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Advancing Recovery: State and Provider Partnerships for Quality Addiction Care

An RWJF national program

Advancing Recovery: State and Provider Partnerships for Quality Addiction Care supported 12 state-provider partnerships in selecting and implementing evidence-based practices known to be effective for treatment of substance abuse. These included medication-assisted treatment, continuing care management, psychosocial interventions (motivational interviewing), and case management or wraparound support services. The partnerships used the NIATx process-improvement model to integrate the evidence-based practices at both state policy and service delivery levels. The Robert Wood Johnson Foundation (RWJF) Board of Trustees authorized the program for up to $11 million. Advancing Recovery ran from 2006 to 2010.

CONTEXT

Youth and adults in the United States with drug or alcohol-related disorders have limited access to high-quality treatment. According to the federal Substance Abuse and Mental Health Services Administration (SAMHSA), in 2003 only slightly more than 10 percent of the estimated 22.2 million Americans age 12 and older who needed treatment actually received it. Of those who received treatment, the quality of care varied widely.

Evidence-based practices can improve the quality of care for people with substance abuse disorders. However, although proven treatments existed, in 2002 they were not routinely used by the nation's 13,000 publicly funded treatment programs. Only 17 percent of addiction treatment programs used pharmaceutical interventions for the treatment of alcohol or opioid dependence.[1] Furthermore, less than 50 percent of addiction treatment programs used proven psychosocial interventions such as motivational interviewing.

Clinical barriers, such as the lack of knowledgeable providers, are obvious impediments to adoption of evidence-based practices. However, barriers embedded in the policies and

[1] Knudsen HK, Abraham AJ and Roman PM. "Adoption and Implementation of Medications in Addiction Treatment Programs." *Journal of Addiction Medicine*, 5 (1):21–27, 2011.

culture of an organization, such as an overly complex admissions process or frontline staff resistant to change, also act as deterrents to adoption.

The Role of State Governments

States governments play an essential role in the adoption and spread of evidenced-based practices and system improvements by treatment agencies. They are both the largest purchasers of treatment services (70 %) and the regulators and licensers of those services. Thus state policies and procedures can either facilitate or inhibit treatment agencies from providing accessible high-quality care.

Barriers to system improvement, such as lack of performance expectations and complicated licensing regulations, exist at the state as well as the provider level. However, "with appropriate resources and leadership, state substance abuse authorities can have a powerful effect on the implementation and diffusion of evidence-based practices through the system," according to an article in the *Journal of Behavioral Health Services & Research*.[2]

RWJF's Interest in This Area

Prior to 2000, RWJF's primary focus in the area of substance abuse was on preventing addiction, principally through initiatives to combat underage drinking and drug use. Programs such as *Fighting Back*, *Free to Grow,* and *A Matter of Degree* mobilized parents, college students, and entire communities to work together to reduce the demand for illegal drugs and alcohol by youth.[3] (Follow the links above for a Program Results Report on each of the programs.)

In 2000, a staff report recommended that RWJF give priority to increasing access to quality addiction treatment as well as to prevention. Viewing addiction as a chronic medical condition, the report pointed to a "reservoir of scientific understanding of neurology, biology and the psychosocial dimensions of addiction." It also noted the availability of medications and proven clinical interventions to treat addiction as well as the significant gap between treatment need and resources.

Following the staff report, the RWJF Board of Trustees in 2001 authorized the first of a series of national programs to increase availability and quality of addiction treatment in the United States.

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[2] Rieckmann TR, Kovas AE, Fussell HE and Stettler NM. "Implementation of Evidence-Based Practices for Treatment of Alcohol and Drug Disorders: The Role of the State Authority." *Journal of Behavioral Health Services & Research*, 36(4):407–419, 2008. Abstract available online.

[3] Capoccia VA. "The Evolution of the Robert Wood Johnson Foundation's Approach to Alcohol and Drug Addiction," in *To Improve Health and Health Care*, Volume IX, 2005. Available online.

"Our underlying approach was that whether you're a community-based provider or a state entity, it is within your power to redesign and improve the system you use to do what you do," said Victor Capoccia, PhD, RWJF program officer for *Advancing Recovery*. *Advancing Recovery* was therefore one component of a multi-component strategy. Other components include:

Improving Access to Treatment Through Process Improvement

Paths to Recovery: Changing the Process of Care for Substance Abuse Programs ran from July 2002 through December 2008 and served as the framework for *Advancing Recovery*. *Paths to Recovery* aimed to increase access to and retention in substance abuse treatment by improving the quality and efficiency of services delivered by providers.

The University of Wisconsin–Madison Center for Health Enhancement Systems Studies served as the national program office for *Paths to Recovery*. The director of the center, David H. Gustafson, PhD, Research Professor of Industrial and Systems Engineering at the University of Wisconsin–Madison, directed the program.

Gustafson was an early proponent of the hypothesis underlying *Paths to Recovery*, namely, that process-improvement strategies used in private industry and other segments of the health care sector could be applied to addiction treatment. These strategies emphasized incremental changes that were tested, revised, retested, and adopted in a series of rapid-cycle changes.

RWJF collaborated with the federal Center for Substance Abuse Treatment (CSAT) Strengthening Treatment Access and Retention (STAR) program. Together, STAR and *Paths to Recovery* funded some 38 nonprofit treatment agencies in two cohorts.

The first cohort of projects demonstrated that, with coaching and assistance, treatment agencies were able to integrate systems-improvement strategies. By changing the *process* of care, agencies improved the *quality* of care, as measured by significant reductions in waiting time to admission and no-shows, increased admissions, and longer retention in treatment.[4]

This evidence of effectiveness led to the founding, in 2003, of NIATx (Network for the Improvement of Addiction Treatment) as a learning collaborative that could spread the system improvement model to the nation's 13,000 treatment providers.

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[4] McCarty D, Gustafson DH, Wisdom JP, Ford J, Choy, D, Molfenter T, Capoccia V and Cotter F. "The Network for the Improvement of Addiction Treatment (NIATx): Enhancing Access and Retention." *Drug and Alcohol Dependence*, 88: 138–145, 2007. Abstract available online. Also see Hoffman KA, Ford JH, Choi D, Gustafson DH and McCarty D. "Replication and Sustainability of Improved Access and Retention Within the Network for the Improvement of Addiction Treatment." *Drug and Alcohol Dependence*, 98: 63–69. PMID: 18565693; PMCID = PMC2607248, 2008.

For more on *Paths to Recovery*, see Program Results Report. For more on the NIATx model of system improvement see the NIATx website. To see how the model was applied to *Advancing Recovery*, see the Program section of this report.

Improving the Quality of Addiction Treatment Through Evidence-Based Practices

RWJF also funded programs focusing on adoption of evidence-based practices for treating substance use conditions, with two grants between 2004 and 2007 to the Washington-based National Quality Forum (NQF). The mission of NQF is to build consensus on national priorities and goals for performance improvement, endorse consensus standards for measuring and publicly reporting on performance, and promote the attainment of goals.

Under the first grant, NQF convened a workshop at which experts in addiction research, treatment and policy made recommendations for evidence-based practices that should receive a high priority for widespread implementation. See Program Results Report for more information.

The second grant built on the workshop recommendations. The NQF used its consensus-development process to identify and endorse 11 evidence-based treatment practices for patients with substance abuse conditions. These became the basis for the practices implemented in *Advancing Recovery*. For a list of the practices, see Appendix 1.

In September 2007, NQF produced a report, *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices*, describing these practices in detail (available online). For additional information, see the Program Results Report.

Spreading Addiction Treatment Through State-Provider Partnerships

Treatment agencies acting alone cannot achieve lasting quality improvements. A key collaborator to ensure sustainability and spread of quality improvement initiatives is the single state agency within each state. The single state agency is responsible for establishing policies, disbursing funds, and providing budget and program oversight for alcohol and other drug abuse treatment.

RWJF collaborated with CSAT to support the following programs that also encouraged partnerships between providers and their single state agencies.

- *State-Payer Pilot Initiatives.* Building on *Paths to Recovery* and STAR, from 2004 to 2007, RWJF and CSAT funded six single state agencies or other payers to test process-improvement techniques on a small scale and use what they learned to expand the improvements statewide.

- RWJF funded the Oklahoma single state agency to work with local treatment agencies to improve access to and retention in services. CSAT funded single state agencies in Delaware, Iowa, North Carolina, and Texas, and a behavioral health network in Colorado.

- *Strengthening Treatment Access and Retention—State Implementation (STAR-SI).* Building on the state-payer pilot projects, STAR-SI, which ran from 2006 through 2009, promoted state-level process-improvement strategies to improve access to and retention in outpatient treatment.

  RWJF funded STAR-SI projects in New York (ID# 59064) and Oklahoma (ID# 59317). CSAT funded projects in Florida, Illinois, Iowa, Maine, Ohio, South Carolina, and Wisconsin. Montana participated as a self-funded state. For more information on RWJF's support for STAR-SI, see Program Results Report on the New York and Oklahoma projects.

RWJF also funded a study that examined efforts by 49 states and the District of Columbia to implement evidence-based practices for addiction treatment. Researchers interviewed personnel from each state's single state agency to gain a better understanding of the interplay of state policies, contracting criteria, activities, and strategies for accelerating the use of evidence-based practices.

