and from less to more integrated programs, such that coordinated care precedes co-located care, which precedes integrated care (Collins et al., 2010; Treatment Research Institutes, 2010). Section 2 describes useful models for conceptualizing the integration of behavioral health and health care services (see also the SAMHSA-HRSA CIHS website: <http://www.integration.samhsa.gov/integrated-care-models>). Patient-centered medical homes, FQHCs, and the newly developing certified community behavioral health clinics are three settings that have begun integrating services. The ATTC Network has been actively bringing health and SUD treatment players to the table to accelerate integration efforts across the country. The Appendix provides a convenience sample of some current real-world examples that emphasize the integration of SUD and health care services.

## 3. Interventions

Regardless of the model of integration applied, evidence-based practices must be used to meet the goal of improving quality of care. During the past 30 years, a substantial body of rigorous study has led to the development and validation of numerous evidence-based treatments for SUDs (e.g., medication-assisted treatment, motivational interviewing, contingency management). A number of effective clinical practices are compatible with the existing structure and functioning of primary or other health care services. Section 3 of this white paper describes evidence-based SUD treatment interventions that may be easily integrated with other health care services, analyzes the research evidence for each, and presents an overview of the Network's activities in supporting and guiding the use of these interventions.

Promoting dissemination and implementation of evidence-based practices for SUD treatment is the primary focus of the NIDA/SAMHSA-ATTC Blending Initiative (Martino et al., 2010). Using recently completed NIDA research, "blending teams," comprised of NIDA researchers, clinical treatment providers, and ATTC Network staff design user-friendly tools or products and introduce them to treatment providers. The Network uses the NIDA/SAMHSA Blending products for medication-assisted treatment, motivational interviewing, technology-assisted care, and contingency management/motivational incentives in its training, technical assistance, and technology transfer/implementation activities.

## 4. Technology Transfer/Implementation Support and Guidance

Changing practice patterns, routines, and treatments is difficult. Integrating SUD treatment services and health care is subject to all the complexity and difficulties that attend any organizational change initiative. Recent advances in implementation science have delineated conceptual models and principles that help to change treatment practices (see for example, Damschroder et al., 2009). The ATTC Network places a unique emphasis on technology transfer and implementation support/guidance to achieve lasting changes in practice. Section 4 describes these scientific/conceptual advances and the related products and methods the Network employs to accomplish change.

## 5. Summary and Conclusions

This paper focuses on: 1) the need for better integration of SUD and health care services; and 2) a description of effective models, evidence-based interventions, and implementation strategies that are useful in treating SUDs in health care settings, highlighting efforts of the ATTC. SAMHSA's ATTC Network is uniquely situated to facilitate and accelerate SUD and health care service integration at the state, regional, and national levels.

# Integrating Substance Use Disorder and Health Care Services in an Era of Health Reform

*ATTC Technology Transfer Workgroup: Stanley Sacks, PhD, and Heather J. Gotham, PhD, (Co-Chairs) with Kim Johnson, PhD, Howard Padwa, PhD, Deena Murphy, PhD, and Laurie Krom, MS*

## Introduction

*Integrating Substance Use Disorder and Health Care Services in an Era of Health Care Reform* is the first in a series of white papers produced as part of the Addiction Technology Transfer Center (ATTC) Network's initiative, Advancing the Integration of Substance Use Disorder Services and Health Care. The main goals of this white paper are to emphasize the need for better integration of substance use disorder (SUD) and health care services and describe an array of effective models, interventions and implementation strategies for treating SUDs in health care settings, highlighting efforts of the ATTC Network. The target audience for this document includes all those concerned with the integration of SUD and health care: the SUD, mental health, and health care workforces; policy makers; state officials; health and behavioral health treatment administrators; physicians, nurses, social workers, psychologists, and peer workers; and third party payers.

The ATTC Network is the Substance Abuse and Mental Health Services Administration's (SAMHSA) most experienced program to provide workforce development and to promote the adoption and implementation of research-based interventions in the SUD field. The ATTC Network employs a full array of technology transfer techniques, including product development, academic education, training, technical assistance and skills building, online and distance learning, coaching and implementation guidance, to help individ-



uals, organizations and systems prepare for, make, and sustain change.

Comprised of ten Regional Centers that align with the ten Department of Health and Human Services (HHS) regions, four National Focus Area Centers and a Network Coordinating Office, the ATTC Network has both a national reach and a targeted regional/state emphasis. At the national level, the Network collaborates and partners with many national SUD and behavioral health care organizations (e.g., NAADAC, the National Council for Behavioral Health, Faces and Voices of Recovery, the American Association of Addiction Psychiatrists, the American Society of Addiction Medicine, the International Certification and Reciprocity Consortium) to produce projects and activities that have an impact

nationwide. At the regional/state level, ATTCs reach deep into local communities and are able to customize services to meet the needs of a particular area.

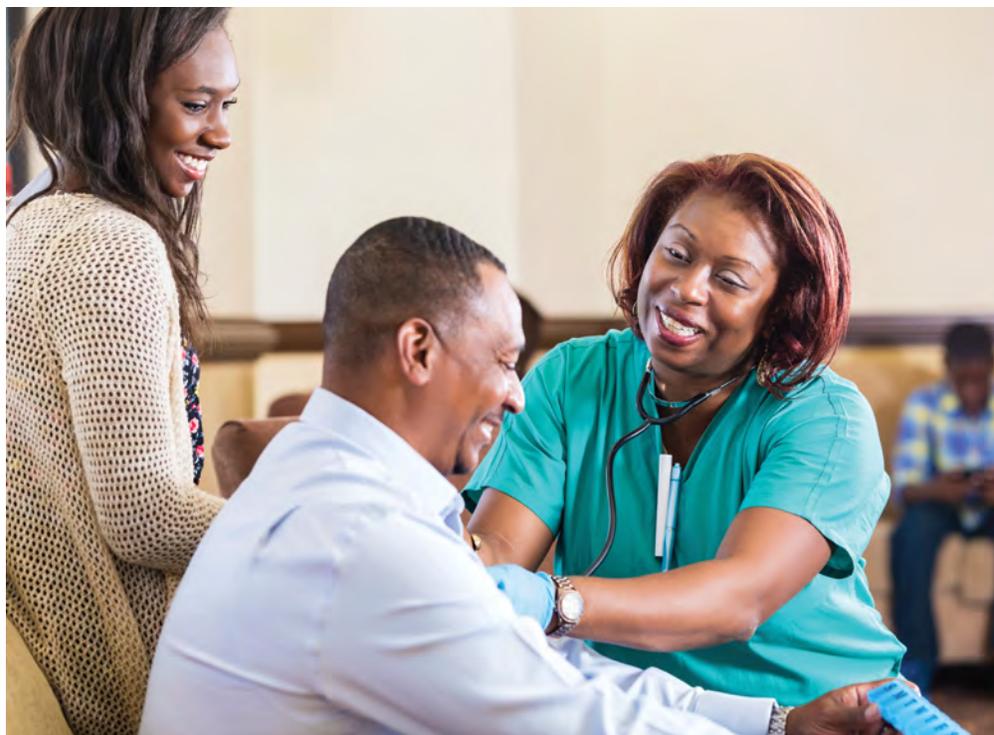
One of the unique features of the ATTC Network is its ability to bring locally tested efforts to scale nationally. Due to the structure of the Network, ATTCs are able to develop and test projects locally in organizations, states and regions, and then bring them to scale nationally through cross-ATTC collaboration. One example of this process is the soon-to-be released hepatitis C virus (HCV) initiative, “HCV Current,” a national campaign to train medical and behavioral health professionals on HCV. Beginning work at the local level, ATTC Regional Centers identified the needs of their regional workforces and sought the expertise of regional stakeholders. This local model, in which the needs and expertise of each region were leveraged, is now being brought to scale nationally through a cross-ATTC workgroup. Workgroup members developed online and in-person training curricula and resources to increase knowledge of HCV among medical and behavioral health professionals. Through national and regional training of trainer events, experts across the country will be trained to deliver the curricula. It is anticipated that “HCV Current” will increase the capacity of medical and behavioral health professionals to screen for and appropriately address HCV among patients.

ATTC expertise in technology transfer strategies combined with the national and regional reach of the various Centers situates the ATTC Network in a favorable place to promote and facilitate efforts to integrate SUD services and health care. A number of ATTCs have already begun such work. Throughout this paper, specific activities of the ATTCs to facilitate integration

of health care services will be highlighted. Look for the “Spotlight on ATTC Integration Work” examples that provide these selected illustrations. For a comprehensive list of the Network’s integration projects, please visit:

<http://attcnetwork.org/advancingintegration/index.aspx>.

This paper is divided into five primary sections. Section 1 discusses two major influences on integration: the growing body of evidence for the effectiveness of integration, and health care reform, including the Affordable Care Act (ACA). This section also examines the ACA’s powerful influence on health care, SUD treatment, and workforce development. Sections 2 and 3 respectively examine a variety of effective models of integration and clinical interventions that can be utilized in health care settings. Section 4 describes strategies for implementing evidence-based SUD practices in health care environments. Each of these sections reviews representative research in support of integration and illustrates selected ATTC activities in that area. Section 5 presents a summary and conclusions. The paper can serve as a resource for those who are pursuing the integration of SUD and health care services.



# 1. Integration in the Era of Health Care Reform

The SAMHSA – Health Resources and Services Administration (HRSA) Center for Integrated Health Solutions defines integrated care as “the systematic coordination of general and behavioral health care. Integrating mental health, substance abuse, and primary care services [that] produces the best outcomes and proves the most effective approach to caring for people with multiple health care needs” (2015).

The momentum for the integration of SUD and health care services is being driven by (a) a growing body of research evidence showing better patient outcomes from integrated services, and (b) policy changes resulting from health care reform (the ACA, its implementing regulations, and the Mental Health Parity and Addiction Equity Act). As these forces coalesce to move integration forward, the current SUD specialty care system will need to expand and adapt. This section highlights research evidence for integration, the impact of health care reform, and challenges and opportunities for the SUD workforce.

## Evidence for Integrating SUD and Health Care Services

### The Integration of SUD Services into Health Care

The benefits of integrated care extend to patients, caregivers, providers, and the health care system. Research demonstrates that the integration of SUD services and primary care can lead to improved physical and mental

health (Friedmann, Hendrickson, Gerstein, Zhang, & Stein, 2006; Gourevitch, Chatterji, Deb, Schoenbaum, & Turner, 2007; Laine et al., 2000; Madras et al., 2009) and reduce levels of substance use (Gryczynski et al., 2011; Madras et al., 2009), and can result in cost savings for health care (Babor et al., 2007; Parthasarathy, Mertens, Moore & Weiner, 2003).

More specifically, integrating SUD services into health care can help improve access to much needed treatment services for many who could benefit from SUD services but do not receive them. Of the 22.7 million Americans who need specialty treatment for SUDs, only 2.5 million—just under 11%—actually receive these services (SAMHSA, 2014a). Many of the 20.2 million people who need but do not receive SUD services appear in medical settings for physical or mental health issues

that are related—directly or indirectly—to their substance use (Ernst, Miller, & Rollnick, 2007). Over 7.5 million individuals receive emergency room treatment for problems related to alcohol use (McDonald, Wang, & Camargo, 2004), and approximately 22% of all patients in health care settings have a substance use condition (Treatment Research Institute, 2010). Consequently, medical settings are ideal places to identify individuals with SUDs, engage them in understanding the need for treatment, and begin providing services (Babor et al., 2007; Cantor et al., 2014; Cherpitel & Ye, 2008).

The integration of SUD services into health care can also help prevent risky drinking and drug use from developing into more serious problems. Approximately 68 million Amer-

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icans drink alcohol or use drugs in harmful ways but do not meet diagnostic criteria for a SUD (Humphreys & McLellan, 2010). These individuals may not need intensive, specialty SUD treatment, but their drinking and drug use behaviors can produce an undesirable effect. It can cause significant and permanent changes in the brain's reward circuitry—alterations that may, in some individuals, lead to SUDs. Through brief intervention services to address these behaviors, providers in primary and specialty health care settings can reduce the frequency and intensity of substance use and help prevent drinking and drug habits from evolving into more serious disorders. Accordingly, health care settings can supply SUD prevention/early intervention services.

