# Continued Dissemination of Contingency Management in Oregon – New Efforts to Improve Treatment Engagement Among Clients Referred from the Criminal Justice System

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emergence
addiction and behavioral therapies

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# Panelist Introductions

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|---|---|---|
| | John McIlveen | State Opioid Treatment Authority |
| | Kelsey Payne-Smith | SOR Grant Project Director |

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| | Bryan Hartzler | CAAHS Director |

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| | Chris Wig | Executive Director |
| | Laura Cooper | Site Leader/Supervisor |
| | Jason Tran | Site Leader/Supervisor |

TREATMENT PROVIDERS ARE BEING SUPPORTED TO EXPAND

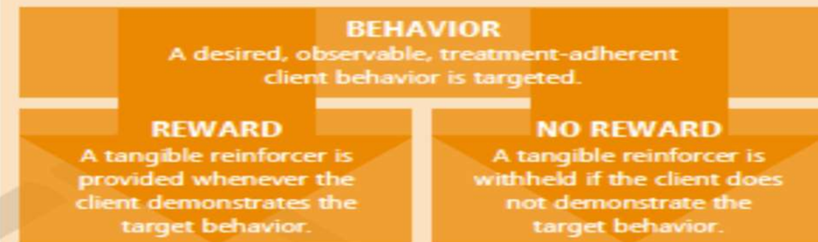
# CONTINGENCY MANAGEMENT IN OREGON

## WHAT IS CONTINGENCY MANAGEMENT?

Contingency management (CM) is an evidence-based therapy that provides incentives to reinforce targeted client behavior among people with substance use disorder (SUD), and more specifically, stimulant use disorder (StimUD). In CM, treatment staff encourage clients to achieve their goals by providing them with material rewards or prizes soon after a client completes a treatment-adherent behavior, like attending a therapy visit, taking a prescribed medication, or abstaining from drug use.

There is robust and reliable research that supports the effectiveness of CM. It is flexible and can be adapted and utilized in a variety of treatment settings.

### THREE CORE TENETS




## HOW DOES OREGON SUPPORT CONTINGENCY MANAGEMENT IMPLEMENTATION?

Since 2020 through the State Opioid Response (SOR) grant, the Oregon Health Authority (OHA) has encouraged CM uptake and supported the implementation of CM across SUD treatment settings in three ways:

### PILOT IMPLEMENTATION

Under the SOR 2 grant, **three treatment programs** received funding to pilot the implementation of CM. Between October 2020 and September 2022, **363** clients with StimUD received CM treatment.

### TRAINING AND TECHNICAL ASSISTANCE

OHA has funded training and technical assistance opportunities for SUD treatment organizations. The CM technical assistance package includes:

- Virtual, in-person, web-based staff training
- Ongoing consultation
- Collaborative design with CM subject matter expert(s)
- Staff readiness assessment
- Program evaluation training
- Eligibility to join the CM Community of Practice

Under the current SOR 3 grant between January 2023 and September 2024, CM training and technical assistance will be provided to up to **fourteen treatment providers**, prioritizing Behavioral Health Networks (BHRNs) providers that were funded to implement CM through the Drug Addiction Treatment and Recovery Act, commonly referred to as Measure 110.

### COMMUNITY OF PRACTICE

OHA is working to develop a **community-based structure to diffuse CM principles** across treatment organizations in the state. Treatment providers will have the opportunity to meet, correct misconceptions, share information, successes, and challenges, and continuously expand, integrate, and improve the quality of CM implementation in Oregon.



DRAFT

# OHA Vision for CM

- SAMHSA's State Opioid Response Grant
  - "Flagship" Federal grant to mitigate opioid and stimulant use and misuse
  - CM as an emerging Federal policy priority
- Co-occurring opioid and stimulant misuse
  - Unique challenges and opportunities
- Development of Partnerships
  - State, academia, providers, stakeholders
  - "Practice based evidence" – one size might not fit all
- Implementation and Education
  - Changing paradigm around addressing substance use
  - Challenging long held beliefs around people and motivation to change behaviors in the field

# What is Contingency Management (CM)?

Something you may already be applying, or have had applied to you…

# CM Defined…

*“Contingency management refers to a type of behavioral therapy in which individuals are ‘reinforced’, or rewarded, for evidence of positive behavioral change.”*