Traci R. Rieckmann, PhD, a member of the *Advancing Recovery* evaluation team, directed this project. For more information about the study, see the Program Results Report.

Increasing the Resources Available to Treat Addiction Through Effective Payment Strategies

Another component necessary to ensure greater access to high quality treatment is to maximize sources of funding, a particularly urgent need at a time when states are experiencing severe fiscal constraints.

- *Resources for Recovery: State Practices That Expand Treatment Opportunities.* Under this $3 million national program, which ran from July 2002 to October 2007, RWJF made grants to state agencies in Alabama, Connecticut, Florida, Nebraska, and Wyoming to implement strategies that would expand outpatient treatment. It provided funds for technical assistance to 10 additional states for the same purpose.

  Teams in the 15 states analyzed how treatment in their states was financed, administered, and delivered and identified strategies to use current resources to purchase more and better services. Maximizing use of Medicaid to cover substance abuse treatment was a key focus of the program.

  To manage *Resources for Recovery* and provide technical assistance to the participating states, RWJF established a national program office at the Technical

Assistance Collaborative, a Boston-based consulting firm. For more on this program, see the Program Results Report.

THE PROGRAM

Advancing Recovery: State and Provider Partnerships for Quality Addiction Care was an $9.3 million national program of RWJF designed to promote the use of evidence-based practices by substance abuse treatment providers through innovative partnerships between providers and the state agencies that fund and regulate them. The goal of the program, which ran from January 2006 through June 2010, was to improve clinical and administrative practices that impede the use of evidence-based practices.

Victor Capoccia, PhD, the first RWJF program officer for *Advancing Recovery*, described the rationale for the initiative. "By changing and strengthening state- and provider-level practices that promote the use of evidence-based care, *Advancing Recovery* sought to improve consumer outcomes and highlight addiction treatment as an essential component of the health care system."

Program Design

Advancing Recovery originated with the concept of expanding the application of the systems-change and process-improvement methods developed under *Paths to Recovery*. According to former RWJF Program Associate Ann Pomphrey, who took over from Capoccia in 2007, "the decision to fund *Advancing Recovery* was a natural evolution from *Paths to Recovery*-—almost a continuation—with the focus on payer-provider partnerships. If you really wanted to have significant quality improvement, you couldn't do it without both providers and the state."

National Program Deputy Director Todd Molfenter, PhD, points out key differences between the earlier STAR-SI and *Advancing Recovery*. "STAR-SI focused on spreading the NIATx model statewide, primarily through education, conferences and learning collaboratives. With Advancing *Recovery*, we learned that to spread evidence-based practices like medication-assisted treatment or continuing care, you need more than education. You need system change to address issues related to reimbursement and regulation. For example, when we started we had states where it was against the licensure rules even to prescribe medications."

Two calls for proposals (2006[5] and 2007[6]) outlined requirements for *Advancing Recovery* applicants with regard to the composition of state-provider partnerships and the selection of evidence-based practices.

[5] *Advancing Recovery:* State and Provider Partnerships for Quality Addition Care: 2006 Call For Proposals Round 1. Princeton, N.J.: Robert Wood Johnson Foundation, 2006.

State-Provider Partnerships

To be eligible for funds, applicants had to show evidence of a partnership that included the single state agency and at least three treatment providers. The lead agency for the application could be the single state agency, a treatment provider, or a network of providers. The aim was to implement evidence-based practices within these agencies and then spread them throughout the state.

Each of the provider agencies in the partnership was required to serve a significant number of people, be in good financial health, and rely on public sources such as Medicaid for at least 50 percent of funding. In addition, partnerships were encouraged to consider strategies that could affect multiple levels of care (for example, inpatient, outpatient, and residential) and include providers that served minority consumers.

The calls for proposals suggested change strategies that applicants could propose. Change strategies that *providers* could use to promote evidence-based practices included:

- Strengthening administrative and clinical systems, such as those used to engage patients and families in treatment
- Creating inter-system linkages, such as between treatment providers and community health centers in order to make medications more readily available

Change strategies that *state agencies* could use to promote adoption of evidence-based practices included:

- Identifying and mitigating the unintended negative consequences of funding or regulatory practices
- Implementing a group purchasing mechanism to make inexpensive medications available
- Adding language to provider contracts and certification requirements stating that not offering medications for addictions treatment is sub-standard care

The Five Evidence-Based Categories

The state-provider partnerships were required to select and implement two evidence-based practices based on those endorsed by NQF. *Advancing Recovery* grouped the practices into five broad *categories*. Providers were expected to choose specific practices or interventions within these categories and then adapt them to the needs of their patients. The five categories are:

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[6] *Advancing Recovery:* State and Provider Partnerships for Quality Addition Care: 2007 Call For Proposals Round 2. Princeton, NJ: Robert Wood Johnson Foundation, 2007. Available online.

Medication-Assisted Treatment (MAT)

Medication-assisted treatment is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Research shows that a combination of medication and behavioral therapies is most successful in treating substance use disorders.

The most common medications used in treatment of opioid addiction to prevent withdrawals and reduce craving are methadone and buprenorphine (marketed as Suboxone®. Methadone is dispensed only at specially licensed treatment centers. Buprenorphine can be dispensed at opioid treatment centers or prescribed in primary care settings by doctors certified to prescribe it.[7]

Medications approved for treatment of alcohol use disorders include naltrexone and acamprosate, and are called anti-craving drugs[8] because they reduce the intoxicating effects of alcohol and the urge to drink.

The Use of Continuing Care

The goal of continuing care (or after care) and follow-up is to keep people engaged in their recovery after the acute phase of treatment is over. All continuing care is community-based in order to assist people with the difficult job of adjusting to their day-to-day lives with a new perspective and resolve. Continuing care can include individual, group, and family therapy, and telephone counseling.

Provision of Wraparound and Supportive Services

This collaborative team-based approach offers comprehensive support to adults and youth with substance use problems and their families. Wraparound support includes case management and ancillary services such as job training, transitional housing, and child care.

The Use of Specific Psychosocial Clinical Interventions

This category includes individual and group interventions with a wide range of aims. Some are designed to reduce substance use while others aim to reduce substance use-related problems (such as employment and housing).

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[7] *Medication-Assisted Treatment for Opioid Addiction.* Washington: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, 2009. Available online.

[8] Center for Substance Abuse Treatment. *Incorporating Alcohol Pharmacotherapies Into Medical Practice. Treatment Improvement Protocol (TIP) Series 49*. HHS Publication No. (SMA) 09-4380. Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, 2009. Available online.

One commonly used intervention is motivational interviewing, a counseling approach that acknowledges that many people resist changing behavior and that focuses on enhancing their motivation to change.

Screening and Brief Intervention

Screening and brief interventions aim to intercede early with people who have substance use disorders and people at risk of developing these disorders. Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment. Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change. Providers refer those needing more extensive treatment to specialty care.

For more information on the five categories, the rationale for selecting each one, system changes needed to integrate them into provider practices statewide, and additional resources, see the *Advancing Recovery* website.

Executing the Design: The NIATx System Change Model

Partnerships used the NIATx model as the framework for system change at both the provider and state level. The NIATx model consists of five broad principles of organizational change and four specific aims for increasing access and retention. Agency leaders, staff, and consumers form change teams to achieve these aims, using the Plan-Do-Study-Act system of rapid-cycle change.

For example, "walkthroughs" are a key component of the NIATx model. In walkthroughs, senior staff members apply for services at their agency as if they are clients, gaining a view of the organization from the consumer's perspective. Walkthroughs uncover barriers, identify problems, and generate practical ideas for improvements.

In *Advancing Recovery*, representatives of both the treatment agency and the state agency conducted walkthroughs, which were required for the application, and were used to identify problems that impeded implementation of evidence-based practices. In state walkthroughs, the "customer" was typically a treatment agency in need of information regarding certification, licensure, or other issues related to provision of services.

For a brief overview of the NIATx model, see Appendix 2. For more on how the NIATx change model is applied to system-level change projects, see the System-Change Toolkit available from the NIATx Resource Center.

Management

National Program Office

NIATx served as the national program office for *Advancing Recovery.* It is a learning collaborative within the at the University of Wisconsin–Madison's Center for Health Enhancement Systems Studies. David H. Gustafson, PhD, was national program director; Todd Molfenter, PhD, was deputy director.

The NIATx mission is to spread the system improvement model piloted under *Paths to Recovery* and STAR to substance abuse treatment agencies throughout the country.

Advancing Recovery was a collaboration between NIATx and the Treatment Research Institute (TRI). The Philadelphia-based TRI specializes in science-based transformation of addiction and substance use practice and policy. A. Thomas McLellan, PhD, at that time the executive director of TRI and professor of psychiatry at the University of Pennsylvania, worked with NIATx staff to provide technical assistance to help grantee organizations adopt evidence-based practices.

National Advisory Committee

A broad-based and diverse national advisory committee advised the national program office on all aspects of *Advancing Recovery,* including assisting with the grantee selection process, attending grantee meetings, and helping with the dissemination of program results. For a list of members, see the *Advancing Recovery* website.

The Twelve State-Provider Partnerships

The national advisory committee reviewed 23 *Advancing Recovery* proposals for Round I funding. Then committee members visited 10 applicant sites, and recommended six for grant awards. The committee reviewed 19 proposals for Round II funding, visited 12 applicant sites, and recommended six for awards. RWJF subsequently awarded two-year grants of approximately $360,000 to these 12 state-provider partnerships.

