State-level Contingency Management Programs: Training, Outcomes, & Provider Panel

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Disclosure Information

- Michael McDonell, PhD
  - Paid by the states of Montana and Washington to provide training and technical assistance
- Sara Parent, ND
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- K. Michelle Peavy, PhD
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- Katherine Pinnell, RN-MSN
  - No Disclosures
- Keshia Flaten
  - No Disclosures
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How to Design, Implement and Support a State-wide Contingency Management Intervention for Stimulant Use Disorders

Michael McDonell, PhD

Department of Community and Behavioral Health
PRISM Collaborative
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Learning Objectives

- Describe the ingredients of effective CM, research supporting CM, and federal regulations relevant to CM
- Our team’s CM training and implementation model
- Creation of culturally tailored training and implementation supports
What is Contingency Management?

- A behavioral treatment for substance use disorders that uses **positive reinforcement** to encourage **substance abstinence**

Petry, 2011
CM: Key Ingredients

1. **Define behavior goal:** Stimulant negative urine

2. **Measure behavior goal:** Point of care urine drug screens

3. **Give tangible reinforcement:** e.g. Gift cards

4. **Give contingent reinforcement:** Gift card only provided when target behavior is measured

5. **Give consistent and frequent reinforcement:** Twice weekly; 12 weeks
CM: Does it Work?

- Meta-analysis of 60 studies of CM for MOUD patients
- CM targeting stimulant use:
  - Large Effect Size (Cohen d=0.7)

Bolivar et al., 2021
Does it Work?

- 22% more likely to be abstinent for up to 12 months after treatment, relative to people who didn’t receive CM

- Secondary positive effects on
  - Attendance
  - Non-targeted substance use (alcohol, cannabis, nicotine use)
  - Psychiatric symptoms
  - Inpatient psychiatric hospitalizations

Ginley et al., 2021; McDonell et al., 2013
TTA for CM

Phase 1: Planning and Model Development
  Pre-implementation Meetings with funders

Phase 2: Didactic Training
  Overview  Nuts and Bolts

Phase 3: Implementation Coaching
  Biweekly/Monthly Calls with Sites  Monthly Meetings with Funder
Tools for Implementation

- Treatment manual
- Policies and Procedures templates
- Electronic incentive tracker
- Compliance monitoring
CM and Anti-kickback Regulations

- Office of Inspector General regulates the use of incentives in Medicaid/Medicare environments

- Guardrails to protect a CM program:
  - Do not advertise the use of incentives
  - Document need for CM in treatment plan
  - Use an evidence-based CM protocol
  - Document that incentives were only given when behavior goal is objectively demonstrated
  - Do not use cash or cash-equivalents as incentives
Culturally Tailored CM

- CM co-created with American Indian/Alaska Native Communities, two studies:
  - Rewarding Recovery
  - Helping Our Native Ongoing Recovery (HONOR)

McDonell, Hirchak, Herron, 2021
Culturally Tailored CM

- CM group more likely to be alcohol-abstinent compared with the Non-CM group (OR 1.70; 95% CI, 1.05-2.76; \( p=0.03 \))
- Secondary impact on cannabis use.

McDonell, Hirchak, Herron, 2021; Hirchak et al., 2022
Contingency Management in Montana and Washington: Outcomes and Lessons Learned

Sara Parent, ND

Department of Community and Behavioral Health
PRISM Collaborative
Washington State University
Learning Objectives

- Compare and contrast Montana and Washington CM programs
- Describe training outcomes
- Implementation challenges
- Implications for other states, healthcare systems, or providers
TTA Timeline

Phase 1: Planning
First meeting with funder:
MT: January 2021
WA: July 2021

Phase 2: Didactic Training
MT: April 2021; January 2022
WA: Sept 2021; January 2022, May 2022 (refresher)

Phase 3: Coaching
MT: initiated May 2021, ongoing
WA: initiated March 2022, ongoing
CM in MT

1. CM for Stimulant Use Disorder
2. CM program integrated with other behavioral treatments
3. Total reinforcers = $315 ($5 initial/$1.25 escalation)
4. Twice weekly visits for 12 weeks
5. Have submitted a Medicaid Waiver

CM in WA

1. CM for Stimulant Use Disorder
2. CM program connected to SOR contract
3. Total reinforcers = $528 ($10 initial/ $2 escalation)
4. Twice weekly visits for 12 weeks
5. Have submitted a Medicaid Waiver
Training ➔ Coaching ➔ Implementation

- Trained: 35
- MT: 11
- WA: 24
- Engaged in Coaching Calls: 28
- Did Not Engage in Coaching Calls: 7
- Implementing CM: 18
- Not Implementing CM: 10

- 10
- 18
- 8
- 10
- 6
Challenges: provider/patient-level

- Fit with existing services (logistical, philosophical)
- Staffing shortages/turnover
- Agency policies (use of gift cards and point of care drug screen)
- Patient recruitment/retention
Challenges: State/funder-level

- Understanding Anti-kickback regulations\(^1\)
- Funding for sufficient magnitude of reinforcer (incentive)
  - SAMHSA Cap of $75
- Selection of appropriate sites

\(^1\)Medicare and State Health Care Programs: Fraud and Abuse; Revisions to Safe Harbors Under the Anti-Kickback Statute, and Civil Monetary Penalty Rules Regarding Beneficiary Inducements. Federal Register. Published December 2, 2020.
Lessons Learned: Big Picture

- One state-wide model/incentive funding source
- On-going planning meetings with funders
- Monthly coaching calls with providers
- Provide Access to ongoing/on-demand training
- Balance fidelity to the model with site-specific adaptations
Lessons Learned: Specific Examples

- Using Point of Care Urine Tests
- Choosing reinforcers (gift cards; prize-shelf)
- The challenge of twice weekly visits
Contingency Management in Montana and Washington: Provider Perspectives

K. Michelle Peavy, PhD
PRISM Collaborative, Washington State University

Keshia Flatten
Bullhook Community Health Center, Havre, MT

Katherine Pinnell, RN
Providence Northeast Medical Group, Colville, WA
Thank you!!

- We’d like to acknowledge the Montana Primary Care Association and the Washington Health Care Authority for their partnership.
References


More on CM

◆ Contingency Management: Critical Issues for Successful Adoption
  ◆ Tomorrow 10:15-11:30 (Maryland D, Ballroom Level)
  ◆ Presenters:
    ◆ H. Westley Clark, MD, MD, MPH, DFASAM
    ◆ Thomas D. Freese, PhD
    ◆ Richard Rawson, PhD