



## Regular articles

## Introduction to the Special Issue on the Studies on the Implementation of Integrated Models of Alcohol, Tobacco, and/or Drug Use Interventions and Medical Care



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## ABSTRACT

National efforts are underway to integrate medical care and behavioral health treatment. This special issue of the *Journal of Substance Abuse Treatment* presents 13 papers that examine the integration of substance use interventions and medical care. In this introduction, the guest editors first describe the need to examine the integration of substance use treatment into medical care settings. Next, an overview of the emerging field of implementation science and its applicability to substance use intervention integration is presented. Preview summaries of each of the articles included in this special issue are given. Articles include empirical studies of various integration models, study protocol papers that describe currently funded implementation research, and one review/commentary piece that discusses federal research priorities, integration support activities and remaining research gaps. These articles provide important information about how to guide future health system integration efforts to treat the millions of medical patients with substance use problems.

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### 1. Introduction

The integration of substance (i.e., alcohol, tobacco and/or drug) use interventions into medical care settings has been supported by recent legislation that advocates for parity to treat substance use disorders similar to other medical conditions (e.g., the Mental Health Parity and Addiction Equity Act of 2008) and increased federal funding to provide benefits to those in need of such care (i.e., Affordable Care Act, 2010). More specifically, these policy innovations promise to accelerate the integration of substance abuse and mental health services into medical settings (Buck, 2011).

Medical settings are ideal environments to identify and manage individuals with substance use disorders (Friedmann, Saitz, & Samet, 1998). Primary care is often the first contact individuals have with the health care system, and most people visit primary care at least once a year (Blackwell, Lucas, & Clarke, 2012). Additionally, patients who visit primary care typically have higher rates of substance abuse than the general population (Humphreys & McLellan, 2010; O'Connor & Schottenfeld, 1998; Samet, Friedmann, & Saitz, 2001). For example, research has suggested that approximately 22% of general health care patients report a comorbid substance use condition (SAMHSA, 2005; Treatment Research Institute, Inc, 2010) suggesting that the primary

care setting may be an appropriate venue to identify and potentially address substance use problems.

How best to implement substance use interventions in medical care settings is not well known. Addiction treatment has traditionally been provided in a separate specialty services sector from general health care. Publicly funded substance use treatment settings contrast from general medical care settings in several ways. For example, few substance use treatment facilities report having integrated clinical information systems that allow ready access to electronic health records (Andrews et al., 2015; McLellan & Meyers, 2004). Next, having a physician on staff or on contract, which will be necessary under new Medicaid regulations, is not common among many publicly funded substance use treatment programs. Finally, the use of evidence based practices, such as pharmacotherapy for alcohol or opioid use disorders, is not well integrated into much of the publicly-funded substance abuse specialty sector. In sum, the resources typically found in substance use treatment settings varies from traditional medical care settings, suggesting that increased attention will be needed on how to best to transfer substance use treatment practices from typical delivery settings to general health care settings.

This service provision conundrum is a prime candidate for implementation science. Implementation science is the scientific study of methods to promote the systematic uptake of clinical research findings and other evidence-based practices into routine practice, and hence to improve the quality (i.e., effectiveness, reliability, safety, appropriateness, equity, and efficiency) of health care (Eccles et al.,

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2009). The relatively new field of implementation science addresses the slow and unpredictable process through which findings from clinical and health services research become standard health care practices. Increasingly more research has been examining this research-to-practice gap, that is, how best to translate methods and practices deemed efficacious in research settings for use in real world health care settings.

Implementation science incorporates the study of the behavior of healthcare professionals and related staff, healthcare organizations, healthcare consumers, and policymakers as key factors in the adoption, implementation and sustainment of evidence-based interventions and guidelines (e.g., see the [National Institutes of Health Program Announcement for the Dissemination and Implementation Research in Health](http://grants.nih.gov/grants/guide/pa-files/PAR-13-055.html) at <http://grants.nih.gov/grants/guide/pa-files/PAR-13-055.html>). The added complexity of transitioning effective substance use care to medical settings requires attention to the context both within and external to the service setting, such as how federal, state and local policies encourage or challenge primary care providers to practice substance use care and how characteristics of the organization, such as culture, climate, staff training and support impact the delivery of substance use treatment.

Determination of how well a particular approach to integrate substance use interventions into primary care works from an implementation science perspective, may require consideration of such factors as provider and patient acceptability of the intervention and the intervention's feasibility, uptake, fidelity, penetration, sustainability, and costs in the proposed setting (Proctor et al., 2009). Other important outcomes for consideration in implementation research studies include those from a service system perspective, that is effectiveness, efficiency, timeliness, equity and patient-centeredness (i.e., the IOM standards) and from a clinical perspective (e.g., symptomology, functioning, and satisfaction).

