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Enhancing Transitions from Addiction Treatment to Primary Care

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ENHANCING TRANSITIONS FROM ADDICTION TREATMENT TO PRIMARY CARE

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Despite long-standing recommendations that patients with substance use disorders receive primary care, only one-half of patients with substance use disorders receive such care. This article presents a conceptual model to facilitate the transition of patients from addiction treatment to primary care. A narrative review of the healthcare transition literature was conducted with an emphasis on identifying substance use disorder-specific model elements. The resulting model is intended to guide addiction treatment and primary care providers and researchers in understanding factors that impact care coordination between addiction treatment and primary care and to provide an overview of evidence-based methods for supporting this care transition.

KEYWORDS. Care transitions, addiction treatment, primary care

INTRODUCTION

Ensuring that patients leaving addiction treatment (AT) begin or continue regular primary care may be associated with many important health benefits. Patients with substance use disorders (SUDs) who regularly access primary care experience reductions in addiction severity,¹ higher abstinence rates,^{2–4} and fewer hospitalizations.⁵ Use of primary care by patients with SUDs may facilitate the detection and treatment of alcohol and drug use disorders and attention to comorbid medical and mental health conditions through increased screening and monitoring.⁶ At the post-specialty care stage, primary care physicians (PCPs) can also provide systematic medical and recovery check-ups; facilitate the provision of healthcare resources based on a stepped care model; and use laboratory monitoring of substance use associated with rewards and sanctions.⁷

Despite documented and potential health benefits of primary care, many patients with

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SUDs fail to receive it.8 Of about 6,000 patients entering AT, 41% did not have a PCP.⁹ In addition, small proportions of patients with SUDs obtain primary care subsequent to AT. For example, 56% of detoxification patients failed to receive primary care in the following 2 years.¹⁰ These findings are alarming because patients with SUDs who lack primary care are likely to experience increased health burden. Of SUD patients without any primary care in the prior 2 years, 61% had experienced medical problems in the prior 30 days, 47% had one or more chronic health conditions, and 20% had two or more chronic health conditions, with asthma and high blood pressure being the most common.¹¹ The increased burden of medical illness experienced by patients with SUDs not using primary care also translates into higher use of hospital and emergency department services;¹¹ 47% of such patients reported one or more visits to an emergency department in the prior 6 months.¹²

Together, these findings suggest that AT settings should actively facilitate the continuity of, or new transition to, primary care among their patients. Because strategies to foster regular patient–PCP relationships may positively affect SUDs and other mental health and medical conditions, interventions are needed to facilitate such relationships.¹³ Because AT settings are often a point of first contact with the healthcare system, they have the potential to engage patients in primary care and thus, possibly reduce the larger healthcare expenditures associated with these patients' lack of primary care services.¹⁴ Interventions within AT settings that address barriers to accessing primary care might help establish a sustained patient-physician relationship that improves outcomes and healthcare utilization patterns.¹² Treatment for SUDs may benefit from a similar approach as that recommended for chronic medical disorders: specialty care when the condition is severe, followed by the provision of services in primary care that are oriented toward the long-term management of SUDs when the condition is stabilized.^{15,16} In the case of SUDs, management may need to be more intensive and of longer duration.¹⁷

Despite now long-standing recommendations that enhanced efforts should be made to link SUD patients to primary care,⁹ to the authors' knowledge, no conceptual models exist that help AT providers select among evidencebased strategies to promote patients' use of primary care after discharge from or completion of the acute phase of AT. The purpose of this narrative review is to address this gap in the literature by presenting a conceptual model that includes patient, provider, and system-level facilitators and barriers that may impact care coordination between these two care sites. This article focuses on presenting examples of evidencebased strategies that may effectively help connect patients with SUDs to primary care with a special emphasis on the feasibility of utilizing these approaches (and their specific components) in AT settings. This latter emphasis is designed to help support AT directors, managers, and providers in understanding the range of potential options that exist for improving access to primary care for their patient population and understanding resources needed for implementation.

METHODS

Literature Review

Model development occurred in three phases. First, a literature search was conducted to identify conceptual models describing care transitions from AT to primary care. Search terms including "care transitions (and) addiction" and "care transitions (and) substance use (and) primary care" yielded no conceptual models of care transitions from AT to primary care. The authors did, however, identify a large literature^{18,19} on healthcare transitions more generally on which the present model was based.

