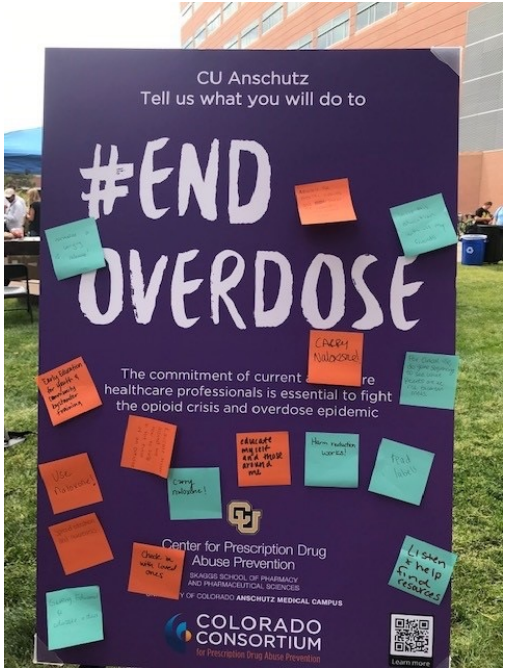
CONTINGENCY MANAGEMENT

Welcome! We are glad you are joining the Consortium's 10th annual meeting today!



INTRODUCTIONS

- Session host & co-host
  - Jessica Eaddy & Teresa Cantwell
- Speakers
  - JK Costello, MD, MPH
  - Lindsay Houston, MPH

HOUSEKEEPING

- Participants are muted
- Session is being recorded
- Questions and comments can be put into the chat box

JOIN US FOR THE GENERAL SESSION STARTING AT 10:00

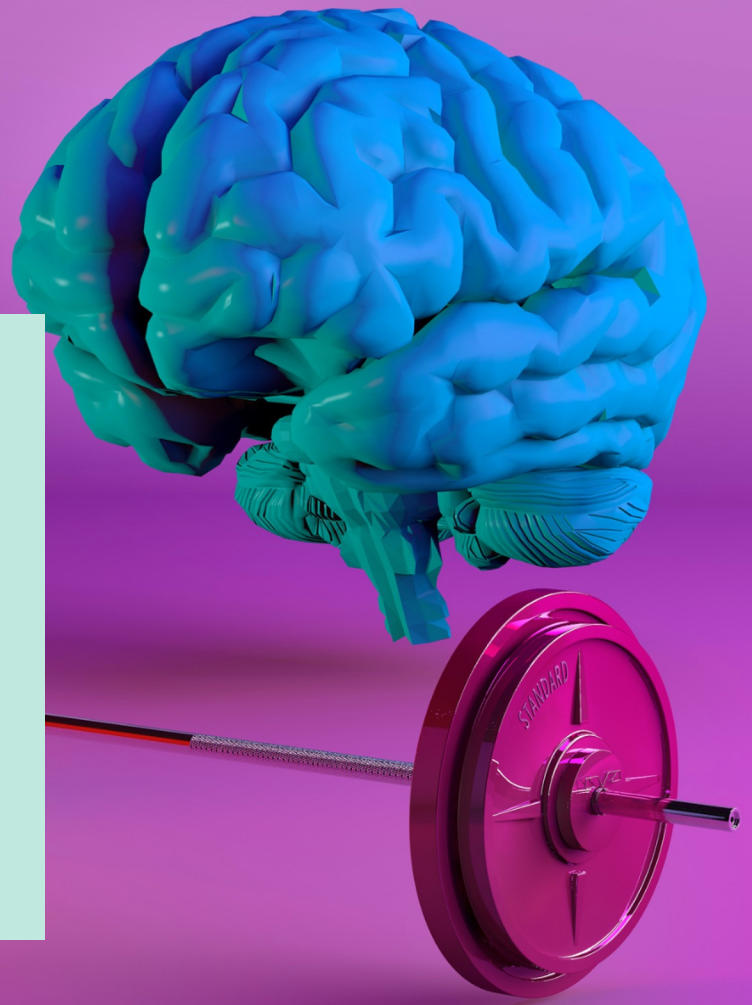
- New Zoom link will be provided at the end of this presentation

