



# NMF Standards of Care

*Improving the Quality of Addiction Treatment*

## NMF Standards of Care

### *Frequently Asked Questions*

***Q: Why do we need standards for treatment of substance use disorders?***

For many years, experts have agreed that treatment for substance use disorders (SUD) should follow a chronic, not acute model of care in which a full continuum of services is offered as appropriate, with reciprocal linkages to other medical and mental health treatment services and settings. Experts have also agreed that general medical settings (*i.e.*, emergency rooms, trauma centers, and doctors' offices) are places where patients should be screened for drug/alcohol use and appropriate interventions taken. Despite widespread agreement, a conceptual framework that embraced and collapsed both sets of principles and practices into their component parts ("domains"), each separately defined, had not been clearly set out or gained widespread acceptance. That changed with introduction of the NMF Standards.

***Q: Describe the Standards.***

There are eleven standards grouped into four domains: *Identification* involves screening and case finding for patients presenting in healthcare and mental health settings as well as diagnosis and biopsychosocial assessment using standardized tools; *Initiation and Engagement* applies to medical settings in which brief interventions may be carried out when unhealthy patterns of substance use (not rising to the level of an SUD) are detected, as well as specialty settings which should be promoted and patients referred to if an SUD is detected; *Therapeutic Interventions* in specialty care specifying management of detoxification with medications (as appropriate), psychosocial interventions using evidence based practices, and medications directly linked to clinical care; and *Continuing Care* calling for long-term, coordinated patient care during transitions across levels of care and following acute SUD treatment, including patient monitoring, recovery support services, and recovery management.

***Q: Do the Standards apply to treatment for substance abusing offenders?***

The Standards were designed to be applied in *all treatment settings for diverse populations*. Although no specific population other than "adults" is identified, the Standards would be fine for criminal justice populations with some customization. The same is true for treatment of adolescents. In both cases, the Standards identify appropriate domains although the specific strategies may have to be revised for these populations.

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***Q: If a chronic care model with appropriate involvement by general medicine is the goal, why not just mandate adoption of the Standards in all medical and specialty care (SUD treatment) settings?***

The short answer is that the substance abuse treatment delivery system in this country was organized, financed and regulated around an acute, not chronic model, one that never envisioned multiple inputs and outputs. Ditto for the medical system: doctors never envisioned needing to look for, much less respond to drinking or drug taking in patients. System change is a lot of work, and states and local governments and treatment counselors need to plan for and prioritize changes and need technical assistance to do so. An additional complication is that over 80% of SUD treatment in the specialty sector is funded by public dollars. So, the Standards have to be adopted by public sector providers in a treatment system in which only 40% of facilities have more than 60 clients at any one time, less than 20% of treatment programs use medications (N-SSATS, 2007), and in which coordination between primary and specialty care is not a tradition.

***Q: Are there examples of the system changes possibly required?***

A short, not comprehensive list would include some or all of the following:

- ◆ If you are a policy maker, is the assistance offered by medical societies and others to doctors and medical subspecialists sufficient for them to be able to implement the Standards or do you need to add incentives?
- ◆ Can you promote a continuum of treatment services by revising purchasing practices - contract-based incentives, for example - or through accreditation changes?
- ◆ How do you measure and report performance results and patient health status outcomes to satisfy accountability requirements?
- ◆ How do you encourage involvement from non-AOD agencies – criminal justice, for example where there are different attitudes and practices related to treatment and different funding streams to pay for it?
- ◆ If you are a provider of treatment services and want to refer patients to additional services, how do you overcome confidentiality protections when referrals require sharing of patient data?
- ◆ For everyone: do you have the right data collection systems that allow confidential data to follow patients and be shared?
- ◆ What kinds of continuing care systems do you need to provide? What kinds can you afford?
- ◆ What types of professional and continuing education are required for treatment counselors, nurse practitioners in healthcare settings, and social workers to provide services that meet the standards of care?

***Q: Implementation sounds daunting. Why pursue at this time?***

In the middle of the worse recession to hit this nation since the Great Depression, now is the perfect time to pursue low-cost capacity building that positions state and local systems for better outcomes - and associated cost savings - when funding streams recover and healthcare reform increases benefits for and access to treatment for increasing populations in need.