

INNOVATIONS IN ADDICTIONS TREATMENT

Addiction Treatment Providers Working with
Integrated Primary Care Services



SAMHSA-HRSA
Center for Integrated Health Solutions



NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE



MAY 2013

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	3
OVERVIEW	4
THE CASE FOR INTEGRATING SUBSTANCE ABUSE SERVICES AND PRIMARY CARE	4
DRIVING FORCE FOR INTEGRATION	5
Advances in Addiction Treatment Medications	5
Healthcare Reform	6
PREPARING FOR INTEGRATION	6
CONFIDENTIALITY	7
FRAMEWORK FOR INTEGRATION	7
Standard Framework for Levels of Integrated Care	7
Integration Approaches Employed by Addiction Programs	7
FINANCING LANDSCAPE	12
SUCCESSSES, BARRIERS, AND LESSONS LEARNED	12
Build a Fruitful Partnership	13
Communication	13
Operations and Administration	13
Information Sharing	14
Financing	14
Policy and Stakeholder Education	15
Workforce Development	15
Consumer, Family, and Community Engagement	15
SUBSTANCE ABUSE SERVICE PROVIDER INTEGRATION CHECKLIST	16
Administrative Questions	16
Capacity/Resource Questions	16
Financing	17
Data/Technology	17
CONCLUSION	17
Appendix A	18
Participants List: April 16, 2012 Innovations in Addictions Treatment: Addiction Treatment Providers with Integrated Primary Care Services meeting	18

ACKNOWLEDGEMENTS

Innovations in Addictions Treatment was developed by the SAMHSA-HRSA Center for Integrated Health Solutions with funds under grant number 1UR1SMO60319-01 from SAMHSA-HRSA, U.S. Department of Health and Human Services. The statements, findings, conclusions, and recommendation are those of the author(s) and do not necessarily reflect the view of SAMHSA, HRSA, or the U.S. Department of Health and Human Services.

Special thanks to the Chalk Group, Health and Resources Services Administration, National Association of State Alcohol/Drug Abuse Directors, State Associations of Addictions Services, and Substance Abuse and Mental Health Services Administration for informing the development of this document.

SAMHSA-HRSA CENTER FOR INTEGRATED HEALTH SOLUTIONS

The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings. CIHS is the first “national home” for information, experts, and other resources dedicated to bidirectional integration of behavioral health and primary care.

Jointly funded by the Substance Abuse and Mental Health Services Administration and the Health Resources and Services Administration, and run by the National Council for Community Behavioral Healthcare, CIHS provides training and technical assistance to community behavioral health organizations that received Primary and Behavioral Health Care Integration grants, as well as to community health centers and other primary care and behavioral health organizations. CIHS’s wide array of training and technical assistance helps improve the effectiveness, efficiency, and sustainability of integrated services, which ultimately improves the health and wellness of individuals living with behavioral health disorders.

***SAMHSA-HRSA
Center for Integrated Health Solutions***

1701 K Street NW, Suite 400

Washington, DC 20006

202.684.7457

integration@theNationalCouncil.org

www.integration.samhsa.gov

This document is in the public domain and may be used and reprinted without permission except those copyrighted materials noted for which further reproduction is prohibited without the specific permission of copyright holders.

OVERVIEW

On April 16, 2012, the SAMHSA-HRSA Center for Integrated Health Solutions convened a meeting of substance abuse providers that have integrated primary care services. The meeting aimed to gain insights and perspectives from addiction treatment programs, and their primary care partners, experienced in integrating primary care services. This document is structured around the aspects of the organizations' integrated services, including events that precipitated their integration efforts, common and significant challenges, and lessons learned, with additional information to help other substance abuse providers integrate service delivery with primary care. It also aims to inform other specialty substance abuse treatment providers interested in integrating primary care.

THE CASE FOR INTEGRATING SUBSTANCE ABUSE SERVICES AND PRIMARY CARE

Alcohol and drug addiction cost American society \$193 billion annually, according to a 2011 White House Office of Drug Control Policy report.¹ In addition to the crime, violence, and loss of productivity associated with drug use, individuals living with a substance abuse disorder often have one or more physical health problems such as lung disease, hepatitis, HIV/AIDS, cardiovascular disease, and cancer and mental disorders such as depression, anxiety, bipolar disorder, and schizophrenia.² In fact, research³ has indicated that persons with substance abuse disorders have:

- ▶▶ Nine times greater risk of congestive heart failure.
- ▶▶ 12 times greater risk of liver cirrhosis.
- ▶▶ 12 times the risk of developing pneumonia.

When persons with addictions have co-occurring physical illnesses, they may require medical care that is not traditionally available in, or linked to, specialty substance abuse care. The high quality treatment needed by individuals with addictions requires a team of different professionals that includes both specialty substance abuse providers and primary care providers.

The integration of primary and addiction care can help address these often interrelated physical illnesses by ensuring higher quality care. In fact, clinical trials have demonstrated that when someone has a substance abuse problem and one or more nonsubstance-related disorders, integrated care can be more effective than traditional treatment delivery (i.e., separate, siloed primary care and substance abuse programs) in terms of clinical outcome and cost.⁴ It results in better health outcomes for individuals, in contrast to back-and-forth referrals between behavioral health and primary care offices that result in up to 80% of individuals not receiving care.⁵

Substance abuse disorders can also complicate the management of other chronic disorders. For example, a number of researchers have found that people with HIV/AIDS who reported alcohol and drug use were more likely to be non-adherent to antiretroviral treatment.^{6,7,8} Other researchers reported that substance abuse disorders, depression, and medical comorbidities relate to poor adherence to medications to treat type 2 diabetes.⁹ Yet, many individuals served in specialty substance abuse settings do not have a primary care provider.¹⁰

1 2011 The Economic Impact of Illicit Drug Use on American Society. Washington D.C: U.S. Department of Justice.

2 Mertens JR, Lu YW, Parthasarathy S, Moore C, Weisner CM. Medical and psychiatric conditions of alcohol and drug treatment patients in an HMO. 2003, Arch Int Med 163:2511-2517.

3 ibid

4 Parthasarathy, S., Mertens, J., Moore, C., & Weisner, C. (2003). Utilization and cost impact of integrating substance abuse treatment and primary care. Medical Care, 41(3), 357-367.

5 Oslin, D.W., Grantham, S., Coakley, E., Maxwell, J. Miles, K., Ware, J., et al. (2006). PRISM-E: Comparison of Integrated Care and Enhanced Specialty Referral in Managing At-Risk Alcohol Use. Psychc Servs, 57(7), 954-958.

