

# Workforce Issues: Integrating Substance Use Services into Primary Care

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*August 10–11, 2011 Summit Proceedings*

Sponsored by the Office of National Drug Control Policy and the Department of Health and Human Services (SAMHSA, Substance Abuse and Mental Health Services Administration and HRSA, Health Resources and Services Administration)

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## Introduction

“Healthcare reform,” “the Affordable Care Act,” “Health Homes,” “co-occurring mental health and substance use disorders,” “disease management for chronic conditions,” “Medication Assisted Treatment,” “Screening, Brief Intervention, and Referral to Treatment for substance use disorders in primary care,” “mental health and substance abuse parity” — these terms, relatively new in the behavioral health and broader healthcare fields, have become part of today’s everyday lexicon.

Within the current landscape, many facts and issues drive healthcare reform discussions across the country, creating concern and opportunity for addiction specialty providers, including:

- Substance use increases the risk for hypertension (x2), congestive heart failure (x9), and pneumonia (x12);
- Inhalant use and depression among 12-17 year olds is increasing;
- Patients in chemical dependency programs are 18 times more likely to have major psychosis, 15 times more likely to have depression, and nine times more likely to have an anxiety disorder;
- Patients with HIV and a substance use disorder are more likely to be non-adherent to HIV care;
- Medicaid recipients with a substance use disorder are more likely to be readmitted to a hospital within 30 days;
- Substance use increases the rate of hip replacements complications;
- Patients treated with medication for alcoholism had fewer emergency room visits and detoxification and alcohol-related inpatient days;
- Medicaid recipients with HIV incur 40% more in costs for treatment of comorbidities, and mental and substance use disorders are the most common comorbidity; and
- Treating patients with substance abuse related medical disorders in an integrated setting can achieve cost savings.

Understanding these facts and other issues regarding substance use care in this nation, myriad questions arise: Where do specialty addiction providers fit within the service continuum? Will there be an adequate workforce to address substance use disorders in primary care? What substance use services belong in primary care and what services should remain in specialty addiction settings?

To begin to look at these and other issues, the Office of National Drug Control Policy (ONDCP), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Health Resources and Services Administration (HRSA) hosted **Workforce Issues: Integrating Substance Abuse Services into Primary Care Summit** on August 10-11, 2011 in Washington, D.C. The Summit provided experts from across the country the opportunity to discuss and review workforce issues and begin to identify innovative solutions regarding substance use disorders in primary care. This document summarizes the key themes and discussions that occurred during the Summit.

## Opening Session

ONDCP Director R. Gil Kerlikowske and Deputy Director David Mineta, MSW; Department of Health and Human Services Assistant Secretary for Health Howard Koh, MD, MPH; HRSA Administrator Mary Wakefield, PhD, RN; and SAMHSA Administrator Pamela Hyde, JD, opened the Summit by emphasizing the need for collaboration and partnership in addressing substance use in the United States. Each of these federal leaders expressed their commitment to eradicating the tremendous impact substance use disorders have on individuals, communities, and states, as well as their commitment to both federal-level and provider-level collaboration to identify and implement solutions. By providing agency overviews and an inventory of potential federal resources, the opening session set the stage for the 2-day Summit and provided a platform to examine issues, identify innovative programs, and generate dialogue on the integration of substance use services into primary care.

The Summit included opening and closing sessions, five plenary sessions, and two breakout sessions that allowed participants to develop a shared understanding of the scope of issues, interact, and problem solve. The robust dialogue gave participants a platform to share perspective and for areas of consensus to develop.

## The Plenaries

### Plenary 1: State of the Workforce, Workforce Issues, and Financing

Mathew Burke, MD, senior clinical advisor, Office of Quality and Data, Bureau of Primary Health Care, HRSA, facilitated the Summit's first plenary, **State of the Workforce, Workforce Issues, and Financing**. Speakers included H. Wesley Clark, MD, JD, MPH, CAS, FASAM, director, Center for Substance Abuse Treatment, SAMHSA; John O'Brien, MA, senior advisor on health financing, SAMHSA; and Mary Pat Farkas, health insurance specialist, Disabled and Elderly Health Programs Group, Center for Medicare and Medicaid Services. The session provided core information on the state of the substance abuse workforce and Medicaid financing for substance use disorders and related behavioral healthcare services.