*Source: Petry, 2011*

# Harvesting A Half-Century of Science

- Availability of 648 unique publications describing application of CM programming in addiction treatment settings
- Efficacy for improving treatment adherence among persons with substance use disorders evidenced via 200+ published trials
- Empirical validation of procedurally-diverse CM protocols that utilize setting privileges, vouchers, and/or prizes as reinforcers
- Limited evidence of moderating influences among a set of demographic and economic patient background attributes

*Sources: Forster et.al, 2019; Hartzler et.al, 2012; Hartzler et.al, 2010; Olmstead et.al, 2012*

# What May Promote Wider CM Dissemination?

Customization of CM programming to a given setting's local needs and resources, so it is…

# The Times, They Are (Perpetually) a-Changing…

Sources of continual change for the treatment community:

- Staffing/Turnover
- Program Requirements/Initiatives
- Availability of New Treatments
- Funding/Policy*

# Federal Policy Constraints?

The Health and Human Services Office of the Inspector General, under the Trump Administration, had restricted the value of the reinforcers a patient could earn:

*"Currently, only $75 a year is allowed per patient, whether the payer is Medicaid or a SOR grant."*

As debate continues, some in the treatment community have forged ahead to creatively use other funding sources.

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IN THIS ISSUE...

This week on page 1 we write about the federal government's denial of a request to allow contingency management, the best treatment for stimulant use disorders, to proceed, and a recent study showing that if patients with drugcohol use disorders engage in 12-step groups, the outcomes are far better for

... See stories, this page

GAO: Role of pharmacists in access to bupe shots and implants

... See page 5

## HHS OIG doubles down on constraints against contingency management

**Bottom Line...**

*The request to increase allow payments to patients in contingency management for stimulant use disorder was rejected by the federal government, which calls it a "kickback."*

Stimulant use disorders are on the rise resulting in exacerbation of the opioid epidemic, with stimulants often present in opioid overdoses. Subcontractors are lining up to implement the new stimulant use disorder treatment provisions of the $1 billion annual State Opioid Response (SOR) federal grant program. And contingency management (CM), in which patients are given monetary rewards for not using drugs, is the best — by far — treatment for stimulant use disorder.

Against this backdrop, with tone-deaf timing, the federal government is insisting that CM is not an allowable cost, leaving SOR grantees and their patients with less than optimal treatment options. The federal Department of Health and Human Services (HHS) has held, and last week upheld, that these rewards are actually "kickbacks," because they come out of funding that goes to the treatment provider. Last month a group headed by H. Westley Clark, M.D., J.D., dean's executive professor at Santa Clara University, wrote

See CONTINGENCY MANAGEMENT page 2

# A Significant Undertaking

# A Technical Assistance Package for CM

Offered by the UW UW Center for Advancing Addition Health Services (CAAHS) and with support from the ongoing Oregon SOR grant:

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## Exploration Strategies

Build relationship with community treatment program
Conduct informal assessment of local program needs/resources
Engage in collaborative design to customize CM programming

## Preparation Strategies

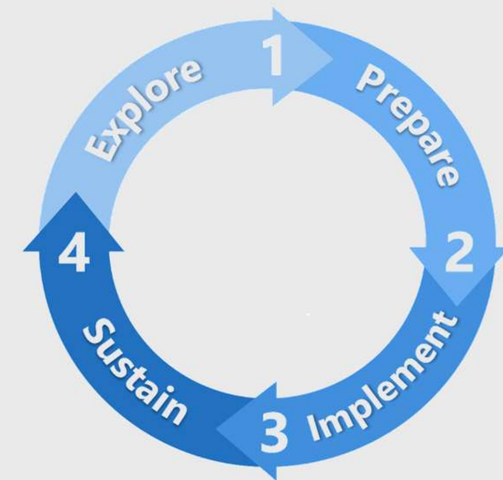
Identify local implementation team comprised of program staff
Examine program systems (ie accounting, documentation, supervision)
Orient staff to CM via sequence of didactic and skills-based training

## Implementation Strategies

Support systems change efforts as program implements CM programming
Provide troubleshooting and support via recurrent consultative meetings
Monitor and evaluate impact of CM programming on desired outcomes