A growing body of evidence supports the use of treatments that integrate SUD services with medical care. Care management programs for alcohol use disorders delivered in primary care have been associated with higher rates of patient engagement in treatment and a significantly lower number of drinking days than specialty SUD care provided separately (Lee, Kresina, Campopiano, Lubran, & Clark, 2015; Oslin et al., 2014).

Services for individuals with severe SUDs can also utilize a chronic disease management approach, which involves the delivery of longitudinal, patient-centered care by a multidisciplinary team of health professionals. Primary care patients with severe SUD are frequently willing to engage in chronic disease management programs focused on SUDs (Kim et al., 2011), and individuals who receive these services have an increased likelihood of achieving abstinence from heroin, cocaine, and heavy alcohol use (Kim et al., 2012). Studies have shown that for individuals with SUD-related medical conditions, SUD services that are integrated with primary care are almost twice as likely to lead to abstinence than services provided separately (Weisner, Mertens, Parthasarathy, Moore & Lu, 2001), and are associated with significant decreases in hospitalization, inpatient medical care, and emergency room use (Parthasarathy et

al., 2003). Consequently, integrating SUD services with primary care for individuals with SUD-related medical conditions can cut their overall medical costs by more than 50 percent (Parthasarathy et al., 2003).

## **The Integration of Health Care into Specialty SUD Treatment Settings**

Integrating health care services into specialty SUD treatment settings has also shown promise for improving outcomes for SUD patients. Individuals with SUDs have complex health needs, as frequent drinking and drug use are associated with myriad health problems (Druss & von Esenwein, 2006). Overall, substance use contributes to more than 70 conditions that require medical care, and over half of individuals with an SUD have another health condition as well (National Center on Addiction and Substance Abuse, 2012). SUDs increase risks for pregnancy complications, cancer, and a host of gastrointestinal, cardiovascular, pulmonary, renal, hematological, gynecological, and metabolic problems (National Center on Addiction and Substance Abuse, 2012; Parthasarathy et al., 2003; Stein, 1999). Chronic and serious conditions such as arthritis, asthma, hypertension, and ischemic heart disease are more than twice as prevalent among patients with SUDs as in the rest of the patient population (Mertens, Lu, Parthasarathy, Moore, & Weisner, 2003). Moreover, the risk-taking behavior and needle sharing associated with some types of substance use put individuals at increased risk for communicable diseases such as HIV/AIDS and Hepatitis C (Clark, O'Connell, & Samnaliev, 2010).

Providing primary care services integrated with specialty SUD care has shown promise as a way to reduce the elevated risk for medical problems associated with SUDs. Individuals in specialty SUD treatment that is co-located with primary care services are more likely to remain engaged in SUD treatment and to access primary care services (Saxon et al., 2006), and have significantly lower SUD severity

after 12 months when compared to patients in SUD treatment who were referred to outside providers for medical care (Friedmann, Zhang, Hendrickson, Stein & Gerstein, 2003).

In methadone treatment settings, patients are more likely to receive medical care if it is offered onsite instead of through a referral to an outside clinic (Umbricht-Schneiter, Ginn, Pabst, & Bigelow, 1994), and the delivery of primary care services on site in specialty SUD programs is associated with decreased use of emergency department and hospital services (Friedmann et al., 2006). Research has also demonstrated improved health outcomes when SUD treatment programs provide health care services in opiate treatment programs for people with HIV / AIDS (Bakti, 1988; Selwyn, Budner, Wasserman, & Arno, 1993).

## Impact of Health Care Reform

As research evidence mounts for the effectiveness of integrated care, on the policy side, health care reform is destined to have a powerful effect on the delivery of health care services nationwide, including treatment for SUDs and the training of the SUD workforce. “The Affordable Care Act and its implementing regulations, building on the Mental Health Parity and Addiction Equity Act, will expand

coverage of mental health and substance use disorder benefits and federal parity protections in three distinct ways: 1) by including mental health and substance use disorder benefits in the Essential Health Benefits; 2) by applying federal parity protections to mental health and substance use disorder benefits in the individual and small group markets; and 3) by providing more Americans with access to quality health care that includes coverage for mental health and substance use disorder services” (Beronio, Po, Skopec, & Glied, 2013).

The ACA includes coverage for SUDs in recognition of their prevalence and role in causing or contributing to other serious health conditions (Buck, 2011; McLellan, 2014). Through the Triple Aim of improving the patient experience of care, improving the health of the population, and decreasing the per capita cost of care (Berwick, Nolan, & Whittington, 2008), the ACA incentivizes coordinated and integrated care with the use of evidence-based practices that lead to improved clinical outcomes.

For the SUD treatment and recovery fields, health care reform is projected to lead to a number of changes. Historically, services for SUD were time or session limited by insurance coverage. These financial limitations have restricted the range of treatment components (medications, therapies, support services, etc.) that could be provided within any treatment program. However, as health insurance coverage continues to increase, more individuals who engage in substance use or have SUDs will become eligible for services. As care for addictions is required to be similar in content and structure as care for other chronic illnesses, the amount of services that people are eligible for will increase. Also, the structure and nature of providers and services will also change, in that rather than being restricted to community-based specialty providers, financed for the most part by state and locally generated and administered funds, health care reform will expand treatment to other health care settings, including the integration of SUD and health care services (Patient Protection and Affordable Care Act, 2013).



## Guide for the Addiction Workforce to Prepare for Integrating SUD/Health Care Services

- Obtain retraining to acquire the knowledge and skills required in the new integrated service settings.
- Plan to work in different organizational entities, and engage with a variety of medical and mental health professionals.
- Expand your role to include prevention, wellness, and early intervention to help those with risky alcohol and/or drug use but not SUDs.
- Obtain training to provide recovery supports and assume new roles as patient navigators, health educators, and care coordinators.
- Attain credentialing that allows billing services under Medicaid and private insurer funding standards. (Funding standards may also need some adaptation.)
- Prepare to assume leadership roles on behavioral health/primary care teams.
- Enhance your clinical supervisory skills.
- Support health care integration using a variety of models (including locating SUD treatment and primary care in community, work and school settings; locating primary care services in SUD treatment facilities; and integrating records across services in multiple locations).

Sources: Buck, 2011; Chalk, 2014; Dennis, Clark, & Huang, 2014; Treatment Research Institute 2010, 2011.

## Opportunities and Challenges in Integration

As desirable as the objective of integrated care is, a variety of challenges may impede its progress. These include the needs to define and develop appropriate services; cultivate staff support for new initiatives; identify strategies for implementing change; train the SUD, mental health, and medical workforces; bring payers to the table (as they will be important drivers of integrated care); and transcend the currently bifurcated systems of SUD and mental health care.

With change and challenges, also come new opportunities. Expanding services for SUDs, including prevention and early intervention, will provide new opportunities for the current SUD treatment workforce to work in new settings. Several authors (Buck, 2011; Chalk, 2014; Dennis, Clark, & Huang, 2014; Padwa et al., 2012; Treatment Research Institute, 2010, 2011) have described the following as signif-

icant areas of change for the SUD treatment community in fulfilling the intent of the ACA:

- Behavioral health care staff will need retraining to acquire the knowledge and skills required in the new integrated service settings. Physicians will have to learn how to identify, treat, or refer patients with substance use problems. Currently, few medical schools include a comprehensive course in SUDs.
- The SUD (and primary care) workforces will both need to support health care integration using a variety of models (including locating SUD treatment and primary care in community, work and school settings; locating primary care services in SUD treatment facilities; and integrating records across services in multiple locations).
- SUD counselors will need to pursue credentialing that permits them to bill their services under Medicaid and private insurer funding

## ■ Spotlight on ATTC Integration Work: Mid-America ATTC

### *A Changing Health Care Landscape: Can Your Organization Weather the Storm?*



The Mid-America ATTC collaborated with the State Associations of Addiction Services (SAAS) to create the model program, “A Changing Health Care Landscape: Can Your Organization Weather the Storm?”, which was designed to facilitate state discussion of health care reform and integration of SUD services into health care settings. The program included the following components:

**Securing buy-in from state leadership:** Mid-America ATTC met with state leaders in Iowa, Kansas, Missouri, and Nebraska to gain SSA Director support for state-specific events.

**Assessing readiness for health care reform:** State-licensed SUD treatment program leaders were invited to complete a free, confidential, online tool to assess their readiness for health care reform. Developed by SAAS, the Provider Readiness and Capabilities Assessment (RCA) generated an automatic health care reform readiness assessment.

**“A Changing Health Care Landscape: Can Your Organization Weather the Storm?”** event held in each state: Each event included presenters from organizations such as the National Association of County Behavioral Health and Developmental Disabilities Directors, Advocates for Human Potential, and SAAS. The events also featured a presentation on the RCA results, with comparisons of the data aggregated across the state to a national data set of 500 organizations across six key areas: general management, marketing, information technology and data management, clinical and human resources, finance, and provider network organizations. The program included focus groups and discussion sessions for in-depth conversations about what actions to take based on the RCA results.

**Follow-up technical assistance:** The Mid-America ATTC provided follow-up TA in each state targeting the readiness areas of most concern to providers.

standards. The funding standards may also need some adaptation.

- As the patient population expands beyond SUDs to include those with risky use, the SUD workforce will need to expand its role to include prevention, wellness, and early intervention.
- Senior SUD staff will need to be prepared to assume leadership roles on behavioral health/primary care teams.
- Clinical supervision will become even more critical.

Despite the increased evidence for the effectiveness of integrated SUD and health services and the push toward integration through health care reform, unfortunately, early signs suggest that the integration of SUD treatment services is not receiving adequate attention in health care settings. (Lardiere, Jones, & Perez, 2011; NORC, 2011; Sacks & Chaple, 2013; SAMHSA, 2010a, b).

The ATTC Network has the resources to overcome these impediments. One of the goals of this paper is to provide the audience with critical information on models, interventions and implementation strategies that are useful when engaging in efforts to integrate SUD and health care services.

## 2. Models of Integrated Care

The past decade has witnessed a significant emphasis on integrating behavioral health treatment services with health care. For example, Federally Qualified Health Centers (FQHCs) have shown leadership in integrating mental health treatment and primary care, based on their mandate to provide some level of treatment for behavioral health conditions. The SAMHSA-HRSA Center for Integrated Health Solutions, managed by the National Council for Behavioral Health ([www.integration.samhsa.gov](http://www.integration.samhsa.gov)), has spearheaded efforts to integrate behavioral health and primary care services and has made a significant contribution to this goal. This section describes an array of models of integrated behavioral health and health care services that can be applied to the integration of SUD and health care services and offers several illustrations of ATTC work. The Appendix provides a convenience sample of recent models of integration of SUD and health care services.

### Models and Components of Integrated Care

Existing models that have been used to deliver integrated behavioral health services in health care settings can inform current initiatives to integrate SUD treatment into health care.

These models offer conceptual frameworks for organizing services based on characteristics such as location of services, severity of the behavioral health diagnosis, and the level of integration of services. The following is a brief review of several frameworks and specific models designed to foster the integration of behavioral health, SUD and medical services.

Two popular frameworks for conceptualizing integrated services are the National Council's Four Quadrant Clinical Integration Model (Mauer, 2006, 2009) and the Levels of Collaboration Model first developed by Doherty, McDaniel, and Baird (1996) and then expanded by Reynolds (2006).