Dr. Wesley Clark provided the plenary overview, emphasizing how anticipated changes in the healthcare system could generate an influx of millions of new clients into the behavioral health system, increasing the importance of credentials and education for the behavioral health workforce. Currently, 55% of U.S. counties – all rural – have no practicing psychiatrists, psychologists, or social workers. Yet, projections estimate 12,624 child and adolescent psychologists will be needed by 2020; the projected supply is anticipated at only 8,312 (SAMHSA, 2007). When considering minority staffing, the issues are compounded (see box). Another substantial challenge for the behavioral health workforce is disparities in pay. A recent National Council for Community Behavioral Health Care Report found that:

**Although minorities make up 30% of the U.S. population, they currently account for only:**

- **24.3% of psychiatrists**
- **5.3% of psychologists**
- **14.9% of social workers**
- **20% of counselors**
- **8.5% of marriage and family therapists**
- **4.9% of school psychologists**
- **9.8% of psychiatric nurses**

*(Duffy, 2004)*

- A direct care worker in a 24-hour residential treatment center has a lower median salary than an assistant manager at Burger King (\$23,000 vs. \$25,589)
- A social worker with a master's degree employed in a mental health-addictions treatment organization earns less than a peer at a general healthcare agency (\$45,344 vs. \$50,470)
- A registered nurse working in behavioral health earns less than the national average for nurses (\$42,987 vs. \$66,530) (National Council, 2011.)

Financing is critical to the future of any work related to the integration of substance use services into primary care settings. While most states' specialty addiction services are covered by SAMHSA's Substance Abuse Prevention and Treatment (SAPT) Block Grant, some states include substance use services as a Medicaid-covered service.

Medicaid is a federal-state partnership, covered by federal statutes, regulations, and policies. Federal Medicaid goals for mental health and substance use disorder support include: (1) offering effective services, (2) improving the integration of physical and behavioral healthcare, (3) offering person-centered,

consumer-directed care that supports successful community integration; and (4) improving accountability and program integrity (Farkas 2011). Within these federal guidelines, each state establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for services; and administers its own program, resulting in 50 distinct state-based eligibility criteria, benefits, payment rates and standards for professionals credentialed to provide care for persons with substance use disorders.

*CMS' Mary Pat Farkas provided information on the percent of Medicaid recipients who utilize mental health or substance abuse services. In Figure 1, only 0.7% of existing Medicaid recipients received substance use services (Farkas, 2011). This percentage generated extensive discussion at the Summit as to why it was so low. Several potential "causes" that were discussed included (1) that a number of states offer limited or no Medicaid reimbursement for substance use disorder services; (2) persons with substance use disorders may be unwilling or unable to seek*

