ATTC
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# ATTC ISSUE BRIEF:

## ADVANCING THE INTEGRATION OF SUBSTANCE USE DISORDER SERVICES AND HEALTH CARE

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**ATTC**
Advancing the Integration of Substance Use Disorder Services and Health Care

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# INTRODUCTION

Nikola Tesla famously said, *"The spread of civilization may be likened to a fire; first, a feeble spark, next a flickering flame, then a mighty blaze, ever increasing in speed and power."* Tesla has been described as an innovator and visionary.[1] His description of the spread of civilization reflects his understanding of how ideas, science and technology move society ever forward. Few societal structures in the United States are more in flux today than health care. As health care reform spreads, the flames of opportunity for better, more cost-effective care are fanned. The Addiction Technology Transfer (ATTC) Network is catalyzing a national, multidisciplinary "blaze" to ensure that when equilibrium is restored substance use disorder (SUD) services are an integrated, accessible part of mainstream health care. This Issue Brief describes the ATTC Network's plans to advance the integration of care.

## SETTING THE CONTEXT

SUDs range in severity from risky use of alcohol and other drugs to addiction, which is a chronic, relapsing disease.[2] The prevalence of SUDs is widespread. Of Americans aged 12 and over, 22.1 million had a diagnosable substance use disorder in the past year.[3] Evidence-based interventions for SUDs do exist and recovery from addiction is possible. SAMHSA defines recovery as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."[4] Between 25 and 40 million Americans are in recovery from addiction.[5] There are many pathways to recovery, some of which incorporate clinical treatment provided by a qualified health professional. When treatment is necessary, the use of evidence-based practices (EBPs) has been shown to enhance patient outcomes.[6] EBPs, however, are not widely incorporated into routine clinical practice and are rarely administered with fidelity.[6, 7]

For decades, the majority of clinical treatment of SUDs has occurred in specialty service settings. Three-quarters of the funding for these nonprofit and government-operated facilities has come from public sources, and more than half of the public funding has come from sources other than Medicaid.[9] Federal health reform laws, including the Mental Health Parity and Addiction Equity Act (MHPAEA) and the Patient Protection and Affordable Care Act (ACA), are drastically transforming this system such that more and more individuals will be expected to access behavioral health services through mainstream health care settings.

The MHPAEA expands behavioral health coverage by requiring most group health plans, including Medicaid, to cover mental health and SUDs in a way comparable to their coverage of all other medical conditions.[3] For example, the law requires parity for financial requirements like deductibles as well as for treatment requirements like limits on visits. The principle underlying the law is that Americans should have the same access to behavioral health care as they have access to physical health care.

The overarching goal of the ACA is "to create high quality, accessible, efficient health care for all which is supported by effective care coordination."[10] The Department of Health and Human Services (HHS) has identified four themes in the ACA.[11] First, the law increases access to care through coverage expansion provisions (e.g., family coverage for young adults up to age 26). The law also increases access to care for underserved communities by growing the network of community health centers and increasing payments for rural providers. Second, the ACA ends insurance abuses, eliminating annual and lifetime limits and instituting new appeals processes for consumers denied care. Third, the law makes health care more affordable. Under the ACA, Medicaid eligibility requirements are changed to allow more people to enroll. Also, low and moderate-income people without insurance are able to purchase affordable private insurance through health insurance exchanges (HIEs). Health plan policies offered through HIEs must contain essential health benefits, including mental health and SUD services. The ACA also emphasizes the importance of prevention and wellness programs in order to lower lifetime health care costs. Furthermore, the law supports national quality measures and the meaningful use of health information technology. Finally, the ACA enhances health care quality and increases efficiency in the health care system. For example, the law supports the creation of medical and health homes and accountable care organizations to create a person-centered, integrated health care system.