“[CM is] a type of behavioral therapy in which individuals are ‘reinforced’, or rewarded, for evidence of positive behavioral change”

-Nancy Petrie, author of Contingency Management for Substance Abuse Treatment

Operant Conditioning

- Addresses delay discounting as part of the intervention
- ‘Rewires’ the brain’s reward circuits to activities in line with sustained healing and recovery
- Effectively intervenes on neurological level for clients with complex health issues **without clear pharmacological solutions to support a change in lifestyle**



What is Contingency Management?

- **Evidence-based practice** that provides tangible incentives for desired behavior changes
  - Diverse settings
  - Many substances
  - All subpopulations
- Usually conducted over 3-6 month course of treatment
- Often coincides with individual/group/IOP treatment

Incentives

- No upper limit
- Incentive size moderates effectiveness
- Best outcomes from $400-$500 (cash or equivalents) over course of program; Total incentives below ~$200 are insignificant
- Cash or cash equivalents
- Immediately upon displaying desired behavior

“I was hesitant to try it — like, hey, is this legal?”

But the results have been striking, he said, adding, “I’m talking about significant improvements in attendance to therapy sessions, significant reductions in drug and alcohol use.”

-Dr. Shawn Ryan, CMO and president of BrightView Health

Brain Reinforcement: The Origins of Addiction

Questions:

1. What percent of U.S. treatment programs report using CM?
2. In what specific population(s) are contingencies routinely used as a treatment adjunct in addiction treatment?
3. To what extent do these promote recovery?

*Thanks To David Gastfriend, MD, for slides 9-11!

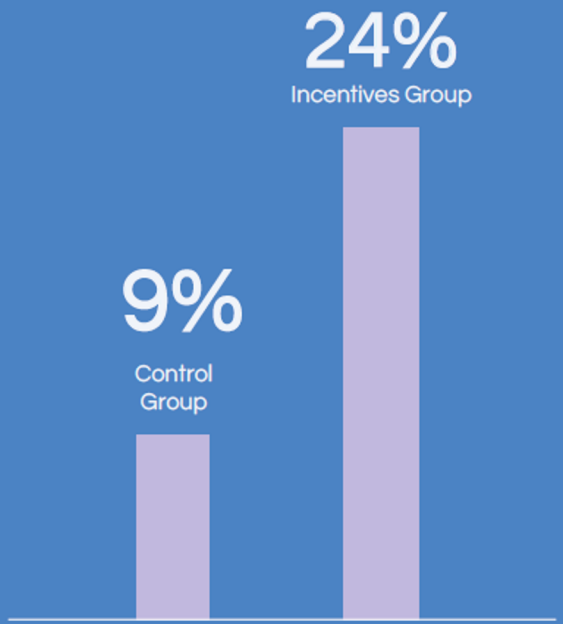
Brain Reinforcement: The Origins of Addiction

Answers:

1. ~13 % of U.S. treatment programs report using CM
2. Contingencies are routinely used in:
    - Physician SUD & mental health disorders
    - Methadone take-homes
    - Drug/DUI courts
3. Response rates are best established in Physician health programs:
    - 5-year abstinence & employment success rates = 70–90%