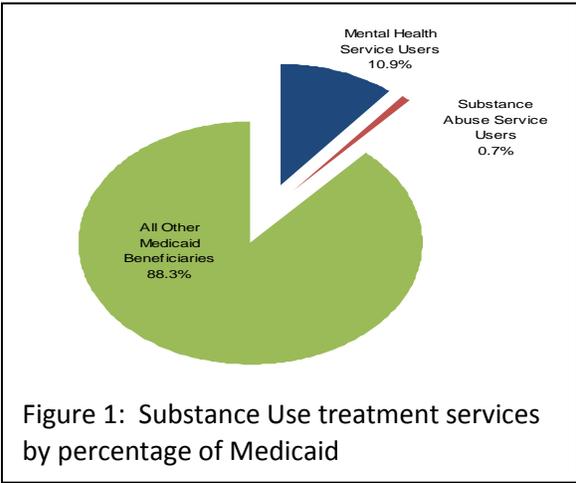


Figure 1: Substance Use treatment services by percentage of Medicaid

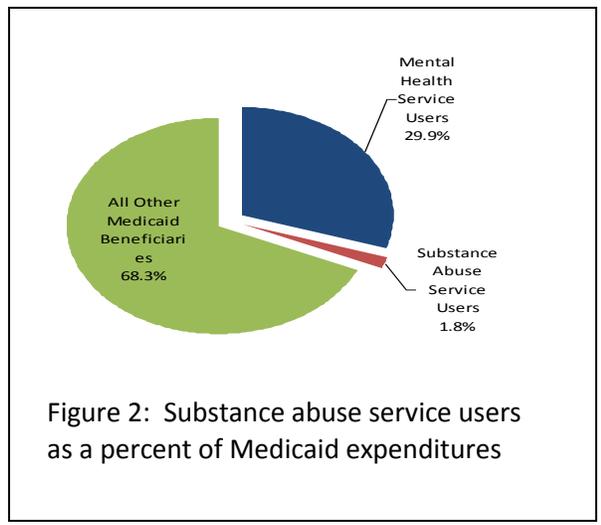


Figure 2: Substance abuse service users as a percent of Medicaid expenditures

*treatment; (3) care may be provided for physical health issues associated with substance use with no reference to the substance use and/or (4) billing may be done in ways that protect consumers from stigma that claims using substance use service codes may generate.*

*Figure 2 reframes this information reflecting the percent of Medicaid eligibles that used substance abuse services. 1.8% of the total number of Medicaid eligible consumers accessed substance use related services. (Farkas, 2011).*

Addiction services generally covered by states include:

- Inpatient services, including medical detoxification
- Emergency department services
- Outpatient services (clinic or individual practitioner)
  - Individual
  - Group
  - Family/multifamily
  - Accredited residential treatment facilities (youth)

Medicaid infrequently covers intensive outpatient services, skill building, case management, and Medication Assisted Treatment (MAT). These latter services are often critical for a successful recovery

lifestyle and can support integrated models as well. Medicaid *does not cover Institutions for Mental Diseases (IMD)*, which are defined as institutions with more than 16 beds that provide treatment to persons with “mental diseases,” including substance use disorders, with more than 50% of individuals having a mental disorder (O'Brien, 2011).

The Affordable Care Act (ACA) provides several new options to improve substance use care within the concept of the Health Home. ACA Section 2703 provides for the creation of Health Homes for individuals with chronic conditions. The definition of chronic conditions within the ACA includes mental health, substance use disorders, asthma, diabetes, heart disease, being overweight (as evidenced by a BMI of >25), and other conditions determined through Secretarial authority. Health Homes will provide new Medicaid services that include comprehensive care management, care coordination, health promotion, comprehensive transitional care from inpatient to other settings, individual and family support, referral to community and social support services, and the use of health information technology, as feasible and appropriate (Farkas, 2011).

## Plenary 2: Federally-Funded Initiatives: Paving the Way for Integrated Care

Kathleen Reynolds, LMSW, ACSW, director, SAMHSA-HRSA Center for Integrated Health Solutions, facilitated the second plenary, **Federally-Funded Initiatives: Paving the Way for Integrated Care**, which featured the following experts: Jose Esquibel, director, Colorado Department of Public Health and Environment/Colorado Statewide Initiative on SBIRT; Sharon Levy, MD, MPH, Developmental-Behavioral Pediatrics, Harvard Medical School; Laura Cheever, MD, MPH, deputy associate administrator for HIV/AIDS, HRSA; and Colleen LaBelle, RN, CARN, state director, Boston University Medical Center. The panelists provided case examples of well-functioning, substance use service integration activities, including Screening, Brief Intervention, and Referral to Treatment (SBIRT) programs for both adults and youth and MAT projects within primary care settings.

Case Examples included:

- **The Colorado Statewide SBIRT Initiative** comprises 22 sites statewide, including rural clinics, Federally Qualified Health Centers (FQHCs), a rural hospital, urban clinics, urban hospitals, and a dental clinic. The project has completed over 100,000 client screens by successfully modifying the clinic workflow to include SBIRT services. The initiative’s providers include nurses, medical social workers, physicians, HIV care workers, psychologists, state employee assistance workers, dental assistants, and a dentist. The project also uses unlicensed health care professionals with 90 hours of combined face-to-face and other training.

The Initiative’s Director Jose Esquibel identified three key barriers to overcome when implementing a statewide SBIRT project: (1) substance abuse treatment providers traditionally work within a specialty care model and must be open to briefer models in the area of intervention (primary care); (2) the SBIRT model is quick, with shorter time spent with patients, whereas substance abuse providers are trained to provide services of longer duration; and (3) interdisciplinary teams are not currently the norm in substance use treatment. For more information, email Mr. Esquibel at [j.esquibel@state.co.us](mailto:j.esquibel@state.co.us).