Identification of Three Model Domains

The second step consisted of identifying the three conceptual domains included in our model. To identify these domains, the



FIGURE 1. Model of transitions from addiction treatment to primary care.

authors reviewed recent articles describing care transition models. Special attention was paid to articles published in the last 15 years (since the year 2000) in an attempt to capture current thinking about care transitions, and, thus identify relevant conceptual domains (however, the review was not limited to articles published after the year 2000 when conducting the remaining review of the literature, e.g., identifying evidence-based approaches for supporting the transition process). The review of transitional care literature revealed a general consensus among scholars regarding the conceptual domains deemed critical in both understanding and optimizing the healthcare transition process. This consensus was the foundation on which the model was developed (see Figure 1).

The first of these domains includes the context in which the care transitions occurs, covering factors that help to promote or impede the transition process, which are often identified at the patient, provider, and/or system level.^{18,20} The second domain includes intervention practices to address specific factors that impact the transition process.^{18,21} These include interventions that are evidence-based⁵ or those that may have promise for improving care transitions in a specific setting.²² The third domain includes common health or process outcomes used to evaluate the clinical utility of an intervention in a given setting.²³

Identification of SUD-Specific Model Elements

Third, a second literature review was conducted to ensure the model is relevant to patients with SUDs. This involved reviewing the literature to identify patient, provider, and system factors that may influence care transitions in this population. The authors also identified care practices that are evidencebased or that may have promise for optimizing transitions of patients with SUDs from AT to primary care. We chose examples of interventions using the following criteria: (1) strength of available evidence (e.g., efficacy demonstrated in a randomized trial versus pilot study) within an AT or primary care setting and (2) resources (e.g., staff time and expertise) that might be needed to implement an intervention within the AT settings. Recognizing that AT and primary care settings vary in resources available to adopt and implement new practices; we present examples of care practices along a continuum of low to high resources needed to adopt such practices. Some commonly utilized health and process outcomes clinics and providers might consider when evaluating the impact of these care transition practices in this patient population are also provided.

CONCEPTUAL MODEL: TRANSITIONS FROM AT TO PRIMARY CARE

Figure 1 presents the conceptual model of transitions from AT to primary care. The model includes patient-, provider-, and system-related barriers and facilitators that can impact whether successful transitions take place and the extent to which patients subsequently access and engage in primary care. The model also includes transition practices that AT directors, managers, and providers might consider to enhance the care transition process.

The model indicates that patient, provider, and system characteristics may directly influence the type of transition practice that is selected by an AT setting. For example, patients with access to primary care may benefit from facilitated referral, whereby they are supported and encouraged to engage with their provider, which also supports continuity of care. In contrast, patients without health insurance or access to a provider might benefit from co-located or integrated primary care services. In addition, people with a need for frequent ongoing visits to AT, such as those in methadone care or those with severe addiction with frequent relapse, and few medical conditions, integrated care at the addiction specialty treatment program might be preferable, whereas for those likely to do well from an addiction standpoint may

benefit from care in the primary care location with follow-up and basic relapse prevention integrated into medical care. The model also highlights patient outcomes such as knowledge about primary care resources that may, at least partially, impact the degree to which patient's access and engage in primary care. In turn, the model stresses that efforts to improve access and engagement to primary care may lead to better outcomes such as reduced substance use.

Moreover, barriers and facilitators to receiving or delivering primary care may also influence patient outcomes via transition practices. For example, AT settings that include providers with knowledge about available primary care resources and that offer incentives to providers for supporting patients through the care transition process are likely to engage more in transition practices that lead to improved patient outcomes. Increasing care transitions between AT and primary care settings may also lead to greater interaction among providers within these two settings. Furthermore, fostering collaboration may lead to increased sharing of clinical knowledge and expertise, development of more efficient and effective methods for connecting the two care sites, and support focused on transitioning SUD patients' between these care settings.

Patient Factors

Among SUD patients, those without a physician were often male and of younger age.⁹ Also influencing the receipt of healthcare services are the patient's substance of choice, level of distress, attitudes, and social support, and the cost of care and ease of access.²⁴ Primary care patients are more likely to have problems related to alcohol than to illicit drugs.²⁵ Patients may believe that they do not need primary care, their SUD makes them ineligible for seeking primary care, the PCP will treat them with disrespect or mismanage pain-related conditions, or other people will find out about their substance userelated problems.¹² Patient factors, such as beliefs, values, and ability to maintain abstinence, may play an important role in both obtaining primary care and accounting for better outcomes observed in SUD patients who receive primary care services. For example, patients who relapse following SUD treatment may be especially reluctant to obtain primary care because of feeling awkward or embarrassed about not being able to maintain abstinence,¹² leading to self-selection bias in attributing poor outcomes to the lack of primary care alone.