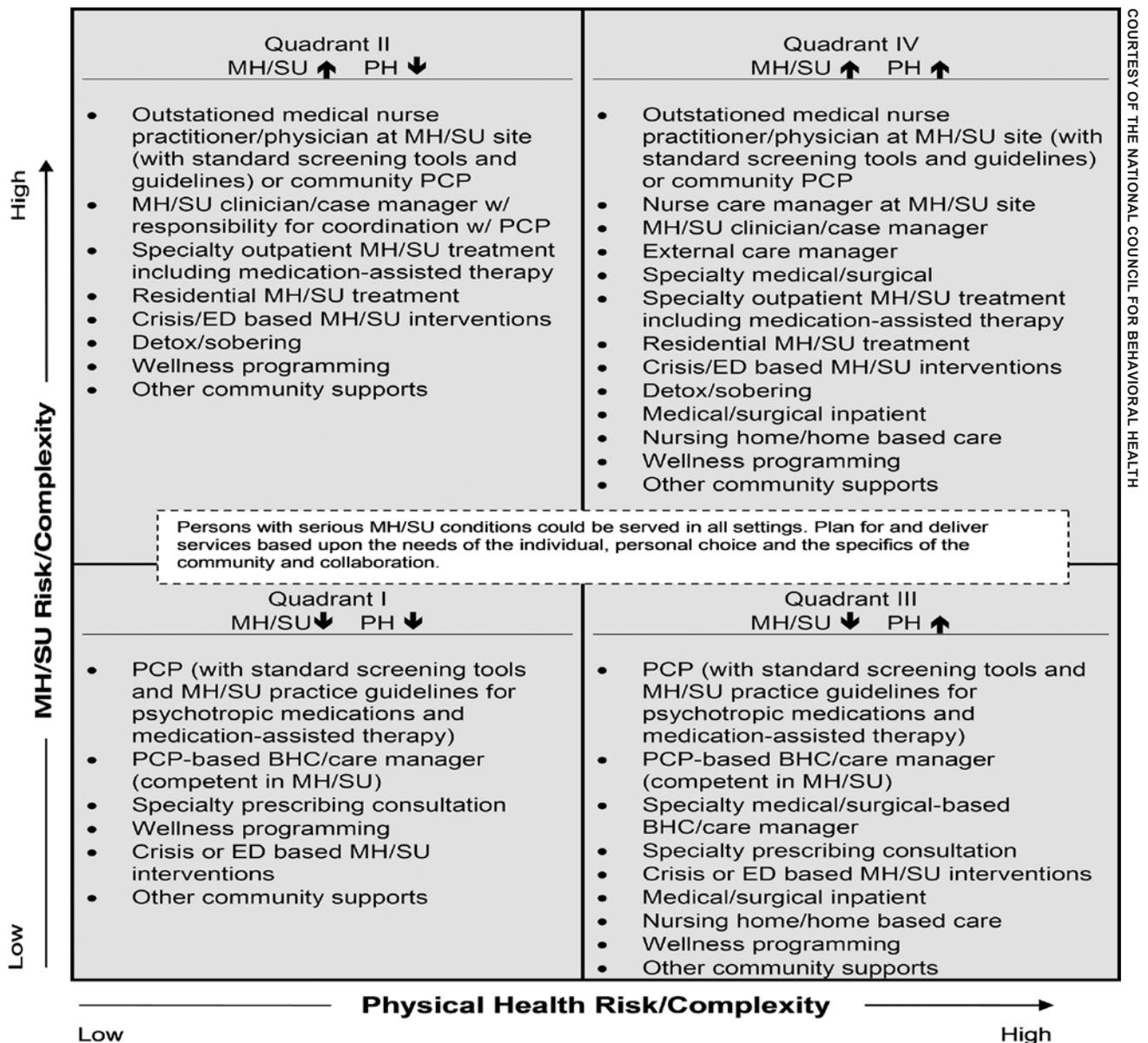


# The Four Quadrant Clinical Integration Model

The Four Quadrant Clinical Integration Model (Mauer, 2009), developed for the integration of behavioral health and primary care services, describes the best location for care based on the severity of both behavioral health (including

SUDs) and other medical conditions. It delineates the range of service providers and to some extent the services that should be available to patients depending on their level of need.

Figure 1. The Four Quadrant Clinical Integration Model.



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## The Levels of Collaboration Model

Another framework that has appeared in much of the published literature is the Levels of Collaboration Model first described by Doherty and colleagues (Doherty, 1995; Doherty et al., 1996). This framework identifies five models for collaboration based on the extent to which services are integrated, ranging from minimal collaboration to fully integrated. Recently, the SAMHSA-HRSA Center for Integrated Health Solutions released

an issue brief that reviews these levels of integrated health care and proposes a functional standard framework for classifying sites according to these levels (Heath, Wise, Romero, & Reynolds, 2013). The following chart shows a version of the original model that was expanded by Reynolds (2006) and describes differences in the five models across functional components.

Figure 2. Levels of Collaboration. MH/Primary Care Integration Options.

Function	Minimal Collaboration	Basic Collaboration from a Distance	Basic Collaboration On-Site	Close Collaboration/ Partly Integrated	Fully Integrated/Merged
<b>THE CONSUMER and STAFF PERSPECTIVE/EXPERIENCE</b>					
<b>Access</b>	Two front doors; consumers go to separate sites and organizations for services	Two front doors; cross system conversations on individual cases with signed releases of information	Separate reception, but accessible at same site; easier collaboration at time of service	Same reception; some joint service provided with two providers with some overlap	One reception area where appointments are scheduled; usually one health record, one visit to address all needs; integrated provider model
<b>Services</b>	Separate and distinct services and treatment plans; two physicians prescribing	Separate and distinct services with occasional sharing of treatment plans for Q4 consumers	Two physicians prescribing with consultation; two treatment plans but routine sharing on individual plans, probably in all quadrants;	Q1 and Q3 one physician prescribing, with consultation; Q2 & 4 two physicians prescribing some treatment plan integration, but not consistently with all consumers	One treatment plan with all consumers, one site for all services; ongoing consultation and involvement in services; one physician prescribing for Q1, 2, 3, and some 4; two physicians for some Q4: one set of lab work
<b>Funding</b>	Separate systems and funding sources, no sharing of resources	Separate funding systems; both may contribute to one project	Separate funding, but sharing of some on-site expenses	Separate funding with shared on-site expenses, shared staffing costs and infrastructure	Integrated funding, with resources shared across needs; maximization of billing and support staff; potential new flexibility
<b>Governance</b>	Separate systems with little of no collaboration; consumer is left to navigate the chasm	Two governing Boards; line staff work together on individual cases	Two governing Boards with Executive Director collaboration on services for groups of consumers, probably Q4	Two governing Boards that meet together periodically to discuss mutual issues	One Board with equal representation from each partner
<b>EBP</b>	Individual EBP's implemented in each system;	Two providers, some sharing of information but responsibility for care cited in one clinic or the other	Some sharing of EBP's around high utilizers (Q4) ; some sharing of knowledge across disciplines	Sharing of EBP's across systems; joint monitoring of health conditions for more quadrants	EBP's like PHQ9; IDDT, diabetes management; cardiac care provider across populations in all quadrants
<b>Data</b>	Separate systems, often paper based, little if any sharing of data	Separate data sets, some discussion with each other of what data shares	Separate data sets; some collaboration on individual cases	Separate data sets, some collaboration around some individual cases; maybe some aggregate data sharing on population groups	Fully integrated, (electronic) health record with information available to all practitioners on need to know basis; data collection from one source

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ADAPTED FROM: DOHERTY, MCDANIEL AND BAIRD, 1996.

## Core Components

In addition to the two models just mentioned, the National Association of Community Health Centers (NACHC) designates six indicators of integrated care: communication and collaboration, co-location, joint decision making, shared medication lists and lab results, shared treatment plans, and shared problem lists. NACHC used these elements in their 2010 and 2011 evaluations of the level of integrated care offered within their member organizations (NORC, 2011).

Most of the models of integration currently operating were developed within one or a combination of these frameworks and can be classified or categorized based on these frameworks. The Core Components model is also being used as a heuristic to understand what aspects of treatment need to be integrated to achieve ‘integrated care.’ As with other types of frameworks and models, their value lies in offering a way to readily discern similarities and differences between specific examples. Future research is needed to show the most

effective level of integration for certain types of patients and which components of care must be integrated in order to achieve the best patient outcomes.

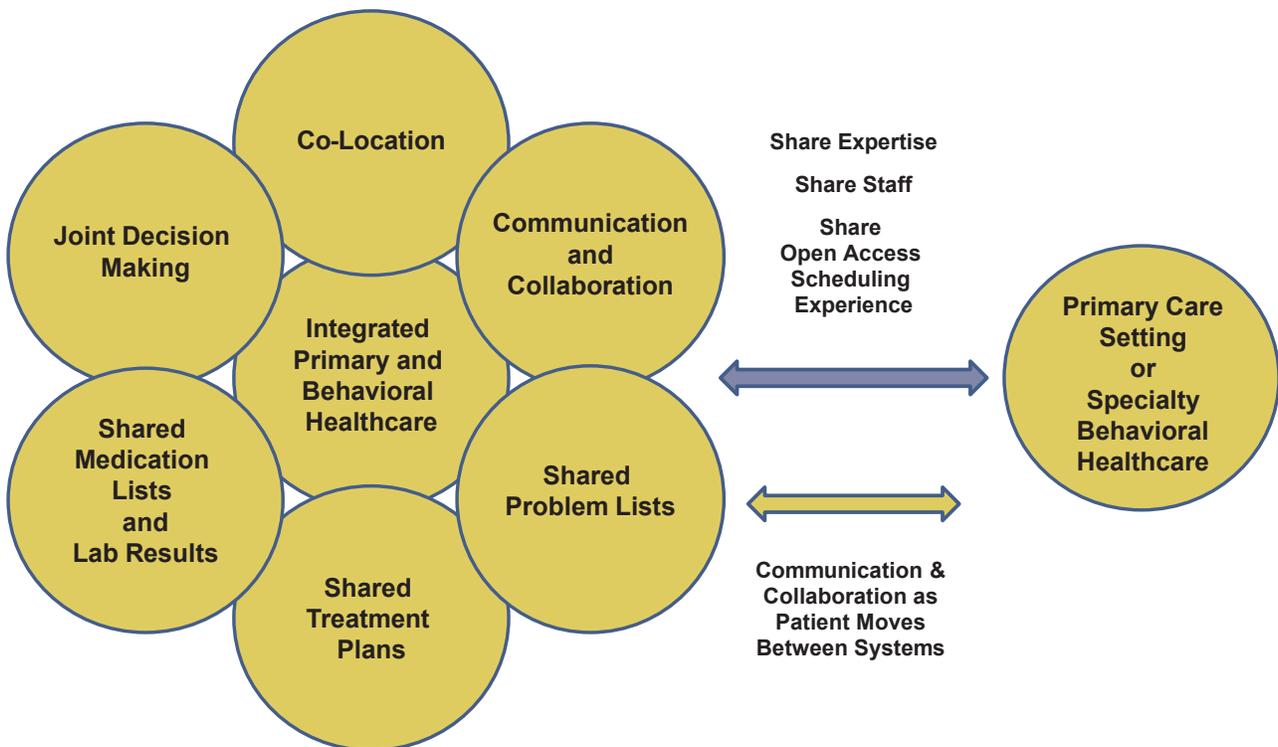
## Movements Promoting Integrated Care Systems

Four significant movements in the United States are driving the development of integrated care models and delivery systems. These initiatives will likely shape integrated care service systems within the next five years.

## Whole System Models

Several states are using Medicaid policy and regulatory authority to accelerate the integration of SUD treatment with primary care. Vermont’s Blueprint for Health is one of the best examples of a state organizing its entire system based on an integrated model. Blueprint for Health offers specialty programs and enhanced rates for care coordination under

Figure 3. Core Components of Successful Integration Models (Lardiere et al., 2011)



the Medicaid Health Home waiver. Primary care providers receive access to additional staff when providing treatment for SUDs. Vermont has aligned all payers to cover the same services under a uniform bundled rate, so that all patients have access to the same services and providers regardless of payer.

Vermont currently uses this model only for patients with opioid dependence. The state methadone providers offer several medications, including buprenorphine or naltrexone, to treat patients with an opioid use disorder. Patients are stabilized in the methadone program and then referred to a physician for continuing care and medication management. This hub (specialty provider) and spoke (primary care provider) system for medications ensures that all patients get care appropriate to the severity of their symptoms. Hubs receive a per member, per month rate enhancement for providing additional case management and coordination services. Physician practices have an additional nurse and counselor for every 100 patients with an opioid use disorder. Vermont has used its regulatory role, its Medicaid authority, and its position of authority to engage private providers to create a statewide, systemic approach to integrated care.

