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. Moreover, 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

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.*

**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. (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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“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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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 and 2007) outlined requirements for *Advancing Recovery* applicants with regard to the composition of state-provider partnerships and the selection of evidence-based practices.

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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.

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The five categories are:

**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 drugs⁸ 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.

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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).

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.¹⁹

- **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.

¹⁹ 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).
— 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.

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\(^\text{10}\) 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\(^\text{®}\), 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?

- 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*.** 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 Prester 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,

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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.

— 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
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—opiod addiction—by spreading the use of medication-assisted treatment throughout the state.

According to SAMHSA’s National Survey on Drug Use and Health,\textsuperscript{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.

- **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*, 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.

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— 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 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.

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 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.

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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.

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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.

- **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](http://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](http://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/Pumphrey)

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/Pumphrey)

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' 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

\(^{17}\) Grant ID# 59714
• 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.
ADVANCING RECOVERY IN MISSOURI: USING MEDICATIONS TO TREAT ALCOHOLISM

In Missouri, 10 treatment agencies participating in the Robert Wood Johnson Foundation (RWJF) national program, Advancing Recovery: State and Provider Partnerships for Quality Addiction Care, were able to overcome barriers to the use of medications for treating people suffering with alcoholism. Medication-assisted treatment is an evidence-based approach that combines medications with counseling to treat alcoholism and other substance use disorders. Participating agencies worked with the Missouri Division of Alcohol and Drug Abuse to bring about lasting improvements in the way people with severe alcoholism are treated.

A Large and Diverse Partnership

The Missouri Division of Alcohol and Drug Abuse invited all 23 addiction treatment providers who had contracts with the state to join the Advancing Recovery partnership. Ten accepted and participated in this two-year initiative. The large and diverse group served Missouri’s two biggest urban centers, Kansas City and St. Louis, as well as rural areas in the southernmost part of the state.

Comprehensive Mental Health Services, an Independence-based multi-site provider of mental health and substance abuse services, exemplifies the diversity of the Missouri partnership. Its Renaissance West program, located in the urban core of Kansas City, was the site for Advancing Recovery. Renaissance West offers detoxification services as well as residential and outpatient programs for adults, including pregnant and post-partum women with children.

Renaissance West clients are predominantly Black, mostly low-income and in many cases under supervision of the state Department of Corrections. “Our urban community is very close knit,” according to Kay Murphy-Collins, director of Addiction Recovery at Comprehensive Mental Health Services, “so it was really nice to work with people from different regions and get a larger perspective.”

“Prior to participating in Advancing Recovery, addiction program directors in the state met on a quarterly basis. We had worked together on specialized projects, but had not worked as closely with each other as we did during Advancing Recovery. At first we met every two weeks in person or by phone. Once we got established, we continued having monthly conference calls. Being able to say ‘help me’ to the group was one of the things that made our grant so successful.”
**Focusing on People with Severe Alcoholism**

Data for 2005 show that for nine of the 10 participating agencies, alcohol was the drug most frequently used by adult clients. None of the agencies had used medication-assisted treatment for alcoholism, although most were interested in trying it. The state was interested as well. According to Mark Stringer, director of the Division of Alcohol and Drug Abuse, *Advancing Recovery* was an opportunity to have “another run” at medication-assisted treatment, which the state had tried to implement several years earlier.

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 effects of alcohol and the urge to drink. Most *Advancing Recovery* providers and clients preferred naltrexone, which is taken once a day in tablet form, to acamprosate, which must be taken three times a day.

In 2006, the Food and Drug Administration (FDA) approved a once-a-month injectable form of naltrexone, which is marketed as Vivitrol™. Long-acting Vivitrol is a “godsand” compared with earlier drugs like acamprosate, says Murphy-Collins. For her clients, who often struggle to remain compliant with treatment regimens, the reaction was “Oh my gosh. I don’t have to remember to take a pill three times a day?”

Murphy-Collins and other providers appreciated the support and training that the drug’s manufacturer, Waltham, Mass.-based Alkermes, provided for physicians, counselors, and other staff members. A representative of the company was a member of the project team.

**Using the Walkthrough to Identify Barriers**

As part of applying for an *Advancing Recovery* award, providers and states were required to walk through a selected system or process. In walkthroughs, senior staff members apply for services at their agency as if they are clients, gaining a view of the organization from the client’s perspective. Walkthroughs also help identify the most significant barriers that prevent use of medication-assisted treatment or other evidence-based practices.

Missouri’s walkthrough showed providers that their screening processes were not set up to evaluate whether the client was appropriate for medication-assisted treatment. Before participating in *Advancing Recovery*, staff at Renaissance West did not screen for eligibility for medications until three weeks after the person had been admitted. “That’s all changed now,” says Murphy-Collins. “On the first day, clinicians determine whether a client is alcohol-dependent and at the same time whether he or she is eligible for Vivitrol.”