Consistent with primary care shortages in poor and rural communities,²⁶ other barriers to medical care reported by SUD patients involved payment (no insurance, no way to pay for services even if insured, not eligible for free care) and access (unaware where to go for care, do not speak English, no transportation, inconvenient clinic hours, unable to miss work, no child care) barriers.¹² Barriers, such as lack of knowledge about how to efficiently access healthcare and feeling overwhelmed at the prospect, are associated with less satisfaction with the healthcare system among drug users when compared to non-drug users.²⁷

Provider Factors

AT program staff may be unaware of the benefits of primary care to patients' SUD recovery. To ensure their patients' engagement with primary care, providers in AT programs may need to provide education to patients about available primary care resources, and especially among those without health insurance. This may require increasing patients' knowledge of or access to free or publicly funded programs, such as Medicaid. Knowing about available treatment resources, and having a clear plan to access services, will likely help facilitate patients' access to primary care.²⁸ AT program staff may have or develop ongoing relationships with primary care sites to which they refer patients.²⁹

SUD treatment providers are likely to lack training in transition practices.³⁰ Formal training in care transitions that improves communication, such as sharing confidential information with appropriate releases with PCPs, and learning to regularly elicit and implement patient and family preferences into treatment plans, may be critical for improving the care transition process. Indeed, a study of care coordination practices identified the weakest step to be feedback from SUD treatment providers to PCPs; among patients in SUD treatment, provider collaboration and information sharing was minimal.⁸ It is also imperative that AT providers understand and support PCPs' prescription of medications for treating common comorbid health conditions including pain, hypertension, and depression, and that the two types of providers work together to integrate these treatment recommendations into the larger SUD treatment plan.

AT staff may be dissuaded from primary care facilitation by awareness that PCPs themselves may be reluctant to engage in SUDrelated monitoring and management. This reluctance has been apparent in efforts to increase PCPs' integration of buprenorphine treatment for opioid addiction into their practices, which was allowed by the Drug Addiction Treatment Act of 2000. Although PCPs view greater continuity of care as an incentive for such integration, many disincentives exist including lack of addiction expertise and training, confidence, interest, time, remuneration, and counseling services which enhance pharmacologic treatment; competing activities; institutional and partner resistance; and concern that patients would worry about confidentiality and cost, and lack both need and motivation.^{31,32} These potential obstacles are significant in that >40% of physicians allowed to treat patients with buprenorphine had not done so, and of those who had, 25% stated that these challenges had caused them to reduce or discontinue this treatment.³³ Greater incentives and clinical support have been identified as potentially facilitating expansion of buprenorphine maintenance therapy into primary care^{34,35} which could be used as a model for enhancing SUD care within this setting.

The challenges of implementing buprenorphine treatment reflect more general providerrelated barriers to addiction management in primary care. Despite demonstrations that specific physician-training curricula, especially those incorporating interactive teaching methods with experiential and didactic components,

increase self-efficacy in addiction management,36-38 addiction-related training remains under-emphasized compared with training in other chronic medical disorders.³⁷ Physician trainings in addiction focus initially on SUD epidemiology and medical impact. Providers then learn about interventions for substance misuse in primary care that are relatively well-established and include identification (i.e., screening and brief assessment to categorize patients as hazardous users or as having substance abuse or dependence) and management with specific strategies (i.e., brief intervention for hazardous use; brief counseling with ongoing follow-up and reevaluation for substance abuse; referral to specialty care with counseling and pharmacotherapy for substance dependence).39-41

Much less established are effective approaches to SUD management in primary care after patients successfully transition from specialty care. Recommendations are that the physician should remain nonjudgmental while monitoring the patient's recovery.⁴¹ Monitoring may include patient and family interviews, physical and psychological exams, review of medications, laboratory studies, and encouragement of recovery activities.^{42,43} To promote physician uptake of SUD management in their practices beyond current levels, suggestions are to offer online trainings, but more importantly, to develop physician role models to provide supervised experiences to medical staff, expose physicians to patients who have benefitted from treatment, provide adequate reimbursement and supportive administrative environments, and reinforce trainings with multiple, longitudinal follow-ups, especially for physicians hesitant to begin SUD management, to improve and maintain impact.^{37,44,45}

