



Commentary

David H. Gustafson (1940–2026): A tribute

Victor Capoccia^{a,*}, Dennis McCarty^b, James H. Ford^c, Kim A. Hoffman^d, Kim Johnson^e,
Todd Molfenter^f, Elizabeth Owens^g, Andrew Quanbeck^h

^a Retired and Volunteer, Vineyard Haven, MA, 02568, United States of America

^b Oregon Health & Science University, Portland, OR, 97239, United States of America

^c School of Pharmacy, University of Wisconsin, Madison, WI, 53705, United States of America

^d School of Medicine, Department of General and Internal Medicine, Oregon Health and Science University, Portland, OR, 97239, United States of America

^e Department of Behavioral Health Science and Practice, University of South Florida, Tampa, FL, 33612, United States of America

^f College of Engineering, University of Wisconsin, Madison, WI, 53706, United States of America

^g Center for Health Systems Research and Analysis, College of Engineering, University of Wisconsin, Madison, 53796, United States of America

^h School of Medicine and Public Health, Department of Family Medicine and Community Health, University of Wisconsin, Madison, WI, 53705, United States of America

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ABSTRACT

David H. Gustafson, PhD, contributed to improving the quality of services for the treatment of alcohol and drug use disorders, and the addiction health services research that evolved with the maturation of NIATx's improvement strategies. David led the development of NIATx (originally the Network for the Improvement of Addiction Treatment). David died March 3, 2026.

Addiction health services research and practice lost a leader in the application of process improvement and use of technology to the treatment of alcohol and drug use disorders.

David studied patient and client experiences to improve healthcare, addiction, and behavioral health services. He began public presentations with a humble smile stating simply “Hi, I’m Dave Gustafson.” He immediately communicated his desire to connect with the audience regardless of its size or prominence. David explained he was an engineer and not an expert in addiction treatment, prevention, and recovery support. He asked what others knew, gave credit to the audience, and told them they were the experts.

His presentations explained how he ‘became the patient.’ These were not secret shopper jaunts; they were done with the knowledge and understanding that he would be treated as ‘anyone’ seeking the same treatment. He was admitted and processed, short of an actual intervention. When he began to work on improving behavioral health, he telephoned the county detoxification center and sought help for his “drug” use. The receptionist explained that everyone seeking admission calls daily and are admitted when a bed is available. Dave called every day for a month. He experienced delayed access to care. When a bed was open, he was treated like every patient. He completed forms and answered redundant questions. He was stripped and searched for

contraband. His phone was taken. Dave found that admission to treatment can be dehumanizing and isolating. He spent a night in the detox bed listening to women and men moaning during opioid withdrawal and understood that care for many was ineffective. David’s first contribution to behavioral healthcare was reminding us to “*understand the customer experience*.” The ‘Walk Through’ is a simple and basic step – be the customer. This basic principle is often lost in the regulatory and financing systems that support care.

As a cofounder (Berwick, Batalden & Gustafson) of the Institute for Healthcare Improvement (IHI), an international organization seeking a reduction in errors in healthcare and improved care quality in community, acute specialty care hospitals, the Robert Wood Johnson Foundation (RWJF) invited David to lead a national program office that would apply IHI methods to strengthen care in community-based addiction treatment programs. The program, initially called “Paths to Recovery”, released a request for proposals, held four national regional meetings to explain the initiative, reviewed over 300 three-page letters of interest, and selected 20 applications funded in two cohorts (McCarty et al., 2007). The Substance Abuse and Mental Health Services Administration’s (SAMHSA), Center for Substance Abuse Treatment (CAST) collaborated with RWJF and added many state directed programs to the cohort of study sites. The RWJF and CSAT awards were integrated as

* Corresponding author.

E-mail addresses: vcapoccia@gmail.com (V. Capoccia), mccartyd@ohsu.edu (D. McCarty), jhfordii@wisc.edu (J.H. Ford), hoffmaki@ohsu.edu (K.A. Hoffman), kjohnson33@usf.edu (K. Johnson), todd.molfenter@chess.wisc.edu (T. Molfenter), b Owens@chrsa.wisc.edu (E. Owens), arquanbe@wisc.edu (A. Quanbeck).