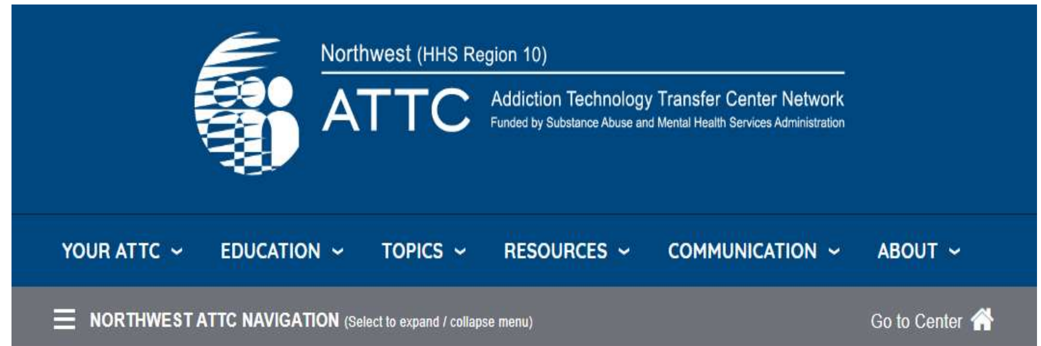
## Sustainment Strategies

Elicit and support a sustainment decision from program leadership
Foster supportive organizational policies to help support CM sustainment
Offer suggestions for creation of on-boarding materials for future staff



# Northwest ATTC Online Training

***"the primary intent of this online course is as <u>a bridge to more intensive technical assistance."</u>***




## Contingency Management for Healthcare Settings

This comprehensive online course, developed by the Northwest ATTC, features separate modules for each of four common personnel roles in healthcare organizations: **decision-makers, clinical supervisors, direct care staff, and administrative support staff.**

Healthcare organizations may utilize these training modules as means of an initial introduction to CM principles and practices for their staff; however, **the primary intent of this online course is as a bridge to more intensive technical assistance—as outlined by Hartzler and colleagues in this article in the *Journal of Substance Use and Addiction Treatment* (2023)** (free online).

All four modules include an introduction to contingency management (CM) describing:

- its core elements,
- 3 scientifically-supported systems,
- how it can be used in healthcare settings to have a positive impact on clients.

Each module also offers unique content on how each role can successfully integrate CM into their program.

***CEU Available!*** 1.0 Decision Makers, 2.5 Clinical Supervisors, 2.0 Direct Care Staff, 1.0 Administrative Support Staff.

In response to SAMHSA instruction provided to State Opioid Response grantees (in FY 22 SOR Grants TI-22-005, Appendix J: Contingency Management), a set of **four supplemental brief information guides** have been created on targeted topics to complement the material included in this online course. These information guides provide further information on: **Discussing Client Eligibility**, **Allowable Rewards**, **Drug Screening Methods**, and **Documentation Practices**.

**Find the complete set of modules on HealtheKnowledge.***

Other Intensive TA Provisions:

1) Organizational consultation on CM programming design and planning
2) Skills-based virtual coaching, with training-to-criterion process
3) Resourcing of a 'CM library' to benefit current and future staff
4) Troubleshooting during active implementation in the setting
5) Focused training in methods of program evaluation to aid programs' assessment of clinical effectiveness

# Establishing Organizational Readiness

Collaborative Design of Customized CM Programming. An iterative process that pools expertise to produce theoretically sound, clearly-defined CM programming tailored to a setting's needs and resources.

Preparation of Clinical Staff. Inclusion of didactic and skills-based training, the latter allowing for demonstration of capable CM delivery by individual clinical staff members.

Coordination of Supporting Systems. Assembly and support of a local implementation team to identify and address setting systems that will be involved in active implementation (i.e., accounting, clinical documentation, staff supervision, program evaluation).