Advancing Recovery Round I Sites

In November 2006, the first cohort of six state-provider partnerships received *Advancing Recovery* grants. The lead agencies and the primary evidence-based practice they chose to implement were:

- *Delaware Division of Substance Abuse and Mental Health.* The division is Delaware's single state agency. It is located in the Department of Health and Social Services and serves people age 18 and older in need of publicly funded behavioral health services.
  - Primary evidence-based practice: Psychosocial intervention

- *Florida Department of Children and Families.* Florida's single state agency, the Substance Abuse Program Office, is housed in this department. The office provides a comprehensive system of prevention and treatment services for individuals and families at risk of or affected by substance abuse.
  - Primary evidence-based practice: Medication-assisted treatment
- *Kentucky River Community Care.* This community mental health center provides mental health, substance abuse, and trauma services to individuals and families in an eight-county area of the Kentucky River region.
  - Primary evidence-based practice: Continuing care
- *Maine Office of Substance Abuse.* As the state's single state agency, the office is responsible for the planning, development, implementation, regulation, and evaluation of substance abuse services. It provides leadership in substance abuse prevention, intervention, and treatment.
  - Primary evidence-based practice: Medication-assisted treatment
- *Division of Alcohol and Drug Abuse, Missouri Department of Mental Health.* The division is the single state agency responsible for overseeing a network of publicly funded substance abuse prevention, treatment, and recovery support services. It reports that approximately 73,600 Missourians received substance abuse treatment or intervention services and 1.1 million received prevention services in 2009.
  - Primary evidence-based practice: Medication-assisted treatment
- *NRI Community Services.* Based in Woonsocket, R.I., NRI is a nonprofit, licensed behavioral health care agency founded in 1966. The agency reports assisting more than 3,700 individuals with mental health, behavioral, emotional, and substance abuse issues in 2010.
  - Primary evidence-based practice: Continuing care

Advancing Recovery Round II Sites

The second cohort of six state partnerships received *Advancing Recovery* grants in February 2008. The lead agencies and their primary evidence-based practices were:

- *The Alabama Substance Abuse Service Division.* This single state agency is located in the Department of Mental Health and Mental Retardation. The division is responsible for development, coordination, and management of a comprehensive system of treatment and prevention services for alcohol and drug addiction and abuse.
  - Primary evidence-based practice: Continuing care
- *Office of Alcohol and Drug Abuse Prevention*. This single state agency is located in the Arkansas Division of Behavioral Health Services. The office is responsible for the

establishment of a comprehensive and coordinated program for the prevention and treatment for alcohol and drug abuse in Arkansas.

  - Primary evidence-based practice: Continuing care

- *Signal Behavioral Health Network, Denver.* Signal is a managed service organization formed by six behavioral health organizations. The six have a history of contracting with the State of Colorado to provide substance abuse treatment services to the citizens of Colorado.

  - Primary evidence-based practice: Continuing care

- *Baltimore Substance Abuse Systems.* The agency is responsible for defining and meeting the city's need for alcohol and drug treatment and prevention services. It plans, develops, and implements a comprehensive and integrated service system, managing state, federal, and local grant funds. Since 1995, the agency has served as the substance abuse authority for Baltimore City.

  - Primary evidence-based practice: Medication-assisted treatment

- *Homeward Bound, Dallas*. Homeward Bound is one of the largest nonprofit substance abuse and mental health treatment agencies in Texas. It operates a 120-bed treatment facility as well as outpatient services, serving some 6,000 patients annually.

  - *Primary evidence-based practice:* Medication-assisted treatment

- *Prestera Center for Mental Health Services, West Virginia.* Prestera is a nonprofit organization providing behavioral health services at more than 50 locations in an eight-county area of the state. Prestera offers a continuum of care ranging from outpatient services to 24-hour emergency care and residential substance abuse treatment.

  - Primary evidence-based practice: Medication-assisted treatment

See Appendix 3 for grant details.

Technical Assistance

NIATx and TRI staff collaborated to provide technical assistance to the 12 partnerships in the following areas:

- **Coaching.** While coaching is a critical element of any NIATx initiative, *Advancing Recovery* was unique in assigning a state coach and a provider coach to each partnership. Paired coaches worked together to coordinate activities between state officials and the provider agency leaders, in many cases transforming previously adversarial relationships into more cooperative ones.

- **Learning Sessions.** Between November 2006 and January 2010, the national program office hosted seven learning sessions. These were attended by members from

the state and provider agencies for each partnership as well as a variety of guest presenters, members of the national advisory committee, and clinical experts. Attendance ranged from 125 to 225 people per session, depending upon whether cohorts I and II were overlapping.[9]

- **Interest Circle Calls.** The 12 partnerships participated in some 135 interest circle calls. Typically four conference calls were held per month, one for each of the following topics: (1) medication-assisted treatment policy, and/or reimbursement strategies; (2) evidence-based continuing care/wraparound service strategies; (3) NIATx process-improvement strategies; and (4) state government leadership.

OVERALL PROGRAM RESULTS

Overall Results

In a report to RWJF, NIATx staff reported the following:

- ***Advancing Recovery's*** **"human impact" was significant.** Some 10,000 patients with substance use disorders and addictions accessed evidence-based treatments and services that were not available prior to *Advancing Recovery*.
  - 5,505 patients received medication-assisted treatment for drug or alcohol addiction. Most of these patients had no access to these medications prior to *Advancing Recovery*.
  - 2,588 patients transferred from higher-cost in-patient, to lower-cost out-patient programs.
  - 2,106 patients enrolled in outpatient continuing care programs, receiving telephone follow-up, case management, and other support services that either had not existed or were not fully developed prior to 2006.
  - For 1,956 patients the wait time between discharge from an inpatient detoxification program to ongoing treatment decreased by at least 75 percent.
  - 2,324 patients receiving ongoing continuing care/wraparound services stayed in treatment longer than they would have prior to *Advancing Recovery*.
- **The *Five Levers of Change,* a model for implementing large-systems change in complex health care environments, emerged from the work of the 12 partnerships.** The framework evolved from observing how Round I partnerships approached their challenges and barriers and then deducing what was common to their strategies for addressing them.

[9] Sessions were held in Philadelphia (November 14–15, 2006); San Antonio (April 23, 2007); Bethesda, MD (November 8–9, 2007); Atlanta (April 23–24, 2008); Chicago (October 15–16, 2008); Tucson, AZ. (July 29, 2009); and Washington (January 14–15, 2010).

Round II partnerships were required to select two levers to assess their state's challenges and then concentrate their change efforts in those areas. In all cases, the states and their provider partners had to employ the levers within the context of the NIATx model with its emphasis on rapid-cycle change and meeting the needs of consumers.

The five levers[10] and examples of how they were utilized are:

— ***Financial lever***. How much will it cost and how will we pay for it?

- Florida reallocated funds from the state's indigent drug program to purchase Vivitrol®, a long-acting injectable form of naltrexone, used to treat alcohol abuse.

— ***Regulatory lever.*** What barriers exist in regulations to prevent implementation and spread of evidence-based practices?

- Baltimore partners worked with providers on a new Medicaid subcommittee to draft regulations for buprenorphine treatment. The partnership also joined a state legislative substance abuse workgroup to plan the delivery of substance abuse services for the state.
- In West Virginia, partners negotiated with the state Office of Health Facility Licensure and Certification to change stringent data requirements. Reduced paperwork requirements allowed clinicians more time to engage clients in medication-assisted treatment.

— ***Internal operations lever.*** How can an organization change internal processes to promote evidence-based practices?

- Delaware changed state licensing regulations to support telephone-based continuing care services.
- Rhode Island defined "continuing care" in regulatory and policy language and developed contracting and purchasing plans to support it.

— ***Inter-organizational capability lever.*** What organizations should be working together to achieve the desired outcomes?

- In Maine, the Office of Substance Abuse worked with the state Medical Association to increase the number of physicians certified to prescribe buprenorphine.

— ***Purchasing and contracting lever.*** How does an organization buy or contract for services? What are the incentives for purchasing?

[10] *Advancing Recovery and the Five Levers of Change.* In NIATx System-Level Toolkit, 2010. Available online.

- Baltimore found that many providers did not have the capacity to bill Medicaid managed care organizations for substance abuse services. The partnership hired a consultant to build provider capacity to bill Medicaid.

- **Seven *Advancing Recovery* partnerships contributed to a medication-assisted treatment toolkit, *Getting Started With Medication-Assisted Treatment.***[11] Providers in Baltimore, Colorado, Florida, Maine, Missouri, Texas, and West Virginia contributed case studies from their projects, sharing lessons about establishing a medication-assisted treatment program. Some of the topics and case studies include:

  — ***Making the business case***. Providers demonstrated that medication-assisted treatment can both lower costs and improve client outcomes. For example, a Maine treatment agency found that, after adding an in-house physician certified to prescribe buprenorphine, 85 percent of patients engaged in treatment compared to 25 percent who engaged before the physician joined the staff.

  — ***Securing buy-in from staff and board.*** West Virginia's Prestera Center demonstrated the value of providing both outcome data from programs around the country and personal stories to convince its board of the benefits of medication-assisted treatment.