It is evident that both the MHPAEA and the ACA demand a change in health care delivery, including the care of people who have, or who are at risk of developing, SUDs. More people are gaining access to SUD services through coverage by Medicaid or private insurance.[12] More services, including more prevention services, are being provided in integrated care environments like federally qualified health centers, and as part of care coordination arrangements like health homes.[12, 13] Therefore, the role of non-specialty providers is increasing in importance, and the meaningful use of interoperable electronic health records is becoming a practice necessity.[14] Also, the number of specialty SUD providers is decreasing as providers consolidate to take advantage of the move from a grant/contract-based funding system to a fee-for-service payment system. Larger, better-operated providers are creating efficiencies that are causing small organizations to close.[14] The routine use of EBPs to treat SUDs, such as pharmacological interventions, is increasing in significance as national quality measures are implemented.[15] Moreover, since physician-directed treatment is a general requirement for most Medicaid eligible outpatient services, the SUD system is experiencing further medicalization.[10] Meanwhile, the predominance of Medicaid is reducing the role of residential facilities, most of which are excluded from receiving Medicaid reimbursement, and elevating the use of other, lower-intensity modes of treatment. Finally, State Block Grant funds, which have traditionally been directed toward supporting treatment for the poor and uninsured, are shifting focus since most people will now be covered through other means.[16]

The transformation of the health care and SUD service delivery systems spurred by the federal health reform laws focuses on integration of care. SAMHSA defines integrated care as the *systematic coordination of general and behavioral healthcare. Integrating mental health, substance use disorders, and healthcare services [that] produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs*.[17, 18] Yet, a variety of obstacles impede progress toward the integration of care. These include defining and developing appropriate services; training the SUD, mental health, and medical workforce; creating strategies for implementing change; and uniting the currently bifurcated SUD and mental health care systems. Furthermore, early signs suggest that while the incorporation of mental health services in health care settings is steadily advancing, the inclusion of similar care for people who have, or who are at risk of developing, SUDs is not receiving adequate attention.[17, 18, 19] As one of SAMHSA's flagship workforce development programs, the ATTC Network has a unique opportunity to address this gap and to refocus the national dialogue to ensure that SUD services are included as an essential component of all integration efforts.

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## NATIONAL FORUM

In November 2014, health leaders from across the country will meet at the ATTC Network Forum to highlight what is known about the integration of health care and SUD services; explore the unique issues involved in health care and SUD services integration; identify the workforce development needs of people who work in integrated health care and SUD services settings, including pre-service education requirements and clinical supervision needs; and discuss the ATTC Network's role in facilitating the integration of health care and SUD services. The Forum will kick-off a national conversation about this topic and will be followed by a series of papers that address specific aspects of the integration of care.

**PAPER I: *Health Reform and the Integration of Addiction and Health Care Services*, ATTC Network Technology Transfer Committee (Stan Sacks and Heather Gotham, Co-Chairs)**

The Technology Transfer Committee is the

ATTC Network's platform for discussing and developing strategies that promote the adoption and implementation of evidence-based SUD treatment practices. In the first paper of the ATTC series, the Technology Transfer Committee will focus on evidence-based SUD treatment practices in integrated health care settings to ensure quality care for all patients who have, or who are at risk of developing, SUDs. The Committee will outline what is currently known about the integration of SUD services and health care, review specific EBPs that can be employed in primary care settings, describe models of integrated services, provide specific examples and lessons learned from integration efforts at state and local levels, and discuss strategies to facilitate EBP implementation in integrated environments, particularly routine medical settings.

Research firmly supports a number of interventions for SUDs, and the Committee's paper will include a review of several that can be employed in primary care settings: screening, brief intervention and referral to treatment (SBIRT); medication assisted treatment; technology-assisted care; motivational interviewing; motivational incentives; trauma-informed care; and cognitive behavioral therapy. Some of these EBPs may be implemented via health care professionals who receive additional training (e.g., motivational interviewing, SBIRT), whereas others may work better when provided by the traditional SUD treatment workforce embedded in primary care (e.g., motivational incentives, trauma-informed care).

The ATTC Network has the standing, programs, and approaches to ensure that integrated care settings across the country utilize EBPs to improve the quality of patient care.

The paper also includes a review of models of integrated care, meaning how staff, services, and other resources are arranged to bring care together for SUDs and other health issues (i.e., within what practice context are EBPs provided). For example, in a co-location model, specialty SUD professionals provide services in the same site as primary care, but not in actual coordination with medical providers, whereas in a unified primary care and SUD services model, specialty SUD services are offered within a larger primary care practice. The models of integrated care are useful in conceptualizing the organization of integrated services and real world examples from the field will be provided as valuable illustrations of methods of service delivery.