- The Children’s Hospital in Boston has a fully developed **Adolescent SBIRT Protocol**. Based on the unique needs of adolescents and their families, the protocol provides a developmentally appropriate screening process with an algorithmic brief intervention approach that is easily inserted into a provider’s workflow. Providers use very brief statements for intervening with pre-initiates, low-risk users, moderate-risk users, and high-risk users.

The project provides a supporting training curriculum that includes an overview of SBIRT, motivational interviewing, pain management, ADHD and substance abuse, drug testing, parental guidance, confidentiality, and neurobiology of alcohol and cannabis, buprenorphine, and co-occurring mental health disorders. Data on the project’s outcomes are available at [www.ceasar.org](http://www.ceasar.org).

- HRSA’s Dr. Laura Cheever and Boston University Medical Center’s Colleen LaBelle provided overviews of their respective programs, which both provide MAT for substance use disorders in primary care settings.
  - The HRSA-funded initiative, **Medication Assisted Treatment Initiatives in HIV/AIDS Settings**, provided substantial insight into the benefit of providing MAT to individuals with HIV/AIDS and offered examples of how the initiative improved treatment adherence. For additional information access the [Journal of Acquired Immune Deficiency Syndrome March 1, 2011 issue](#), email Dr. Cheever at [lccheever@hhs.hrsa.gov](mailto:lccheever@hhs.hrsa.gov).
  - Colleen LaBelle addressed the **Role of Nurse Care Managers in Medication Assisted Treatment for Substance Use Disorders**. Ms. LaBelle coordinates a program in Massachusetts that places nurse care managers in FQHCs to provide substance use treatment. The program supports the use of buprenorphine. This statewide training initiative for nurses includes initial training, site visits, and ongoing learning community services that include webinars and quarterly face-to-face meetings, email, phone support, and a listserv. The project provides funding for one registered nurse care manager who operates with a 1:100 staff to patient ratio. For more information, email Ms. LaBelle at [colleen.labelle@bmc.org](mailto:colleen.labelle@bmc.org).

### Plenary 3: Workforce Issues in Integrated Care: Framing the Challenges

Joan Dilonardo, PhD, RN, consultant, framed the challenges facing specialty addiction provider and primary care provider networks across the country in a pre-conference white paper: **Workforce Issues Related to: Physical and Behavioral Healthcare Integration, Specifically Substance Use Disorders and Primary Care: A Framework** (Dilonardo, 2011). In her plenary address, Dr. Dilonardo summarized the paper and challenged the group to shift their focus from “the individual” to a “target population.” Once such a shift occurs, core issues will emerge, including: (1) training and use of brief, focused interventions; (2) facilitating patient self-management/care management; (3) credentialing; (4)

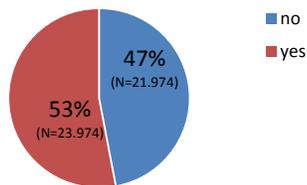
financing; (5) workforce education and training; (6) after hours coverage; and (7) information technology.

As this work will occur in different environmental settings, different aspects of cultures, workflow, skill sets, and uneven preparation of professionals will emerge as issues, and key questions will include: Will substance abuse professionals be prepared to work in integrated healthcare environments? Will primary care practitioners have sufficient preparation and training to treat substance use disorders? Will addiction professionals have sufficient preparation to work within the context of different health/disease states?

Using information from Washington State, Dr. Dilonardo illustrated the increased need for substance use treatment specialists. The Washington Medicaid expansion identified at least 23,974 people with a substance use disorder who will have Medicaid and be eligible for services. This increased demand for care will require additional trained workers and place a greater burden on an already extended

addiction treatment system. Some of the screening and brief interventions needed by this population could be provided in primary care settings, and these new workers will need an enhanced skill set that includes evidence-based practice expertise, enhanced interpersonal skills, strong communication skills, conflict resolution training, teamwork, quality improvement, and the ability to use data to incite change.

**Figure 3: AOD treatment need of future disability lifeline and ADATSA clients in the State of Washington - SFY 2009.**



Key elements that will drive the success of such integration efforts include:

- Adequate training in substance use disorders and complex teamwork;
- Necessary competence and certification/licensure for substance abuse counselors;
- Broad and high quality adoption of SBIRT and MAT;
- Use of evidence-based training methods for evidence-based practices; and
- Team competencies with follow-up. (Dilonardo, 2011.)