  — ***Paying for the program.*** Grantee organizations shared strategies for covering the costs of medications, such as Vivitrol and Suboxone™, through Medicaid, block grants, partnering with health centers that receive discounted rates on medications and enrolling clients in state or pharmaceutical company patient assistance programs.

  — ***Finding prescribers.*** *Advancing Recovery* partners recommended multiple strategies to expand both in-house medical resources and referral relationships with community physicians. These included involving the patient's physician, partnering with primary care providers and federally qualified health centers, and asking medical societies and pharmaceutical companies to help.

    Baltimore Buprenorphine Initiative offers a study of how building support from stakeholders increased the supply of physician prescribers. Project leaders requested that the mayor and legislators reach out to every major hospital in the city, asking each to provide buprenorphine treatment. Team members themselves contacted hospital presidents and directors of the city's federally qualified health centers for support.

    These investments in leadership from multiple spheres helped increased the number of slots for buprenorphine treatment from 112 in 2008 to 506 in 2009.

[11] Clark L, Haram E, Johnson K and Molfenter T. *Getting Started With Medication Assisted Treatment.* University of Wisconsin–Madison, 2010. Available online.

- — ***Sustaining the program.*** Providers recommended sharing outcomes and client recovery stories through a public celebration or special event. This visibility helps keep a provider team motivated and educates others about the value of medication-assisted treatment.

- ***Advancing Recovery* partnerships both informed and had a direct impact on public policy in their states.** The national program office reported that 10 of the 12 participating states incorporated changes to administrative rules, statutes, formulary changes, financing/reimbursement/contracting strategies, or related licensure topics.

  - — Maine and Missouri were particularly successful in securing state funds and amending contracts that allowed medication-assisted treatment to flourish statewide.

Conclusions

NIATx staff concluded that *Advancing Recovery* challenged conventional wisdom about the ability of slow-moving state bureaucracies to adapt to change. In a report to RWJF, staff observed that *Advancing Recovery* demonstrates that "rapid change can be implemented at large-systems levels—including state governments—to improve the quality and accessibility of addiction treatment."

The keys to success are:

- **Having strong executive sponsorship strategically placed in a position that can advocate for and affect change.** Overall, coalitions led by the single state agency performed better than those led by a provider agency. These states had already embraced the concepts of process improvement and were prepared to allocate resources for evidence-based practices. State agencies also have the capacity to convene multiple, sometimes competing, stakeholders

- **Educating stakeholders at every level about the clinical and financial merits of evidence-based practices.** Stakeholders include state government officials, provider agencies, administrators, clinicians, advocacy organizations, patients, and their families.

- **Forming collaborative, synergistic, and transparent partnerships among all these groups to identify and remove change barriers.**

For more results of Advancing *Recovery*, see the Key Site Results and the Evaluation and its Findings sections.

Key Site Results

The efforts of six *Advancing Recovery* partnerships to implement medication-assisted treatment and continuing care—the two most frequently selected evidence-based practices—are described in this section.

Medication-Assisted Treatment

Advancing Recovery in Maine

The Maine Office of Substance Abuse (OSA), the single state agency, led a coalition that tackled the state's fastest growing drug problem—opioid addiction—by spreading the use of medication-assisted treatment throughout the state.

According to SAMHSA's National *Survey on Drug Use and Health,*[12] Maine had the third highest unmet treatment need for drug dependent people ages 18–25 in 2006 and the fourth highest unmet treatment need for drug dependent adolescents.

Although Maine had opened five methadone treatment programs since 2000, the demand for treatment continued to exceed availability. Rather than adding more methadone programs, which require daily trips to a clinic, the state Office of Substance Abuse decided to work with treatment providers and primary care physicians to increase the availability of buprenorphine (marketed as Suboxone) for opiate addiction and new medications, such as Vivitrol, for alcohol addiction.

Ten substance abuse treatment providers partnered with the single state agency to implement medication-assisted treatment in their programs. Five pilot sites participated from the beginning of the *Advancing Recovery* in October 2006. Five others joined in the spring of 2009. Some had a history of providing medication-assisted treatment, but others had no experience prior to the project.

The Maine Office of Substance Abuse cited the following results in a 2010 report to RWJF:

- **Within the primary care system, the number of patients receiving buprenorphine increased from 3,051 in 2006 to 8,025 in 2009.** Although the increase may reflect other factors, such as growth in the number of people needing treatment, the Office of Substance Abuse concludes "the data do suggest that the use of the evidence-based practice spread significantly throughout Maine during participation in this grant."
- **The Maine legislature appropriated $500,000 in 2007 and $600,000 annually thereafter to be used to purchase medication and support implementation of medication-assisted treatment.** These funds expanded access to non-methadone maintenance medications and were designated to cover the cost of medications for clients without coverage for medication-assisted treatment. The state agency also allocated a portion of these funds to expand technical assistance, training, and support for the implementation of medication-assisted treatment statewide.

[12] Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *Results from the 2006 National Survey on Drug Use and Health: National Findings*. NSDUH Series H-32, DHHS Publication No. SMA 07-4293. Rockville, MD, 2007. Available online.

- **Other collaborators helped spread medication-assisted treatment statewide.** The Maine Association of Substance Abuse Providers provided technical assistance. A grassroots advocacy organization, the Maine Alliance for Addiction Recovery, held events to promote increased acceptance of medication-assisted treatment.

The Office of Substance Abuse hired an external evaluator, Hornsby Zeller Associates, to determine the impact of *Advancing Recovery* on the delivery of medication-assisted treatment in Maine. The evaluators interviewed providers and consumers at *Advancing Recovery* pilot agencies and reviewed administrative data maintained by the state agency. Their report, *Evaluation of the Impact of Medication Assisted Treatment in Maine*,[13] presents the following key findings and recommendations:

- **The number of individuals receiving medication-assisted treatment increased.** Between 2007 and 2009, the proportion of individuals receiving medication-assisted treatment at the five *Advancing Recovery* pilot agencies increased from 8 percent to 21 percent. Statewide the use of medication-assisted treatment increased from 9 percent to 16 percent.
- **Consumers and providers supported the use of medication-assisted treatment, but stressed the importance of receiving behavioral health services as well.**
  - Support for medication-assisted treatment among consumers was "almost universal," according to the report, but most clients also highlighted the importance of receiving behavioral health treatment in conjunction with medication.
  - Providers, both individuals and agencies, supported the use of medication-assisted treatment as a "tool" enabling clients to engage in other therapeutic interventions, but noted it is not the only component needed.
  - Providers differed significantly in their treatment philosophy. Some agencies offering a medication-assisted treatment program believed it was strictly a "harm-reduction practice" while others saw it as part of a long-term abstinence expectation.
  - The majority of medical providers questioned whether free-standing physicians not connected with a behavioral health agency should deliver medication-assisted treatment.
- **Practices varied.** Providers varied in their choice of treatment regimens, dosage levels, and knowledge of best practices. All agencies agreed that buprenorphine was not a "crisis stabilization" tool.
- **Demand for buprenorphine outpaced the availability of physicians to prescribe it.** Many agencies maintained waiting lists. Providers and clients agreed that difficulty

[13] McAuley K, Maurice D, Ferguson A and Hornby H. *Evaluation of the Impact of Medication Assisted Treatment in Maine.* Maine Office of Substance Abuse, March 2010. Available online.

finding providers was the most significant barrier to care, followed by transportation and lack of insurance.

- **Clients preferred buprenorphine over methadone.** Methadone's unpleasant side effects, as well as the need to make a daily commitment to obtaining the medication from a clinic, were reasons why clients preferred buprenorphine.
- **Clients who received medication-assisted treatment in conjunction with behavioral health treatment remained in treatment longer than those who received behavioral health treatment alone.**

The evaluators recommended that the Maine Office of Substance Abuse:

- **Disseminate "best practices" to establish greater consistency in delivery of medication-assisted treatment.** SAMHSA's Treatment Improvement Protocol (TIP) for the use of buprenorphine in opioid addiction treatment should be the "building block" for the development of best practices.[14]
- **Develop formal training opportunities for individuals and agencies seeking to learn about or provide medication-assisted treatment.**
- **Increase the number of prescribers.** The state should "incentivize the waiver" process, perhaps with grant funding, to increase the number of Maine doctors able to prescribe buprenorphine. The state should also work to connect existing free-standing prescribers with agencies that provide behavioral health services.

Advancing Recovery in Missouri

In Missouri, the Division of Alcohol and Drug Abuse and 10 treatment agency partners worked to reduce barriers to the use of medication-assisted treatment for patients with alcoholism. Client data for 2005 showed that, for nine of the 10 partners, alcohol was the drug most frequently used and abused by adults. None of the partners had used medication-assisted treatment for alcoholism before, although most were interested in trying it.

The goal was to increase the use of two medications approved for the treatment of moderate-to-severe alcoholism, naltrexone and acamprosate. These are called anti-craving drugs because they reduce the intoxicating efforts of alcohol and the urge to drink.

[14] Center for Substance Abuse Treatment. *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction.* Treatment Improvement Protocol (TIP) Series 40. DHHS Publication No. (SMA) 04-3939. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004. Available online.