# Collaborative Design – A Pooling of Expertise

Subject Matter (CM) Knowledge

Local Setting Experience

Organizational Vision

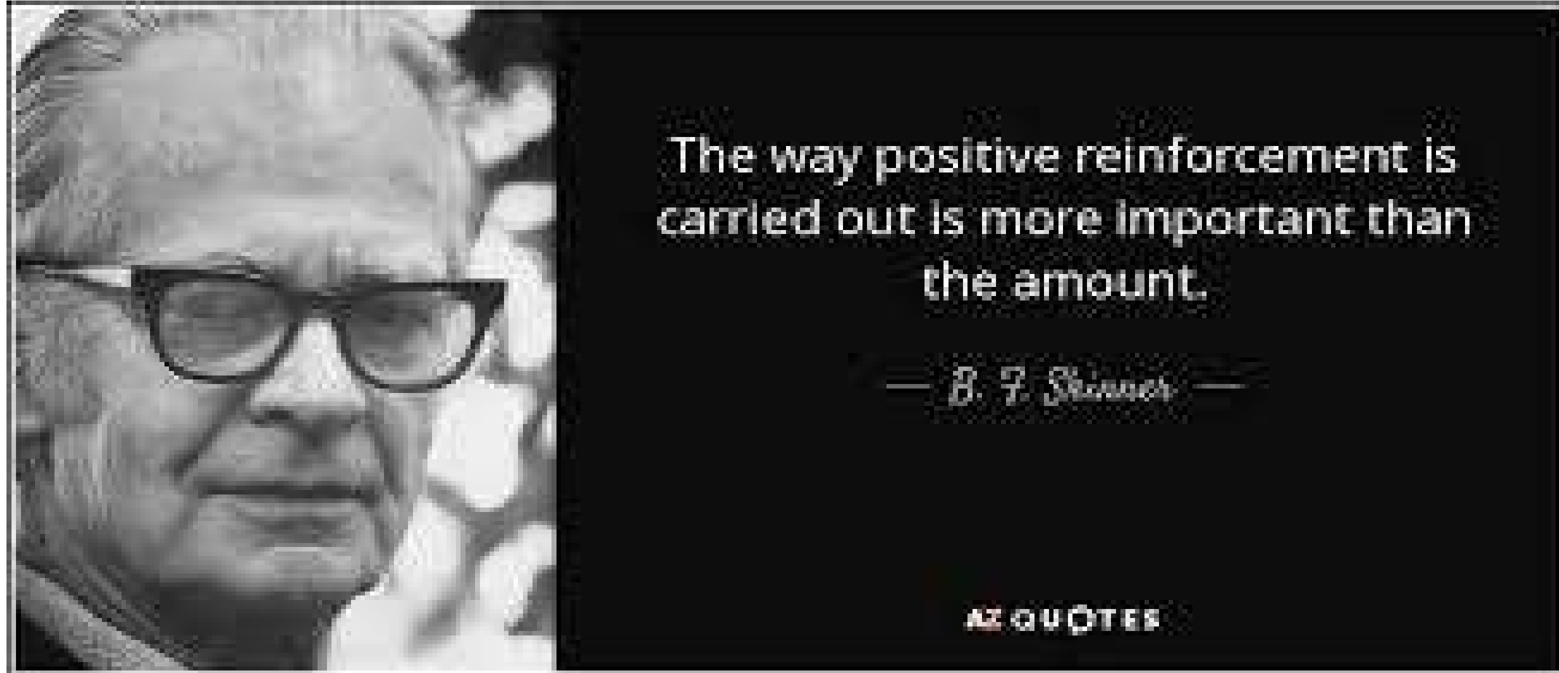
# Establishing Organizational Readiness

Culling of Customized CM Programming – clearly-defined CM programming tailored to the setting's needs and resources

Preparation of Clinical Staff – didactic and skills-based training, to include demonstration of capable CM delivery by individual staff

Coordination of Supporting Systems – identification of staff and processes that will support active implementation (i.e., accounting, clinical documentation, staff supervision, program evaluation)

# Fidelity Matters




- Six communication-focused skills in CM delivery, per validated fidelity scale*
- This skillset is universal across diverse CM paradigms/protocols
- Clinician skillfulness predicts clinical outcomes of CM (Petry et.al, 2014; Hartzler et.al, 2017)