#### Plenary 4: Integrated Models and Use of Teams

Richard Saitz, MD, MPH, FACP, FASAM, professor of medicine and epidemiology at Boston Medical Center and Boston University Schools of Medicine and Public Health, facilitated a panel featuring four case studies on the use of teams in the integration of substance use services in primary care settings. Plenary speakers included Lois Simon, chief operating officer, Community Care Alliance; Leslie Preston,

behavioral health director, La Clinica de la Raza; Mary Zelazny, chief executive officer, Finger Lakes Community Health; and Mireya Macias, project developer, Worker Education and Resource Center.

- **The Commonwealth Care Alliance (CCA)** is a Massachusetts-wide, not-for-profit, consumer-governed, prepaid care delivery system that provides a fully integrated, dual eligible Medicare Advantage Special Needs Plan. An Accountable Care Organization prototype, CCA focuses exclusively on the care of Medicare and Medicaid’s complex and high-cost beneficiaries. It relies on Medicare and Medicaid risk adjusted premiums to redesign care with a focus on investment in primary care. Its care model enhances primary care and care coordination capabilities through deployment of multidisciplinary primary care teams.

CCA’s primary care redesign includes nine key elements considered critical to its success. The description of these nine elements and additional information on CCA and its cost curve bending program are available at [www.communitycarealliance.org](http://www.communitycarealliance.org).

- **La Clinica de la Raza**, a HRSA-funded health center, operates five primary care sites with over 68,000 active members and 328,000 visits per year. La Clinica places behavioral medicine specialists in the exam room area as part of the primary care team to serve as consultants to the medical provider and the patient by providing 15-30 minute consultations, assessments, and brief interventions. Medical social workers/case managers provide brief counseling, group visits, advocacy, linkage, tracking and monitoring, and perinatal visits in 1-10 visits for a membership comprised of 91% people of color. For additional information on La Clinica de la Raza, email Ms. Preston at [lpreston@laclinica.org](mailto:lpreston@laclinica.org).
- **Finger Lakes Community Health** is a community-based organization that provides comprehensive primary care services to vulnerable, high-risk populations in 42 New York counties. Finger Lakes provides a telehealth program that offers:

Telemedicine for Specialty Care:

- Dentistry
- Dermatology
- Psychiatry
- Counseling
- Pulmonology
- Tele-ninos
- Urgent Care
- Ear, Nose and Throat

Distance Learning & Education:

- Substance Use Case Conferencing
- Staff Development & Training
- CMEs & Grand Rounds
- Chronic Disease Management
- Outreach

Enabling Services:

- Interpreter Services
- Outreach Services

For additional information on the Finger Lakes TeleHealth Program, email Ms. Zelazny at [maryz@flchealth.org](mailto:maryz@flchealth.org).

- **The Worker Education and Resource Center** is a nonprofit organization that helps lower-wage workers and job seekers attain the skills and credentials most needed in the public health sector in California. The Center's programs are geared toward high demand careers in the healthcare safety net and in green industries. Its comprehensive training course is designed to train community health outreach workers to become active members of multidisciplinary care teams at the hospital, clinic, healthcare center, and community levels. The integrated curriculum includes: (1) mental and physical health concepts; (2) basic anatomy, biology, and life science; (3) vocabulary; (4) math; (5) soft skills; and (6) computer skills. For information on this training program, email Ms. Macias at [mmacias@hcwdp.org](mailto:mmacias@hcwdp.org).

## Plenary 5: Contributions to Workforce Development and Training

Rick Rawson, PhD, professor and associate director, Semel Institute, UCLA Integrated Substance Abuse Programs, facilitated the final plenary session, **Contributions to Workforce Development and Training**. This plenary was designed to provide participants with an overview of five existing workforce development programs. Speakers included Dr. Richard Brown, professor of family medicine at the School of Medicine and Public Health at the University of Wisconsin and director of the Wisconsin Initiative to Promote Healthy Lifestyles; Carol McDaid, co-founder, McShin Foundation; Mark Stringer, MA, LPC, NCC, director, Missouri Divisions of Alcohol and Drug Abuse and Comprehensive Psychiatric Services; Scott Breedlove, MS, MATS, administrator, Missouri Substance Abuse Professional Credentialing Board/IC&RC; Alexander Blount EdD, clinical professor of family medicine and psychiatry, University of Massachusetts; and Alex Walley, MD, MSc, professor of family medicine and psychiatry, University of Massachusetts Medical School.