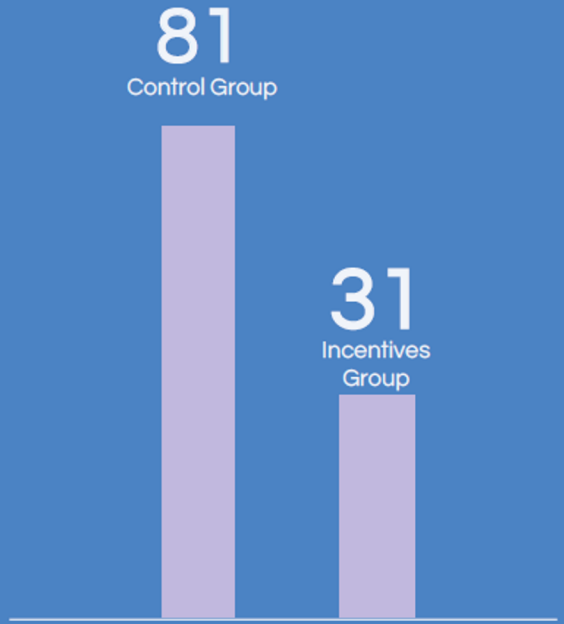
Contingency Management: The Evidence

Drug Abstinence
increased by 2.7x



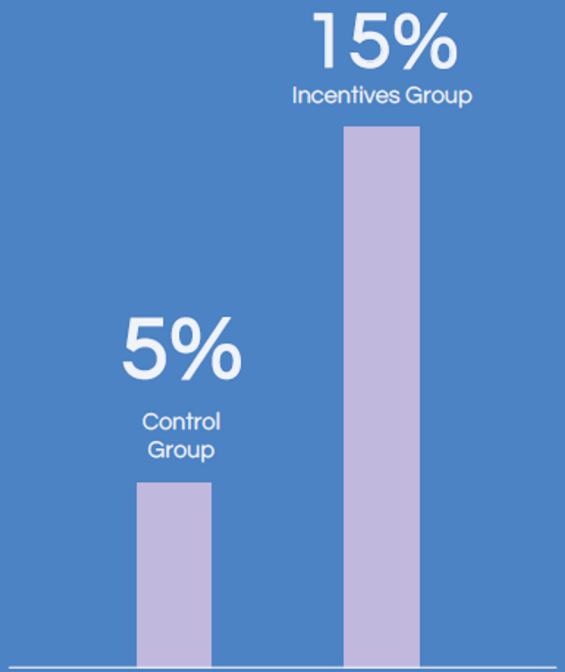
% of patients reaching 4 weeks of continuous abstinence in 12-week study. n=800 cocaine/meth using patients. Peirce et al 2006

Drinks per Month
Reduced by 62%



Proof-of-concept pilot, n=30 heavy drinkers, 1-3 selfie breathalyzer tests/day over 28 days, earned $219 on avg. Pilot Study Publication: Alessi & Petry 2013