6 Rachel Power, Cheryl Koopman, Jonathan Volk, Dennis M. Israelski, Louisa Stone, Margaret A. Chesney and David Spiegel. (2003). Social support, substance abuse and denial in relationship to antiretroviral treatment adherence among HIV-infected persons. AIDS Patient Care and STDs, 17: 245-252..

7 Keren Lehavot, David Huh, Karina L. Walters, Kevin M. King, Michele P. Andrasik and Jane M. Simoni. (2011). AIDS Patient Care and STDs, 25: 181-189

8 Hinkin CH, Barclay CR, Castellon CA, Levine AJ, Durvasula RS, Marion SD, Myers HF, Longshore D. (2007). AIDS Behav, 11:185-194.

9 Kreyenbuhl J, Dixon LB, McCarthy JF, Soliman S, Ignacio RV, Valenstein M. (2010) Does adherence to medications for Type 2 diabetes differ between individuals with and without schizophrenia? Schiz Bull, 36:428-435.

10 Saitz, R., M. J. Larson, et al. (2004). "Linkage with primary medical care in a prospective cohort of adults with addictions in inpatient detoxification: room for improvement." Health Serv Res, 39(3): 587-606.

The integration of physical health and addictions care can also help negate barriers to primary care, as providing primary care to individuals with addictions enhances their recovery from substance abuse.¹¹ In fact, two or more primary care visits in a 6-month period has shown to improve abstinence by 50% in individuals with substance abuse disorders,¹² and those with medical conditions related to substance abuse are three times more likely to achieve remission over 5 years¹³. Regular health and addictions care for people with substance abuse disorders also decreased hospitalizations by up to 30%.¹⁴ Lastly, substance use screening and services improve the general health of individuals with co-occurring substance use and physical health conditions and reduces overall costs to the healthcare system.¹⁵

DRIVING FORCE FOR INTEGRATION

Diverse motivations led early adopters (i.e., participants of CIHS' April 2012 Innovations in Addictions Treatment meeting) to implement integrated addiction and primary care as a healthcare strategy. Overall, most sought partnerships with primary care providers because of a need for affordable, cost-effective, geographically accessible, and comprehensive care for people living with addictions who often had comorbid chronic physical health conditions. However, other issues also motivate addiction providers to integrate care, including the need for expanded access to prescribing physicians, nurses, or physician assistants to manage new medications indicated for addiction treatment. Changes to the healthcare system such as passage of the Affordable Care Act, which emphasizes care coordination and the use of multidisciplinary teams, may continue to increase interest among substance abuse providers to integrate care.

Advances in Addiction Treatment Medications

Over the past decade, the Food and Drug Administration approved three new medications for the treatment of substance abuse disorders: buprenorphine to treat opioid addictions in 2002; acamprosate to treat alcohol addiction in 2004; and extended-release naltrexone to treat alcohol addictions in 2006 and opioid addiction in 2010. Two of the newer medications – buprenorphine and naltrexone – are referred to as “office-based” medications because they can be prescribed and/or administered in a physician's office rather than in a specialty opioid treatment program; however, physicians seeking to prescribe buprenorphine must complete training to receive a waiver for these prescribing privileges.

With efficacy comparable to treatment for other chronic conditions such as diabetes, asthma, and hypertension, substance abuse medications give providers new tools to fight addiction by expanding the range of treatment options for individuals with alcohol and drug addictions. These medications help reduce drinking and drug use, achieve and maintain control over behaviors that can lead to relapse, and maintain adherence to other treatment components that support sustained recovery (e.g., counseling, lifestyle changes). They are safe and highly effective in helping individuals achieve and sustain recovery^{16,17}. Yet, 54% of addiction treatment programs have no physician.¹⁸ This workforce gap creates a barrier to recovery. In order for substance abuse treatment providers to take full advantage of these new medications, medical staff will need to be available and work closely with addiction treatment staff to monitor medications and coordinate care. Integrating primary care and substance use treatment provides an opportunity to capitalize on these new advances in medicine and more convenient access to primary care services.

11 Holder D. (1998). Cost benefits of substance abuse treatment: an overview of results from alcohol and drug abuse, volume 1, Issue 1, pages 23-29.

12 Saitz et al. (2005). Primary medical care and reductions in addiction severity: a prospective cohort study. *Addiction* Volume 100, Issue 1, pp 70-78.

13 Mertens et al. (2008). The role of medical conditions and primary care services in five-year substance abuse outcomes among chemical dependency treatment patients. *Drug Alc Depend*, 98(1-2): 45-53.

14 Laine C, et al. (2001) Regular outpatient medical and drug abuse care and subsequent hospitalization of persons who use illicit drugs. *JAMA*, 9;285(18):2355-62.

15 Ray, G.T., J.R. Mertens, et al. (2007). “The excess medical cost and health problems of family members of persons diagnosed with alcohol or drug problems.” *Med Care*, 45(2): 116-22.

16 Doran, Shanahan, et al. (2003). Buprenorphine versus methadone maintenance: a cost effectiveness analysis. *Drug Alcohol Dependence*, 71(3): 295 - 305.

17 Anton RF, O'Malley SS, Ciraulo DA, et al. (2003). Combined Pharmacotherapies and Behavioral Interventions for Alcohol Dependence: The COMBINE Study: A Randomized Controlled Trial. *JAMA*, 2006;295(17):2003-2017. doi:10.1001/jama.295.17.

18 McLellan AT, Carise D, Kleber HD. (2003). Can the national addiction treatment infrastructure support the public's demand for quality care? *J Subst Abuse Treat*, p;25(2):117-21. PubMed PMID: 14680015.

Healthcare Reform

The Patient Protection and Affordable Care Act, and its companion, the Health Care and Education Reconciliation Act of 2010 – known jointly as the Affordable Care Act – requires parity for substance abuse and mental health benefits in both the state exchange plans and the Medicaid expansion. The new Medicaid coverage is for all individuals under the age of 65 whose incomes fall below 133% of the federal poverty level. This is a significant expansion of Medicaid that will add approximately 16 million additional beneficiaries, a large number of whom suffer from multiple or severe chronic conditions, including addiction. Armed with this new ability to pay for healthcare services (including mental health and substance abuse treatment), many more people will enter the healthcare marketplace seeking substance abuse and mental health services. In addition to the Medicaid expansion and mental health and substance abuse parity, the Affordable Care Act also establishes incentives such as the Medicaid health home state option to improve care coordination and implement multidisciplinary teams of providers to address patients' total healthcare needs in a more efficient and cost-effective way.

Given these system changes and the clear need for more coordination of services with primary care, addiction treatment providers will need to consider adding a broader array of services or integrating primary care services.