System Factors

The context in which AT is positioned, such as part of a larger healthcare system or as a standalone clinic, may impact the transition process. Managed care or health maintenance organizations may foster ongoing patient-provider relationships through the gatekeeper system and the requirement that patients choose a single PCP. Managed care is a potential mechanism for ensuring continuity and better access to providers, especially among Medicaid patients.¹³ Primary care practices with fewer staff tend to lack dedicated care coordination, and are less likely to provide positive patient experiences at a sustainable cost.46 Formal relationships between care settings, and the availability of information systems such as electronic medical records that facilitate the sharing of critical information between care sites, vary according to setting location and have implications for the ability to transition patients to primary care. The availability of comprehensive medical records that contain all care received and recommended across sites, and contact information for all providers involved in patient care, offer greater opportunity for AT programs to improve transitions to primary care.⁴⁷ Also conceptually appealing, although untested with regard to AT to primary care transitions, is the use of incentives for providers to manage patients to make the transition successfully.⁴⁸ Such performance-based contracting has been shown to be associated with improvements in length of treatment stay and wait times for treatment,⁴⁹ although not consistently.⁵⁰

EVIDENCE-BASED STRATEGIES TO FACILITATE PRIMARY CARE

Interventions to improve care transitions from AT to primary care are presented in Figure 1. Example interventions are presented from most to least resource-intensive to provide AT directors, managers, and providers options for improving the use of primary care in this patient population.

Co-Location and Integration of AT and Primary Care

Co-location, or in this context, "reverse" co-location, refers to the integration of primary care into a behavioral health setting.^{1,2} This concept contrasts from the more widely known model of co-location, whereby mental or

behavioral health services are located within a primary care setting. Thus, reverse co-location typically includes stationing a full- or part-time PCP into a specialty mental health setting.⁵¹ Importantly, co-location differs from the concept of integration, which involves more than simply co-locating a physician or mental health provider within a specialty setting or primary care setting, respectively (www.integration. samhsa.gov/integrated-care-models).

Integration covers the dimensions of program structure and milieu; assessment, treatment, and continuity of care; and staffing and training.⁵² Integrated approaches may lead to improvements in substance use outcomes² and initial and longer-term use of outpatient medical care services⁵³ among patients with SUDs. For example, when detoxification patients were randomized to receive primary care in either an integrated primary care clinic or in a separate but nearby clinic, both groups improved in alcohol and drug use severity at 6 months posttreatment.² However, patients with substance use-related psychiatric and medical conditions receiving integrated care showed higher abstinence rates.² A comparison of per patient medical costs showed the integrated protocol to be a cost-effective option, especially for patients with substance use-related medical conditions. To extend this line of research in a wider variety of AT programs, Friedmann et al.¹ examined outcomes among patients receiving colocated primary care in 52 AT programs across the United States. Patients in clinics with colocated primary care showed greater improvements in substance use severity at a 12-month follow-up when compared to patients in clinics without onsite primary care.

Co-located primary care within AT may also increase initial and subsequent use of onsite primary care among SUD patients with at least one chronic medical condition even after discharge from AT. Patients with both SUD and a chronic medical condition assigned to a colocated primary care clinic reported fewer days to receiving an initial primary care appointment and greater odds of initial attendance and return visits to primary care, when compared to patients assigned to an off-site primary care clinic.⁵⁴ Patients assigned to the co-located protocol received care from nurse practitioners and physicians' assistants without specialized training in SUDs. They were more likely to have greater SUD treatment engagement at 60 and 90 days post-treatment entry and fewer visits to the emergency department. However, no direct benefits were observed on substance use outcomes among patients assigned to the co-located approach.⁵⁴

Facilitated Referral to Primary Care

Another method to ensure that patients engage with primary care following discharge from AT is facilitated referral.^{5,55,56} This approach involves utilizing a social worker, nurse, physician, or other staff member serving in a case management role in an AT setting to help facilitate the linkage of patients to offsite primary care appointments.^{55,56} The provider first conducts a health evaluation that includes education about the importance and potential health benefits of receiving primary care, followed by contacting the patient, and family and friends if necessary, by phone after discharge to provide reminders about upcoming primary care appointments, and to conduct appointment rescheduling if necessary.^{55,56} The initial appointment is made with special attention to the patient's preferences regarding the physician's gender, particular expertise, scheduling availability, and spoken languages. A detailed letter containing the patient's medical conditions is provided to the offsite primary care clinic to support the referral process. Facilitated referral is associated with increased rates of primary care usage and reduced substance use compared to standard care among detoxification patients.^{5,55}