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Even after improving the screening system, staff struggled to convince clients to take advantage of medications as part of treatment. They found that clients lacked information about medications, indicating that they entered treatment to become drug free. “Their perception is still the biggest barrier, says Murphy-Collins. “They’re afraid of the side effects. They worry that, if they drink when on the medications, they will become severely ill, as they would with some other drugs. It takes ongoing training and constant reminders from clinicians and counselors to let clients know the medication is available and to overcome their resistance.”

**Increasing Retention with Motivational Interviewing Results in Changed State Policy**

To help clients overcome resistance to using medications, the Missouri partner agencies introduced motivational interviewing, a counseling approach which acknowledges that many people are ambivalent about making changes. The goal for the project’s second year was to coach clinical supervisors in motivational interviewing and then have them monitor and mentor counselors as they delivered the service.

Stringer believed that motivational interviewing could be an effective strategy for engaging clients in medication-assisted treatment. He also saw it as a way to lower the 30 percent consumer dropout rate between first contact and completion of the clinical assessment. Stringer claims he “stole the idea” from a former state substance abuse director in Kentucky whom he met at a separate RWJF-sponsored conference.

Historically, Missouri had not reimbursed providers for treatment services delivered prior to completion of the clinical assessment. However, to test the impact of motivational interviewing, the state authorized and reimbursed two *Advancing Recovery* providers to begin delivering one hour of motivational interviewing to consumers between first contact and completion of the clinical assessment.

The two providers offered an hour of motivational interviewing to clients before they began their treatment. The providers examined the impact of the service on client return rates and found, on average, that return rates increased dramatically from 70 percent to 97 percent. This success convinced the state to reimburse all contracted providers for an hour of motivational interviewing before the clinical assessment was completed.

Not all providers had equal success implementing motivational interviewing. Like other *Advancing Recovery* grantees across the country, the Missouri providers found that the intense effort to implement one evidence-based practice depleted the resources they could devote to next. As Murphy-Collins explains, “All of us put so much into getting medication-assisted treatment up and running that our response to motivational interviewing in the second year was ‘Whoa wait a minute.’”
Changing the System to Support Medication-Assisted Treatment: The State’s Role

While providers addressed clients’ resistance to engaging in treatment, the state used its leverage to overcome financial barriers. The Division of Alcohol and Drug Abuse amended provider contracts, allowing agencies to use allocated funds to pay for the services of physicians and advanced practice nurses who assessed clients and prescribed medications. The amended contracts also covered the cost of medications and laboratory services.

Despite state coverage for medication-assisted treatment services, Stringer found that some providers remained resistant. With some frustration he notes that “back in 1956, when alcoholism was first considered a disease, we testified with passion to get insurance coverage. Now when medications become available, we balk.”

Stringer says that at first he tried “coaxing and fussing,” but, in January 2011, he began requiring that medication-assisted treatment be available for people who needed it. “We will no longer certify providers that will not offer—no, don’t deliver—medication-assisted treatment. We will examine paid claims to verify that providers are actually intervening, not just offering it. If it isn’t part of their service delivery continuum, they will lose their certification.”

Murphy-Collins agrees. “Most providers are now providing medication-assisted treatment, but they got to that point kicking and screaming. It was a dream of Mark’s for a very long time to make medications available to clients in addiction programs, the same way that people with schizophrenia or bipolar disorders have them in mental health.”

As a result of Advancing Recovery, we went from no funding for medication-assisted treatment for addiction clients to making it mandatory. That was a huge change for the state and a huge change for providers who weren’t originally involved in Advancing Recovery.”

Funding Medication-Assisted Treatment

Since participating in Advancing Recovery, the state has designated annual funding for medication-assisted treatment, a commitment that has continued since the project ended. According to Murphy-Collins, this happened because “Mark Stringer really believed in MAT [medication-assisted treatment]. He put people in charge of the project who were also believers as well as good change agents willing to get out there and work.”

These committed individuals included the first Advancing Recovery Project Director Terry Morris, director of Clinical Services in the Division of Alcohol and Drug Abuse in 2006. “Terry was very dedicated to making sure everyone in the governor’s office and the Department of Mental Health understood medication-assisted treatment and why it
was important to have it. His groundwork has put us where we are today,” says Murphy-Collins.

Interagency cooperation also brought in funds for medication-assisted treatment. The Division of Alcohol and Drug Abuse developed a collaborative agreement with the Department of Corrections, which provided $500,000 to purchase medications for corrections-referred consumers on probation and parole.