PREPARING FOR INTEGRATION

Once an addiction provider decides to integrate primary care services, a great deal of advance planning must occur with ample consideration of a variety of factors. First, the provider must prioritize a chronic disease approach in which care is person-centered. This means there must be opportunities for meaningful interactions between the person served and his or her entire care team. Also, an extensive review of administrative and clinical processes may be required to achieve integration. For most providers, integration requires devoting greater time to information sharing between clinicians, use of clinical decision support within electronic health records, hiring a multidisciplinary team and developing a more collaborative approach, patient self-management and recovery support options, and stronger linkages to community resources.

- ▶▶ **SELF-MANAGEMENT AND RECOVERY SUPPORT** – A person actively partners with their healthcare professional(s) to manage their health and recovery, working to maintain recovery and wellness by setting goals to change behaviors.
- ▶▶ **PERSON-CENTEREDNESS** – A person's healthcare is self-directed and based on a partnership between the individual, the team of providers, and when appropriate, the individual's family. The provider works to ensure that treatment decisions respect the person's wants, needs, and preferences, and that the person receives education and support in engaging in care and making healthcare related decisions.¹⁹
- ▶▶ **DELIVERY SYSTEM DESIGN** – A team manages healthcare delivery that encompasses a collaborative approach with an expanded scope of provider types who have clearly defined roles.
- ▶▶ **CLINICAL DECISION SUPPORT** – Treatment services and provider processes embrace evidence-based clinical guidelines.
- ▶▶ **CLINICAL INFORMATION SYSTEMS** – Information sharing systems identify relevant treatment options and other data on individuals and populations.
- ▶▶ **COMMUNITY RESOURCES** – Relationships with other community resources (e.g., housing, employment) help support and meet individuals' needs and preferences.

19 Institute of Medicine. (2012) Crossing the Quality Chasm: A New Health System for the 21st Century. Institute of Medicine.

CONFIDENTIALITY

Confidentiality is a key challenge facing integrated healthcare partnerships. Yet, providers can effectively address Health Insurance Portability and Accountability Act (HIPAA), federal law (42 U.S.C. § 290dd-2), regulations (42 CFR Part 2), and state-based confidentiality policies to enable integration partners to safely and confidently share information. With proper precautions, provider agencies can share information cross-agency. The organization's privacy officer, corporation counsel, and/or HIPAA privacy and security committees must approve any policies or procedures an organization considers adopting in this area.

- ▶▶ HIPAA allows for information sharing between organizations for the purpose of healthcare coordination. To feel comfortable with sharing information under HIPAA, partnering organizations often enter into more formal relationships (i.e., qualified service agreements) to share information. Section 160.103 of HIPAA describes this arrangement.
- ▶▶ 42 CFR Part II defines the parameters for sharing substance abuse information for organizations that hold themselves out as substance abuse treatment providers. The Substance Abuse and Mental Health Services Administration has provided a number of documents and materials that address issues related to the sharing of substance abuse treatment information under 42 CFR Part II.
- ▶▶ State mental health code, state facility licensing requirements, or a state alcohol and drug abuse agency may impose additional confidentiality protections that must be addressed. These must be linked with HIPAA and 42 CFR Part II to create an overarching policy for information sharing.

Confidentiality laws, regulations, and policies provide the framework for the sharing of healthcare information. Before moving forward with integration efforts the pertinent confidentiality laws and the tools available for effective patient protection and information sharing must be understood.

FRAMEWORK FOR INTEGRATION

A variety of structural and clinical approaches enhances coordination between substance abuse providers and primary care organizations. In practice, the specific environment and other functional activities governs which approach fits best.

Standard Framework for Levels of Integrated Care

Standard Framework for Levels of Integrated Care²⁰ offers a point of reference and reflection for providers planning, implementing, and sustaining integration projects.

Table 1 Standard Framework for Levels of Integrated Care²¹ (see page 8)

INTEGRATION APPROACHES EMPLOYED BY ADDICTION PROGRAMS

In practice, addiction provider organizations are implementing a variety of integration approaches to provide comprehensive care and improve health outcomes for people with substance abuse problems. Based on discussions with participants of the April 2012 meeting, and using the Standard Framework for Levels of Integrated Care, it was determined that the approaches used by the participants tend toward “basic collaboration onsite,” “close collaboration onsite with some system integration,” “close collaboration approaching an integrated practice,” or “full collaboration in a transformed/merged integrated practice” categories. Below, participating organizations are grouped based on where they fit using the Standard Framework for Levels of Integrated Care. The organizations self-reported on their programs and approaches.

20 Heath B, Wise Romero P, and Reynolds K. (2013). A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, D.C. SAMHSA-HRSA Center for Integrated Health Solutions.

21 *ibid.*

Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
<ul style="list-style-type: none"> ▶▶ Have separate systems ▶▶ Communicate about cases only rarely and under compelling circumstances ▶▶ Communicate, driven by provider need ▶▶ May never meet in person ▶▶ Have limited understanding of each other's roles 	<ul style="list-style-type: none"> ▶▶ Have separate systems ▶▶ Communicate periodically about shared patients ▶▶ Communicate, driven by specific patient issues ▶▶ May meet as part of larger community ▶▶ Appreciate each other's roles as resources 	<ul style="list-style-type: none"> ▶▶ Have separate systems ▶▶ Communicate regularly about shared patients, by phone or e-mail ▶▶ Collaborate, driven by need for each other's services and more reliable referral ▶▶ Meet occasionally to discuss cases due to close proximity ▶▶ Feel part of a larger yet non-formal team 	<ul style="list-style-type: none"> ▶▶ Share some systems, like scheduling or medical records ▶▶ Communicate in person as needed ▶▶ Collaborate, driven by need for consultation and coordinated plans for difficult patients ▶▶ Have regular face-to-face interactions about some patients ▶▶ Have a basic understanding of roles and culture 	<ul style="list-style-type: none"> ▶▶ Actively seek system solutions together or develop work-a-rounds ▶▶ Communicate frequently in person ▶▶ Collaborate, driven by desire to be a member of the care team ▶▶ Have regular team meetings to discuss overall patient care and specific patient issues ▶▶ Have an in-depth understanding of roles and culture 	<ul style="list-style-type: none"> ▶▶ Have resolved most or all system issues, functioning as one integrated system ▶▶ Communicate consistently at the system, team and individual levels ▶▶ Collaborate, driven by shared concept of team care ▶▶ Have formal and informal meetings to support integrated model of care ▶▶ Have roles and cultures that blur or blend

▶ **Basic Collaboration Onsite**

CENTRAL KANSAS FOUNDATION (SALINA, KS)

The Central Kansas Foundation is a nonprofit organization that provides quality and affordable alcohol and drug abuse treatment and prevention services, including residential short-term treatment (30 days or less), residential long-term treatment (more than 30 days), outpatient, and partial hospitalization substance abuse treatment and detoxification. CKF provides alcohol and drug abuse treatment and prevention services to the emergency departments of acute care hospitals and will soon contract with 15 hospitals to extend coverage. CKF has fully integrated substance abuse services into acute and primary care settings and has included universal screening, brief intervention, outpatient, and detoxification services. The integrated care system brings effective substance abuse treatment services to medical settings and has established a referral network for patients to access primary medical care. The agency receives many referrals from acute and primary medical settings and follows individuals through the referral and care provision processes to ensure both behavioral and primary care needs are effectively addressed. They employ substance use peer mentors to provide follow-up support expand their services. They also seek to increase visibility to encourage medical residents to train in whole healthcare, which includes medical, mental health, and substance abuse treatment and services. The foundation no longer considers itself a specialty addiction program, as they employ expertise to integrate all healthcare specialties.