- In discussing the **Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL)**, Dr. Richard Brown provided data on the outcomes and usefulness of screening for behavioral health issues in primary care. A slide from his presentation identified the following effectiveness data for brief alcohol interventions in primary care:
  - Primary care — \$950/patient net savings in 1 year continuing out to at least 4 years; ROI >400% in 1 year (Campbell, 2006; Estee, 2010; Fleming, 2006)
  - Emergency room/trauma centers — 47% reduction in recurrent alcohol related injury; nearly 400% in 1 year (Fleming, 2002, Gentilello, 2005)
  - Washington Medicaid disabled — \$366 decrease in healthcare costs per recipient per month for 12 months (Estee, 2010)
  - Estimated employer savings — \$771 per employee per year (Quanbeck, 2010)

The potential for excessive demand for interventions and/or services is often cited as a reason for not screening for substance use disorders in primary care. However, of the 117,580 SBIRT screens WIPHL has completed statewide, only 26,336 (approximately 22%) of the screenings required intervention. Patient satisfaction regarding screening for behavioral health issues in primary care is often a secondary perceived barrier. Yet, the WIPHL program found the average patient satisfaction with SBIRT services ranged from 4.24-4.45 (on a scale of 1 to 5, with 1 meaning disagree and 5 meaning agree) on the following four questions:

- What I am doing or have done with my health educator has given me new ways of looking at my drinking or drug use.
- I feel that the things I am doing or have done with my health educator will help me to accomplish the changes that I want.
- As a result of these sessions, I am clearer as to how I might be able to change my drinking or drug use.
- I believe that the way we are working with my drinking or drug use is correct.

For additional information on WIPHL, email Dr. Brown at [rlbrown@wisc.edu](mailto:rlbrown@wisc.edu) or visit [www.wiphl.com](http://www.wiphl.com)

- **An addiction recovery coach or peer recovery coach** is “a personal guide and mentor for individuals/families seeking to initiate, achieve and sustain long-term recovery from addiction including medication assisted, faith based, 12 step and other pathways to recovery. This person may be a connector and navigator to recovery support systems and resources including housing, employment, and other professional and non-professional services and/or serve as a liaison to formal and informal community supports, resources and recovery supporting activities” (Faces and Voices of Recovery). These coaches can work in nearly all settings and are an effective adjunct to any treatment program. Similar to community health workers in primary care settings, peer recovery coaches can assist at any point in the recovery process. Certification is currently available for peer supports in 25 states and Medicaid is beginning to reimburse these services. For more information on addiction/peer recovery coaches, visit [www.mcshin.org](http://www.mcshin.org).
- **The Missouri MAT specialist** credentialing process began in 2007 with a grant from the Robert Wood Johnson Foundation; Missouri began certifying MAT specialists in 2010. Currently, 139 individuals including doctors, nurses, individuals in recovery, social workers, and faith-based workers have earned credentials. This formalized, innovative credential creates a certified workforce for medical and behavioral health settings looking to initiate MAT. For more information, email Mr. Stringer at [mark.stringer@dmh.mo.gov](mailto:mark.stringer@dmh.mo.gov) or Mr. Breedlove at [scott.breedlove@dmh.mo.gov](mailto:scott.breedlove@dmh.mo.gov).
- **The Certificate Program for Behavioral Health Specialists** was developed by Dr. Alexander Blount and his staff at the University of Massachusetts. This training curriculum has produced over 1,000 certified behavioral health specialists across the country. The Certificate Program includes six one-day workshops (one per month over 6 months), which are conducted synchronously over the Web. For information, visit [www.integratedprimarycare.com](http://www.integratedprimarycare.com).
- **The Chief Resident Immersion Training (CRIT) Program in Addiction Medicine** brings together chief residents from across the country for a 4-day immersion course that uses role modeled teaching methods, including lectures, case presentations, small group discussions, skills practice sessions, visits to 12-step meetings, and group visits with people in recovery. All of the chief residents learn to teach addiction medicine and design a teaching project in their programs. The project is designed to provide incoming chief residents (primarily internal and family medicine residents) with teaching and practice knowledge and skills so that they will integrate addiction

medicine into their residency curricula. Operating with more than 10 years of experience, the project has trained more than 200 chief residents. For more information, email Dr. Walley at [awalley@bu.edu](mailto:awalley@bu.edu) or go to [www.bumc.bu.edu/care](http://www.bumc.bu.edu/care).