The division also worked collaboratively with providers and a state pharmacy to create a centralized purchasing system that reduced the cost of naltrexone and acamprosate by 70 percent. Although this arrangement did not continue after the project ended, Stringer notes that providers are more conscious of the advantages of collaboration in lowering the cost of medications.

**Helping Hundreds, One at a Time**

The results of these provider and state-level changes can be measured in aggregate numbers and in individual stories. In 2005, no consumers served by the partner agencies were receiving medication-assisted treatment to treat their alcoholism. By October 2008, at the end of the two-year *Advancing Recovery* project, the state reported that:

- 3,259 clients were screened for medication-assisted treatment.
- 429 were referred to medical professionals for evaluation.
- 299 received one or more prescriptions of naltrexone or acamprosate to support recovery.

Calling medication-assisted treatment one of best tools that has come along for people with severe alcoholism, Kay Murphy-Collins describes its impact on one client.

“A gentleman who had been drinking for 30 years came to us. After detox and residential treatment, we discharged him on Vivitrol and an antidepressant with instructions to come back for weekly psychiatrist appointments. To do so, he had to drive past the store where he used to buy his liquor. By reducing his craving, Vivitrol helped him do that. Now he has housing and a job for the first time in 15 years.”

**The Legacy of Advancing Recovery in Missouri**

According to Murphy-Collins, *Advancing Recovery* and the spread of medication-assisted treatment it produced was the “best thing since sliced bread” for the state and the individual agencies. Unlike other grants she has participated in, Murphy-Collins notes that *Advancing Recovery* has prompted change across the Division of Alcohol and Drug Abuse. These changes have spread to other state agencies and to providers within the partnership and outside it.
The division continues to work with providers to promote the use of medication-assisted treatment and other evidence-based practices. Staff holds conference calls to discuss problems in addiction treatment. These are open to all providers, not only those in Advancing Recovery. As Murphy-Collins puts it, “I was always somewhat engaged with the state but Advancing Recovery was a catalyst to stay very engaged.”

The state supports the spread of motivational interviewing by paying for an early motivational interviewing session designed to keep consumers in treatment between first contact and completion of the clinical assessment. It also pays for clinical supervision of staff as they learn to use motivational interviewing and other evidence-based practices.

The Missouri Department of Mental Health includes information about the efficacy of medication-assisted treatment and best practices for delivering it to clients in its Spring Training Institute, which provides continuing education to over 1,000 clinicians and mental health administrators every year.

In October 2010, the FDA approved the use of Vivitrol as a treatment for opioid-based addictions. Although Missouri’s Advancing Recovery project focused on people with alcoholism, people with opioid addiction are also in urgent need of treatment. About 40 percent of Renaissance West clients, for example, are opioid dependent. Applying what they have learned from Advancing Recovery, Murphy-Collins is hopeful that her agency and other providers will be able to address these needs in the future.

Grant ID# 56895

WEST VIRGINIA TACKLES A SUBSTANCE ABUSE EPIDEMIC WITH MEDICATION-ASSISTED TREATMENT

Four West Virginia substance abuse treatment agencies were able to overcome barriers and expand the use of medication-assisted treatment, an evidence-based approach that combines medications with counseling to treat opioid addiction and other substance use disorders.

West Virginia was one of 12 sites that participated in the Robert Wood Johnson Foundation (RWJF) Advancing Recovery: State and Provider Partnerships for Quality Addiction Care national program. West Virginia’s experience illustrates how an agency-led partnership with limited involvement from the state was able to work collaboratively. The partners made agency-level changes that resulted in a “dramatic expansion” of medication-assisted treatment in the state, according to Project Coach Colette Croze.
Getting Ready for Advancing Recovery

Even before becoming an Advancing Recovery grantee agency, the Prestera Center for Mental Health Services and three partner agencies in West Virginia benefited from being part of NIATx, a learning collaborative based at the University of Wisconsin that works to improve the cost and effectiveness of the nation’s substance abuse treatment system. Bob Hansen, Prestera’s executive director, learned about Advancing Recovery from colleagues at Kentucky River Community Care, a prior Advancing Recovery grantee as well as a grantee under RWJF’s earlier national program, Paths to Recovery: Changing the Process of Care for Substance Abuse Programs. See Program Results Report for more information.

Although the four West Virginia agencies were interested in Advancing Recovery, they decided they were not ready to apply for the first round of funding. “Punting during Round I gave us time to become involved with NIATx,” says Hansen.

“We participated in a NIATx training and worked with coaches Lynn Madden and Scott Farnham, who were Paths to Recovery grantees. They were two of the best consultants I’ve ever worked with, as both role models and teachers. They encouraged us to do more to develop relationships with state agencies. When the second round of Advancing Recovery competition came out, we were in better shape.”