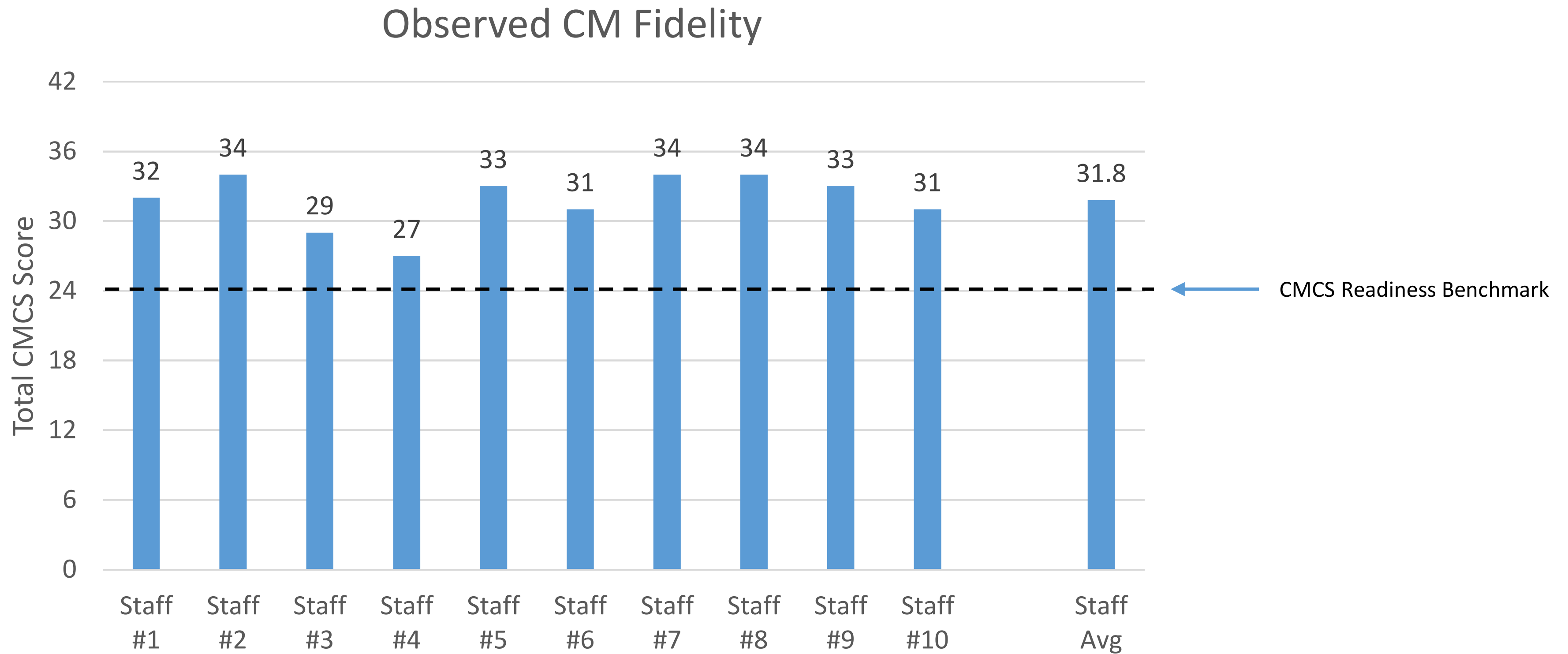
* Contingency Management Competence Scale (CMCS; Petry et.al, 2012)

# Skills-Based Coaching

The CAAHS coaching-to-criterion process includes:

- Two-hour group-based virtual coaching sessions (6 hrs total, typically)
- Primary focus on live demonstration and behavioral rehearsal
- Simple client scenario to start, later branch out to clinical challenges
- Eventual individual readiness assessment, with standardized patient, at which trainer uses fidelity rating scale and provides immediate feedback

# Staff Readiness to Implement




In an observed encounter with a standardized patient, each trained Emergence staff member exceeded an *a priori* competency benchmark for delivering CM.