## Patient-Centered Medical Home

The Patient-Centered Medical Home (PCMH) is a rapidly expanding model of primary care practice: it is also a preferred method of service delivery within accountable care organizations (American Hospital Association, 2010). While not originally part of the model, behavioral health has become a more common aspect of this form of primary care service delivery. The National Committee for Quality Assurance (NCQA) 2012 requirements for PCMH certification include specific measures of patient access to behavioral health care services. An organization must meet criteria in a range of scoring categories to earn designation as a patient-centered medical home; the inclusion of behavioral health services appears in several scoring categories. Having a protocol for treating substance

use and mental disorders is a critical factor that, if absent, results in failure to meet criteria for certification.

The PCMH certification does not require that behavioral health services be offered at the same location as primary care services. Rather, behavioral health issues are addressed within the context of primary care, coordinated by the primary care provider, and managed along with other health care needs. All providers treating a patient have access to documentation of these activities.

## Federally Qualified Health Centers

FQHCs are required to either provide or refer patients to mental health and SUD treatment [Section 330 of the Public Health Service Act (42 USCS § 254b)]. Obtaining status as an FQHC is one way that SUD treatment programs can integrate and fund primary care services for their patients. For example, SSTAR, a treatment program located in Fall River, Massachusetts, became an FQHC in 2013. The program offers a full array of primary care, wellness, and disease management services to patients in its SUD treatment facility as well as to other community members (see Appendix).

However, 2009 Federal Uniform Data Set (UDS) data submitted by FQHCs showed that while 70% of FQHCs report providing mental



health services, only 20% reported providing SUD services. Moreover, in a survey of FQHCs (39% responding), 85% reported providing mental health services on site, while only 55% reported providing SUD services on-site (Lardiere et al., 2011; see also NORC, 2011).

## **Certified Community Behavioral Health Clinics**

The Protecting Access to Medicare Act of 2014 (Public Law 113-93) included a Medicaid demonstration project (Section 223) that in 2015 will offer planning grants to create certified community behavioral health clinics modeled after FQHCs. The federal government will pay states a similar specified percentage of program expenditures (Federal Medical Assistance Percentage, or FMAP) for these clinics, which will be required to assess and refer or provide for medical care as necessary.

## **ATTC Network Activities to Accelerate the Integration of SUD and Health Care Services**

A main role of the ATTC Network across the country is to improve the quality of SUD treatment and recovery services by facilitating collaborations among front line counselors, treatment and recovery services agency administrators, policy makers, the health and mental health communities, consumers, and other stakeholders. The ATTC Network has been active in bringing health and SUD treatment players to the table to accelerate integration efforts:

- The Great Lakes ATTC sponsored the development of a Recovery-Oriented Systems of Care Learning Community in collaboration with the Office of National Drug Control



## ■ Spotlight on ATTC Integration Work: Central Rockies ATTC

### *Behavioral Health Care Integration with Primary Care Subcommittee*



The Central Rockies ATTC is working at a regional level to accelerate the implementation of integrated care. They have convened the Behavioral Health Care Integration with Primary Care Subcommittee that includes 12 representatives from the six states in Region 8 (CO, MT, ND, SD, UT, WY). The Subcommittee members represent state-level SSA and integrated mental health and SUD treatment offices, SUD treatment organizations, primary care providers, and integrated SUD/mental health/primary care service providers.

The Subcommittee developed a work plan that focuses on two major topics: workforce development and integrated models. Related to workforce development, the Subcommittee has identified the need to help prepare the SUD workforce to work in integrated settings, such as through a learning collaborative or other training and technical assistance provided by the Central Rockies ATTC.

In addition, the Subcommittee recognized the need to disseminate information to SUD and mental health providers about integrated models and ways that SUD providers can begin the integration process. This will include pulling together examples of integrated care provision in the region, as well as developing a road map of steps states can take to facilitate integration quickly, such as by focusing on Medicaid populations and blending SUD and mental health into primary care (e.g., via SBIRT). As the Subcommittee further develops their plan, the Central Rockies ATTC will provide training and technical assistance at the region, state, and provider levels.

Policy. Thirteen states and three counties participated in the Learning Community, in which one major focus was the integration of SUD services into primary care settings.

- Staff from the New England ATTC recently met with the Chief Operating Officer and President/CEO of the Rhode Island Health Center Association (RIHCA), and then with the RIHCA Clinical Leadership Committee, consisting of FQHC medical directors. New England ATTC staff described SUD treatment strategies appropriate for integration, the work of the New England ATTC, and how training and technical assistance could benefit staff at their health centers.
- The Northwest ATTC has conducted outreach to the FQHC membership associations in all four states of Region 10 (Alaska, Idaho, Oregon, and Washington) and is disseminating training and technical assistance opportunities throughout these states' primary care associations.
- The South Southwest ATTC provided technical assistance on integration to a treatment center in Lake Charles, LA, that has historically provided SUD treatment, but is transitioning into an integrated health and behavioral health (mental health, developmental disabilities, and SUD) center, with a pharmacy and off-site hospital unit that includes detoxification beds.

## 3. Interventions

Regardless of the model of integration applied, evidence-based practices must be used to meet the goal of improving quality of care. During the past 30 years, a substantial body of rigorous study has led to the development and validation of numerous evidence-based treatments for SUDs (e.g., medication-assisted treatment, motivational interviewing, contingency management). Of the research-based interventions available, some are particularly well-suited for use in health care settings. In this section, we present a review of effective interventions for SUDs that can be integrated with other health care services. A brief description of the intervention, research evidence, and examples of how ATTCs have promoted the practice are provided. Note that the research review is not meant to be exhaustive, but to capture the essence of the current state of this literature.

### 1. Screening, Brief Intervention, and Referral for Treatment

SAMHSA describes SBIRT as “a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders” (<http://beta.samhsa.gov/sbirt/about>). SBIRT includes universal screening for alcohol and drug use, brief intervention or brief treatment for those found to be using substances at a risky or harmful level, and referral to treatment for those who may have a substance use disorder.

#### Research Evidence

Initial studies established a particularly strong evidence base for SBIRT’s capacity to reduce alcohol use in “heavy drinkers” (Babor, et al., 2007; Ballesteros, Duffy, Querejeta, Ariño, & González-Pinto, 2004; Bien, Miller, & Tonigan,

1993; Kahan, Wilson, & Becker, 1995). SBIRT services delivered in primary care settings can reduce the average number of drinks consumed by heavy alcohol users to safer levels and reduce the frequency of heavy drinking episodes (Jonas et al., 2012; Kaner et al., 2007; Whitlock, Polen, Green, Orleans, & Klein, 2004). SBIRT for risky alcohol use delivered in emergency departments can also significantly reduce alcohol consumption in three-month follow-ups (Academic Emergency Department SBIRT Research Collaborative, 2007; Désy, Howard, Perhats, & Li, 2010), and heavy drinkers who receive brief interventions are approximately twice as likely to be drinking at moderate levels 6 to 12 months later when compared to matched controls (Wilk, Jensen, & Havighurst, 1997).

By reducing the frequency and intensity of alcohol consumption, SBIRT can help prevent the development of many of the physical and mental health conditions associated with excessive alcohol use, leading to reduced utilization of costly medical and psychiatric services (Fleming et al., 2002). Consequently, the implementation of SBIRT for alcohol use in medical settings is cost effective (Kraemer, 2007), and can lead to significant cost savings for the

#### Evidence-Based Practices for SUD treatment that can be Integrated into Health Care Services

1. Screening, Brief Intervention, and Referral to Treatment (SBIRT)
2. Medication-Assisted Treatment (MAT)
3. Technology-Assisted Care (TAC)
4. Motivational Interviewing (MI)
5. Contingency Management (CM)
6. Trauma-Informed Care (TIC)
7. Cognitive Behavioral Therapy (CBT)

## ■ Spotlight on ATTC Integration Work: National SBIRT ATTC

### *Helping an FQHC Implement SBIRT*



In addition to their work promoting the implementation of SBIRT at the national level, the National SBIRT ATTC has worked with specific health care groups. One example is their association with an FQHC in Youngstown, Ohio. One Health Ohio's CEO Ron Dwinnells has been on a mission to implement SBIRT into the clinic, and the National SBIRT ATTC assisted this process by providing technical assistance and training. During an initial meeting, the National SBIRT ATTC provided feedback and consultation to Dr. Dwinnells and his staff as they were in the beginning stages of implementing SBIRT. Discussions included the specific SBIRT model and processes that would be used in the clinic (e.g., who conducts the screening? Which screening tools to use? How to effectively get patients referred to treatment?). After this initial meeting, the National SBIRT ATTC provided an all staff training, including physicians, nurses, dentists, medical assistants, receptionists, and other support staff, so that everyone had at least a basic understanding of the rationale for SBIRT and the process that would be used. Dwinnells and One Health Ohio conducted an evaluation, showing that SBIRT did not significantly increase doctors' average time with patients, and that rates of identification of substance use issues were higher in clinics where SBIRT was implemented (<http://iretablog.org/2014/11/27/out-of-sight-out-of-mind/>).

health care system as a whole. Studies show that the implementation of SBIRT protocols for alcohol in emergency departments can lead to \$3.81 in health care savings for every dollar invested in SBIRT (Gentilello, Ebel, Wickizer, Salkever, & Rivara, 2005); and for every dollar spent on brief physician advice concerning alcohol use, the health care system can save \$4.30 (Fleming et al., 2002).

Questions remain about SBIRT's effectiveness for individuals who use illicit drugs. There is a lack of evidence concerning the validity of screening tests for illicit drug use and the effectiveness of SBIRT to address drug use behaviors (Babor et al., 2007; Bernstein, Bernstein, Stein, & Saitz, 2009; Young et al., 2014). A recent well-controlled clinical trial of two brief interventions compared to no intervention found no differences between the groups in "adjusted mean number of days using the main drug" at six months or on other outcomes (e.g., other self-reported measures of drug use, drug use according to hair testing, unsafe sex, health care

utilization; Saitz et al., 2014). The investigators concluded that "these results do not support widespread implementation of illicit drug use and prescription drug misuse screening and brief intervention" (Saitz et. al., 2014, p. 501). The study did not fully test SBIRT, since it did not focus on the Screening and Referral to Treatment components. In response to the study by Saitz and colleagues, the Director of SAMHSA's Center for Substance Abuse Treatment wrote "the value of SBIRT is that it makes an 'invisible' clinical issue visible by providing the tools to identify and address alcohol and drug use disorders at every point in public health, from primary care to specialty care" (Clark, 2014).

Overall, research on SBIRT provides an evidence base for its use with heavy drinkers but additional research is needed to clarify its potential impact on individuals with alcohol dependence or who are using illicit drugs. Further, there is the need for more research on SBIRT screening, differing brief interventions, and on protocols for referral to treatment, as

well as SBIRT research to differentiate between persons with perhaps mild substance use disorders who respond favorably to brief interventions and those requiring intermediate or long-term treatment.

## ATTC Network Activities

The ATTC Network has an entire center devoted to SBIRT. The National SBIRT ATTC, run by the Institute for Research, Education, and Training in Addictions (IRETA) in partnership with NORC at the University of Chicago, ensures the coordination of multiple national SBIRT initiatives and offers a large body of services to advance the adoption of SBIRT practices within systems. These services include: a national registry of qualified SBIRT trainers; monthly live webinars on a variety of SBIRT topics; a library of recorded webinars available on demand at no cost; technical assistance and consultation; online resources; downloadable products; an SBIRT tool kit for patients, practitioners, and organizations; digital tools; and overviews of featured products.

### Online SBIRT Training

The ATTC Network currently offers five online courses on SBIRT for public use: “Foundations of SBIRT,” “SBIRT 101,” “Introduction to SBIRT for Adolescents,” “Dentistry & the SBIRT Model: How You Can Help Patients

with Substance Abuse Issues,” and “SBIRT in Older Adults” (See Figure 4). During 2013 and 2014, 3,700 individuals took these courses.