In February 2008, RWJF awarded the collaborative a two-year grant of $358,299, with Prestera as the lead agency. Prestera Addiction Recovery Centers operates more than 50 substance abuse facilities that provide a full continuum of care. Prestera facilities offer outpatient services, short and long term residential programs, medically monitored detoxification and a transitional living program that helps former substance abusers adjust to life in the community.

Three partners worked with Prestera:

- **Seneca Health Services**, a behavioral health provider serving adults and adolescents in southeastern West Virginia with substance abuse, mental health, or developmental disabilities
- **Westbrook Health Services**, a comprehensive behavioral health service provider
- **Valley Healthcare System**, based in Morgantown, offers outpatient and residential care for adults and adolescents. New Beginnings is the agency’s specialized extended care program for women.
Together, these 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.19

**Building a United Front Against Addiction**

Prior to participating in *Advancing Recovery*, the partners had worked individually to introduce evidence-based practices for addiction treatment, including motivational interviewing (a counseling approach which acknowledges that many people are ambivalent about making changes) and medication-assisted treatment. Seneca and Prestera also had established programs using buprenorphine to treat opioid addiction. (Buprenorphine, marketed as Suboxone, was approved in 2002 by the FDA for treatment of opioid addiction). But, says Prestera’s director of addiction services, Genise Lalos, “when you work individually within your own agency, you don’t have to go through the changes and compromises that are necessary when you’re part of a group. When *Advancing Recovery* began, we talked every day on the phone and eventually became a separate entity, a hybrid of all agencies. We were accountable to each other. That was the *Advancing Recovery* way.”

Focusing on medication-assisted treatment made sense. Nearly one out of five West Virginians in substance abuse treatment uses opiates like OxyContin® and Percocet®, which have become the drugs of choice in the state. West Virginia has the fastest growing rate of opiate addiction in the country, according to Hansen.20

“West Virginia is unusual in that methadone treatment is for-profit only. Those with no income, our patients, weren’t being served. Medication-assisted treatment was a new level of care that we, as public providers, needed to offer,” says Hansen.

**Recruiting Physicians**

Like most *Advancing Recovery* grantee organizations that proposed to implement medication-assisted treatment, West Virginia found that recruiting physicians to administer buprenorphine was a major hurdle. When *Advancing Recovery* began in 2008, just three doctors among those working at the four participating providers were certified to prescribe buprenorphine. By the end of the first year, thanks to the partners’ diligent use of educational resources and outreach efforts to the medical community, nine doctors were using medication-assisted therapy, including five at Prestera, one at Valley, one at Westbrook, and two at Seneca.

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19 Clark L, Haram E, Johnson K and Molfenter T. *Getting Started with Medication-Assisted Treatment*. Madison, Wis.: NIATx.

20 *Getting Started with Medication-Assisted Treatment*
Despite their success in recruiting physicians within their agencies, the partners stress that the stigma attached to medication-assisted treatment remains a barrier to building a larger, statewide network of prescribers. Physicians in primary care settings are often reluctant to start a medication-assisted treatment program because they are afraid they would be treating a different and difficult clientele. “We pointed out that ‘those people’ are quite likely their patients already—just not revealing their addiction problems,” said Hansen.

Adding more physicians was not the only challenge Prestera’s Lalos, explains: “We had to find a way to make it feasible for our physicians to add 50 to 100 clients to their case load, see these clients every week and continue to provide quality care. After much passionate discussion, we decided that having physicians see clients in groups was the most efficient way to use their time as well and the client’s.

To help physicians manage higher caseloads, Prestera added a full-time nurse. Even though the nurse’s services were not billable, Prestera considered the position necessary to raise physician productivity. The nurse prepared treatment information for the physician’s review, collected urine drug screens from patients and co-facilitated the physician groups. She also made sure prescriptions were received and clients’ questions about side effects of their medication were answered.

**Overcoming Resistance from “Everywhere”**

Hansen and his partners knew they would “face resistance from everywhere, not only from providers, but from clients, the recovering community and staff. We had to do a lot of education.”

Prestera staff gave board members outcome data from successful medication-assisted treatment programs around the country. They also provided personal recovery stories from individuals who had tried and failed many times to sustain their recovery from opiates with traditional therapies. Presenting these outcomes along with a well-thought-out business case helped convince skeptical board members that medication-assisted treatment was in the best interest of the agency and its clients.

Hansen and his colleagues knew that starting a medication-assisted treatment program would likely also cause controversy in the community at large. To make their case to the public, the partners shared stories through the local newspapers and other media. In a December 2009 *Charleston Gazette* editorial, Hansen stressed that while opioid addiction remains a “huge problem in West Virginia, medication-assisted treatment can make a difference.” He urged extending the service more broadly across the state.