It is not well known what level of integration works best or how best to disseminate, encourage adoption and widespread use of substance use treatment practices in primary care. It may depend on the context of the care environment (e.g., outpatient, inpatient) and the populations served (e.g., private payer, Medicaid/Medicare populations, veteran, racial/ethnicity minority). More than one model may be appropriate and effective and the changing landscapes of health care provision and payment models make this an especially vexing problem for research as particular integration models may be only feasible for practice under particular provision and payment models.

Addressing this integration issue requires robust studies of implementation strategies to improve the delivery of substance use treatment in primary care, including the identification of facilitators of and barriers to service delivery, along with the development and testing of strategies for the scale up, spread, and sustainment of such treatments. For example, studies are needed that yield information about how to prepare the medical service context for successful implementation, how to promote quality implementation and sustainment in these settings, and how to de-implement interventions, practices or policies that run counter to the goal of providing substance use care within these settings. Moreover, it is also important to consider that interventions that have been found effective in substance use treatment settings may need to be re-designed to be effective in primary care given the variations across these service sectors on many factors related to implementation.

Because implementation science research often addresses both effectiveness and the “how” and “why” for such findings, mixed method approaches that utilize both quantitative and qualitative data are often utilized (Palinkas et al., 2011). For example, variations in penetration rates across sites (i.e., a quantitative measure) may be explained by information from in-depth interviews with providers that denote the facilitators and barriers to integrating care into their setting (i.e., qualitative data). In this issue, a number of articles utilized mixed methods (e.g., Brooks et al. (2016), Guerrero et al. (2016), Kaiser and

Karuntzos (2016)) or rely on qualitative approaches to help explain previously noted quantitative findings (e.g., Williams et al. (2016)).

This special issue highlights recent advances in the field on integrating substance use treatment into real-world medical care. Consistent with previous literature (Collins, Hewson, Munger, & Wade, 2010; Heath, Wise Romero, & Reynolds, 2013), the articles presented in this issue describe models of health care integration that represent a broad array of different levels of service integration. For example, a high level of integration may be exhibited by having primary care physicians deliver substance use treatment. A medium level of integration may be demonstrated by employing a behavioral health specialist in primary care to address substance use whereas an example of low level of integration would be to screen for a substance use problem in primary care but to refer patient to another setting to receive substance use treatment. A number of different approaches have been developed and examined to integrate substance use care within primary care, many of which are reported here. We start this issue with a presentation of studies that examined models that suggest higher levels of integration in that they employ physician-involvement in the treatment. In most cases, integration models also employ other health professionals, such as nurses, social workers, and/or health educators to assist in the delivery of care and many of these approaches are also presented.

## 2. Research of high level integration approaches

Pharmacotherapy for alcohol and opioid use disorders has been shown to be effective when delivered in primary care settings (e.g., Fiellin et al., 2014; Kranzler & Van Kirk, 2001), making it an natural choice for a study of implementation in real world practice settings. For example in this issue, LaBelle, Han, Bergeron, & Samet, 2016 report the results from a statewide dissemination initiative to increase opioid agonist therapy with buprenorphine in community health centers (CHCs) in Massachusetts. The state supported the use of the Collaborative Care Model for Office-Based Opioid Treatment (Alford et al., 2007, 2011) that included training and support to physicians to become eligible to prescribe treatment (i.e., “waivered” status) and the utilization of nurse care managers to conduct screening, medication induction, and ongoing assessment and treatment sessions. This paper describes implementation of the state initiative across a 3 year period, including adoption rates across CHCs, the number of trained physicians, and the number of patients receiving treatment. The authors consider program costs and sustainability in the discussion section. This work serves as a model by which other entities may assess scale-up of buprenorphine treatment within primary care settings.

Next, Barnes et al. (2016) examined the effectiveness of a multicomponent intervention targeting risky alcohol use among older adults. The intervention consisted of provision of information to both patients and providers about an individual's risk. Providers were asked to discuss risk factors with their patients. Health educators were also employed to contact intervention patients at regular intervals to discuss the patient risk report. The results showed a modest intervention effect on functioning and health-related quality of life. Further exploration of the data suggested that the provider intervention may have been more effective than the health educator intervention, indicating more work may be needed in finding the most feasible and effective approach to delivering interventions for risky use in these settings.

## 3. Screening and brief intervention studies

Screening, brief intervention and referral to treatment (SBIRT) interventions typically employ a range of health care professionals in its delivery, including medical assistants who may be primarily responsible for screening, and physicians, nurses or other health care providers (including behavioral health counselors) who are primarily responsible for providing brief intervention and referrals to treatment. Brief intervention (BI) for unhealthy alcohol use is recommended by the US

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