The Primary Care Research in Substance Abuse and Mental Health for the Elderly (PRISM-E) study compared integrated behavioral healthcare (a behavioral health professional was co-located in the primary care setting, and the PCP continued involvement in the patient's mental health/substance abuse care) to enhanced specialty referral care in primary care settings. Patients (who, on average, drank only seven drinks per week) were more likely to

engage in treatment for at-risk alcohol use (not alcohol dependence), depression, or anxiety in the integrated model than in the enhanced referral model (71% versus 49%, respectively). In addition, greater engagement was associated with closer proximity of substance abuse or mental health services to primary care.⁵⁷ Despite greater engagement by those in integrated care, a 6-month follow-up found that atrisk drinkers in both conditions substantially reduced their drinking.⁵⁸ Most PCPs in the study (N = 127) stated that integrated care led to better communication between PCPs and mental health specialists (93%), less stigma for patients (93%), better coordination of care (92%), and better management of alcohol problems $(66\%).^{59}$

Despite the clear benefits of co-location, integration, and facilitated referral, factors such as limited financial resources, staff size and training, and available space make the task of improving the accessibility and engagement of primary care services within AT settings an enormous challenge for providers and clinics.^{5,6} Although it may be feasible for some wellresourced AT clinics to adopt and implement a co-located primary care clinic or facilitated referral, widespread adoption of these strategies will likely remain elusive. It may, however, be more feasible for AT settings to adopt components of these approaches such as providing education to patients on the benefits of seeking primary care, available care options, and how to address insurance and coverage concerns, as well as implement follow-up procedures such as periodic reminders via telephone or other means (e-mail, letter) to schedule or attend follow-up appointments.

Brief Counseling and Referral to Primary Care

Many AT settings will not have the capability to implement co-located or integrated services and/or facilitated referral out of concern for impact on limited resources. In such cases, they may choose to implement components of these intervention approaches with the hope that some portion of effects observed in more comprehensive packages will generalize to their setting and patient population. Another option may be to adopt briefer approaches, such as counseling and referral.

Project ASSERT [improving Alcohol and Substance abuse Services and Educating providers to Refer patients to Treatment] was developed as a brief approach to facilitate referral to primary care and other services for patients with SUDs presenting to emergency departments.²² It includes the detection of SUDs, a brief counseling session based on the principles of motivational interviewing, and linkage to primary care and specialty care services.²² The counseling session consists of establishing rapport, providing feedback and education about the importance of receiving primary care or other relevant services, and assessing readiness to accept a referral using a single-item "readiness ruler" (1 to 10, with 10 indicating readiness). Depending on the patient's response, counseling follows to either help facilitate the referral process or address ambivalence to receiving a referral.²² In a pre-post-evaluation of this approach, 47% of 1,096 enrolled substance misusing patients received a referral to primary care. Although follow-up rates were low (22%). among those who did return for 60- and 90-day follow-ups and had received a referral, alcohol, and drug use severity was reduced and satisfaction with the referral process was high.²² This approach may be promising, but the existing evidence is not yet sufficient for demonstrating effectiveness. Studies are needed to determine whether this approach will reveal itself to be an effective method for transitioning SUD patients from AT to primary care.

DISCUSSION

This article put forth promising approaches to help AT settings transition patients with SUDs to primary care: reverse co-location and/or integration of primary care in AT settings, facilitated referral from AT to primary care, and brief counseling and referral. Depending on available resources, the feasibility of implementing these models may be limited, and in such cases, components of these models may be utilized, although with as-yet unknown effectiveness. Brief counseling and referral in particular may hold promise as a relatively low-cost method for connecting patients with SUDs to primary care. Research should determine whether this approach is effective in improving rates of initial and longer-term engagement with primary care in this patient population, and whether it has corresponding health benefits, including reductions in substance misuse and inappropriate use of costly inpatient and emergency health services.

More generally, research is needed to examine the comparative effectiveness of the presented approaches in improving primary care access and health outcomes. Future studies might also focus on examining the effectiveness of "trimmed down" (e.g., use of periodic reminders, "light" case management) versions of these strategies and identifying resources needed for their successful implementation. Studies finding components or lighter versions of these more comprehensive models to be effective may have the upshot of increasing enthusiasm on the part of AT settings, especially those with limited resources, to adopt such care practices.