The team’s outreach and education efforts paid off. At the start of *Advancing Recovery*, only Seneca and Prestera were providing medication-assisted treatment to 128 clients.
One year later, all four agencies had prescribed buprenorphine to 259 clients, an increase of 131 individuals, or 102 percent. By the end of the project period, the team reported providing medication-assisted treatment to 627 people.

The providers also changed their internal admissions protocols, streamlining the intake process and decreasing wait time for medication-assisted treatment from 34 days to seven. Preesta implemented either open access or 24-hour access for all new admissions at two of its three medication-assisted treatment locations. This change drastically decreased no-show rates and increased the number of clients seen at each location.

**Creating Medication-Assisted Recovery Support Groups**

Treatment alone isn’t enough. People in recovery need fellowship and support from others. Many clients in medication-assisted treatment were reluctant to attend traditional 12-step support groups, such as Alcoholics Anonymous and Narcotics Anonymous, where the use of medication is not accepted as part of a recovery-based lifestyle.

To give these people a community of peers, the team created Medication-Assisted Recovery Support (MARS) groups throughout the state. The number of groups, the first of their kind in the state, grew in response to the need. At the end of the second year, there were 14 MARS groups up and running across the state. In 2010, Preesta’s medication-assisted treatment program coordinator, Josh Parker, reported there were some 20 groups operating in the state.

Preesta recruited recovery coaches to lead its MARS groups. Recovery coaches are people recovering from addiction who work with people in treatment, providing between-session contact, home visits, and encouragement to attend support group meetings. Working with people in treatment added a valuable component to their own recovery, according to the coaches.

**Finding Funding for Medication-Assisted Treatment**

West Virginia was one of four Advancing Recovery partnerships led by a provider rather than by a state agency. “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 state leadership transitions complicated matters further, with mid-level staff assigned to the project who lacked the authority to be strong advocates for funding to support medication-assisted treatment.

The biggest users of opioids such as OxyContin are single adult males, who are typically not eligible for Medicaid, which covers prescription drugs for low-income consumers. During the first project year, the team worked diligently to obtain state funding for
medications. On February 6, 2009, their efforts paid off when the Division of Alcohol and Drug Abuse set aside $75,000 to be shared by partners to assist indigent clients. A local foundation added a grant of $11,162 to purchase 100 hours of physician time.

In September 2009, the state budget office decided not to continue this funding for a second year and also ruled that unexpended funds could not be carried over. Unfortunately, the providers, afraid that they would deplete the $75,000 too quickly, had not used all the money.

“We thought we were being good stewards, but instead we had to leave the money on the table,” says Lolas. The team’s representative at the state advocated for approval to use the unexpended funds.

**Out of the Blue: A Cease and Desist Order**

In September 2009, West Virginia’s Office of Health Facility Licensure and Certification ordered Prestera to cease and desist providing office-based medication-assisted treatment within 30 days. “We still don’t know why they did it. It was right out of the blue,” says Prestera’s Hansen.

The state claimed that Prestera was not a licensed Opioid Treatment Program. “That’s an example of a bureaucracy making assumptions based on erroneous beliefs. They were not aware that a buprenorphine program, unlike methadone, doesn’t require an opioid license.”

For short period of time, Prestera stopped admitting new consumers, although it never stopped serving existing consumers. “Where else would they go?” asked Hansen. To avoid increasing stress for clients, the partners decided not to alert the public or press about the problem. Instead they called on the resources of their agencies and their NIATx coaches.

**Advancing Recovery** provided two coaches to each site, one focused on treatment providers and one focused on state agencies. “This was where Colette and I earned our keep,” says provider coach Eric Haram, director of Outpatient Behavioral Health at Maine’s MidCoast Hospital and a recipient of a prior Advancing Recovery grant. Colette Croze, an expert in state government financing and experience working in the Illinois governor’s budget office, was the state coach.

“Colette and I read the licensing rules and regulations in West Virginia and saw that the person who brought the complaint was out on a limb. We wrote a letter clearly illustrating that and called on experts at SAMHSA and the National Methadone Association to weigh in.” Haram also appealed to Todd Molfenter, deputy director for **Advancing Recovery**, to write a letter from the national program office to officials at the state.
About a month after the cease and desist order was issued, Hansen set up an informal meeting with state officials to present Prestera’s evidence. With the “full court press” from NIATx coaches and the providers, the state conceded immediately. “What’s the lesson we learned from this? We dispelled problems with people working together. Since then, we’ve had other issues and we deal with them using this collaborative model,” says Hansen.