LOYOLA RECOVERY — BATH RECOVERY ENGAGEMENT CENTER (BATH, NY)

The Bath Recovery Engagement Center, operated by Loyola Recovery Foundation, is a unique partnership between the U.S. Department of Health and Human Services and Department of Veterans Affairs (VA). A hospital environment entry service, the Bath Recovery Engagement Center provides addiction treatment services in partnership with the VA, which provides primary care services. Working primarily with veterans, the most common service is an onsite 7- to 10-day detox program. The Center offers two distinct areas of care: crisis intervention services that have operated through the VA for 5 years and a SAMHSA-funded specialty outpatient project. The Center serves 1,265 veterans for crisis addiction services, and while it does not yet provide the outpatient services it does provide substance abuse treatment and medication-assisted treatment (buprenorphine) along with onsite nurses who provide general health screenings and HIV and STD testing.

MONTROSE COUNSELING CENTER (HOUSTON, TX)

The Montrose Counseling Center (Montrose) provides substance abuse and mental health services, as well as primary care services through their FQHC partner Legacy Community Health Services (Legacy) to Lesbian, Gay, Bi-sexual, Transgender (LGBT) and HIV positive populations. Montrose's state-licensed clinicians, Master's-level therapists, skilled educators, support staff, and volunteers work together to offer a continuum of care using a combination of traditional therapy, outreach, education, peer support, advocacy and case management to achieve the best behavioral health possible outcomes, and targets members of its community with the greatest needs. Its community programs have offerings for various sectors of the community, with an emphasis on wellness, skills development, and community-building. Montrose identifies health issues through a holistic assessment process which includes lab work completed by an on-site phlebotomist provided by Legacy. Individuals needing further care are then connected with primary care at Legacy Montrose and Legacy meet regularly to discuss the behavioral health and primary care needs of these shared patients.

▶ **Close Collaboration Onsite with Some System Integration**

VERDE VALLEY GUIDANCE CLINIC — A WOMAN'S WORLD (COTTONWOOD, AZ)

Verde Valley Guidance Clinic, a behavioral health clinic, provides primary care to Arizona Health Care Cost Containment System's (Medicaid) clients with mental health and substance abuse disorders. The center's program, A Woman's World, serves females with serious mental illnesses who have co-occurring substance abuse disorders. The program centers on three areas of treatment, believing in a whole health model that urges those they serve to focus not only on their mental health and substance abuse, but also their physical, emotional, and spiritual health. The program aims to help women get sober and staff members work with participants to maintain sobriety by focusing on their mental health concerns and supporting them toward a consistent, workable medication regime. The program also addresses physical healthcare needs through an onsite health

clinic which is staffed by physicians, nurse practitioners and physician assistants. It currently serves 238 individuals with substance abuse disorders (approximately 400 per year) and has three outpatient addictions staff and 11 residential treatment staff. The program provides substance abuse treatment, detoxification, and buprenorphine treatment. The program's design is based on the American Society of Addiction Medicine criteria, and women can stay for 3-9 months. A Woman's World supports women working through a 12-step program and other addiction education treatments. Many residents have untreated medical concerns, which the program addresses while they are in a clean, sober environment for more than the traditional 30 days. The program offers art, music, and other activities, as well as various mental health and codependency groups. The residents are supported in meeting court, CPS, and probation requirements, applying for social security, and in educational needs.

► *Close Collaboration Approaching an Integrated Practice*

BAART PROGRAMS (CA, VT, NH, NC, AZ)

BAART Behavioral Health Services and its' sister organization BAART Community HealthCare provide substance abuse, mental health, and medical services through one provider site to maintain cohesive service delivery for each person. In this model, resources such as staffing, medical supplies, and facilities are shared between behavior health and primary care, and certified substance abuse specialists serve as care managers. BAART Community HealthCare is a licensed community health clinic and patients can access primary care services in many different ways. At intake for behavioral health services, BAART provides a physical exam and subsequently requires annual physicals. BAART regularly staffs their medical departments so that on any given day a person can "walk-in" to see medical staff for immediate health concerns (e.g., wound, flu, immunization, routine medical care) or can schedule an medical appointment (e.g., physical exams, labs, prescriptions, immunizations, chronic disease management and care).

BETH ISRAEL MEDICAL CENTER (NEW YORK, NY)

The Methadone Maintenance Treatment Program (MMTP) at Beth Israel Medical Center, the nation's largest nonprofit methadone clinic, provides healthcare to individuals and their families, including health maintenance, disease prevention, and illness management, through its primary medical practice. Physicians and physician assistants work with other medical and specialty care members of Beth Israel Medical Center's comprehensive healthcare network to provide access to state-of-the-art diagnostic and specialty services. The Beth Israel methadone clinics are comprised of a full-service health and behavioral health interdisciplinary team, which works to help individuals overcome their opioid addiction. The MMTP team includes physicians, physician assistants, nurses, social workers, substance abuse counselors, financial counselors, and vocational rehabilitation staff.

ST. JUDE'S RECOVERY CENTER (ATLANTA, GA)

St. Jude's Recovery Center plans to build a primary care clinic adjacent to their other substance abuse facilities. They partner with Mercy Care (an FQHC), which will staff the new clinic. St. Jude's also partners with Emory University Department of Psychiatry and the Grady Hospital Department of Psychiatry to provide comprehensive behavioral health services. Upon entry to addiction treatment services, a nurse will conduct a health assessment detailing any health issues needing attention. The nursing staff will maintain daily sick call hours to treat minor health issues. Individuals with more serious health issues will be referred to Grady Hospital. All clients who enter St Jude's will have a medical history and physical completed by a physician.