Finally, while using EBPs will improve the quality of care provided to patients, moving EBPs into routine practice with fidelity is difficult to achieve. The Committee will describe three models of technology transfer and implementation used by the ATTC Network to accelerate the use of EBPs. First, the ATTC Technology Transfer Model is a field-driven, conceptual model that explains how an EBP moves from development through full implementation.[20] The model has practical applications for the integration of health care and SUD services as it clarifies the multi-tiered change process needed for successful implementation of EBPs, and assists stakeholders in determining how to invest limited resources to increase the utilization and monitoring of EBPs. Second, the NIATx model applies the principles of process improvement to behavioral health settings. It outlines a way for organizations to make small changes that can have a significant impact on treatment outcomes (e.g., reducing waiting time for service, increasing continuation in treatment).[21,22,23] Finally, the National Development And Research Institutes' (NDRI) "assessment-implementation guidance" approach measures integration, develops a plan for making a core

set of changes, advises programs on how to accomplish those changes, and then reassesses the degree of integration the program achieves.[24]

During the past 30 years, the SUD treatment field has become increasingly professionalized and has developed an array of research-based interventions that improve treatment outcomes. As SUD services and health care integrate, the implementation of these protocols with high fidelity will maximize patient outcomes. Through the paper, the Committee will highlight the experience and expertise of the ATTC Network in assisting individual SUD treatment providers, treatment systems, and states in adopting and implementing EBPs, as well as ATTC efforts to promote the integration of SUD services in health care settings. The Committee will make the case that the ATTC Network has the standing, programs, and approaches to ensure that integrated care settings across the country utilize EBPs to improve the quality of patient care.

Strengthening teaching practices to improve basic SUD treatment education with health care pre-professionals and ensuring a prepared health care provider workforce will be essential for implementing ACA requirements and ensuring that SUD treatment is an integrated, accessible part of mainstream health care.

**PAPER II: *Enhancing the Pre-Service Non-Specialty and Substance Use Disorders Specialty Workforce: Preparing Students to Work in Integrated Health Care Systems*, ATTC Network Pre-Service Education Committee (Holly Hagle and Renata Henry, Co-Chairs)**

Pre-service education refers to the training that health professionals (doctors, nurses, social workers, behavioral health counselors, SUD counselors, community health workers, and other allied professionals) receive prior to graduation and licensure, usually at a college, university or post-secondary setting.[25] In 2012, the Association for Medical Education and Research in Substance Abuse (AMERSA) released a strategic plan to address the serious deficits in pre-service health professional curricula in relation to substance use and SUDs. In the plan AMERSA states, "Curricula in most health professions education programs either inadequately address substance use disorders or fail to include them at all, the impact of this deficiency is extensive."[26] Even in the behavioral health field, SUDs are not always included in academic programming. For example, a 2014 study demonstrated that only one of 58 masters of social work programs reviewed required at least one course in substance abuse.[27] The ATTC Pre-service Education Committee was created to advance the academic preparation of pre-service non-specialty health professionals to better address substance use in patient populations.

Strengthening teaching practices to improve basic SUD treatment education with health care pre-professionals and ensuring a prepared health care provider workforce will be essential for implementing ACA requirements and ensuring that SUD treatment is an integrated, accessible part of mainstream health care. Various efforts have already taken place to encourage interprofessional collaboration in addressing patients' behavioral health. For example, in *Technical Assistance Publication 21*, SAMHSA included the transdisciplinary foundations that undergird the specific knowledge, skills and attitudes that addictions counselors need in order to practice competently. The transdisciplinary foundations include: understanding addiction; treatment knowledge; application to practice; and professional readiness.[28] Furthermore, the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) recently published core competencies on integrated practice relevant to behavioral health and primary care providers. These core competencies are divided into nine categories: interpersonal communication; collaboration and teamwork; screening and assessment; care planning and care coordination; intervention; cultural competence and adaptation; systems oriented practice; practice-based learning and quality improvement; and informatics. In addition to serving as a resource

for employers to shape such activities as employee on-boarding and performance reviews, CIHS intends the competencies to inform educators as they develop curricula and training programs on integrated care.[29] As health care reform is implemented, efforts such as these will need to be brought to scale nationally and the ATTC Network is the ideal vehicle for facilitating this broad expansion.

The number of individuals who have health insurance coverage and who have, or are at risk of acquiring, SUDs is expected to balloon under the ACA.[12] The United States needs a health workforce that has the skills and abilities to appropriately care for these patients. In the ATTC Network's Pre-Service Education paper, the Committee will discuss what is known about how health care, SUD treatment and behavioral health professionals are academically prepared to utilize EBPs for treating patients with SUDs. Furthermore, the Committee will present recommendations on changes in policy, curricula, and certification/licensure; discuss considerations in providing evidence-based, culturally appropriate academic coursework; and describe the resources that the ATTC Network will provide to academic programs and professors in support of the implementation of the recommended strategies.