**Planting a Seed: Spreading NIATx Principles**

With their foundation in NIATx change principles and their experience in collaborative problem solving, the partners were ready to invite other West Virginia behavioral health providers to join their coalition. In February 2010, the team issued a request for proposals and selected three agencies: FMRS Health Systems, serving a four-county area in southern West Virginia; United Summit Center, serving the north central part of the state; and Healthways, a worldwide disease-management provider headquartered in Franklin.

The team held a “Performance Improvement 101” event in March 2010 to welcome the new partners, and it contracted with Eric Haram to help train staff from the three new agencies. Haram also mentored change leaders from the four original Advance Recovery partner agencies, preparing them to serve as coaches for the new partners.

According to Lalos, as of December 2010, only FMRS continued to provide buprenorphine treatment. While the others did not establish a medication-assisted treatment program, they were introduced to NIATx principals and are applying NIATx tools within their organizations. “We planted a seed,” says Lalos.

**Legacy of a Provider-Led Partnership**

West Virginia is a franchise state, Croze explains, which means that the state funds a single treatment organization in a particular area. “There are just 13 addiction treatment agencies in West Virginia, and Advance Recovery was involved to some degree in seven of them. The project changed the statewide addiction treatment system for the better.

In spite of difficulty with the state, the four providers made internal changes to accommodate medication-assisted treatment, which resulted in a dramatic expansion of services. More than 600 individuals received treatment, none of whom would have been served without Advance Recovery. Having accomplished this, the partners went on to use the principles for other areas of quality improvement.”

Grant ID# 63701
ALABAMA HELPS ADDICTED ADOLESCENTS RECOVER FROM SUBSTANCE ABUSE WITH CONTINUING CARE

A team of substance abuse treatment providers and state officials in Alabama introduced continuing care into treatment protocols, helping clients sustain their successes. Continuing care is an evidence-based practice in which a care manager provides ongoing coordination and management of services, including monitoring of progress and recovery management support throughout the course of treatment in all care settings. Regular contact with a treatment professional (in person or by telephone) is a core component of continuing care.21

FINDING THE RIGHT TEAM OF PROVIDERS

Alabama was one of 12 sites selected to participate in the Robert Wood Johnson Foundation (RWJF) Advancing Recovery: State and Provider Partnerships for Quality Addiction Care national program. Tammy Peacock, PhD, coordinator of adolescent services for the Substance Abuse Services Division in the Department of Mental Health and Mental Retardation led the effort. Gwen Thomas LeBlanc, director of substance abuse services at Northwest Alabama Mental Health Center, describes how Advancing Recovery came to Alabama: “Tammy wanted to find providers interested in participating who could also make changes to improve services to our consumers.”

Peacock recruited three treatment agencies to participate in Advancing Recovery. These include START, a short-term residential program for adolescent females operated by LeBlanc’s agency in a section of northwest Alabama. The two additional partners are The Bridge, a program for adolescent males with seven residential facilities, and the NOVA Center for Youth and Family, a division of the Madison County Mental Health Center located in Huntsville. NOVA provides intensive outpatient services for adolescents through its New Horizons Recovery Center.

Together, these agencies provide 100 percent of the publicly funded residential substance abuse treatment for adolescents in the state and approximately 65 percent of the state’s publicly funded outpatient services.

Linking Teens to Care in the Community

“We chose continuing care and case management because we wanted to address the problem of a high relapse rate among adolescents we referred to outpatient programs.

Teens were coming back to our residential programs for readmission and a lot of time that’s taking up a bed that someone needs,” says LeBlanc.

The initial plan envisioned that residential programs at Northwest Alabama Mental Health Center and The Bridge would refer teens to NOVA/New Horizons for continuing outpatient care. To increase the number of teens receiving continuing care services, however, the partners decided to expand the service area and began making referrals to their own outpatient sites as well. “We expanded to 11 counties, including five served by The Bridge and another five served by Northwest Alabama Mental Health,” says LeBlanc.

During the first year of the two-year Advancing Recovery grant, the partners developed a system to first identify all adolescents referred to residential treatment by either the state Substance Abuse Services Division or Department of Youth Services and to then link them to continuing care in their communities when they left the residential program.

From February 2008 through January 2010, 365 youth received a referral from residential treatment to continuing care services: 218 in the first year and 147 in the second. More than half (58%) of the youth successfully transitioned into continuing care in their home community (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 discharge planning from residential treatment. “Teens knew they would be followed by a continuing care provider and receive the support they needed to maintain a recovery mindset during the stressful transition period. This was a significant change from the past practice of merely recommending continuing involvement in treatment with little or no follow through,” according to Peacock.