## 2. Medication-Assisted Treatment

Medication-assisted treatment (MAT) refers to the use of medications to treat SUDs. MAT is used during detoxification to avoid withdrawal symptoms, for short-term use in early recovery, and for maintenance treatment over time. Medications for alcohol use disorders include those approved for aversive therapy (e.g., disulfiram, which produces nausea and vomiting when alcohol is ingested) and for decreasing craving and preventing relapse (e.g., naltrexone, acamprosate). Medications available for opioid dependence include opiate-blocking agents and synthetic opioids (e.g., buprenorphine, buprenorphine and naloxone combination, methadone). Methadone is only available through state-licensed treatment programs. Physicians who complete special training and licensing can prescribe buprenorphine. Physicians and mid-level providers such as physician assistants and nurse practitioners can prescribe the other medications. Note that NIDA lists MAT, when combined with counseling and behavioral

Figure 4. ATTC Network Online SBIRT Courses

TITLE	NUMBER OF HOURS	AUTHOR	LOCATION
<b>Foundations of Screening, Brief Intervention, and Referral to Treatment (SBIRT)</b>	1.5 hours	Pacific Southwest ATTC	<a href="http://HealthKnowledge.org">HealthKnowledge.org</a>
<b>SBIRT 101</b>	10 hours	National SBIRT ATTC	<a href="http://ireta.org">ireta.org</a>
<b>Introduction to SBIRT for Adolescents</b>	3 hours	National SBIRT ATTC	<a href="http://ireta.org">ireta.org</a>
<b>Dentistry &amp; the SBIRT Model: How You Can Help Patients with Substance Abuse Issues</b>	1.5 hours	Pacific Southwest ATTC and Arizona State's Center for Applied Behavioral Health Policy	<a href="http://HealthKnowledge.org">HealthKnowledge.org</a>
<b>Substance Use in Older Adults: Screening and Treatment Intervention Strategies</b>	3 hours	Pacific Southwest ATTC	<a href="http://HealthKnowledge.org">HealthKnowledge.org</a>

therapies, as a principle of effective treatment (NIDA, 2012). (For additional NIDA resources on MAT see <http://www.drugabuse.gov/nidamed-medical-health-professionals>)

## Research Evidence

A well-established body of evidence supports the use of medications to manage SUDs, and all of these medications have been utilized successfully in primary care (Fiellin et al., 2001, 2002; Hersh, Little, & Gleghorn, 2011; Lee et al., 2010; O'Connor et al., 1997, 1998; Soeffing, Martin, Fingerhood, Jasinski, & Rastegar, 2009). For people with alcohol dependence, the use of oral naltrexone in primary care settings decreases the number of days patients drink heavily, decreases the amount patients drink when they consume alcohol, and increases the number of days patients abstain from alcohol (O'Connor et al., 1997).

When combined with medical management services delivered in primary care, oral naltrexone increases the percentage of days patients abstain from drinking while reducing the frequency of heavy drinking episodes (Anton et al., 2006). Extended-release naltrexone is effective in primary care settings when used in combination with monthly medical management services. Its use has been associated with decreases in the amount of alcohol patients consume each day (Lee et al., 2010) and the number of days they drink heavily, while also increasing the number of days they abstain from alcohol (Lee et al., 2012).

The use of buprenorphine to manage opioid dependence has also shown considerable promise in primary care settings. Primary care providers in Boston (Alford et al., 2011), Connecticut (Haddad, Zelenev, & Altice, 2013), and San Francisco (Hersh et al., 2011) have all been able to keep the majority of patients on buprenorphine engaged in treatment for at least six months. Primary care patients with opioid use disorders who successfully engage in buprenorphine treatment are likely to become abstinent from opioids and cocaine

(Alford et al., 2011), report high rates of satisfaction (Hersh et al., 2011; Soeffing et al., 2009), and experience improvements in chronic pain (Pade, Cardon, Hoffman, & Geppert, 2012).

Individuals who have an opioid use disorder and HIV benefit from the integration of buprenorphine with their medical care. The use of buprenorphine for patients with HIV increases adherence to antiretroviral therapy (Altice et al., 2011), and is associated with improved CD-4 cell counts (Altice et al., 2011), reduced rates of drug use (Lucas et al., 2010) and needle sharing (Edelman et al., 2014), and improvements in patients' physical and mental quality of life (Korthuis et al., 2011).

## ATTC Network Activities

Based on findings of effectiveness in studies of MAT, the ATTC Network has developed materials and strategies to support its adoption. The ATTC Network launched the campaign, "Your Doctor Understands Your Addiction," which includes a website, outreach materials, and two online trainings to increase outreach, access, and engagement of hard-to-reach populations in MAT (African American, Asian/Pacific Islander, Hispanic/Latino(a) and Native American/Alaska Native populations; <http://attc-network.org/mat>). The campaign includes printed marketing materials that SUD treatment and health care professionals can use to talk about MAT with their patients in English and Spanish. The online course, "Medication-Assisted Treatment with Special Populations," is a 12-hour, self-paced course, available at <http://www.healthknowledge.org/>, designed to enhance general knowledge of MAT and improve providers' skills related to reaching and educating identified special populations about MAT. The course is provided in two versions, one for physicians and other medical professionals, and one for non-medical treatment providers. During 2013 and 2014, over 800 health care providers took the course.

## **MAT and Buprenorphine NIDA/SAMHSA Blending Products**

Promoting dissemination and implementation of evidence-based practices for SUD treatment is the primary focus of the NIDA/SAMHSA-ATTC Blending Initiative (Martino et al., 2010). Using recently completed NIDA research, “blending teams,” comprised of NIDA researchers, clinical treatment providers, and ATTC Network staff, design user-friendly tools or products and introduce them to treatment providers. The Network developed the “Buprenorphine Suite of Blending Products” (<http://attcnetwork.org/projects/buptx.aspx>) as part of the NIDA/SAMHSA-ATTC Blending Initiative. The suite includes face-to-face and online trainings, as well as educational materials to raise awareness in health care professionals about MAT and provide instruction on using MAT with clients. The training resources are shown in Figure 5.

## **MAT Regional Trainings and Technical Assistance**

The ATTC Network provides MAT-related trainings, technical assistance, and implementation projects to assist the health care workforce to implement MAT. For example, the Central East ATTC provided training and technical assistance to SAMHSA Primary Care Behavioral Health Integration (PCBHI) grantees Family Services, Inc. (a behavioral health provider) and Community Clinic, Inc. (an FQHC), as they integrate SUD services into their primary care/mental health programs.

## **3. Technology-Assisted Care**

Technology-assisted treatments or technology-assisted care (TAC) include a range of services, such as phone-based or telehealth services, or web-based or stand-alone computer applications (Aronson, Marsch, & Acosta, 2013). One very common form of TAC is computerized versions of evidence-based treatments such as CBT, and potentially MI, contingency management (also known as motivational incentives), or SBIRT. The probable benefits

of TAC for SUDs are substantial. Technology can help close the SUD treatment gap by making evidence-based interventions available to people who need SUD treatment, but are unable to access services. TAC can take place at anytime and anyplace, making SUD treatment available on demand when it is needed and wanted by patients.

TAC can also facilitate linkage to services in the community, and could increase receptivity to accessing care by serving as a “foot in the door” for prospective patients who are reticent to access SUD services. The anonymity afforded by computer-assisted treatment can help ease concerns people may have about asking for help with their substance use (Hausotter, 2014). Most importantly, for efforts to integrate SUD services with primary care, TAC has the potential to make SUD services available in a broader array of clinical settings—including general health care settings—that do not have SUD specialists working on-site (Marsch, 2012).

One example of TAC is the Therapeutic Education System (TES), a computerized, psychosocial intervention for SUD and HIV. TES includes 48 interactive, multimedia modules delivered for two hours per week over 12 weeks. The content in TES is grounded in research-based psychosocial treatments (community reinforcement approach [CRA] and CBT). In delivering this content, TES employs state-of-the-art informational technologies to enhance knowledge, skills acquisition, and behavioral change. Specifically, TES uses fluency-based computer-assisted instruction (CAI), grounded in the precision teaching approach (e.g., Binder, 1993), which continually assesses an individual’s grasp of the material, and adjusts the pace and level of repetition of material to promote mastery of skills and information. Because this approach responds to each individual’s level of understanding, the technique is useful even when individuals have cognitive deficits.

TES also creates an experiential learning environment, using interactive videos of peer actors who model various behaviors (e.g., drug refusal skills) to help the program user learn the modeled behavior. TES employs a variety of inter-

**Figure 5. NIDA/SAMHSA-ATTC Blending Products for MAT**

Title	Course Length	Description	Web address
<b>Buprenorphine Treatment: Training for Multidisciplinary Addiction Professionals</b>	4-6 hours	Face-to-face training curriculum. Overviews the medication and the role of non-physician health care providers in supporting patients receiving buprenorphine.	<a href="http://attcnetwork.org/projects/buptx.aspx">http://attcnetwork.org/projects/buptx.aspx</a>
<b>Short-Term Opioid Withdrawal Using Buprenorphine: Findings and Strategies from a NIDA Clinical Trials Network (CTN) Study</b>	4 hours	Face-to-face training curriculum. Instructs treatment providers in the administration of a 13-day buprenorphine taper intervention for patients who are opioid-dependent.	<a href="http://attcnetwork.org/projects/bupdetox.aspx">http://attcnetwork.org/projects/bupdetox.aspx</a>
<b>Buprenorphine Treatment for Young Adults</b>	3 hours	Fact-to-face training curriculum. Highlights the findings of a NIDA CTN study that compared longer-term versus short-term buprenorphine/naloxone treatment in an outpatient setting.	<a href="http://attcnetwork.org/projects/bupyong.aspx">http://attcnetwork.org/projects/bupyong.aspx</a>
<b>The Prescription Opioid Addiction Treatment Study (POATS)</b>		Package of tools and training resources. Presents the results of a NIDA CTN study that compared brief and extended buprenorphine treatments, and helps treatment providers incorporate study findings and recommendations into practice.	<a href="http://attcnetwork.org/projects/poats.aspx">http://attcnetwork.org/projects/poats.aspx</a>

active exercises to enhance learning (e.g., graphics and animation) and to personalize content (e.g., personalized functional analysis). In this way, TES ensures the delivery of science-based, psychosocial treatment in a manner that promotes mastery of key information and skills. An electronic reporting system generates summaries of participants’ TES activity and progress.

## Research Evidence

The field of TAC is still relatively new, but several rigorous studies have tested its effectiveness for treating problematic alcohol (Bewick et al., 2008; Gustafson et al., 2014; Khadjesari, Murray, Hewitt, Hartley, & Godfrey, 2011; White et al., 2010) and drug use (Dennis, Scott, Funk, & Nicholson, 2014; Moore, Fazzino, Garnet, Cutter, & Barry, 2011). For example, in a recent multi-site trial, patients who received TES as an adjunct to treatment as usual had lower dropout rates, and were more likely to achieve abstinence (Campbell et al., 2014). In a prison-based multi-site study, the TES group showed reductions in re-incarceration, criminal activity and HIV risk behavior that were equal

to the reductions reported by a standard treatment control group. (Chaple et al., 2014).

Computer-Based Training for CBT (CBT4CBT), another web-based program that teaches skills for reducing substance use, has also been studied. In randomized controlled trials comparing standard treatment to standard treatment enhanced by CBT4CBT, individuals who received CBT4CBT were more likely to test negative for drugs and tended to have longer continuous periods of abstinence during treatment (Carroll et al., 2008). Subsequent studies showed that individuals receiving methadone maintenance who also received CBT4CBT were more likely to have a greater reduction in cocaine use after six months (Carroll et al., 2014).

The body of research evidence concerning TAC is growing rapidly and is sufficient to support its use in health care settings, especially in view of its accessibility.

## ATTC Network Activities

A NIDA/SAMHSA Blending Team created a TAC Blending Product, “Technology-Assisted Care” (<http://sudtech.org>). The website

includes information on a number of TAC examples, including TES, along with videos, a training curriculum to assist health and behavioral health care staff in learning about and becoming comfortable with TAC, and other resources for implementing technology-assisted treatments/care. The site features several filmed case examples of treatment agencies and patients who have used TES.

The National Frontier and Rural ATTC focuses on several aspects of TAC as ways to bridge SUD service gaps in less-populated areas. For example, they held the 2014 Addiction Treatment Technology Summit which included presentations from professionals on TAC as well as behavioral health treatment professionals from 33 states. The National Frontier and Rural ATTC also holds trainings and develops products related to TAC including telephone, text, telehealth, and computer-based programs.