The Missouri Division of Alcohol and Drug Abuse reported the following results in a report to RWJF:

- **By October 2008, 299 patients received one or more prescriptions of medications (naltrexone or acamprosate) to support recovery.** In 2005, when the project began, no consumers served by the partner agencies were receiving medication-assisted treatment to treat their alcoholism.
- **The Division of Alcohol and Drug Abuse amended provider contracts to reimburse agencies for the services of physicians and advanced practice nurses who assessed clients and prescribed medications.**
- **The Division of Alcohol and Drug Abuse developed an agreement with the Department of Corrections, which provided $500,000 to purchase medications for corrections-referred clients on probation and parole.**

For more on this project, see the sidebar on *Advancing Recovery* in Missouri.

Advancing Recovery in West Virginia

Overcoming barriers to the use of medication-assisted treatment was a priority in West Virginia, as it was in Maine. Nearly one out of five West Virginians in substance abuse treatment used opioids like OxyContin® and Percocet®, which have become the drugs of choice in the state. West Virginia had the fastest growing rate of opioid dependence in the country, according to *Advancing Recovery* Project Director Bob Hansen.

Hansen is executive director of the Prestera Center for Mental Health Services, lead agency for *Advancing Recovery*. The Prestera Addiction Recovery Centers, known as PARC, provide a full continuum of outpatient and residential services. Three other behavioral health agencies participated in *Advancing Recovery*. Together, the four agencies provide substance abuse services to more than 40 percent of West Virginia's 55 counties and to 49 percent of the population of the state.[15]

The West Virginia partners reported the following accomplishments in a report to RWJF:

- **By the end of the project period, the four providers served some 627 clients.**
  - At the start of *Advancing Recovery*, only two of the partner providers were providing medication-assisted treatment. A year later all four agencies had these programs, prescribing buprenorphine to 259 individuals, greater than a 100 percent increase over baseline.
  - The providers decreased wait time for medication-assisted treatment from an average of 34 days to seven days. Prestera implemented open access or 24-hour

[15] Clark L, Haram E, Johnson K and Molfenter T. *Getting Started With Medication-Assisted Treatment*. Madison, WI: NIATx, 2010.

access for all new admissions at two of its three medication-assisted treatment locations.

- **Medication-Assisted Recovery Support (MARS) groups spread throughout the state.** The groups were the first that catered to medication-assisted treatment clients, who often did not feel welcome in traditional 12-step support programs where using buprenorphine was considered replacing one drug with another. At the end of year two, there were 14 MARS groups up and running throughout the state and staff reported some 20 groups operating by 2010.
- **The provider-led West Virginia partnership failed to gain the full support of the state.** "Although state representatives participated in *Advancing Recovery*, the state may not have realized it had to do heavy lifting to support innovation," according to NIATx Coach Colette Croze. Multiple leadership transitions complicated matters further.
- **Strong relationships among partners prompted state action.** In September 2009, the state licensing bureau ordered Prestera to cease and desist providing office-based medication-assisted treatment, but concerted efforts by providers, NIATx coaches, and national program office and SAMHSA staff finally convinced the state to rescind its order.

For more on this project, see the sidebar on *Advancing Recovery* in West Virginia.

Continuing Care

Advancing Recovery in Alabama

In Alabama, the state Substance Abuse Services Division joined with two providers of residential treatment for adolescents and an outpatient provider to pilot-test strategies for implementing continuing care.

Together, the partners provide all of the publicly funded residential substance abuse treatment for adolescents in the state and approximately 65 percent of its publicly funded outpatient services. They chose continuing care management with the goal of reducing the high relapse rate among adolescents referred to outpatient programs after discharge from residential treatment.

Tammy Peacock, PhD, project director and coordinator of adolescent services for the Substance Abuse Services Division, reported the following results to the RWJF:

- **Over the two-year grant period, 365 youth received a referral from residential to continuing care (218 in year one and 147 in year two).** More than half (58%) successfully transitioned into continuing care (119 in year one and 93 in year two).

- Under the new system, making an appointment with continuing care providers became an integral part of the discharge planning process from residential treatment.
- "Teens and their families knew they would be followed by a continuing care provider and receive the support they need to maintain a recovery mindset during the stressful transition period," according to Peacock.
- By the end of the first year all of the pilot sites offered a continuing care option which was considerably less time intensive than the existing intensive outpatient program. Of the 119 youth who were admitted to continuing care, 70 were admitted to intensive outpatient and 54 were admitted to a continuing care group or other services specifically tailored to their needs.

- **Substance Abuse Services Division staff established linkages to other state agencies and stakeholders who also serve substance-using adolescents.** Among these were the Department of Youth Services and the Administrative Office of Courts (which operates juvenile drug courts), school systems, and juvenile judges. According to Peacock, "the first step in creating systems change is building relationships," so these efforts supported the goal of spreading evidence-based practices statewide.

For more on Alabama's *Advancing Recovery* project, see the sidebar.

Arkansas *Advancing Recovery* Partnership

The Arkansas *Advancing Recovery* partnership aimed to change the state's treatment approach from an acute-care treatment model to a more comprehensive, recovery-oriented model by developing a continuing care program for clients who completed treatment.

The lead agency was the Arkansas Office of Alcohol and Drug Abuse Prevention. This single state agency collaborated with two other state agencies: Department of Community Corrections, and the Department of Human Services, Office of Policy and Planning.

Four providers participated: Decision Point (Bentonville), Quapaw House (Hot Springs), Health Resources of Arkansas, and Recovery Centers of Arkansas (Little Rock). The partners worked with faith-based groups and recovery groups to support clients in continuing care programs. The church-based Delta Ministerial Alliance assisted clients with housing, employment security, mental health, and other needs.

The state contracted with the regional Addiction Technology Transfer Center (Mid-America ATTC) at the University of Missouri–Kansas City for technical assistance related to implementing this evidence-based practice. Mid-America ATTC also assisted with data collection, management, and reporting.

The Arkansas partnership noted the following results in a presentation at the January 2010 *Advancing Recovery* learning session in Washington:

- **From August 2008 to November 2009 the four providers linked 234 people (16% of eligible clients) to continuing care services:**
  - Average duration of services was 4.9 months (147 days).
  - The team concluded that introducing clients to continuing care groups before discharge contributed to gains in admissions to continuing care. These early engagements efforts made clients aware early in the treatment process of the benefits of participating in continuing care upon discharge.
  - Arkansas' continuing care model is based on the work of James McKay, PhD, who provided a half-day videoconference and a two-day onsite training workshop to partnership members, followed by six months of group and individual clinical supervision. Mid-America ATTC staff revised staff and client treatment manuals specifically for Arkansas.
- **From April 2009 when the providers began offering case management services through November 2009, they served 325 outpatient and residential treatment clients.** As of January 10, 2010, 239 clients had been discharged.
  - Clients received 4,233 units of case management services (an average of 13.06 units per client, with a range of 1 to 493 units).
- **The state amended provider contracts to allow providers to bill for both continuing care and case management services.** The partners also developed unit costs, client eligibility criteria, and required education level for staff providing both types of service.
- **The state allowed funding for one residential treatment slot to be converted into one continuing care slot and one case management slot.**
  - One residential slot costs $75/day plus a $200 assessment fee for a total value of $27,000 per year. This amount was converted to continuing care units at $10 per 15 minutes for each of the four providers, who can convert it back to a treatment slot at the end of the year if they do not use all the funding.

The Partnership for Advancing Recovery in Kentucky (PARK)

The Partnership for Advancing Recovery in Kentucky (PARK) aimed to improve continuity of care and decrease dropout rates between levels of care through a statewide system that emphasized community linkages and collaborative planning. PARK partners included the Division of Behavioral Health in the Kentucky Department of Behavioral Health, Developmental and Intellectual Disabilities (the single state agency), a regional hospital healthcare system, a regional community mental health system, and a residential substance abuse program for women.

The lead agency for *Advancing Recovery* was Kentucky River Community Care, a comprehensive mental health center that operates 45 sites in eight counties, providing mental health, substance abuse, and trauma services. The agency was also a *Paths to Recovery* grantee.

Other PARK providers were Chrysalis House, a drug and alcohol treatment facility for women and their children, and Appalachian Regional Hospital Psychiatric Center, a regional hospital serving 350,000 residents across eastern Kentucky and southern West Virginia.

At the start of the project, the psychiatric center was experiencing record admissions of clients with both mental health and substance abuse problems. Upon discharge from the psychiatric center, patients were referred to Kentucky River for outpatient services, but that agency had difficulty engaging the dually diagnosed patients. An average of 26 percent were being readmitted to the hospital within 30 days.

To address this problem, PARK chose to implement continuing care in year one of *Advancing Recovery*, supplemented by wraparound/case management services in year two. Staff believed that providing case management services would increase the likelihood that patients would remain engaged in continuing care after discharge. The partners worked with the Center for Research and Data Management at the University of Kentucky to design a data system to track clients who completed four outpatient (continuing care) treatment units after referral from their partner hospital.

PARK cited the following results in a report to the RWJF:

- **A variety of engagement strategies increased clients' participation in continuing care.** These included:
  - A video describing "Your First Visit with Kentucky River Community Care, Inc." that hospital case managers could show to patients prior to discharge.
  - A robo-call system to remind clients of upcoming appointments.
  - Internet-based client-tracking software to share client information from one level of care to the next.
  - Gift bags and appointment card refrigerator magnets to highlight next appointments.
  - A "Recovery Roadmap" poster for use in hospital and other treatment settings showing paths and decision points in the recovery process.
  - Focus groups to understand consumer perspectives and engage consumers as recovery advocates for their peers.