**Opening Up New Avenues of Communication**

Participation in Advancing Recovery opened up avenues of communications among the partners, according to LeBlanc. “Prior to Advancing Recovery we “knew each other but had not done a lot of networking. People have a tendency to get in their own bailiwick and get involved in doing business as usual. The positive aspect of our involvement with the Advancing Recovery project was that we ended up being very good friends and highly collaborative for the betterment of clients.”

The Bridge’s Jeremy Blair agrees. “Advancing Recovery gave us a framework to work together. Before that, we were aware we needed to collaborate but lacked the incentive.”

LeBlanc notes that Advancing Recovery started with a “few scattered attempts. We trained our in-house employees to make an appointment for continuing care for all clients discharging from residential treatment. We began with a networking list with contact
people at all our agencies, their phone numbers, faxes, and emails. Residential staff made
the continuing care appointment and followed up. Then we went to the next level.”

The partners began holding weekly conference calls to discuss discharges and referrals.
“Getting everybody on the same page ensured the handoff from residential treatment to
continuing care,” says Blair.

Having each other’s cell phones helped too, says LeBlanc. “If there was a glitch or a staff
complaint, I could pick up the phone and say ‘This is Gwen, I’m having trouble and need
to get this person in.’ We went from casual business relations, to knowing each other’s
business, to friendship.”

Making sure that all teens discharged from residential treatment had an appointment for
continuing care was “not a burden on staff, but it was a case of making it part of their
daily routine when it hadn’t been before. The process of making it a habit was
challenging,” adds Blair.

The team’s efforts paid off. The number of days between discharge from residential
treatment and admission to continuing care dropped from 19.5 days in April 2008 to 6.5
days in January 2010.

By the end of the Advancing Recovery grant, the practice of making a continuing care
appointment in the client’s home area prior to discharge from residential treatment had
spread statewide. Most of the adolescent substance abuse treatment providers outside of
the Advancing Recovery partners also developed continuing care groups to support their
patients.

“Advancing Recovery also opened up an avenue for our agencies to bring concerns to the
state and have them addressed. It wasn’t always to our liking or in the time frame we
preferred but it was a vehicle for communication nonetheless. No framework for that
existed before Advancing Recovery,” says Blair.

**A More Teen-Friendly Concept of Outpatient Care**

Merely linking teens to continuing care after leaving residential treatment was not
enough. The team also wanted to ensure these teens received the appropriate level of
care. Prior to Advancing Recovery, youth leaving residential care were usually “stepped
down” to an intensive outpatient program, often the only option available.

The problem according to LeBlanc was the nature of intensive outpatient care. “In
Alabama, it [intensive outpatient] is 100 hours of treatment in a six-month period. If you
break that down, that’s four hours of treatment per week. Intensive outpatient care many
times was a duplication of some of the services provided in residential treatment and
added several months to the outpatient treatment episode, which wasn’t always what the teen needed,” says LeBlanc.

Blair agrees. Teens leaving residential treatment need a flexible program that looks at stressors in the home environment and that offers tools to sustain recovery in the real world. At The Bridge, teens had the option of joining a group that met one or two times per week. “We got away from artificial requirements of a four- to six-month commitment and moved more toward individual-based programs. Kids who had stabilized in residential care and had a good support system might not need intensive services.”

By the end of Advancing Recovery’s first year all three treatment agencies offered a less intensive continuing care option that was tailored to the youth. Of the 119 youth who were admitted to continuing care, 70 were admitted to intensive outpatient programs and 54 were admitted to a continuing care group, the placement in the level of care at the outpatient location was completed by the outpatient provider.

**Dealing With Disappointment**

After instituting continuing care services for teens, the Alabama partners decided to implement case management and wraparound services to support youth as they reintegrated into their community. At the time they determined to do this, the state Substance Abuse Services Division planned to expand its service array to include in-home intervention and to increase rates to make case management more fiscally viable.

When it became apparent that the new service array would not be available because of state budget constraints, the state allowed the three treatment agencies to pilot an in-home intervention. The partners developed policies and procedures and proposed a rate they felt would be viable, but, even the pilot failed to move forward because of budget problems.

The Alabama team used this experience as a “lesson learned.” LeBlanc says, “Our message was about dealing with disappointment. You have to recognize you’re powerless in some situations and then make the changes you can. Our Advancing Recovery coach helped by showing us what people had tried in other states. It helped us refocus.”

Blair also points to the upside of the disappointment over in-home counseling. “Although the plan we really wanted never did come to fruition, we found that just being able to ask, not accepting the status quo, and engaging in the discussions was helpful.”

Despite not being able to launch the in-home counseling program, Blair stresses that case management is now part of The Bridge’s core services, thanks to training from the state. “Our clinicians were used to providing clinical services, not case management. Training from the state helped jump-start the program, and our clinicians have adapted to the
paradigm shift. Case management is now part of their job description,” Blair notes. LeBlanc agreed that this is also the practice with Northwest Alabama Mental Health.