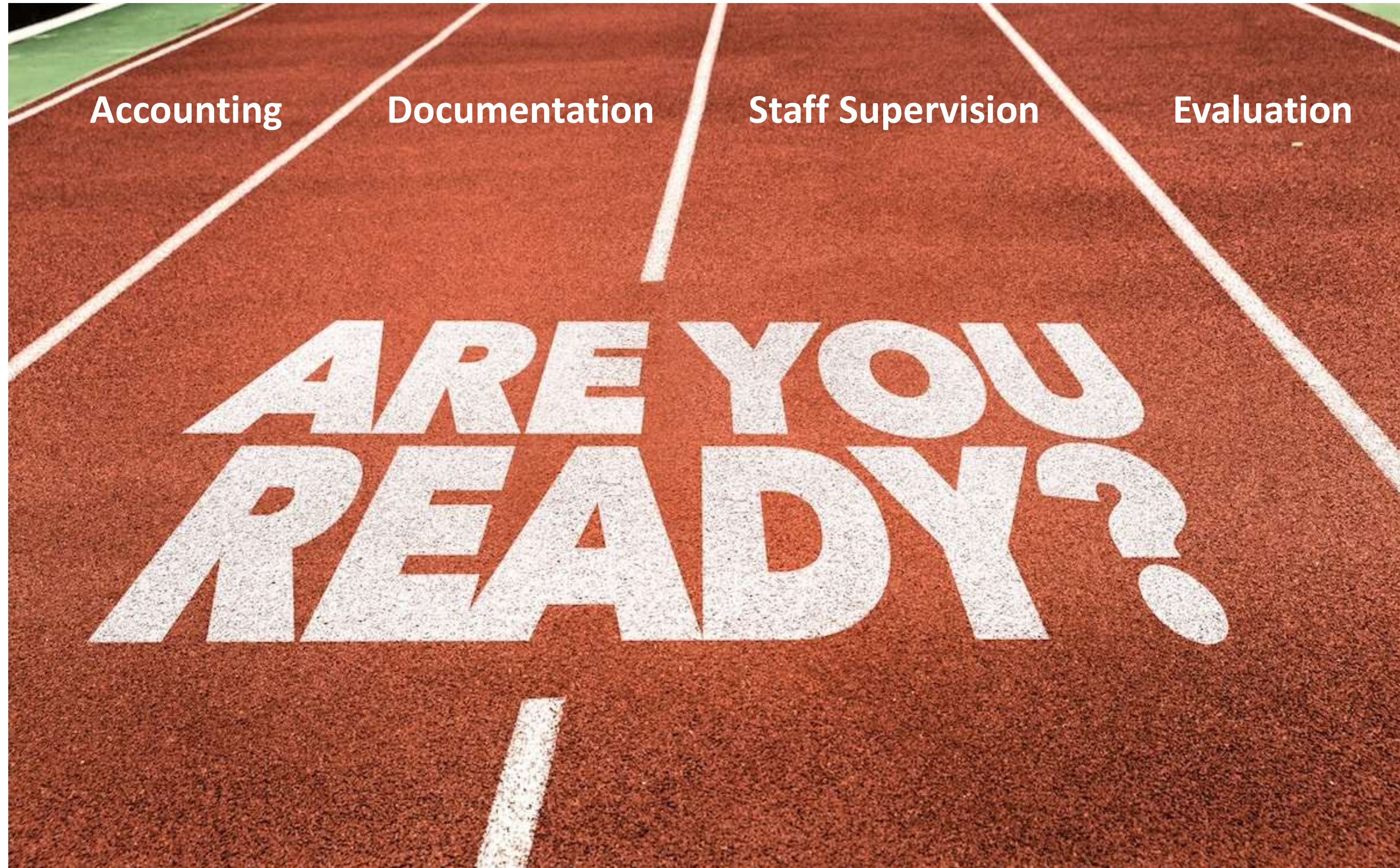
# Establishing Organizational Readiness

Culling of Customized CM Programming – clearly-defined CM programming tailored to the setting's needs and resources

Preparation of Clinical Staff – didactic and skills-based training, to include demonstration of capable CM delivery by individual staff

Coordination of Supporting Systems – identification of staff and processes that will support active implementation (i.e., accounting, clinical documentation, staff supervision, program evaluation)

# All Systems Ready?



# A Published Case Example

Hartzler et.al, 2023 is an open-access publication, appearing in a special JSAT issue on *Stimulants:*

[https://www.sciencedirect.com/journal/journal-of-substance-use-and-addiction-treatment/vol/151/suppl/C](https://www.sciencedirect.com/journal/journal-of-substance-use-and-addiction-treatment/vol/151/suppl/C)

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## Community implementation of contingency management to address stimulant use


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Stimulant use disorders
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ABSTRACT

*Introduction:* Contingency management (CM) is efficacious for reinforcing stimulant abstinence, and technical assistance (TA) is increasingly sought to aid its community-based implementation. In an interagency partnership involving a sponsoring single-state authority and statewide treatment agency in Oregon, an intermediary purveyor organization provided a robust TA package to support design, implementation, and evaluation of CM programming for an opioid treatment program (OTP) over the course of a 12-month implementation service project.