- **Continuity of care increased for dually diagnosed patients referred from the regional psychiatric hospital to Kentucky River.** The PARK team reported that the percentage of patients who kept their outpatient appointments increased from less than 30 percent at baseline (October 2007) to 50 percent (September 2008).
- **Some 255 clients received wraparound services in year two.** The team reported that staff contacted some 20 to 50 clients each month before discharge to explain the benefits of continuing care.
  - PARK created the Kentucky Resource Guide for Referrals. The guide includes a searchable database that providers and consumers can use to locate treatment and support services by county throughout the state.

EVALUATION AND ITS FINDINGS

Findings From the *Advancing Recovery* Evaluation

Research teams from the Department of Public Health and Preventive Medicine, Oregon Health and Science University and the Center for Research on Behavioral Health and Human Services Delivery at the University of Georgia, collaborated on the evaluation of Advancing *Recovery*. Dennis McCarty, PhD, Oregon Health and Science University; and Paul Roman, PhD, University of Georgia, co-directed the evaluation.

In general, Oregon Health and Science University took the lead on collecting data from single state agencies, while the University of Georgia took the lead on collecting data from treatment providers.

The researchers explored three questions to assess the success of *Advancing Recovery* partnerships in promoting the spread of evidence-based practices for substance abuse treatment:

- What system-level factors are associated with successful or unsuccessful (limited, temporary or failed) implementation of evidence-based practices (EBPs)?
- How do provider-level factors impact implementation (e.g., program-level resources; staff resistance, client needs).
- Are evidence-based practices sustained over time? What factors (particularly staff turnover at state and provider levels) affect "sustainability and spread of EBPs?"

The evaluators integrated data collected from representatives of single state agencies, leadership and staff of addiction treatment organizations, and NIATx coaches. Data sources included staff surveys, telephone interviews, agency databases, and focus group feedback.

The evaluators conducted follow-up telephone interviews with all providers, coaches, and state partners after they had implemented their first evidence-based practice. The interviews focused on implementation and barriers to the adoption of the practice, identification of systems changes, and plans for the implementation of the second evidence-based practice.

Evaluators also conducted site visits to collect data and meet with key constituents. They held focus groups with staff involved in implementing strategies in each state-provider partnership to track changes in attitudes and practices over time.

McCarty and the Oregon team reported findings in a 2010 report to RWJF.[16]

- **Collaborations with organizations outside the *Advancing Recovery* partnerships helped to spread the use of evidence-based practices.** Collaborators included state health departments, state pharmacies, pharmaceutical manufacturers, community health centers, faith-based organizations, judges, juvenile courts, Medicaid, Addiction Technology Transfer Centers, departments of corrections, housing and labor authorities, state legislators, and recovery-advocacy programs.
- **Implementation strategies included forming workgroups, forums, and focus groups.** Workgroups were used to revise state licensure requirements and to develop provider guidelines and for contract changes to facilitate implementation. Prescriber forums were used to address stigma and to promote physician recruitment. Focus groups were used to address stigma about medication with clients and their families, and the use of recovery coaches.
- **Medication-assisted treatment was the most common evidence-based practice selected for implementation.** Eight sites implemented medication-assisted treatment. Six chose it as their primary evidence-based practice (Florida, Maine, Baltimore, Missouri, Dallas, and West Virginia). Colorado and Rhode Island chose it as a secondary evidence-based practice.
    - States that implemented medication-assisted treatment saw steady increases in admissions to treatment. Many partnerships saw increased lengths of stay in treatment for patients receiving medication-assisted treatment compared with patients who did not receive it. Some partnerships reported higher employment success rates for patients who received medication-assisted treatment after discharge.
    - Some partnerships that realized initial reductions in monthly drinking days reported by clients using extended-release naltrexone (e.g., Vivitrol) for the treatment of alcohol dependency also saw patients discontinuing medication usually after the third injection.

[16] Croff R, Rieckmann T, Kinneman JS, et al. "Advancing Recovery: A Robert Wood Johnson Foundation Program to Implement Evidence-Based Practices in Addiction Treatment," 2010. Unpublished.

- **Continuing care was the second-most common evidence-based practice, selected by seven sites.** For Alabama, Arkansas, Kentucky and Rhode Island, continuing care was the primary practice selected; for Baltimore, Colorado, and Delaware it was the secondary practice.
  - Partnerships that implemented continuing care experienced increased admissions and retention, and decreased readmission rates and reduced days between residential discharge and outpatient admissions.
- **Three state partnerships (Alabama, Arkansas, and Florida) selected case management and two (Delaware and Kentucky) chose wraparound services.**
  - States that focused on wraparound support saw increases in the average number of clients receiving services as well as increased retention in treatment.
  - States that implemented case management services found clients engaged more intensely in the treatment process and in the recovery community.
- **Two partnerships (Missouri and Texas) selected motivational interviewing**.
  - States that implemented both motivational interviewing and medication-assisted treatment found that the two practices complemented one another, with motivational interviewing enhancing patients' engagement in medication-assisted treatment, especially if introduced early in the treatment process.
- **Many partnerships reported and took steps to address budgetary constraints.** Financial strategies included reallocating existing funds and reorganizing treatment slots to compensate for limited funds.
  - Some partnerships negotiated with state pharmacies and large pharmaceutical companies to purchase medications at reduced cost.
  - Partnerships worked with their Medicaid agencies on expanding benefits, and submitted budget requests to legislature.
  - Many states that implemented medication-assisted treatment reported barriers due to insufficient funds to pay physicians for their services.

Communications Results

The national program office created a website (*www.advancingrecovery.net*) to allow partnerships to communicate among each other and to disseminate information to a national audience. The site includes an overview of the program, listing of the 12 grantees, and information on their five evidence-based categories. A members-only section (maintained during the active grant period for the projects) allowed grantees to access notes from learning sessions and post-project reports.

The NIATx website (*www.niatx.net*) is an online learning community that disseminates the NIATx improvement model to the nation's treatment providers and payers. The Resource Center includes a System-Level Toolkit training materials and evaluation tools related to *Advancing Recovery* and other state-provider programs.

National program office staff produced and disseminated the *Advancing Recovery* toolkit and primers to help state-provider partnerships across the country implement evidence-based practices. These include *Getting Started with Medication-Assisted Treatment,* which contains lessons from *Advancing Recovery* (available online); *Advancing Recovery Model for Whole Systems Change* (available online, scroll down to it on the right-hand margin); and *Advancing Recovery and the Five Levers of Change* (available online; scroll down to it on right-hand margin).

National program and site staff presented at several conferences and meetings, especially regarding the use of medication-assisted treatment.

See the Bibliography for additional information about communications activities.

SIGNIFICANCE OF THE PROGRAM

For National Program Director Gustafson, the significance of *Advancing Recovery* was its "transformation of the relationship between single state agencies and treatment providers. States and providers normally see themselves as the regulators and the regulated, as adversaries rather than partners. *Advancing Recovery* resulted in a closer relationship between providers and state agencies, which set the stage for a greater awareness of the need for evidence-based practices."

Advancing Recovery also fostered closer connections and communication among the providers themselves. "The addiction treatment field is isolated more than other fields," notes Gustafson, "possibly because of ideological differences in treatment approach. *Advancing Recovery* helped overcome that lack of relationship too."

LESSONS LEARNED

National program office staff reported several challenges in *Advancing Recovery* and lessons emerging from the challenges.

Challenges

- **Broad resistance to medication-assisted treatment.** Many states that chose to implement this practice had to overcome resistance from clinicians, consumers, and the public. The lack of certified physicians was a barrier, as was the perception among consumers that treatment with medications such as Suboxone was substituting one drug for another.

- **The downturn in the U.S. economy**. The recession of 2008 and tight state budgets made states reluctant to devote resources to implementing evidence-based practices, especially if they required hiring or training staff. A major financial challenge for states implementing medication-assisted treatment was obtaining medications for young single adult males, who are usually not eligible for Medicaid but are the biggest users of opiates, such as OxyContin.
- **Data collection and tracking systems.** Many agencies had only rudimentary systems for collecting and tracking client information and outcome data. The *Advancing Recovery* grants did not have sufficient funds to reimburse agencies for the cost of staff time and training devoted to data collection.
- **Slow pace of change within state bureaucracies.** State bureaucracies can be notoriously slow in adapting to major change due to lack of coordination among competing state agencies, regulatory challenges, and funding barriers. Applying the NIATx change model within state bureaucracies proved more difficult than it had been within individual agencies. National program office staff regarded the two-year timeframe for spreading evidence-based practices across entire states as too short.
- **Political turmoil and turnover at the state level.** Changes among governors or other state officials caused uncertainty and delays in many cases. In Kentucky, the election of a new governor left project staff in limbo as they waited to see who would be appointed to key positions. Maine experienced delays when staff unfamiliar with *Advancing Recovery* took over following the resignation of the single state agency director.