ODYSSEY HOUSE (SALT LAKE COUNTY, UTAH)

Odyssey House provides outpatient to intensive residential treatment for all ages. It has implemented an integrated medical clinic staffed by primary care doctors, nurses and physicians' assistants to serve Salt Lake County's behavioral health population and provides integrated healthcare to individuals and families with a behavioral health problems. The target population includes individuals who receive formal treatment and services through the Salt Lake County system of care, and services are open to family members since their health can affect an individual's sustained recovery. Odyssey House's behavioral health services include crisis intervention, treatment planning, motivational interviewing, consumer education on behavioral health diagnoses, facilitated peer support, and clinical therapy. Many individuals receive a formal referral into treatment through an assessment & referral services (ARS) unit. For those that pass through ARS, assessors refer clients to the clinic, distribute

brochures, and help those interested make an appointment to increase follow-through. Those who do not funnel through ARS receive clinic referrals through partner treatment providers that employ trained integrated care managers to support people accessing services. The clinic also works with recovery support groups and self-help groups to reach out to additional community members. Behavioral health services in the clinic focus on pre- and post-treatment for individuals and their families. While people receive treatment from a behavioral health provider, their care is overseen by an integrated partnership. A single, cohesive treatment plan that supports recovery is conducted through the behavioral health provider that takes ownership of mental health and substance abuse treatment, and the clinic that responds to medical and dental health care needs.

VERDE VALLEY GUIDANCE CLINIC — A WOMAN'S WORLD (COTTONWOOD, AZ)

Verde Valley Guidance Clinic, a behavioral health clinic, provides primary care to Arizona Health Care Cost Containment System's (Medicaid) clients with mental health and substance abuse disorders. The center's program, A Woman's World, serves females with serious mental illnesses who have co-occurring substance abuse disorders. The program centers on three areas of treatment, believing in a whole health model that urges those they serve to focus not only on their mental health and substance abuse, but also their physical, emotional, and spiritual health. The program aims to help women get sober and staff members work with participants to maintain sobriety by focusing on their mental health concerns and supporting them toward a consistent, workable medication regime. The program also addresses physical healthcare needs through an onsite health clinic which is staffed by physicians, nurse practitioners and physician assistants. It currently serves 238 individuals with substance abuse disorders (approximately 400 per year) and has three outpatient addictions staff and 11 residential treatment staff. The program provides substance abuse treatment, detoxification, and buprenorphine treatment

► *Full Collaboration in a Transformed/Merged Integrated Practice*

EARLY START — KAISER PERMANENTE (CA)

Early Start provides outpatient support to help pregnant and post-partum women make healthy choices regarding cigarettes, alcohol, and drug use. They provide substance abuse treatment, detoxification, methadone maintenance, and methadone detoxification. Primary care intervention begins at the prenatal intake visit when all women complete a self-administered questionnaire that screens for risk of alcohol, tobacco, and illicit drug use during pregnancy. Women diagnosed with an addiction are scheduled for counseling with the Early Start specialist at subsequent prenatal visits, receive routine urine toxicology tests, and are encouraged to participate in any other needed programs such as those provided through their partnership with Kaiser Permanente (e.g., chemical dependency services, social services, mental health, health education, smoking cessation counseling), as well as those in the community (e.g., self-help programs, residential treatment). Women diagnosed with moderate problems are followed exclusively in the Early Start program.

PENOBSCOT COMMUNITY HEALTH CENTER (BANGOR, ME)

At the Penobscot Community Health Center (an FQHC), all individuals enter care through primary care to access mental health and substance abuse services. These services are integrated within the primary care clinics where the entire staff works on all conditions that negatively affect health. Buprenorphine treatment is initiated at one site within the 10-clinic system under the direction of the addiction medicine specialist; the individuals served are also required to attend a group-counseling program. When the individual is stabilized, the primary care provider at the patient's clinic of origin resumes responsibility for suboxone prescribing.

TARZANA TREATMENT CENTERS (LOS ANGELES COUNTY, CA)

Tarzana Treatment Centers (TTC) offer primary care integrated with specialty mental health, substance abuse disorder, HIV/AIDS care, and housing to individuals with co-occurring mental health, substance use, and physical health conditions. These services include: (a) outpatient primary care, including family medicine, family planning services, immunizations, specialty care referrals, care management for chronic conditions such as hypertension, diabetes, congestive heart failure, asthma, or high cholesterol, and HIV specialty care; (b) substance abuse treatment, including outpatient treatment, day treatment, residential treatment, and inpatient detoxification; (c) mental health services, including inpatient psychiatric stabilization,

intensive case management, and outpatient treatment; (d) HIV services, including psychosocial case management, medical case management, home care, and HIV health education and risk reduction; (e) ancillary support services, including housing assistance and medical transportation; and (f) outreach, including community outreach and benefits enrollment and assistance. Roughly 1,500 patients receive both primary care and substance abuse services each year from TTC. In addition, individuals in the residential substance abuse treatment programs receive primary care services while in treatment. Those in the inpatient detox program are referred to primary care upon discharge. Individuals receiving outpatient care are referred to primary care during treatment, and an electronic referral log is used to make referrals.

FINANCING LANDSCAPE

Substance abuse block grants and Medicaid currently serve as the main financial supporters of integrated substance abuse and primary care. Under the current financing landscape, payment structures for specialty behavioral healthcare and primary care, as well as licensing requirements, are not set up to easily facilitate integrated care. Integrated care providers must address a variety of issues to support integrated services such as:

- ▶▶ Need for accrediting and licensing boards to consider behavioral health facilities as possible medical homes.
- ▶▶ Requirements on which healthcare professionals can bill for which services.
- ▶▶ Regulations on what services can be provide in behavioral health and primary care settings.
- ▶▶ Slow-to-emerge payment for health and recovery coaches and peer employees.
- ▶▶ Need for improved payment mechanisms for some integrated care activities (e.g., SBIRT, medication assisted treatment).
- ▶▶ Lack of inclusion of behavioral health providers as eligible for certain payment mechanisms.
- ▶▶ Need for new job classification (e.g., care managers) in state professional licensing laws and payment of services.

The Affordability Care Act addresses some of these issues, and new financial incentives and payment mechanisms that facilitate integration are on the horizon. Until then, treatment organizations and primary care providers must communicate well and work together closely until the current system better supports integrated services.

SUCCESSSES, BARRIERS, AND LESSONS LEARNED

Transitioning traditionally siloed care systems into seamlessly collaborating systems of care is a complex change process. Early adopters of integrated substance abuse and primary care have achieved successes, encountered and overcome barriers, and learned important lessons along the way. Early adopters understand that this evolution is not an overnight project. It requires planning and commitment on the part of healthcare professionals, organizations, and other systems levels. These trailblazers recognize that healthcare is no longer provider-centric; it is person-centered. To succeed in providing integrated healthcare, the entire organization must embrace this philosophy as it is central to the current and future healthcare marketplace.