*Methods:* In addition to an online training offering OTP leaders and staff conceptual foundation for CM, the TA package included purveyor-led activities to: 1) engage leaders in collaborative design to customize CM programming; 2) assemble a local implementation team to logistically prepare OTP systems for CM delivery; 3) provide virtual coaching-to-criterion to assure readiness of counseling staff to deliver CM programming; 4) compile a tailored CM resource library of implementation support materials; and 5) avail ongoing consultation during implementation. Stimulant abstinence was targeted via a voucher-based protocol with escalating reinforcement, for which gift cards from local vendors served as reinforcers. Virtual coaching eventuated in individual role-play assessments, wherein staff delivery of CM programming with a standardized patient was scored via Likert scale (1 = Very Poor, 7 = Excellent) on six CM fidelity dimensions. This observational cohort design subsequently assessed clinical effectiveness during active implementation via OTP records review for CM-exposed and comparison client groups.

*Results:* In role-play assessments, all counseling staff exceeded an a priori fidelity benchmark signifying implementation readiness ($M = 31.33$, $SD = 3.72$). Among 73 clients enrolled in the CM programming, rate of stimulant-free urine drug screens was 11 % greater than among 120 clients serving as historical controls ($p < .01$; Cohen's $D = 0.40$). The study also identified secondary therapeutic benefit in six-month treatment retention, with clients enrolled in CM retained at a 14 % greater rate than 162 CM-ineligible clients concurrently enrolled in OTP services ($p < .05$).

*Conclusions:* Findings from this interagency partnership offer reason for optimism regarding community-based implementation. Beyond the demonstrated empirical support for this TA package and resulting clinical effectiveness of the CM programming, an eventual sustainment decision by OTP leadership strengthens the rationale for customizing CM to clinical settings' local needs and resources.


**1. Introduction**

Several domestic trends contribute to the resurgent interest in stimulant use disorders, including both methamphetamine and cocaine, among which is a precipitous spike in overdose events attributable to synthetic opioids and fentanyl-involved adulteration of stimulants

# CM Timeline at Emergence

- **December 2021** – Application submitted for CM funding through Measure 110 Behavioral Health Resource Network
- **June 2022** – Notified request for funding was approved by OHA and Measure 110 Oversight and Accountability Council
- **September 2022** – First funds for CM received from OHA
- **October 2022** – Sent request for CM technical assistance to NWATTC and connection made with Dr. Hartzler & OHA SOR team
- **January-February 2023** – Dr. Hartzler provides TA and coaching on program development to Emergence supervisors

# CM Timeline at Emergence

- **March-April 2023** – Dr. Hartzler provides TA and facilitates three training sessions to Emergence staff who will be delivering CM interventions
- **March-May 2023** – CM incentives purchased and tracking system developed
- **June 1, 2023** – CM pilot implementation begins at Emergence

# Emergence CM Protocols

**Target Client Population:**

- All new justice-involved enrollees, including self-referrals (n~15/mo.)

**Target Behavior:**

- Intake assessment completion, group therapy attendance (individual instances and as aggregated weekly) for initial 12 weeks post-enrollment

# Emergence CM Protocols

**Rewards:**

- $50 gift card for intake completion
- $10 gift card for attendance at each group therapy session
- $10 gift card ‘bonus’ for attending 100% scheduled sessions per week

**Reinforcement System:**

- Fixed ratio reinforcement
- Fixed interval reinforcement (week-aggregated group attendance)
- Voucher-based; non-escalating scale

# Emergence CM Pilot Parameters

**Time:** 6-9 mos. to include rolling enrollment of pilot cohort

**Clients:** n~90 (approx. 15/mo.)

**Staff:** Assessment counselors & group facilitators

**Cost:** $530/client

- projected maximum potential earnings during pilot – $47,700
- projected maximum annual potential earnings – $95,400

**Sustainment:** If additional funding needed beyond M110, Emergence will need to document local clinical effectiveness to obtain additional future sources of funding to support continuance of this work

# Acknowledgements


- SAMHSA 1H79T1085732, *Implementing Contingency Management in Oregon-based Health Settings to Address Stimulant Misuse*
- CAAHS staff members Mitch Doig, Jennifer Verbeck, and Mandi Nugent
- All of the staff and clients at Emergence Addiction and Behavioral Therapies

*It takes a village to raise a child.*