Smoking Quit Rates
Increased by 3x



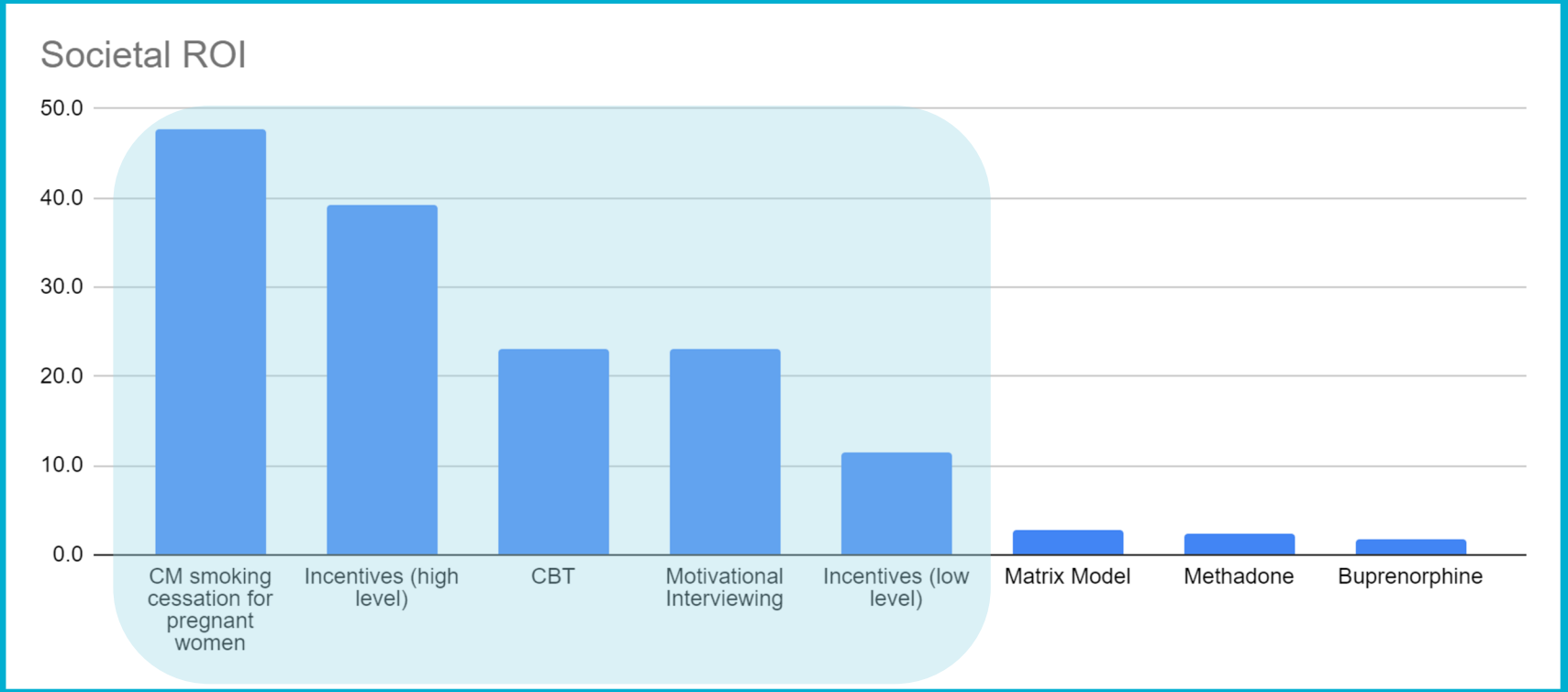
% of patients testing negative for nicotine at 9-months. n=442 GE employees. Volpp et al 2009

Contingency Management: The Evidence

In various populations, settings & treatment modalities:

- **Dual Diagnosis Patients**
  Negative drug tests: 59% (CM) vs. 25% (Control) (Bellack et al 2006)
- **People Experiencing Homelessness**
  Abstinence @ 6 months: 41% vs. 15% (Millby et al 2000)
- **Criminal Justice System**
  Days of abstinence: 27 vs. 19 (Carroll et al 2006)
- **Pregnancy**
  Opioid-negative samples: 90% vs. 82% (Jones et al 2001)
- **Adolescence**
  Smoking abstinence @ 1 month: 53% vs. 0% (Krishnan-Sarin et al 2006)

Cost-Benefit - from the Payers' Perspective



Source: Wash. State Inst. for Public Policy, 4/2021

Barriers

01

Stigma:

“You shouldn’t pay people for doing what they should do anyway”

02

Stigma:

Cash might lead to misbehavior!

03

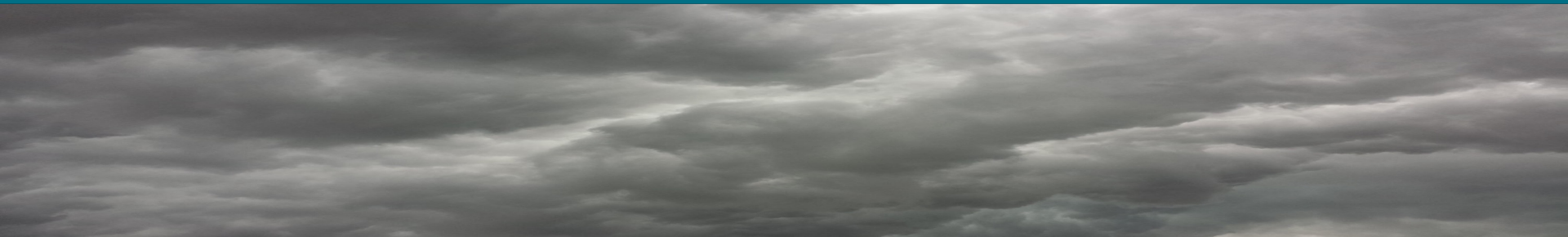
Logistical:

Transferring the incentive securely to the client

04

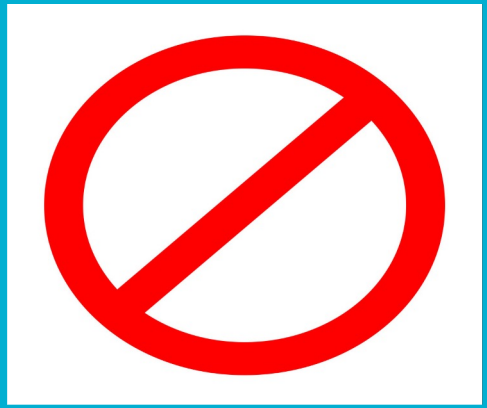
Regulatory:

Limits on incentives



What is Not Permissible (OIG)

- Incentives that result in medically unnecessary or inappropriate items or services reimbursed in whole or in part by a Federal health care program.
- Advertising patient incentives to recruit patients or steer patients away from other providers.
- Using incentives for the purpose of increasing fees.
- Inadequate protection against fraud




“...we recognize that research shows that contingency management interventions are the most effective currently available treatment for stimulant use disorders.”

What is Permissible (OIG)

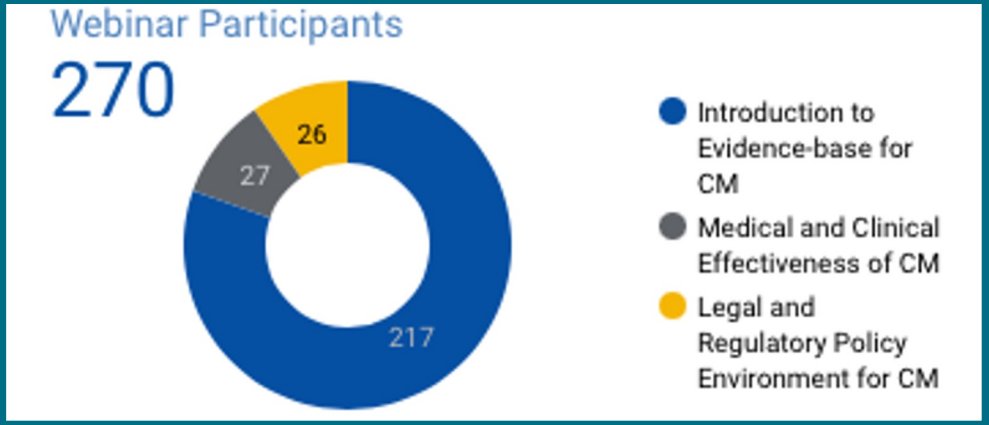
- Incentives that have a **direct connection to the coordination and management of care** of the target population.
- The use of digital health technology such as remote patient monitoring and telehealth
- CM incentives for which the payer only pays when the desired health outcome occurs –attendance, objective, validated measures consistent with treatment (e.g., attendance, abstinent drug tests, and other confirmed behavioral measures).
- Advancing goals, as determined by the patient's licensed health provider, of:
  - adherence to a treatment regimen
  - adherence to a drug regimen
  - adherence to a follow up care plan
  - management of a disease or condition
  - improvement in measurable evidence-based health outcomes for the patient or the target patient population ensuring patient safety."