## 4. Motivational Interviewing

MI is a treatment approach for individuals with SUDs and is a “client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence” (Miller & Rollnick, 2002, p. 25). Generally, all individuals contemplating behavior change have some degree of ambivalence; that is, part of them wants to change and part of them does not. MI is grounded in building rapport between clinician and patient so as to identify, examine, and resolve ambivalence to changing behavior. Collaboration between the clinician and patient evokes the person’s own motivation and skills for change, while recognizing the patient’s autonomy in the change process. Four central processes guide MI: engaging, focusing, evoking and planning (Miller & Rollnick, 2013). Clinicians use these principles and employ micro-counseling skills through a reflective conversational approach to develop a partnership with patients and elicit a discussion about change.

MI has been used in a number of formats. For example, MI is employed by some SUD

clinicians as their primary treatment modality for individual counseling. It has been manualized, such as in motivational enhancement therapy (MET; MI plus assessment feedback) through the Project Match study (Miller, Zweben, DiClemente, & Rychtarik, 1992). Individual MI/MET is used in conjunction with group-based CBT in adolescent SUD treatment (e.g., Godley et al., 2001). MI is also the foundation of several brief intervention models used in SBIRT (e.g., D’Onofrio, Pantalon, Degutis, Fiellin, & O’Connor, 2005). It can also be used in groups (Wagner & Ingersoll, 2012), and in some specialty SUD programs, MI is employed as the basis for treatment readiness groups for patients who are considering treatment.

## Research Evidence

MI has been shown through numerous randomized controlled trials and meta-analyses, to be efficacious and effective across behaviors, primarily related to substance use and SUDs (e.g., Barnett, Sussman, Smith, Rohrbach, & Spruijt-Metz, 2012; Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010) and smoking cessation (e.g., Hettema & Hendricks, 2010). NIDA’s CTN has conducted a number of studies of MI and MET, and found them to improve treatment outcomes (Ball et al., 2007) as well as treatment processes such as retention (Carroll et al., 2006). MI has proven effective in helping patients clarify goals and make commitment to change (Miller & Rollnick, 2002). MI is also effective in helping patients deal with a range of health care issues and diseases such as diabetes, weight management, and exercise (Burke, Arkowitz, & Menchola, 2003; Lundahl et al., 2013; Rollnick, Miller, & Butler, 2008; Rubak, Sandbæk, Lauritzen, & Christensen, 2005; West, DiLillo, Bursac, Gore, & Greene, 2007).

## ATTC Network Activities

The ATTC Network has devoted significant resources and attention to developing products and disseminating and assisting with the implementation of MI. Products include a new

online instructor-led basic MI course, titled “A Tour of MI” and a NIDA/SAMHSA-ATTC Blending Product “Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency” (MIA:STEP; Martino et al., 2006). MIA:STEP builds a supervisor’s ability to provide structured, focused, and effective clinical supervision. The MIA:STEP package is the most downloaded of all of the ATTC Network’s products (over 1,300 downloads from 2012–2014). Other work has focused on MI itself. From 2006 to 2010, the ATTC Network held more than 500 MI-related trainings or events across the country, including planning meetings, face-to-face trainings, coaching calls for clinicians learning MI, and online courses.

Specific to health care, the Southeast ATTC Regional Center conducted a grand rounds presentation and provided technical assistance to the Veterans Hospital in Bay Pines, Florida, on MI. The Southeast ATTC has also conducted MI training with health care staff from an FQHC that is part of the Saint Joseph’s Health System in Atlanta, GA. Also, the SBIRT-related trainings and implementation work that ATTC Regional Centers have conducted with health care providers include a significant focus on MI skills, as MI is the cornerstone of the brief intervention in SBIRT. In addition, the Northwest ATTC is partnering with Oregon’s Coordinated Care Organizations (local health entities providing services to Medicaid and Medicare patients), county public health and other health system partners to provide interdisciplinary MI training.

## 5. Contingency Management (also called Motivational Incentives)

Contingency management (CM), also called motivational incentives, maintains that the form or frequency of a behavior can be altered through a planned and organized system of positive and negative consequences. CM assumes that neurobiological and environ-

mental factors influence behaviors and that the consistent application of reinforcing environmental consequences can change these behaviors. Related to SUDs, a clinician and patient agree upon the target behavior (e.g., drug abstinence), and determine what the reinforcers will be. Reinforcers or rewards may be vouchers that can be exchanged for goods and services, or cash prizes. The clinician gives out the reinforcer when the target behavior is met or withholds it if the behavior is not met. CM techniques are best applied to specific targeted behaviors such as: drug abstinence, clinic attendance and group participation, medication adherence, treatment plan adherence, and the attainment of particular goals.

### Research Evidence

A substantial research base supports the use of CM, including several meta-analyses (e.g., Griffith, Rowan-Szal, Roark, & Simpson, 2000; Prendergast, Podus, Finney, Greenwell, & Roll 2006). CM results in higher rates of treatment program retention and abstinence from substance use (Godley et al., 2014a; Petry, Barry, Alessi, Rounsaville, & Carroll, 2012; Stitzer, Petry, & Peirce, 2010). This cost-efficient practice often includes low-cost reinforcements, such as vouchers, clinic privileges, or small prizes and/or is combined with a fishbowl technique in which patients draw for prizes of various sizes (Petry & Martin, 2002). In the NIDA CTN study “Motivational Incentives for Enhanced Drug Abuse Recovery (MIEDAR),” participants in a CM program (at an average cost of \$120 per participant) were significantly more likely (54.4% vs. 38.7%) to submit drug- and alcohol-negative urine samples than those receiving standard treatment (Peirce et al., 2006; Stitzer et al., 2010).

CM can be regarded as an evidence-based intervention that helps participants modify and change behavior to eliminate or significantly decrease substance use. It also can be used to complement other therapeutic approaches. Although not yet tested within other health care settings, CM has promise within inte-

grated care, especially perhaps for patients with multiple chronic conditions, where motivation for following complex treatment regimens may be difficult to sustain.

## ATTC Network Activities

The ATTC Network has created a number of materials and curricula to support the adoption and early implementation of CM. “Motivational Incentives-A Proven Approach to Treatment” is a suite of NIDA /SAMHSA Blending Products offering well-researched, online training tools to facilitate learning about and implementing CM. Two major products include:

- “Promoting Awareness of Motivational Incentives” (PAMI) is an introductory face-to-face training to raise awareness about the core principles of CM and the evidence for its clinical effectiveness.
- “Motivational Incentives: Positive Reinforcers to Enhance Successful Treatment Outcomes” (MI:PRESTO) is an interactive, self-guided online course designed to deepen knowledge of CM and provide guidance on implementing CM programs. During 2013 and 2014, over 700 individuals took this course.

Specific to health care, Pacific Southwest ATTC Regional Center has provided training on CM for several years to teams participating in the Los Angeles County Department of Mental Health Innovations Pilot Integration Projects. All teams have medical staff (primary care physicians, nurse practitioners, physician assistants), mental health clinicians (psychiatrists, social workers, psychologists, marriage and family therapists), SUD counselors, case managers, housing / work specialists, and peers / peer navigators.

*To conserve space the last two interventions (trauma-informed care and CBT) are described more briefly despite their considerable importance and a well-established research body of literature for each.*

*The ATTC Network has expertise in these evidence-based interventions, through NIDA/SAMHSA Blending Products and other curricula, training and technical assistance activities, conferences, and publications. Moreover, the ATTC Technology Transfer Model and implementation support approaches can guide these real-world integration efforts.*

## 6. Trauma-Informed Care

Trauma is increasingly recognized as being very prevalent in the general population (e.g., Kessler et al., 1999; El-Gabalawy, 2012), and particularly in people with SUD or other mental health disorders. Trauma-informed care (TIC) uses trauma-specific interventions to respond to the effects of trauma within the individual. TIC provides an organizational structure and treatment framework that service organizations can implement, which emphasizes physical, psychological, and emotional safety for all stakeholders, helping survivors feel empowered and rebuild a sense of control. SAMHSA’s six key principles of a trauma-informed approach include: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; as well as cultural, historical, and gender issues (SAMHSA, 2014b).

TIC is increasingly recognized as an important service component in SUD programs and, in a survey of over 10,000 SUD treatment facilities, two-thirds reported using trauma counseling (Capezza & Najavits, 2012). As SUD becomes integrated with health care, the use of TIC approaches should be considered. In addition, we should be aware that health care settings may unwittingly serve as triggers for trauma responses from people who have experienced significant traumatic events in their lives. For example, patients may have trauma reactions in health care settings due to invasive

procedures, removal of clothing, physical touch, or personal questions, or patients may avoid or postpone health care appointments altogether (Sharp, 2013).

SAMHSA offers extensive learning materials on this topic at the National Child Traumatic Stress Network website <http://www.nctsn.org/>. There is also a strong body of research on TIC for adolescents and adults with substance use disorders (e.g., Coccozza et al., 2005; Gatz et al., 2007; Godley et al., 2014b; Hien et al., 2009; Morrissey et al., 2005).

## 7. Cognitive Behavioral Therapy

Cognitive behavioral therapy (CBT) is a therapeutic approach that seeks to modify negative or self-defeating thoughts and behavior. CBT is aimed at both thought and behavior change (i.e., coping by thinking differently and coping by acting differently). CBT includes a focus on overt, observable behaviors—such as the act of taking a drug—and identifies steps to avoid situations that lead to drug taking. CBT also explores the interaction among beliefs, values,

perceptions, expectations, and the patient's explanations for why events occurred.

An underlying assumption of CBT is that the patient systematically and negatively distorts his/her view of the self, the environment, and the future (Beck, 2011). Therefore, a major tenet of CBT is that the person's thinking is the source of difficulty and that this distorted thinking creates behavioral problems. CBT approaches use cognitive and/or behavioral strategies to identify and replace irrational beliefs with rational beliefs. At the same time, the approach prescribes new behaviors that the patient practices, including training on coping skills for dealing with cravings, slips, and relapse, and social skills training.

An extensive body of research on CBT for SUDs is available, including multiple systematic reviews (e.g., Butler, Chapman, Forman, & Beck, 2006; Hogue, Henderson, Ozechowski, & Robbins, 2014; Magill & Ray, 2009; Prendergast, Podus, Chang, & Urada, 2002; Tanner-Smith, Wilson, & Lipsey, 2013). CBT-based strategies are a bedrock of SUD treatment; thus, developing interventions for SUD treatment in integrated settings should include consideration of CBT.



## 4. Technology Transfer/Implementation Support and Guidance

Changing practice patterns, routines, and treatments is difficult. Integrating SUD treatment services and health care is subject to all the complexity and difficulties that attend any organizational change initiative. Section 2 outlined a number of challenges and opportunities attendant upon the integration of SUD and health care services, including federal policy changes, payer system modifications, and workforce development. However, recent advances in implementation science/technology transfer have delineated conceptual models, principles, and strategies that can assist in the implementation of integrated care.

Implementation science combines research across fields such as rural sociology, medical sociology, communication, marketing, evidence-based medicine, and organizational change to study how practice changes (innovations, treatments, practice models) take place in the real world and examine which strategies can help to most efficiently assist with the change process (Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004). Technology transfer is a similar concept that encompasses strategies that promote the movement of new technologies, practices, or skills, from one setting to another (Backer, 1991). A basic finding is that a range of active, engaging strategies is needed for successful practice change (e.g., inform opinion leaders, alter incentives, audit and provide feedback, supply on-site coaching in addition to staff training. See Powell et al., 2012 for a list of 68 strategies).

A number of conceptual models can guide implementation efforts. For example, Damschroder et al.'s (2009) Consolidated Framework for Implementation Research (CFIR), incorporates 19 major theories and models of implementation, grounded in health-related research, and suggests that implementation may be advanced by strategies targeting multiple levels (intervention characteristics, the outer setting [patient needs, policies], the inner setting [organizational char-

acteristics], characteristics of the individuals involved, and the process of implementation). Other theories and models (e.g., Aarons, Hurlburt, & Horwitz, 2011; Fixsen, Naaom, Blase, Friedman, & Wallace, 2005; Proctor et al., 2009; Simpson & Flynn, 2007) also suggest using a range of implementation strategies that target multiple levels.