Conceptual Model

As a basis for these practices, we also presented a new conceptual model to help facilitate transitions from AT to primary care and to potentially guide future research on how to make this transition a successful one. A variety of patient, provider, and system factors may impact the process of transitioning patients with SUDs to primary care. Factors include patients' awareness of available resources and their self-appraised beliefs about the need for such services, as well their health insurance status. Limited or lack of health insurance will create challenges for AT settings to support the transition of SUD patients between AT and primary care. The changing landscape of health insurance coverage in the United States, and the growth of "mini clinics" in large retail stores (e.g., Walgreens, Wal-Mart) will likely have an effect on the availability of such services. Implementation of the Affordable Care Act (ACA; 2010) may also increase the need for a science of care transitions as it mandates greater coverage for SUD treatment. Indeed, the ACA considers SUD treatment an "essential service," and mandates the integration of preventative and long-term management of SUDs in primary care.⁶⁰ Greater numbers of individuals eligible for AT services and the increasing role of primary care in the prevention and long-term management of SUDs suggests a growing importance to enhance collaboration between these care settings, including improving pathways by which patients transition from primary care to AT and back again as needed.

It will also be important for providers to become aware and remain knowledgeable about new healthcare policies and emerging options for patients to obtain primary care to optimize the transition process. Provider factors, including overcoming real or perceived barriers to sharing patient information, as well as communicating about, supporting, and integrating treatment recommendations from both AT and primary care into the treatment plan, are needed to ensure truly coordinated care. System factors, such as the strength of the formal relationship between the two care sites⁸ and strategies for managing the possibility of missed appointments in this patient population^{61,62} will play an important role in whether practices that have the potential to improve the transition of patients from AT to primary care are adopted. For example, providing patients with education on the effects of no-shows, doublebooking, and limiting the interval between date requesting an appointment and date actually seen can reduce primary care no-show rates;⁶¹ these methods may be helpful for primary care patients challenged by substance abuse issues.

Limitations

Because model domains were incorporated from existing models that describe care transitions of other patient populations (e.g., long-term care, patients receiving emergency medicine), the present model may be missing other key elements important to consider in understanding factors that impact the transitioning of patients from AT to primary care. In addition, the authors did not conduct a systematic evidence review of care practices that may support AT settings in helping patients gain access to primary care. Therefore, there may be evidencebased or promising intervention strategies that need to be considered in addition to those presented in this article. Furthermore, as stated earlier, intervention strategies were presented (e.g., Project ASSERT) that require evaluation in the context of improving patients' access and engagement to primary care from the AT setting.

Directions for Future Research

In addition to the model presented here, future research on facilitating transitions from AT to primary care should focus on evaluating interventions that have been shown to help with other types of care transitions. For example, the health evaluation and referral assistant (HERA) is a web-based program designed to facilitate screening, brief intervention, and referral to treatment (SBIRT) for tobacco, alcohol, and drug abuse among patients seen in emergency departments.⁶³ Project Engage, also designed to facilitate entry of emergency department and inpatients with SUDs to AT, utilized a patient engagement specialist.⁶⁴ Similar research is needed to enhance understanding of whether computer-facilitated and specialist referrals can impact the promotion of primary care adherence, as well as its effect on subsequent substance use and related outcomes.

Finally, in the interest of making transition facilitation efforts efficient, it will be fruitful to focus on SUD patients who might show the most short-term benefit by having a PCP involved in their treatment. These might include patients receiving medication-assisted treatments for opioid or alcohol dependence or patients who have one or more chronic health conditions, such as asthma and high blood pressure.¹¹ Emphasizing specific groups to promote efficient use of resources may make facilitation efforts more amenable to health plans and payers. The normalization of collaboration among providers and coordination of care serving patients in treatment for addiction, as we have tried to move forward here, should improve health service quality and efficiency.65,66 Such normalization will be fostered as American healthcare overcomes the barriers entailed by behavioral and medical health providers operating in separate silos, as if biomedical and psychosocial concerns are distinct and parallel domains.^{51,67} The merge of medical and SUD/mental health funding streams would greatly accelerate the development and implementation of innovative strategies to transition patients to settings in which the full range of their care needs can be met.⁶⁸ Patients, providers, and health systems will function more optimally when interlocking clinical, operational, and financial practices are matched to the reality we confront daily, namely, that SUD patients need regular medical care after AT ends. Merged funding streams whereby healthcare plans pay for medical and mental healthcare from the same pot of money would structurally facilitate effective care transitions.67,68

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