Key issues identified by early adopters of integrated substance abuse and primary care programs have learned a variety of strategies to ensure success. These strategies often relate to, partnerships, communications, operations and administration, information collection and sharing, financing, policymaker and stakeholder education, workforce development, and consumer engagement. CIHS collected many of these insights during its 2012 meeting with specialty substance abuse providers and their primary care partners.

Build a Fruitful Partnership

Only partnerships with sound leadership and solid groundwork will prove fruitful. Both formal and informal relationships are pivotal to the success of integration efforts. It's easy to partner, but addressing challenges and difficulties will prove a partnership's strength. According to the organizations highlighted in this paper, providers seeking to build a strong foundation with their partners should:

- ▶▶ **CREATE THE BEST FIT** – Prior to approaching a potential partner, determine the landscape of your community's existing resources and identify the delivery system “politics” and potential key players. View the care system resources you identify as puzzle pieces, rather than overlapping parts; then, piece them together in a way to support integrated care.
- ▶▶ **FIND AN ADVOCATE** – Once you decide to integrate behavioral health services with primary care, identify a high quality primary care partner that serves similar populations, has basic understanding of behavioral healthcare, and will be a strong advocate of the program. Knowing the key players in advance will help you build this relationship.
- ▶▶ **MANAGE EXPECTATIONS** – Keep in mind the time and effort required to build strong relationships and partnerships. It can be easy to underestimate the resources, time, and skills required. Remind you staff, board, and partners that the change process will be ongoing.
- ▶▶ **GET THE MONSTERS OUT OF THE CLOSET** – Discover your potential partner's reservations and alleviate them with data, stories, and potential health and cost saving outcomes.
- ▶▶ **BUILD COMMON GOALS** – Get on the same page with your partner by developing common goals – and revisit them often.
- ▶▶ **CROWN YOUR LEADERS** – Seek transactional and transformational leaders to champion your efforts.
- ▶▶ **ALIGN EXPECTATIONS** – Know your primary care partner's business model and align the two organizations to avoid mismatched expectations.

Communication

Frequent communication and data sharing is central to successful integration efforts. Substance abuse provider organizations and their primary care partners have shared several important lessons to encourage strong communications for other programs.

- ▶▶ **BUILD CROSS-CHANNEL COMMUNICATION** – Break down the silos of “substance abuse” and “primary care” by developing an agreement with primary care partners to form a cross-provider team that facilitates two-way communication and full collaboration.
- ▶▶ **RECOGNIZE DIFFERENCES** – Recognize that messaging around integration and the value placed on it is different in different settings (e.g., primary care professionals may weigh the benefits differently than substance abuse providers do).
- ▶▶ **FOSTER TRUST** – Build trust among patients, providers, and clinicians. Just like in a marriage or family, trust is the foundation upon which all decisions are made and successes achieved.
- ▶▶ **KEEP TALKING** – At times, differing opinions on how or what to do will occur. Maintaining flexibility and ongoing communication will help navigating differences.

Operations and Administration

Successful integration strategies and practice changes requires leaders to address organizational culture, workflow, administrative management, physical space, and clinical operations. Thus, the buy-in of leadership is enormously important. In the 2012 meeting, participants recommended that leaders:

- ▶▶ **MAINTAIN FLEXIBILITY** – When working with another healthcare field and workforce, the importance of flexibility cannot be underestimated. Build your program for optimal flexibility in professional roles, time, structure, and workflow.

- ▶▶ **APPOINTMENT TIMES** – In the current fiscal climate, spending ample time with patients can be a challenge. However, people with substance abuse disorders have complicated health needs that require sufficient time. Administrators must ensure staff and clinicians schedule 30 minutes for primary care appointments, rather than 15 minutes.
- ▶▶ **BUILD AN INFRASTRUCTURE** – Operationalize your clinic’s work by developing policies and procedures that support integration
- ▶▶ **IDENTIFY A CHAMPION** – Hire and promote an integration champion within your organization.
- ▶▶ **KNOW YOUR STRENGTHS** – Your organization has much to offer in a collaboration. Champion your integration program and collaborate with other community programs.
- ▶▶ **TAKE RISKS** – Prepare to take risks and venture into new models of care. This can have an enormous impact on improving health and cost savings.
- ▶▶ **BUILD TEAMS** – The team approach is pivotal to integrated service delivery, and has proven far more effective than an individual clinician approach. Leadership must develop these teams and communicate the importance of the team approach to staff.
- ▶▶ **TRACK TRENDS AND DEVELOPMENTS** – Keeping up-to-date with the current healthcare environment (e.g., understanding national trends) can help you maintain a sense of the improvements, changes, or modifications needed in your programs and efforts.
- ▶▶ **ENCOURAGE ACCOUNTABILITY** – Improve measurement of service effectiveness and provider accountability and use rapid cycle quality efforts to make improvements.

Information Sharing

Information sharing is vitally important to integrated care. It improves the care provided to individuals and strengthens the team working together to provide services to these individuals.

- ▶▶ **SHARE WITH OTHERS** – While maintaining patients’ confidentiality is central to the success of integration programs, electronically sharing patient records encourages true collaboration. Such exchange ensures all appropriate practitioners begin and remain on the same page with regard to an individual’s health.
- ▶▶ **COLLECT DATA** – Data on utilization, health outcomes, processes, and other important indicators informs decision-making. Collecting and tracking such data over time enables evaluation and demonstrates the progress of integration efforts.
- ▶▶ **APPLY CLINICAL INFORMATION SYSTEMS** – Systems that share health information and support decision-making are vital to effectively integrating health information and making informed decisions about individuals’ care.

Financing

Next to selecting the right integration model for your program, financing is your most important consideration.

- ▶▶ **PUT PATIENTS FIRST** – Financing is pivotal to the success of integration efforts. However, it is secondary to determining the true need and best model(s) to meet those needs. Consideration of financing options should always come after determining the appropriate care plan and evidenced-based services to employ.
- ▶▶ **CONSIDER BILLING LOGISTICS** –When determining the best staff to employ and deliver various interventions, know the regulations regarding what professionals are ‘covered’ to provide these services. Map what payers pay for what services rendered by which professionals.

Policy and Stakeholder Education

Engaging policymakers and stakeholders in conversations about integration and its benefits, as well as policy and infrastructures to support such endeavors, is essential to integrated care success.

- ▶▶ **EDUCATE PAYERS** – When it comes to integrated addictions and primary care, success lies in working with health plans to ensure that the needs of those you serve are met. This may involve educating payers on why, for example, it is important not to charge a co-pay.
- ▶▶ **MAKE THE CASE** – Build a business case for your integration efforts. Pull data, collect stories, and document how your journey has benefited those you serve. Share this broadly – and often – with policymakers and other stakeholders.
- ▶▶ **CALL 911** – Connect with hospital emergency and customer service departments right away. They are an enormously important point of contact for individuals with substance abuse problems. Conversations with emergency services about how your organizations resources can provide assistance could be extremely beneficial and potentially lead to a mutually rewarding partnership.