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NIATx (originally, the Network for the Improvement of Addiction Treatment) (Capoccia et al., 2007).

Over a ten-year period, David and his team exposed an estimated 4000 community-based treatment organizations to five principles of organizational change: 1) involve the customer (conduct a walk through to understand what the customer experience), 2) focus on key problems (serious concerns that make a difference), 3) pick a powerful leader (someone who has the skill, authority and support to lead change), 4) get outside ideas and encouragement (e.g., how hotels enhance customer experiences, how fast food restaurants standardize services, how race car pit crew teamwork fuels cars and changes tires quickly), and 5) use rapid change cycles (plan, do, study, act – PDSA) to make quick incremental change (McCarty et al., 2009). Using these principles the initial cohort of treatment programs reduced days to admission 37% and improved retention rates 18% (McCarty et al., 2007). A second cohort replicated the reduction in days to admission (38%) and the improvement in retention in care (13%) and the initial cohort maintained the reduction in days to care and improved retention for 15 additional months (Hoffman et al., 2008). The initial program documented the potential for improvements in care for alcohol and drug treatment services.

NIATx became the foundation for 25 years of work focused on improving the patient experience for people with alcohol and drug use disorders and comorbid mental health problems. RWJF supported two additional initiatives that applied quality improvement techniques to maximize state financing (Resources for Recovery) and remove regulatory and system barriers that inhibited the use of evidence-based practices (Advancing Recovery) (Ford et al., 2017). Research awards from the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Addiction (NIAAA) scaled up the NIATx intervention to work with 200 treatment centers in five states (NIATx 200) (Gustafson et al., 2013), supported studies of sustainability (Ford et al., 2012; Ford & Gilson, 2021), promoted adoption of buprenorphine in Ohio (Molfenter et al., 2019), addressed co-morbid disorders (Franz et al., 2025), improved co-occurring capacity in Washington (Assefa et al., 2019, Chokron Garneau et al., 2022) and enhanced services in criminal justice settings (Molfenter et al., 2025). Overall, the NIATx process was scaled up and generalized to improve care in heterogeneous settings and treatment populations.

The engineer in David drove his interest in how technology can efficiently reach more people, with consistent information and interventions. A presentation on ‘affective computing’ by the MIT Media Lab in a 2006 meeting David organized to envision the future of addiction treatment, evolved to the development and testing of applications (apps) known as A-CHESS (Addiction – Comprehensive Health Enhancement Support System). Variations of the A-CHESS app included creation of peer-led discussion groups, real time connections with urgent care counselors, and highly targeted evidence-based practices and messages that supported recovery and return to treatment for a variety of populations as well as for different substances (Gustafson et al., 2014).

In the final analysis, empathy was the secret sauce in David's work. He improved health care quality, increased access, and developed technologies to disseminate and support effective interventions. Empathy identified the *critical points of suffering* and the focus of his work. David's empathy for patients *led to interventions* and *drove the use of technology* to relieve points of suffering, overcome barriers to care, and widely disseminated interventions. From asthma, to addiction, to breast cancer, and other chronic illnesses, David's empathy was the essence of “understanding the customer experience” or “the Walk Through”. The core idea he expressed and that defined his extraordinary career: “It's just so darn important we keep in mind that there are people out there who are suffering, who we need to be helping; We just have to remember who we're trying to help.”

David's legacy to our field is the empathy that informed his research; his translation of research to practice; and his mentorship for the next

generation of healthcare engineers. We are grateful for David's leadership, vision, skill, and commitment.

CRedit authorship contribution statement

Victor Capoccia: Conceptualization, Writing – original draft, Writing – review & editing. **Dennis McCarty:** Conceptualization, Writing – original draft, Writing – review & editing. **James H. Ford:** Writing – review & editing. **Kim A. Hoffman:** Writing – review & editing. **Kim Johnson:** Writing – review & editing. **Todd Molfenter:** Writing – review & editing. **Elizabeth Owens:** Writing – review & editing. **Andrew Quanbeck:** Writing – review & editing.

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