Lessons From Staff at the National Program Office and RWJF

1. **When partnerships involve state bureaucracies, allow plenty of time to implement evidence-based practices.** Requiring partnerships to implement two evidence-based practices within the two-year timeframe may have been overly ambitious. Instead, they should have been allowed to concentrate on one at a time, adding a second only if time and resources permitted. (Deputy Director/Molfenter)
2. **Make sure your stakeholders are willing to advocate for new treatment models.** Medication-assisted treatment in particular challenged pre-existing treatment paradigms, such as 12-step programs, that view use of medications as another form of drug dependence. Project champions had to be prepared to defend the use of medications to hostile providers, the public, and the press. (Deputy Director/ Molfenter)
3. **Recognize that there is no one model for system change.** The *Five Levers of Change* were useful because they were not a rigid formula for change. Instead, they provided states with general principles for system change that they could apply to their state's unique circumstances. (Program Associate/Pomphrey)

4. **Use national summits to create connections among a wide range of organizations interested in policy change.** The national program office held national summits in partnership with SAAS (State Associations of Addiction Services) in an effort to engage as many providers nationwide as possible and foster a national movement. The summits provide a good example of how the national program office reached out to other organizations. The first summit in 2007 gave providers a sense of being part of a movement, as well as the momentum to keep going. (Program Associate/Pomphrey)

5. **Build state-provider trust relationships before trying to implement rapid cycle change such as the Plan-Do-Study-Act model.** *Advancing Recovery* was never intended as a simple state replication of change strategies that worked in individual treatment agencies, according to RWJF Program Officer Capoccia and *Advancing Recovery* Program Director Gustafson. Gustafson noted, "Processes that cross organizational boundaries, such as interagency agreement, financing, policy, and regulations, had to be addressed before the Plan-Do-Study-Act model could be applied."

Lessons From the State-Provider Partnerships About How to Implement Evidence-Based Practices

6. **Involve multiple levels of management and front-line staff in the change process.** The Arkansas partnership developed change teams on multiple levels to help integrate evidence-based practices into routine clinical practice. This comprehensive approach avoided the need to repeat costly and time-intensive training when staff turnover occurred. (Arkansas *Advancing Recovery* Partnership)

7. **Use NIATx tools to react quickly when problems occur.** Walkthroughs can help to pinpoint problems in service delivery and the results can be turned into the focus of a Plan-Do-Study-Act cycle. (Arkansas *Advancing Recovery* Partnership)

8. **Initiate open conversations about change, even if the effort to change state bureaucracy is ultimately not successful.** In-home counseling was an example of a state level change that providers really wanted, but that never came to fruition, notes Jeremy Blair of The Bridge in Alabama. However, he adds that "just being able to ask questions, not accept the status quo, and engage in discussions was helpful."

9. **Use walkthroughs to enlighten both state officials and providers.** In Alabama, the state walkthrough focused on the hypothetical experience of a new provider interested in becoming a certified treatment agency. The state agency team member saw how simple things like confusing signage complicated the process for providers. The state responded by posting information on its website to make the process more explicit. (Missouri/Mark Stringer, Division of Alcohol and Drug Abuse; Alabama/Jeremy Blair, The Bridge)

10. **Take steps to boost morale**. Boosting morale can be as valuable as providing technical assistance. Kay Murphy-Collins appreciated that Missouri's coaches were

also "cheerleaders," especially at times when we were asking ourselves, 'Why are we doing this?'" Similarly, Alabama's coaches helped providers "refocus" and move forward after negotiations with the state to reimburse for in-home services fell through. (Missouri/Murphy–Collins; Alabama/Blair and Gwen LeBlanc)

Lessons From NIATx Coaches

11. **State officials need to understand and accept their lead role in coalitions to spread evidence-based practices statewide.** In West Virginia, the single state agency was part of the coalition but did not understand that it had to do "heavy lifting" when it came to financing for medications, according to Coach Colette Croze. The state did not grasp that system improvements had to occur at the state as well as provider level, according to Croze.

12. **Don't let the perfect get in the way of the good when asking states for financial support for medication-assisted treatment and other evidence-based practices.** In West Virginia, providers had hoped for "braided" funding for substance abuse treatment, with Medicaid covering the costs of medications for uninsured low-income adults. They designed a clinical service protocol that was far in excess of what was feasible under Medicaid and had to settle for a more modest package. (Coach Croze)

13. **Stay focused on your original aim for system change.** West Virginia Coach Eric Haram notes that many agencies "get stuck" when they "talk themselves out" of their original idea during change-team meetings. Haram recommends having a "parking lot" for new ideas that can be addressed later, allowing the team to remain focused on their objective.

Lessons from the Evaluators

14. **Align evidence-based practices when trying to implement more than one at a time.** After observing how Round I grantees struggled to implement two evidence-based practices, the national program office urged Round II grantees to make them "synergistic, rather than competitive," according to *Advancing Recovery* evaluator Dennis McCarty. For example, Missouri used motivational interviewing to help retain clients in medication-assisted treatment.

AFTERWARD

A National Resource Center

In addition, RWJF provided a final grant[17] for NIATx to develop a sustainable national resource center on quality in addiction treatment that would provide process and system-improvement services for the addiction treatment field. This represented a 'capstone'

[17] Grant ID# 59714

investment by RWJF as it moved away from funding in alcohol and drug prevention and treatment.

Prior to the NIATx Resource Center, no national resource existed for community-based addiction treatment centers to access products, services, and Web resources to improve organizational performance. Program Director Gustafson wrote, "The focus of the resource center is to assure no individual should have to suffer twice—once due to disease and another due to poorly designed treatment and recovery systems. To achieve this aim, the center's initiatives often focus simultaneously on three goals: to improve clinical care, service quality, and an organization's financial standing."

The resource center has been sustained. The 2011 operating budget is approximately $2.5 million with a diverse set of funders that includes the National Institutes on Drug Abuse (NIDA), Open Society Foundation, Substance Abuse and Mental Health Administration (SAMHSA), Veteran Affairs Administration, several state governments, and hundreds of community-based organizations.

NIATx Activities

NIATx used lessons learned from *Advancing Recovery* and allocated some *Advancing Recovery* funds to develop its *Accelerating Reform Initiative*, which ran from December 2009 to July 2010. Some 22 organizations representing substance abuse treatment, mental health treatment, and primary health care in 12 states worked together to accelerate their reform efforts. Strategies included:

- Forming partnerships with primary care and community health centers to capitalize and improve the health care infrastructure
- Enhancing their ability to use technology to share information
- Implementing outreach and marketing strategies to reach individuals who have coverage but have not sought treatment
- Designing strategies to educate and recruit a strong substance abuse treatment workforce

NIATx also used its *Advancing Recovery* experience in systems change and building behavioral health collaboratives to design the *Wisconsin Mental Health Collaborative*. The aim of the initiative, which began in January 2010 and runs through December 2011, is to reduce inpatient readmissions in designated Wisconsin counties. It is supported by the Wisconsin Division of Mental Health and Substance Abuse, the single state agency.

According to *Advancing Recovery* deputy director Molfenter, "We've learned a lot through the addiction treatment centers about how to work with community-based organizations, particularly safety-net organizations. Using the skill set honed through

Advancing Recovery, NIATx is moving into other settings, including community health centers, centers for the aging, and local public health departments."

State-Provider Partnership Activities

State-provider partnerships have continued the statewide spread of evidence-based practices to improve addiction treatment. Examples of their ongoing activities are:

- **Alabama.** To sustain its evidence-based practices, the state mandated that provision of case management/wraparound services be incorporated into the job descriptions and annual reviews for clinicians. Residential treatment sites for adolescents in the state are required to schedule a continuing care appointment in the home environment prior to discharge from residential treatment.
- **Arkansas.** In October 2009, the state received a NIATx State Implementation technical assistance contract to assist with its sustainability plans. The award helped the state design a request-for-proposals process for contracted providers, all of whom will be required to have continuing care programs in fiscal year 2012.The NIATx contract also supported continued coaching and enabled the state to host a NIATx Change Leader Academy in Arkansas in April 2010.
- **Maine.** The Office of Substance Abuse hired a medical consultant with expertise in buprenorphine to provide onsite clinical guidance to state officials and treatment providers about medication-assisted treatment. In 2010, the consultant began hosting conference calls designed to build a supportive professional network for prescribers in Maine.

  The Office of Substance Abuse secured funding to sustain its second evidence-based practice, and wraparound and case management services to help minority and immigrant populations (Hispanic, Somali, and Sudanese) in the greater Portland area gain access to treatment services. The program, which uses community health outreach workers, expanded to other areas of the state with growing immigrant populations.
- **Missouri.** In January 2011, the Division of Alcohol and Drug Abuse made delivery of medication-assisted treatment a requirement for certification of treatment agencies. **"**If it isn't part of their service delivery continuum, they will lose their certification," according to Division Director Mark Stringer.
- **West Virginia.** In 2010, Prestera and its three *Advancing Recovery* provider partners invited three additional agencies to join their coalition. The addition of the new members meant that *Advancing Recovery*'s reach had extended to more than half of the state's 13 addiction treatment programs. The new partners attended a "Performance Improvement 101" workshop facilitated by the NIATx coach.

  As of December 2010, only one of the new members continued to provide buprenorphine treatment. "While the others didn't sustain a medication-assisted

treatment program, they were introduced to NIATx principals and are applying NIATx tools, including walkthroughs, within their organizations. We planted a seed," says Prestera's director of addiction services, Genise Lalos.

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Program Officers: Victor Capoccia, Jane Lowe and Ann Pomphrey

Grant ID#: SDI

Program area: Vulnerable Populations

APPENDIX 1

National Quality Forum Consensus Standards for the Treatment of Substance Use Conditions

The National Quality Forum (NQF) endorsed 11 evidence-based practices in four domains that cover the major phases of the addiction treatment process from identification to aftercare. The abridged report of the endorsements is available online.