Workforce Development

While the changing healthcare landscape will favor the integration of substance abuse and primary care service delivery, several workforce factors need attention to support integration, including: recruitment and retention; relevance, and effectiveness of training; staff competency in integrated care, evidence-based practices, and recovery-oriented approaches; attitudes and skills in prevention and treatment of persons with mental and substance abuse conditions, leadership development; and workforce roles for persons in recovery and their family members.

Recent studies suggest that the implementation of the Affordable Care Act in 2014 will result in a significant increase in the need for addiction treatment professionals who are capable of providing care for individuals with substance use disorders in a variety of healthcare settings. A concerted effort is necessary to decrease this and other workforce shortages currently affecting the entire healthcare. In addition, providers will need to address current issues related to staff competency working in integrated care settings. Meeting participants suggested several ways to address this issue.

- ▶▶ **TEACH STAFF TO FISH** – Providing staff with resources, training, and checklists on the provision of integrated care can help usher behavior change among staff.
- ▶▶ **TRAIN AND EDUCATE STAFF** – Integration requires that an organization's entire staff view person-centered care as holistic. This shift requires proper training of all staff, including education on disease processes, differing practice styles between substance abuse and primary care providers, integrated care competency, confidentiality, credentialing and licensing, and risk and responsibility.
- ▶▶ **BUILD PROVIDER BUY-IN** – Medical and behavioral health staff can have personal biases that affect how they view integration. Appeal to the professional's sense of the "right thing to do." Primary care providers, often unfamiliar with treating individuals with substance abuse problems, can misunderstand behaviors and may benefit from training and education on the nature of addiction, especially that addiction is a brain-based, chronic, and relapsing disease.

Consumer, Family, and Community Engagement

Engaging the community and individuals living with substance abuse disorders is pivotal to person-centered integrated care

- ▶▶ **ENGAGE YOUR COMMUNITY** – Support from others in the community (e.g., individuals with substance abuse disorders, family members, community partners) can help your integration program get off the ground and sustain itself. This engagement can also improve access to care by creating a community that understands the importance and effectiveness of care. Share success stories with partners, stakeholders, those you serve, the community, and the broader policy network.

- ▶▶ **VALUE THE INDIVIDUAL'S EXPERIENCES** – Integration centers on the person receiving care and, therefore, values listening to their experiences and perceptions of care. It's important to make the person feel comfortable, respected, and engaged in treatment. Partnering with those you serve on their care will help foster such engagement and comfort. Answering their “what is in it for me?” questions is particularly important for persons with addictions who may have conflicting feelings about giving up drugs and/or alcohol.

SUBSTANCE ABUSE SERVICE PROVIDER INTEGRATION CHECKLIST

Beginning to integrate services with a primary care provider can seem daunting at times. The following questions may help your organization begin redesigning its substance abuse services delivery systems to support integrated primary care and/or integrated mental health services.

Administrative Questions

- ▶▶ What is the vision and mission of your agency?
- ▶▶ Does it need to change?
- ▶▶ Is integration a part of your vision and mission? Different types of integration option (examples will differ by setting):
 - ▶▶ *Treat substance abuse issues only*
 - ▶▶ *Treat substance abuse with primary care (health home model)*
 - ▶▶ *Treat all substance abuse and mental health without primary care*
 - ▶▶ *Treat all substance abuse and mental health with primary care (health home model)*
- ▶▶ Have you developed a strategic integration plan?
- ▶▶ Is your governing board engaged and knowledgeable about integration?
- ▶▶ Do you understand the primary care needs of the population you are serving?
- ▶▶ Do your administrative policies (e.g., confidentiality, billing and reimbursement, ethics) support integration?
- ▶▶ What changes could better integrate clinical and business processes?
- ▶▶ Have you assessed how your current service delivery model will compete when new and/or integrated services are provided by other primary care and specialty behavioral health providers in your area?
- ▶▶ Have you considered the impact of the federal healthcare law on your current and future business plan?

Capacity/Resource Questions

- ▶▶ Do you have existing relationships (formal or informal) with other service providers in mental health and primary care?
- ▶▶ Is there potential to build on those relationships?
- ▶▶ Have you identified existing resources (e.g., community coalitions, prevention programs) in the community that can be leveraged across systems?
- ▶▶ Do you have access to a variety of levels of care through medical partners so patients can be moved along the continuum of care, as appropriate?
- ▶▶ Do you have the staff and other resources to treat mental health, primary care, and substance-related disorders?

- ▶▶ Does your program have staff with a range of expertise and/or competencies related to integrated care (e.g., case management, care coordination, wellness programming)?
- ▶▶ Is your facility licensed to provide services for mental health, substance-related disorders, or primary care services?
- ▶▶ How difficult and time consuming would adding additional licenses be? Do you have a primary care clinic within your agency or an effective working relationship with a primary care provider organization in your community?
- ▶▶ Are you familiar with the regulations related to licensing a primary care clinic?
- ▶▶ Does your program demonstrate integrated components, even if these elements are informal and not part of the defined program structure (e.g., informal staff exchange processes, as-needed use of case management to coordinate services)?

Financing Questions

- ▶▶ Do you have professional staff capable of providing billable primary care or mental health services?
- ▶▶ What additional investments in people and equipment would be required?
- ▶▶ Do you know how much money your organization needs to make in order to support your integrated care vision (key elements: number of consumers seen; how often are they seen per year; payer mix; reimbursement per visit)?
- ▶▶ Are you able to bill diverse payer groups (i.e., Medicaid, Medicare, private insurance)?
- ▶▶ Are you familiar with how to join provider networks of major payers?

Data/Technology Questions

- ▶▶ Are you using a certified electronic system?
- ▶▶ Can your system generate patient data registries for staff to use to support integration?
- ▶▶ Can you generate a coordination of care document (CCD)?
- ▶▶ Does your clinical record support documentation of physical health-related services?
- ▶▶ Can your system generate an electronic bill after the completion of a documented event?

CONCLUSION

Far too many individuals living with addictions do not receive the healthcare or substance abuse care they need to achieve and maintain recovery. Even when they do receive some care for an addiction, they may not receive necessary medical care. Alternatively, when they see a primary care provider, their substance abuse disorder may go unaddressed or poorly addressed. One answer lies in coordinated and comprehensive care. As national attention continues to focus on integration, substance abuse, mental health, and primary care providers will continue to seek ways to ensure success on the local level, and early adopters such as those represented in this document have paved such a path, negating the need for other organizations to “reinvent the wheel.”