The ATTC Network has a long history of providing training and technical assistance on clinical supervision, including the development of several widely disseminated products.

**PAPER III: *Workforce Development through Clinical Supervision: A Promising Approach for Facilitating the Adoption and Implementation of Evidence-Based Practices for SUDs in Health Care Settings*, ATTC Network Workforce Development Committee (Michael Chaple and Marjean Searcy, Co-Chairs)**

In the final paper of the ATTC series, the Workforce Development Committee will explore the role of and challenges associated with implementing clinical supervision in an integrated environment in order to promote the use of evidence-based and promising practices for the identification and treatment of SUDs in health care settings. As the health care system becomes more integrated and multidisciplinary, there is a need for effective clinical supervision of all practitioners, especially those providing screening and treatment for SUDs in health care settings. The ATTC Network has a long history of providing training and technical assistance on clinical supervision, including the development of several widely disseminated products. First, *Clinical Supervision Foundations* is a 30-hour blended online and in-person training for supervisor credentialing that provides participants with the skills and knowledge necessary to promote professional development of addictions counselors.[30] Second, *Technical Assistance Publication (TAP) 21-A: Competencies for Substance Abuse Treatment Clinical Supervisors* outlines the knowledge, skills and attitudes that professionals need in order to provide adequate supervision of addictions counselors.[31] While TAP 21A is a SAMHSA publication, ATTC staff significantly contributed to the document and a long-time ATTC Director chaired the effort. Finally, *Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency (MIA: STEP)* is a tool kit for clinical supervisors to enhance treatment providers' motivational interviewing skills.[32] This curriculum, developed as part of the NIDA/SAMHSA Blending Initiative, was written in close collaboration by National Institute on Drug Abuse (NIDA) funded researchers and ATTC technology transfer specialists. Each of these products addresses the role of clinical supervision in facilitating the adoption and implementation of EBPs, reflecting a core mission of the ATTC Network.

Numerous studies have been conducted to determine whether and how clinical supervision impacts counselors working in SUD treatment programs across the United States. To date, several benefits have been identified for those receiving effective supervision including increased skill and knowledge acquisition, improved self-efficacy, enhanced self-awareness, improved patient-provider relationships, better job performance, and increased job satisfaction.[33-39] In contrast, very few studies have examined

the benefits of clinical supervision to patients, limiting the conclusions that can be drawn in this regard.[40, 41] Nevertheless, research has generally demonstrated that clinical supervision is a critical method for ensuring and enhancing the quality of SUD treatment.

As SUD services are integrated into health care, there is a need to build staff competencies to ensure that all health care professionals are adequately equipped to identify and manage SUDs. Not only do many SUDs counselors lack graduate level training[42], but most health professionals do not have sufficiently broad expertise to address the full range of issues presented by patients with SUDs. This is true in large part because education related to SUDs and other behavioral health conditions has not traditionally been provided to medical students, residents, or practicing physicians as noted in the earlier summary of Paper II. The limited research that has examined integrated health care models indicates a need for additional training and clinical supervision for SUDs and mental health professionals.[43, 44] In these settings, more attention to clinical supervision practices will help to ensure that staff are adequately prepared to address SUDs.

The ATTC Workforce Development Committee paper will highlight these and other issues related to clinical supervision in integrated environments. More specifically, the paper will define clinical supervision in an integrated environment; describe unique challenges of clinical supervision for SUDs related to staffing structure, program structure, and treatment environment; review models of clinical supervision, emphasizing the structure and implementation of clinical supervision in settings where staff typically is comprised of multidisciplinary professionals; and outline how to assist providers in measuring fidelity to and effectiveness of clinical supervision approaches.

## CONCLUSION

The integration of SUD services and health care has begun to spark, but much work needs to be done to ensure that all Americans have access to high quality care for SUDs as appropriate. Through the National Forum and Papers described in this Brief, the ATTC Network will energize the national conversation about SUD services and health care integration and delineate the key factors that must be addressed in order for such integration efforts to be successful. The ATTC Network has the history, experience and reach to stoke a "mighty blaze" and advance the integration of patient-centered behavioral and physical health care.

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