**System Changes**

To achieve its goals, Alabama used several of the *Five Levers of Change* developed by Advancing Recovery and NIATx, the national program office based at the University of Wisconsin. For example, Peacock used the inter-organizational lever to strengthen the ties between her agency and other state agencies and stakeholders who serve substance-using adolescents.

Among these were the Administrative Office of Courts, which operates juvenile drug courts, as well as juvenile correctional school systems and oversees juvenile judges; and the Department of Youth Services. According to Peacock, “the first step in creating systems change is building relationships,” so these efforts to partner with state agencies outside the Substance Abuse Services Division supported the goal of spreading evidence-based practices statewide.

To enhance its ties to the juvenile court system, the Substance Abuse Services Division used technical assistance from the federal Center for Substance Abuse Treatment (CSAT) to train a group of adolescent counselors and juvenile probation officers in motivational interviewing. Counselors from the three Advancing Recovery agencies and juvenile probation officers from three counties took part in the training, which was intended to increase youth engagement in continuing care.

In 2010, the state legislature funded 10 new drug courts allowing for expansion of adolescent treatment services. Peacock worked with the Administrative Office of Courts and the Department of Youth Services to develop the training curriculum for the expanded program.

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22 *Five Levers of Change* is a model for integrating evidence-based practices into treatment agencies. The levers are: Financial, Regulatory, Internal Operations, Inter-Organizational Capability, and Purchasing/Contracting.

23 Motivational interviewing is a counseling approach that acknowledges that many people resist changing behavior and that focuses on enhancing their motivation to change.
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,” 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 in *Health Care Management Review*, Gustafson reviewed research on organizational change in 13 industries and identified five factors that were especially

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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
BIBLIOGRAPHY: NATIONAL PROGRAM OFFICE

(Current as of date of the report; as provided by the grantee organization; not verified by RWJF; items not available from RWJF.)

Articles

Journal Articles


Articles Published on www.niatx.net

“Advancing Recovery in Baltimore: Customer Input Helps Focus Efforts.” Available online.


“Advancing Recovery Missouri Case Study.” Available online.

“Arkansas Advancing Recovery Partnership.” Available online.

“Baltimore Buprenorphine Initiative.” Available online.

“Continuum of Care in Addiction Treatment.” Available online.

“Delaware’s Advancing Recovery Project.” Available online.

“The Elevator Speech.” Available online.

“Florida Advancing Recovery State and Provider Partnerships for Quality Addiction Care.” Available online.

“Florida’s Advancing Recovery Partnership.” Available online.
“Kentucky’s Advancing Recovery Project.” Available online.

“Lives Cut Short (From Advancing Recovery Texas).” Available online.

“Maine’s Advancing Recovery Project.” Available online.

“Manatee Glens—Advancing Recovery Success Story.” Available online.

“Missouri’s Advancing Recovery Project.” Available online.

“The Partnership for Advancing Recovery in Kentucky (PARK).” Available online.


“Purchasing Plan Presentation.” Available online.

“Rhode Island Partnership—Continuing Care” (PowerPoint®). Available online.

“Rhode Island Partnership—Project Information.” Available online.

“Rhode Island Partnership—Medication-Assisted Treatment.” Available online.

“Target Evidence-Based Practice Category: Wraparound Services.” Available online.

**Non-Journal Articles**


**Education or Toolkits**

**Evaluation Tool**


**Toolkits, Toolboxes or Primers**


**Meetings or Conferences**

**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.

“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.

“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.

“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 Learning Session,” July 29–August 1, 2009, Tucson, AZ. Available online.


**Communication or Promotion**

**Grantee Websites**

www.advancingrecovery.net. Website created for Advancing Recovery. It includes an overview of the program, listing of the 12 grantees, and information on the five evidence-based categories. During the program period, it included a members-only section that allowed grantees to exchange information with each other and national program office staff. (Site is no longer actively maintained.) Madison, WI: NIATx.

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.

**Communications & Promotion**


**BIBLIOGRAPHY: EVALUATION**

(Current as of date of the report; as provided by the grantee organization; not verified by RWJF; items not available from RWJF.)

**Articles**

**Journal Articles**


Report

BIBLIOGRAPHY: PARTNERSHIPS

(Current as of date of the report; as provided by the grantee organization; not verified by RWJF; items not available from RWJF.)

Baltimore Substance Abuse Systems

Articles

Non-Journal Articles


Report


NRI Community Services (Rhode Island)

Education or Toolkits

Curricula


State of Maine, Office of Substance Abuse

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