The ATTC Network places a unique emphasis on technology transfer and implementation support/guidance approaches to achieve lasting changes in practice, as reflected in the following three approaches and two tools.

### ATTC Technology Transfer Model

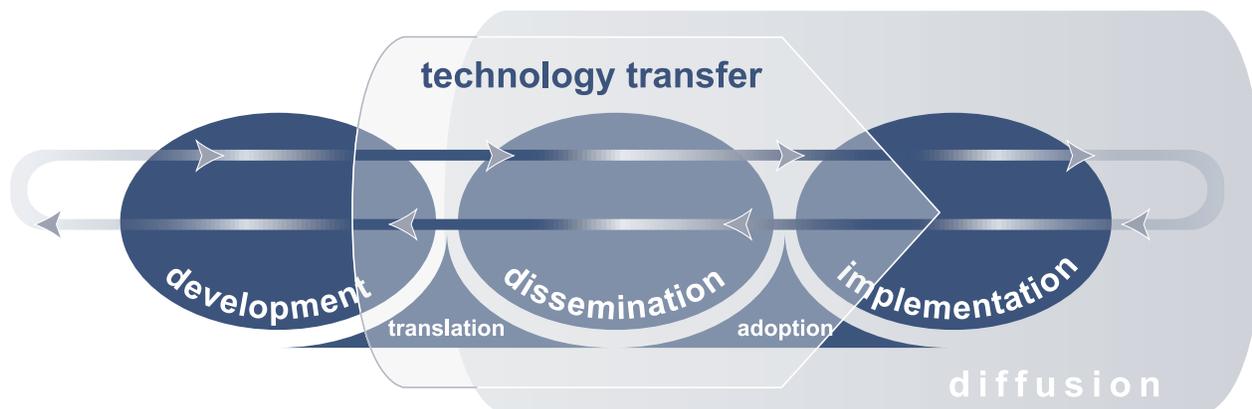
The ATTC Technology Transfer Model is a field-driven conceptual model to explain the development and movement of innovations into practice (ATTC Technology Transfer Workgroup, 2011a, 2011b). The ATTC Technology Transfer Model was developed through a process of reviewing research and theory related to diffusion of innovations and implementation science (e.g., Damschroder et al., 2009; Fixsen et al., 2005; Rogers, 2003; Simpson & Flynn, 2007), consulting with experts in the field, and gathering over 20-years of experience from the ATTC Network (e.g., Squires, Gumbley, & Storti, 2008).

The ATTC model provides a conceptual framework of the life cycle of an innovation (a new concept, technology, or in this case, an evidence-based practice), into which various theories and models that refer to different parts of the process can be contextualized. Figure 6 illustrates the model.

The innovation process begins with the development of a new innovation or technology, including its initial evaluation.

Next, the innovation goes through translation, where the essential elements and relevance

**Figure 6. ATTC Network Technology Transfer Model**



of the innovation are explained and the innovation is packaged to facilitate its spread. In dissemination, awareness about the innovation is promoted with the goal of encouraging its adoption. Adoption is not a single decision but a process of deciding to use the innovation. The final phase, implementation, is the incorporation of the innovation into routine practice in real-world settings. Technology transfer, a main focus of the ATTC Network, is a dynamic, iterative process that incorporates focused, multidimensional strategies to intentionally promote and accelerate the movement of innovations through the continuum, and spans the stages of later development, dissemination, and early implementation (ATTC Technology Transfer Workgroup, 2011a, 2011b).

The ultimate objective of health care is to improve the lives of patients by providing the most effective treatments; this includes providing evidence-based treatments and models of care to patients who have or are at risk of acquiring SUDs. For over 20 years, the ATTC Network has used translation, dissemination, adoption, and implementation strategies to decrease the lag time between the development and testing of an innovative SUD treatment and its implementation into practice. The model has a number of practical applications for the integration of health care and SUD treatment services. The ATTC Technology Transfer Model (ATTC Technology Transfer Workgroup, 2011b):

- Allows health care and SUD treatment providers to more easily comprehend and appreciate the entire change process;
- Clarifies that a range of strategies are needed for successful implementation of practice change;
- Assists stakeholders in determining how to invest limited resources to increase the utilization and monitoring of practices;
- Leads to more satisfaction with the change process and fewer failed attempts to use innovations; and
- Helps stakeholders assess where they are along the diffusion continuum and identify which activities are appropriate to facilitate the long-term implementation of practice change.

## The NIATx Model

The NIATx model is a process improvement model that supports implementation and practice change. This model, based on a meta-analysis of change projects across industries, identifies five fundamental principles to successful change (Gustafson & Hundt, 1995; Gustafson et al., 2011). The first and most important principle is to focus on customer needs. Keeping the customer, usually in health care defined as the patient, at the center of an integration effort is key to success. Efforts that focus solely on administrative functions

## Guide for Health Care Providers to Prepare for Integrating SUD/ Health Care Services

- Revise your mission statement to indicate you welcome SUD, mental health and medical conditions.
- Create a welcoming environment for all (at the reception desk and in the waiting room).
- Use standardized screeners.
- Assess background and history on all three conditions.
- Use interprofessional team meetings or more informal huddles to share information and plan integrated treatment for patients.
- Provide patient education classes on SUD and mental health issues.
- Hold dual recovery mutual support groups.
- Train addiction workers, mental health and medical staff on evidence-based interventions for SUD and risky alcohol and/or drug use (e.g., use SAMHSA's Treatment Improvement Protocols as resources).
- Use technology transfer/ implementation support strategies to bring about program transformations.

*Sources: McGovern, Urada, Lambert-Harris, Sullivan, & Mazade, 2012, and NDRI Assessment Implementation Support and Guidance Approach, Chaple & Sacks, 2014.*

rather than improved patient care are usually unsuccessful. All of the other principles are important to keep in mind, but addressing the remainder of the principles without keeping the customer as the focal point of the change will derail a successful outcome. The second principle, solving key problems, may be related to either customer level problems or organizational level problems. Focusing on metrics that

are important to the organization and outcomes that matter for the patient, family, staff and organization leads to sustainable change efforts. Leadership is the third key component of a successful change effort. Leadership is important at all levels of a change effort, not just senior management. The remaining principles include getting ideas from outside the organization and using a rapid cycle method of testing changes before fully implementing them.

Early work with the NIATx model focused more strictly on process improvement goals for SUD treatment providers, such as decreasing wait time between the first request for treatment and the first session, and reducing no show rates. However, NIATx expanded the model to assist in the implementation of evidence-based practices such as MAT and of broader changes in treatment systems. The NIATx model has also been applied to integration of SUD and health care, such as through a joint learning collaborative with the NACHC, which worked with five FQHCs. ATTCs have had a long standing relationship with NIATx and have been involved in using the NIATx model to advance change. In addition, since 2012, the ATTC Network Coordinating Office has been co-located with NIATx, a division of the Center for Health Enhancement Systems Studies at the University of Wisconsin-Madison.

## NDRI's Assessment Implementation Support and Guidance Approach

The Assessment Implementation Support Approach is a model developed by the National Development and Research Institutes (NDRI), which manages the Northeast and Caribbean ATTC. It uses a coordinated series of activities to assist systems, organizations, and individual health care professionals to change their practices. This model was developed over the past decade as NDRI has provided direct technical assistance to state agencies and individual providers to foster integrated services for people with co-occurring mental and substance

## ■ Spotlight on ATTC Integration Work: Northeast and Caribbean ATTC

### *Integration of Behavioral Health and Primary Care Services in FQHCs*



Staff from NDRI, which is the organizational home of the Northeast and Caribbean ATTC, worked on a project using the Assessment Implementation Support and Guidance Approach model to integrate behavioral health (SUD and mental health) and health care services in FQHC settings in New Jersey. Follow-up assessment data showed that the FQHCs successfully achieved more than the five to seven changes initially proposed. In addition, their capability scores increased substantially, demonstrating that it is possible to achieve significant gains in the integration of SUD, mental health, and medical services in the relatively short period of time of six months (Chaple & Sacks, 2014). Subsequently, the Northeast and Caribbean ATTC offered two full-day, special implementation support and guidance trainings on the integration of SUD, mental health, and primary care services in these FQHCs. The special sessions provided feedback on progress to date, identified staff to carry out the work going forward, and developed plans for making further improvements.

use conditions. The model uses a number of strategies that are supported through implementation science research. Moreover, the same activities, approaches, and successes in integrating SUD and mental health services provide a foundation for further integration with health care services. The Assessment Implementation Support and Guidance Approach includes:

1. **Site Visit and Assessment:** The assessment of program capability to deliver integrated care is conducted in a participatory collegial and encouraging manner designed to produce a positive experience for all; it is not and does not feel like a program audit. NDRI uses the Dual Diagnosis Capability in Health Care Settings (DDCHCS) instrument to measure integration (McGovern, Urada, Lambert-Harris, Sullivan, & Mazade, 2012).
2. **Written Report:** Within 10 days of the visit, a written report is issued that contains ratings on seven dimensions of the DDCHCS, program strengths, and recommendations for enhancing the program.
3. **Implementation Plan:** Site staff develops an implementation plan for “rapid-cycle change” with guidance from NDRI staff. Each program should aim to accomplish five to seven key service improvements during a three- to six-month period.
4. **Technical Assistance/Implementation Support:** NDRI provides individualized technical assistance via conference calls once or twice monthly for six months, focused on how to initiate the implementation plan.
5. **Peer-to-Peer Learning Communities:** Peer-to-peer learning communities are conducted monthly among key staff from the participating sites, with NDRI project staff facilitating to help sustain implementation efforts.
6. **Follow-Up Assessment:** NDRI conducts a DDCHCS follow-up assessment approximately six months after the baseline visit. Programs are compared baseline / follow-up on their overall scores and each DDCHCS dimension. Another written report is generated to describe the program’s level of capability, highlight changes, and itemize recommendations for continued improvement.

As noted in the Spotlight on page 34, NDRI and the Northeast and Caribbean ATTC have used the Assessment Implementation Support and Guidance Approach to assist FQHCs in integrating SUD and mental health services into their primary care array. The ATTC Network uses this and similar strategies across the country to move integration efforts forward.

## Useful Tools

*The Change Book: A Blueprint for Technology Transfer* (ATTC Network, 2000, 2010) is a landmark technology transfer tool developed by the ATTC. Designed to assist practitioners and organizations, it includes principles, steps, strategies and activities for implementing change initiatives to improve treatment outcomes across systems. Since its development, *The Change Book* has proven to be a milestone document for the field of SUD treat-

ment. It was the first publication of its kind to outline multidimensional aspects of instituting change specifically for SUD-related agencies.

*The ATTC/NIATx Network of Practice* is another resource to help agencies move integrated care forward. *The ATTC/NIATx Network of Practice* is an online learning community consisting of a website with implementation specific instructions and resources to assist providers in implementing evidence-based practices for substance use (<http://www.networkofpractice.org/>). The site includes online discussion forums that connect clinicians, administrators, and researchers in an ongoing dialogue about implementation topics such as integrating SUD services and health care, SBIRT and mental health, technology-supported treatment and its reimbursement, and implementing contingency management/motivational incentives.

## 5. Summary and Conclusions

The momentum for the integration of SUD and health care services is being driven by (a) a growing body of research evidence showing better patient outcomes from integrated services, and (b) policy changes resulting from health care reform (the ACA, its implementing

regulations, and the Mental Health Parity and Addiction Equity Act). Unfortunately, early signs suggest that the integration of SUD treatment services is not receiving adequate attention in health care settings. This paper focuses on: 1) the need for better integration of SUD and health care services; and 2) a description of an array of effective models, evidence-based interventions, and implementation strategies that are useful in treating SUDs in health care settings, highlighting efforts of the ATTC Network. SAMHSA's ATTC Network is uniquely situated to facilitate and accelerate SUD and health care service integration at the state, regional and national levels. The Network is an essential resource as states, providers, and the SUD treatment workforce embark on change under health care reform. The Network has the standing, resources, processes and experience to train the SUD workforce and guide the integration of SUD and health care services.