$75 → $599

SAMHSA UPDATE COMING
DOWN THE PIKE
(SOONER THAN LATER)

Education and outreach project learnings

- In spring of 2022, the Colorado Consortium for Prescription Drug Abuse Prevention provided funding for the Steadman Group to give statewide presentations and webinars on CM, conduct a survey, and develop a template policy and protocol for providers.
  - Provided education on evidence-base for CM, legal and regulatory nuances, and clinical effectiveness

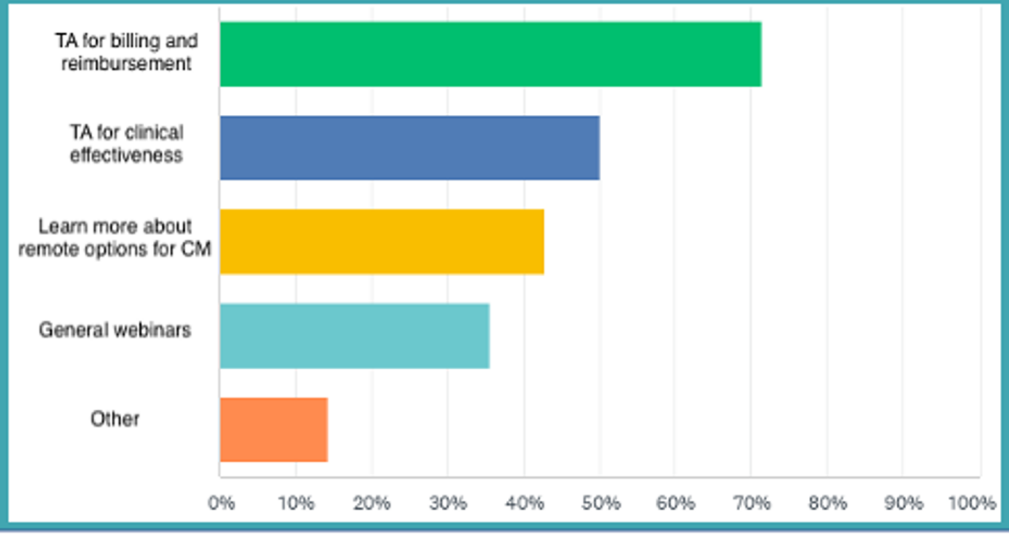


Lessons Learned

	Key Findings from Interviews
	**Myths and Stigma** still exist for CM and more education is needed to dispel myths and grow community understanding of the intervention
	**Education** is needed to fully explain how cash incentives should be distributed
	**Challenges** with implementing CM include sustainability, jealousy among participants, staffing issues, reimbursement for services, and liability concerns
	**Eligibility** for CM programs varies-- some respondents want to focus on stimulants only, while others add opioids.
	**Move CM outside of treatment settings** into settings like recovery community organizations, the criminal justice system, and telehealth
	**CM is an excellent method for keeping people engaged** in treatment and/or recovery
	**Training** and developed policy and protocols are critical to reduce the burden of implementation for new CM programs

Survey Findings

What kind of information would have the potential to make you more interested in providing CM as a billable service?



Funding open to CM

1287, 222, 202 grant programs

RAEs?

Upcoming CM Pilot?

Next Steps!

- Start conversations within your teams
- Brainstorm implementation strategy
- Policy and procedures
- **Seek out payers**
- Look for upcoming funding opportunities!

Available resources through the Colorado Rx Consortium

- Webinars on basics, clinical, and regulatory aspects of CM
- Template document with policy and protocol for clinics
- Template budget

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ANNUAL MEETING CONTINUES AT 10:00

Please join us for the General Session at 10:00

https://ucdenver.zoom.us/s/91648856059

Reminder:

DEA National Rx Take Back Day is THIS

Saturday, October 29

Find the site closest to you

https://www.dea.gov/takebackday#collection-locator