## The Breakout Sessions

### Clinicians/Providers Breakout Sessions

Clinicians and providers attending this Summit breakout session track suggested that when discussing integrating substance abuse into primary care we may be talking about two or more distinct populations of patients: (1) individuals whose use and problems that arise from that use could be expected to respond to brief intervention/education in the primary care setting; and (2) individuals with the disease of addiction with a genetic and environmental etiology whose needs may exceed the substance use disorder treatment capacity of a primary care setting and require a referral to a specialty addiction treatment provider. Participants suggested that perhaps a goal in primary care would be to be able to differentiate these populations of patients and apply evidence-based treatment.

Other key topics during the breakout session dialogues included:

- Enhancing coordination between addiction specialty organizations, FQHCs, and community behavioral health centers on the local level by stimulating conversations that support collaboration at all levels.
- Defining the roles of primary care physicians/providers and behavioral health specialists and determining the level of expertise each needs to properly address substance abuse issues in primary care, as well as knowing the limits of knowledge, skill, and scope of practice and using experts to augment services or to refer clients to specialty services.
- Integrating the recovery paradigm in primary care.
- Securing recognition of non-physician expertise in medical settings.
- Fostering team-based care and strengthening inter-professional bonds.
- Assuring confidentiality of patient information while effectively communicating across providers.
- Addressing credentialing issues for substance abuse staff working in primary care.

### Policy/Financing Breakout Sessions

Financing substance use services in primary care is a consistent barrier to implementation of integration and a potential driver for change. However, in nearly every state, early work on financing has been successful in identifying potential billing mechanisms for SBIRT services including substance abuse services in federally qualified health centers. Examples of these interim billing features are available from the SAMHSA-HRSA Center for Integrated Health Services at [www.integration.samhsa.gov](http://www.integration.samhsa.gov)

Other key elements in these discussions included:

- Credentialing/career path issues for substance abuse professionals
- Roles of peers in primary care
- Training budgets
- Medicare payment codes for alcohol screening
- Alignment of accreditation requirements with desired practice and payment
- Treatment team performance measures
- Coding, diagnosis, and credentialing issues in billing
- Insurance coverage for persons in recovery from substance use/abuse treated with medications

## Education/Schools Breakout Session

Participants of this breakout group worked in or had extensive knowledge of professional schools of education. Two early insights from this workgroup emerged. First, the group recognized the need for distinct educational activities for the existing workforce and the future workforce; participants discussed addressing the existing workforce through continuing education credits, training budgets, and balancing productivity rather than training. A second insight was the need to involve the Department of Education in discussions as efforts are made to influence and/or change professional education curricula. Key discussion topics from this session included:

- Inclusion of addiction medicine as part of the primary care provider education
- Importance of experiential education
- Integrating into curricula education and support for professionals to work in teams
- Motivational Interviewing is a critical skill for primary care
- Teaching students to teach themselves (a self-directed adult learning approach)
- Training/retraining for the existing workforce and training for the future workforce
- Funding and reimbursement can drive the practice in the direction of integration
- Not changing core curriculum but adding necessary content into already existing modules
- Information dissemination of existing best practice education/training programs to the field

## Conclusion

This workforce summit on "Integrating Substance Use Services in Primary Care" identified an array of potential options for preparing the substance abuse workforce for new roles and responsibilities moving forward. The workgroups developed a solid list of key issues and areas for further study. The solid roster of presenters demonstrated that the skills, abilities, and model programs needed for partnering with primary care exist and are available for replication. The field must now embrace this challenge and begin the efforts needed to train the existing and future substance abuse workforce.

Integrating substance use services into primary care settings provides a tremendous opportunity for addiction treatment professionals to intervene earlier in the course of addictions and have a greater

impact on the general health and wellbeing of individuals. Providing these services in primary care settings could also lead to the creation of a more efficient healthcare system and lower overall healthcare cost. The benefits can only be realized with a well-trained workforce capable of providing services in diverse healthcare settings.

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**Appendix A:**

**Workforce Issues Related to Physical and Behavioral Integration Specifically  
Substance Abuse Disorders and Primary Care: A Framework**