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# APPENDIX



## Examples of the Integration of SUD and Health Care Services

### Addiction Institute of New York at Mount Sinai Outpatient Roosevelt Division

#### Description

The Outpatient Roosevelt Division includes intensive outpatient programs, less intensive groups, individual therapy, psycho-pharmacology, and family therapy.

It offers programs for special populations (impaired health professionals, gay and bisexual men with methamphetamine problems, dual diagnosis, and young adults) and also features an innovative addiction psychopharmacology clinic.

#### Interventions

- Evidence-based treatments include: Dialectical Behavior Therapy (DBT), Acceptance and Commitment Therapy (ACT), Cognitive Behavioral Therapy (CBT), and skills-based groups.
- All treatment uses Motivational Interviewing as a platform.
- Manualized groups include Seeking Safety, DBT skills training, and CBT.
- Individualized treatment plans established after evaluation may include exclusively individual therapy or addiction psychopharmacology.
- Patients are able to receive the level of care needed based on evaluation of severity and motivation.
- Patients may change the frequency and intensity of contact based on ongoing assessment.

#### How SUD interventions fit with the primary care program

The program is housed within a hospital, allowing easy access to all general medical services and specialties. As a division of the Department of Behavioral Health, the program enjoys fluid partnerships with all inpatient and outpatient programs. The program works closely with the Liver Clinic and the HIV treatment center to coordinate patient care. It provides consultations to the medical clinics and Emergency Department for substance using patients, and they provide reciprocal consultations.

#### For more information, contact:

**Paul J. Rinaldi, PhD**

Director, The Addiction Institute of New York  
Department of Psychiatry,  
St. Luke's and Roosevelt Hospitals

[PRinaldi@chpnet.org](mailto:PRinaldi@chpnet.org)

212-523-8939

## Henry J. Austin Health Center, Inc. (HJAHC), Trenton, New Jersey

### Description

Henry J. Austin Health Center, Inc. (HJAHC) is located in Trenton, New Jersey. Established in 1969 as Trenton's Neighborhood Health Center, HJAHC was incorporated in 1986 as a private, non-profit 501(c)(3) entity. The mission of Henry J. Austin Health Center is to provide quality, community-based, affordable, accessible primary health care services in a culturally sensitive manner with respect and dignity. Increasing access and decreasing barriers to quality care are the mainstays of HJAHC.

The HJA program combines SBIRT and Trauma-Informed Care. Four licensed clinical social workers, called behavioral health counselors are embedded in primary care teams at all of our four sites. The Northeast and Caribbean ATTC Center, run by NDRI, provided training, technical assistance, and implementation guidance to HJA's integration of SUD, MH and medical services.

### Interventions

HJA uses the SBIRT model, employing a brief intervention based on patient scores from NIAA, AUDIT, and DAST scores.

### How SUD interventions fit with the primary care program

A medical assistant does the screening as part of the routine intake process at each and every visit. Any positive pre-screens are flagged in the EMR to the behavioral health counselor, who can either see the patient immediately or following the appointment with the primary care provider.

HJAHC is becoming a Trauma-Informed Organization. HJAHC believes that TIC is an integral to helping patients with both behavioral health and primary care. Following participation in the National Council for Behavioral Health's Trauma-Informed Learning Collaborative (2013-2014) HJAHC revised its mission statement and has held provider and staff learning sessions and webinars. The organization has distributed brochures and posters throughout the organization to educate patients about TIC.

### For more information, contact:

Kemi Alli, M.D.  
Chief Medical Officer  
Henry J. Austin Health Center  
Kemi.alli@henryjaustin.org  
609-278-5939

# Connecticut Screening, Brief Intervention and Referral to Treatment (CT SBIRT) Program

## Description

The CT SBIRT Program, funded by SAMHSA-CSAT through the state's Department of Mental Health and Addiction Services (DMHAS), targets adults, ages 18 and older, who are at risk for substance misuse or diagnosed with an SUD. CT SBIRT seeks to make screening and brief intervention for substance misuse a routine part of health care.

## Interventions

CT SBIRT uses the following evidence-based practices:

- The Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) is used to identify and determine risk associated with all psychoactive substances. Patients screening negative or low-risk are provided patient education and feedback about those substances; patients scoring in the low-moderate risk range are provided a brief intervention (BI). Individuals scoring in the high-moderate risk range are provided a BI and referral to Brief Treatment. Those scoring very high risk are provided a BI and referral to more intensive treatment.
- Brief intervention (BI) uses widely researched principles shown to provide risk reduction to most patients at lower levels of risk. The BI lasts an average of 6-8 minutes but is generally no longer than 15 minutes. BI can be used as a stand-alone treatment for those at-risk as well as a means of treatment engagement for those in need of more intensive levels of care. A motivational interviewing approach is used to strengthen a patient's own motivation and commitment to change. Feedback about use of the primary substance identified and health effects is given and behavioral change strategies are offered.
- Referral to Treatment (RT) is based on ASAM criteria to link those identified as needing more intensive treatment with access to specialty care. CT SBIRT also employs a complementary approach to ASAM's Patient Placement Criteria (PPC) and treatment matching based on the notion that individuals should initially be matched to the least intensive level of care that is appropriate, and then "stepped up" to more intensive treatment settings if they do not respond. Individuals who screen at high moderate or high-risk for substance use disorder are referred to appropriate treatment (either Brief Treatment or more intensive treatment).
- Brief Treatment (BT) utilizes both MET and CBT components shown to be effective for patients with alcohol and other drug use problems (Kadden, Litt, Kabela-Cormier, & Petry, 2007). The CT SBIRT BT protocol is modeled on the evidence-based Brief Counseling for Marijuana Dependence manual and video package developed for CSAT's MTP Project (MTP Research Group, 2004; Steinberg et al., 2002). This manual-guided therapy, Let's Play (Steinberg-Galluci, Damon, & McRee, 2012) generally consists of 6-8 sessions and allows for tailoring to specific clinical situations while retaining its integrity in terms of a common set of therapeutic tasks. BT services are offered through the behavioral health departments of the FQHCs or at partnering treatment agencies with counselors who have been trained in the model.

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## How SUD interventions fit with the primary care program

CT SBIRT is promoted as another tool to reduce acute or chronic medical problems associated with substance use. SBIRT is integrated as one of the medical screening and educational services offered within the health center, typically as a component of the vital signs process. HEs provide time-limited strategies to promote reducing or stopping use in the case of at-risk patients, and to facilitate referral to the on-site behavioral health counselor or to a partnering

treatment agency in the case of patients with greater substance involvement or possible dependence.

### For more information, contact:

Alyse Chin, MSW  
Project Director, Connecticut SBIRT Project  
Connecticut Department of Mental Health & Addiction Services  
Alyse.chin@ct.gov  
860-418-6904

## HELP/PSI, New York, New York

### Description

The program is integrated in four Federally Qualified Community Health Centers for the homeless population located in the Bronx, Brooklyn, and Queens. One clinic is co-located in partnership with a needle exchange program. The integrated care model provides primary care, article 31 mental health care, dental care, medical case management, and care management

### Interventions

- Initial and annual SUD screening for every primary care and mental health patient. Providers are trained in Motivational Interviewing. Oral and urine toxicology screenings with liquid chromatography technology are available for every program for monitoring.
- Opioid replacement therapy with Suboxone.
- Pain management with a credentialed pain management specialist who is skilled in managing pain in the population with SUDs.
- Counseling and management of co-occurring mental health disorders.

- Internal referrals for a co-located adult day program with substance abuse groups and counseling for the HIV positive population.
- Referrals to an 822, HELP/PSI outpatient substance abuse treatment program.
- Referrals to a co-located NA group.
- External referrals through the medical case manager to detox, 30-day rehab, and MMTP programs.
- Care management for follow-up, retention and treatment plan adherence monitoring.

### How SUD interventions fit with the primary care program

All the interventions above with the exception of external referrals are integrated into the healthcare centers.

### For more information, contact:

Barbara C. Zeller, M.D.  
Chief Clinical Officer  
HELP/PSI  
Bzeller@projectsamaritan.org  
718-681-8700

## Wheeler Health & Wellness Centers, Hartford and Bristol, Connecticut

### Description

Wheeler Clinic has established Health & Wellness Centers Hartford and Bristol, Connecticut, to meet the needs of medically underserved individuals with behavioral health needs and other high-risk populations. These centers are supported by strong collaborative relationships with local hospitals to meet the specific needs of vulnerable populations. Each Health & Wellness Center includes primary and behavioral health care, linkage to dental and specialty health providers, access to pharmacy services, engagement and care management supports and recovery and wellness services.

### Interventions

Wheeler provides a comprehensive continuum of outpatient and community-based behavioral health services for individuals with serious mental illness, co-occurring disorders, and substance use and gambling disorders. Wheeler's Addiction Center of Excellence uses evidence-based substance abuse treatment and recovery support practices that are culturally, gender, and age-responsive, trauma-informed and foster resiliency and recovery. Wheeler's open access model provides immediate access to multidisciplinary care.

### How SUD interventions fit with the primary care program

Integration of SUD interventions and primary care begins when behavioral health clients enter our system. Intake clinicians and engage-

ment specialists address patients' barriers to accessing care. Immediate access to an embedded or nearby health care practitioner is making a difference – in just over six months nearly 700 consumers accepted referrals for primary care. Multidisciplinary care teams ensure a holistic approach for patients with complex medical, behavioral health, and social support needs, and provide a standing forum for review of individual patient and local health concerns. With support from the Connecticut Department of Mental Health and Addiction Services, Wheeler's Health & Wellness Centers provide SUD treatment facilitation services, responding directly to the identified needs of local emergency departments to change the health care utilization patterns and health outcomes of chronic substance abusing populations with frequent, high-cost emergency department and intensive care admissions and re-admissions.

### For more information, contact:

Wendy DeAngelo, MBA  
Chief Business Development Officer  
Wheeler Health & Wellness Centers  
wdeangelo@wheelerclinic.org  
860-224-6388

# SSTAR, Massachusetts

## Description

SSTAR serves approximately 10,000 patients with SUDs and about 7000 patients in its FQHC who may or may not have an SUD. The services are fully integrated, with patients able to receive the health service they need—whether it is psychotropic medication, counseling for various diagnoses, or treatment for an ear infection.

## Interventions

- Ambulatory Behavioral Health Services provides individual, group and family therapy as well as medication evaluation services for a wide variety of psychological problems, including substance abuse/dependence, trauma, stress, depression, anxiety, anger, etc.
- BIP – Batterer’s Intervention Program: Our Certified BIP is a 40-week program, which provides educational groups for batterers and resource information to partners and victims as part of a coordinated community response.
- Driver Alcohol Education Program (DAEP) is a program for individuals charged with a First Offense Driving Under the Influence violation.
- Family Interventions (ARISE) is an approach to engaging reluctant drug and alcohol dependent individuals into treatment using an “invitational” model of intervention.
- Intensive Outpatient Program for Addiction Treatment provides multidisciplinary treatment to address the sub-acute needs of clients with addiction and/or co-occurring disorders.
- Outpatient Groups: SSTAR offers Group Treatment, including Domestic Violence Educational Group, Women’s Evening Domestic Violence Group, Pattern Changing Group, Parenting Wisdom, Pain Management, Creative Expression Group, Building Ourselves Recovery Group, Common Bond, Seeking Safety, Staying Sane, and Other Relapse Prevention Groups.
- Smoking Cessation services that include individual and group counseling. In addition, SSTAR offers tobacco treatment to local businesses that are interested in running a program for their employees.
- The Women’s Center provides individual and group counseling, support groups, and legal advocacy, including assistance with pro se documents and accompaniment to court.

## How SUD interventions fit with the primary care program

The services are fully integrated with patients able to receive the type of health service they need, whether it is psychotropic medication, counseling for various diagnosis, or treatment for an ear infection.

## For more information, contact:

Nancy E. Paull, CEO  
Stanley Street Treatment and Resource Center  
Npaull@sstar.org  
508-324-3500





**ATTC**

Addiction Technology Transfer Center Network  
Funded by Substance Abuse and Mental Health Services Administration



**ATTC**

Advancing the Integration  
of Substance Use Disorder  
Services and Health Care