Research and health outcomes continue to show that integrating primary care with addiction (and mental health) care is likely to provide better care while improving lives, promoting recovery, and controlling costs. While integrated addiction and primary care programs are not yet the norm, cultivating a state and local delivery system infrastructure that supports integrated services is vital to a future healthcare marketplace that emphasizes care coordination and management and the development of health homes, which include addiction and mental healthcare. In order to take advantage of the continuing medical advances, new funding opportunities and continue to provide quality care to you clients, treatment providers must consider offering a broader array of services, which may include primary care. The providers cited in this paper among others, provide living examples of the benefits and challenges of integrating primary care services, but most of all, their efforts have provided much needed information to the field on the value and feasibility of these efforts .

APPENDIX A

Participants List

April 16, 2012 Innovations in Addictions Treatment: Addiction Treatment Providers with Integrated Primary Care Services meeting

Cliff Bersamira

AOD Research Analyst
National Association of State Alcohol and Drug Abuse Directors
(NASADAD)
1025 Connecticut Avenue, NW, Suite 605
Washington, DC 20036
T: 202-293-0090 x 112 | E: cbersamira@nasadad.org

David Bingaman, LCSW, ACSW

Deputy Regional Administrator, HRSA Region V
Chicago, IL
T: 312-353-8121

Brittany Burch

Montrose Counseling Center
401 Branard Street, 2nd Floor
Houston, Texas 77006-5015
T: 713.529.0037

Marjorie Bush

Exec. Director
St. Jude's Recovery Center
139 Renaissance Parkway
Atlanta, GA 30308
T: (404) 263-7262 | E: mbush@sjrcatl.org

Emily Capito, LCSW, MBA

Director of Operations
Odyssey House of Utah
T: 801-428-3475 | E: ecapito@odysseyhouse.org

Robert D. Cartia, MBA, MA, LISAC

Chief Executive Officer
Verde Valley Guidance Clinic, Inc.
T: 928-634-2236 ext. 209

Mady Chalk

Director, Center for Policy Research and Analysis
Treatment Research Institute
600 Public Ledger Building, 150 S. Independence Mall West
Philadelphia, PA 19106
E: mchalk40@gmail.com

Jeffrey Coady, PsyD

CDR, U.S. Public Health Service, Regional Administrator (V)
SAMHSA/Department of Health and Human Services
233 North Michigan Avenue, Suite 200
Chicago, IL 60601
T: (312) 353-1250

Adam Cohen

Odyssey House of Utah
T: 801-428-3475 | E: ACohen@odysseyhouse.org

Leonard Dootson
PBHCI Project Coordinator
Tarzana Treatment Centers, Inc.
18646 Oxnard Street
Tarzana, CA 91356
T: 818-654-3911
www.tarzanatc.org

Laura Galbreath, MPP

Director
SAMHSA-HRSA Center for Integrated Health Solutions
1701 K Street NW Suite 400
Washington, DC 20006
T: (202) 684-7457 ext. 231 |
E: laurag@thenationalcouncil.org

Trip Gardner

Director
Penobscot Community Health Center
34 Summer Street, Bangor, ME 4401
T: (207) 992-2636 | E: tgardner@pchcbangor.org

Nancy Goler MD

Regional Medical Director: Early Start Program
Dept. Ob/Gyn: Vallejo Medical Center
T: 707-651-5410
www.kp.org/mydoctor/nancygoler

Russel Gray

St. Jude's Recovery Center
139 Renaissance Parkway
Atlanta, GA 30308
T: (404) 263-7262 | E: rgray@sjrcatl.org

Rick Harwood

Director of Research and Program Applications
National Association of State Alcohol and Drug Abuse Directors
(NASADAD)
1025 Connecticut Ave., NW, Suite 605, Wash., DC 20036
T: 202-293-0090

Patti Juliana

Supervisor, Clinical Program
Beth Israel Medical Center
pjuliana@chpnet.org

Linda Kaplan, MA

Sr. Public Health Advisor
SAMHSA/CSAT/DSI
1 Choce Cherry Road, Rm 5-1083
Rockville, MD 20850
T: 240-276-2917 | E: linda.kaplan@samhsa.hhs.gov

Michelle Kletter

Primary Care Program Director
La Puente Clinic-BAART Drug Treatment Center
15229 Amar Rd.
La Puente, CA
T: 415-552-7914 x135 | E: mkletter@baartprograms.com

Marcia Melnyk

Loyola Recovery Foundation
1159 Pittsford Victor Road
Pittsford, New York 14534
T: 585.203.1005 | E: mmelnik@loyolarecovery.com

Ashley McCabe

Verde Valley Guidance Clinic, Inc.
T: 928-634-2236

Veronica Osejo

Regional Early Start Project Manager
Patient Care Services
1950 Franklin St, 13th Fl
Oakland, CA 94612
T: 510-987-3678

Kathleen Reynolds, MSW

Senior Consultant
SAMHSA-HRSA Center for Integrated Health Solutions
1701 K Street NW, Suite 400
Washington, DC 20006
T: (202) 684-7457 ext. 241 |
E: kreynolds@thenationalcouncil.org

Ann J. Robison, PhD

Montrose Counseling Center
401 Branard Street, 2nd Fl.
Houston, Texas 77006
T: 713.529.0037 x305

Alexander F. Ross, ScD

Office of Special Affairs
Health Resources and Services Administration
E: alexander.ross@hrsa.hhs.gov

Jim Sorg, PhD

Tarzana Treatment Centers, Inc.
Director of Admissions and Information Technology
18646 Oxnard Street
Tarzana, CA 91356
T: 818-654-3911 | E: jsorg@tarzanatc.org
www.tarzanatc.org

Edward Splichal

Central Kansas Foundation
1805 S. Ohio
Salina, KS 67401
T: 785-825-6224
www.c-k-f.org

Anacea Stambaugh

Central Kansas Foundation
1805 S. Ohio
Salina, KS 67401
T: 785-825-6224
www.c-k-f.org

Becky Vaughn, CEO

State Associations of Addiction Services
236 Massachusetts Ave. NE St 505
Washington, DC 20002
T: 202-546-4600
www.saasnet.org

Christopher R. Wilkins, Sr.

Loyola Recovery Foundation
1159 Pittsford Victor Road
Pittsford, New York 14534
T: 585.203.1005 | E: cwilkins@loyolarecovery.com

Aaron M. Williams, MA

Director, Training and Technical Assistance for Substance Abuse
SAMHSA-HRSA Center for Integrated Health Solutions
1701 K Street NW, Suite 400
Washington, DC 20006
T: (202) 684-7457 ext. 247 | E: aaronw@thenationalcouncil.org

Elizabeth Wilson, MD

Beth Israel Medical Center
Methadone Maintenance Treatment Program,
Clinic 8
132 West 125th Street
New York, NY 10027
T: (212)-864-8177