- ***Identification of a substance abuse condition.*** NQF endorsed three practices in this domain, which covers screening, case finding, and diagnosis and assessment.
- ***Initiation and engagement in treatment.*** NQF endorsed three practices in this domain, which includes brief motivational counseling for patients identified with alcohol or tobacco use problems, services to promote engagement in treatment for substance use illness and supportive services (including pharmacotherapy) for withdrawal management.
- ***Therapeutic intervention to treat substance use illness.*** Noting that "many effective treatments for substance use condition exist,"[18] NQF endorsed four practices related to the two major types of treatment: psychosocial and pharmacological (medication-assisted treatment).
- ***Continuing care management.*** In this domain, NQF endorsed the practice of offering patients long-term, coordinated care management for their substance use illness and any coexisting conditions.

APPENDIX 2

The NIATx System-Change Model

First piloted within the small systems of individual treatment agencies in *Paths to Recovery*, the NIATx model was adapted to serve as the framework for large system change at both the provider and state level in *Advancing Recovery*.

The NIATx model includes the following components:

The Five NIATx Principles

In a 1995 article[19] in *Health Care Management Review*, Gustafson reviewed research on organizational change in 13 industries and identified five factors that were especially

[18] *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices: A Consensus Report.* Washington: National Quality Forum, 2007.

[19] Gustafson DH and Hundt AS. "Findings of Innovation Research Applied to Quality Management Principles for Health Care." *Health Care Management Review*, 20(2): 16–33, 1995.

good predictors of organizational change. In *Advancing Recovery*, these principles applied to both the state and individual agency organizational levels:

- Understand and involve the customer.
- Fix the key problems. These are problems that keep the executive awake at night.
- Pick a powerful change leader.
- Get ideas from outside the organization or field.
- Use rapid-cycle testing to establish effective changes. NIATx uses the Plan-Do-Study-Act system of rapid-cycle change.

NIATx Change Team

To implement the rapid-cycle change, the NIATx model specifies three key roles:

- The executive sponsor, who authorizes time and resources for the project
- The change leader, a person selected by the executive sponsor who has the ability and leverage to lead the project.
- The change team, composed of staff and, in some cases, consumers, that carries out the projects

In *Advancing Recovery* change teams included staff from multiple partner agencies. Some partnerships had an executive sponsor located in the state government, while others tapped the leadership of one of the treatment providers.

The Four NIATx Aims

Each partnership chose indicators of change that were specific to the evidence-based practices they selected to implement and that reflected the unique challenges within their states with regard to illicit substance use, demographics, geography, and other factors. By applying the NIATx system change model, the treatment agencies were also able to increase access to treatment as measured by the four common NIATx aims:

- Reduce wait time between the first request for help and the first treatment session
- Reduce no-shows
- Increase admissions
- Increase continuation rates by keeping people in treatment longer

APPENDIX 3

Project List

Round I: Starting November 2006

Delaware

Delaware Division of Substance Abuse and Mental Health (New Castle, Del.)
Advancing Recovery: State and Provider Partnerships for Quality Addiction Care
ID# 56894 (November 2006 to September 2009): $343,744

Project Director:
Jack Kemp, MS
(302) 255-9433
jack.kemp@state.de.us

Florida

Florida Department of Children and Families (Tallahassee, Fla.)
Advancing Recovery State and Provider Partnerships for Quality Addiction Care: Florida's Advancing Recovery Medically Assisted Treatment Program
ID# 56896 (November 2006 to April 2009): $360,000

Project Director:
Sheila Barbee Collins
(850) 921-8331
sheila_barbee@dcf.state.fl.us

Kentucky

Kentucky River Community Care Inc. (Jackson, Ky.)
Partnership for Advancing Recovery in Kentucky
ID# 56898 (November 2006 to October 2008): $360,000

Project Director:
David Mathews, PhD
(606) 666-9006
wdmathews@aol.com

Maine

State of Maine, Office of Substance Abuse (Augusta, Maine)
Advancing Recovery: State and Provider Partnerships for Quality Addiction Care
ID# 56891 (November 2006 to October 2008): $355,660

Project Director:
Guy R. Cousins
(207) 287-2595
guy.cousins@maine.gov

Missouri

State of Missouri Department of Mental Health (Jefferson City, Mo.)
Advancing Recovery: State and Provider Partnerships for Quality Care
ID# 56895 (November 2006 to October 2008): $360,000

Project Director:
Terry D. Morris, MS
(573) 751-8677
terry.morris@dmh.mo.gov

Rhode Island

NRI Community Services, Inc. (Woonsocket, R.I.)
Advancing Recovery: State and Provider Partnerships for Quality Addiction Care
ID# 56897 (November 2006 to April 2009): $360,000

Project Director:
Michelle P. Taylor
(401) 235-7472
mtaylor@nricommunityservices.org

Round II: Starting February 2008

Alabama

State of Alabama Department of Mental Health and Mental Retardation (Montgomery, Ala.)
Advancing Recovery: State and Provider Partnerships for Quality Addiction Care
ID# 63728 (February 2008 to January 2010): $359,184

Project Director:
Tammy Peacock (no longer at the organization)

Arkansas

Arkansas Division of Behavioral Health Services, Office of Alcohol and Drug Abuse Prevention (Little Rock, Ark.)
Advancing Recovery: State and Provider Partnerships for Quality Care
ID# 63725 (February 2008 to January 2010): $359,916

Project Director:
Garland Ferguson
(501) 686-9875
Garland.ferguson@arkansas.gov

Colorado

Signal Behavioral Health Network (Denver)
Advancing Recovery: State and Provider Partnerships for Quality Addiction Care
ID# 63727 (February 2008 to January 2010): $360,000

Project Director:
Michael W. Kirby, PhD
(303) 639-9320 x1017
mkirby@signalbhn.org

Maryland

Baltimore Substance Abuse Systems Inc. (Baltimore)
Baltimore Buprenorphine Initiative
ID# 63724 (February 2008 to January 2010): $359,462

Project Director:
Bonnie Campbell
(410) 637-1900
bcampbell@bsasinc.org

Texas

Homeward Bound, Inc. (Dallas)
Advancing Recovery: State and Provider Partnerships for Quality Addiction Care
ID# 63726 (February 2008 to January 2010): $360,000

Project Director:
Diana S. Burns
(214) 941-3500 x237
dburns@homewardboundinc.org

West Virginia

Prestera Center for Mental Health Services, Inc. (Huntington, W.Va.)
Advancing Recovery: State and Provider Partnerships for Quality Addiction Care
ID# 63701 (February 2008 to January 2010): $358,299

Project Director:
Robert H. Hansen
(304) 525-7851
Bob.hansen@prestera.org

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National Conferences Sponsored by NIATx

"2010 SAAS Conference and NIATx Summit," July 11–July 14, 2010, Cincinnati. Attended by 600 registrants representing addiction treatment organizations from across the country. National organizations represented included the Robert Wood Johnson Foundation, the Substance Abuse and Mental Health Services Administration, and the Center for Substance Abuse Treatment. Three keynote presentations, two panels, and 60 workshops. Video presentations available online.

"2009 NIATx Summit and SAAS National Conference," July 29–August 1, 2009, Tucson, AZ. Attended by 600 registrants representing addiction treatment organizations from across the country. National organizations represented included the Robert Wood Johnson Foundation, the Substance Abuse and Mental Health Services Administration, and the Center for Substance Abuse Treatment. Three keynote presentations, two panels, and 50 workshops. Video presentations available online.

"2008 SAAS Conference and NIATx Summit," June 23–25, 2008, Orlando, FL. Attended by 650 registrants representing addiction treatment organizations from across the country. National organizations represented included the Robert Wood Johnson Foundation, the Substance Abuse and Mental Health Services Administration, and the Center for Substance Abuse Treatment. Three keynote presentations, two panels, and 40 workshops. Video presentations available online.

"NIATx Summit 2007,"April 2007, San Antonio. Attended by 600 registrants representing addiction treatment organizations from across the country. National organizations represented included the Robert Wood Johnson Foundation, the Substance Abuse and Mental Health Services Administration, and the Center for Substance Abuse Treatment. Three keynote presentations, two panels, and 40 workshops.

Grantee Conferences Sponsored by NIATx

"Advancing Recovery Final Learning Session," January 13–15, 2010, Washington. Available online.

"Advancing Recovery Learning Session," July 29–August 1, 2009, Tucson, AZ. Available online.

"Advancing Recovery Fall 2009 Mid-Course Review," February 11–12, 2009, Philadelphia.

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www.niatx.net. Website was created as an online learning community to share the NIATx improvement model with the nation's treatment providers and payers. The Resource Center includes a System-Level Toolkit with toolkits, training materials, and evaluation tools related to *Advancing Recovery* and other state-provider programs. It also includes a brief overview of *Advancing Recovery* on its Past Projects page. Madison, WI: NIATx.

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- **Prestera Center for Mental Health Services, Inc.** (Huntington, W.Va.)
- **State of Alabama Department of Mental Health and Mental Retardation** (Montgomery, Ala.)
- **State of Missouri Department of Mental Health** (Jefferson City, Mo.)