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Resource Paper

Identifying State Purchasing Levers for Promoting the Use of Evidence-Based Practice in Substance Abuse Treatment

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Funded by the Center for Health Care Strategies, Inc. under The Robert Wood Johnson Foundation's Medicaid Managed Care Program

October 2005

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Executive Summary

This paper examines the use of purchasing levers to encourage the use of evidence-based practices (EBPs) in the field of substance use disorder (SUD) treatment. Innovation and creativity in state purchasers' use of financing and delivery strategies can significantly impact their ability to encourage high quality SUD treatment services that have proven effective and efficient in clinical research settings. Linking these strategies or "purchasing levers" to EBPs is one promising method to ensure a particular standard or method of treatment services.

The Legal Action Center (LAC) and the Center for Health Care Strategies (CHCS) conducted an environmental scan and convened a Small Group Consultation of substance use disorder treatment experts and leading purchasers from multiple state agencies to identify activity related to implementation of effective EBPs and purchasing levers. The Small Group participants identified emerging key areas concerning the use of purchasing levers to promote evidence-based practice in substance use disorder treatment and made a set of comprehensive recommendations for further research.

Small group participants were provided with the initial findings of the environmental scan, which included a literature review and expert interviews, and asked to consider the following topics:

- The comparative value of specific methods for promoting EBPs that state purchasers have identified as effective, such as strategies that require or encourage that program staff receive training about EBPs versus those which make explicit requirements for the use of EBPs.

- The need to develop mechanisms that not only cater to high performing providers but also build the capacity of less experienced or lower performing providers, as well as those who serve more challenging populations.

- The efficacy of purchasing strategies that require outcomes rather than mandate that programs use EBP to achieve improved outcomes.

- The development of new methods for prioritizing quality improvement, either through EBPs or other purchasing strategies, in SUD treatment services.

- The applicability of quality improvement strategies in the general health care field to the purchase of substance abuse treatment services, specifically regarding performance incentives and systems integration models.

The Small Group Consultation enabled CHCS and LAC to formulate specific policy proposals to guide state purchasers on the implementation of strategies aimed at aligning state purchasing power and cost-effective care. Significant information was gathered on the broader use of incentives and other approaches to implementing EBPs. Because of its possible utility to purchasers, this information has also been included in this report.

Overview of Findings

The environmental scan revealed two overarching findings regarding the promotion of EBPs, which were reaffirmed during the Small Group Consultation. First, some state agencies are using contractual levers, such as incentives or penalties, to engage in general quality improvement in the treatment of substance use disorders. Second, although a number of states are engaged in projects and programming to promote the implementation of EBPs, it appears that a significantly smaller number of states are implementing EBPs on a systemic basis. There is *interest* among state officials to develop and expand such programming. Moreover, it appears that the linkage between purchasing levers and the use of EBPs in treatment services is generally not occurring in most states.

There was also consensus that emerging discussions and work should focus on several related ideas:

- State purchasers must develop clearer consensus on the criteria for EBPs. Small group participants emphasized that before beginning a discussion about using levers to promote evidence-based practice, there needs to be a common definition of "evidence-based practice." Several Small Group participants also questioned whether it would be more effective to focus on using levers to promote quality improvement generally in SUD treatment instead of narrowly focusing on EBPs.
- In addition to the work that is occurring on the national stage, state purchasers must develop and enhance performance measures for SUD treatment services. These measures should be reliant on a standardized set of performance indicators that are well-defined, accepted by the treatment community at large, and adequately supported by information systems.
- In linking performance indicators for EBPs to incentives and penalties it is essential to develop mechanisms that cater to high performing providers but also can be structured to build the capacity of less experienced or lower performing providers, as well as those who serve more challenging populations.
- Models for the promotion of EBPs in SUD treatment services exist in general health care "value-based" purchasing strategies and systems integration models. These deserve further investigation and analysis regarding their suitability for replication.

Recommendations

The environmental scan and the Small Group Consultation identified five areas that need further attention and research:

1. States need help to develop Memoranda of Understanding (MOU) across state government agencies representing various funding streams as a means of expanding collaboration, maximizing funding, and creating incentives for quality improvement.
2. The unintended consequences of existing incentives needs to be more comprehensively studied to better inform state purchasers' decisions as they leverage their buying power. Several participants asserted that the existing

incentives for EBPs or general quality improvement produce unintended results that are not always favorable.
3. More attention needs to be paid to ensuring that a more diverse group of providers is brought into the discussion.
4. States need assistance in developing joint contracting models that would allow for purchasing of services across the continuum of care regardless of program ownership or management.
5. Research should be conducted on the role of consumers in improving the quality of SUD treatment, especially in supporting a chronic illness model of care.

The small group participants also felt that more detailed information should be gathered on states with extensive experience related to this project. As a result, four case studies were conducted and included in this report.

Overview

The ultimate goal of developing value-based financing and delivery strategies or "purchasing levers" is to maximize purchasing power to obtain higher quality services. Purchasing levers can be used to drive service coordination, link reimbursement to outcomes, encourage multi-agency collaboration, and ensure accountability. The environmental scan identified a few key strategies that states currently use as purchasing levers to encourage the implementation of EBPs.

The environmental scan research and the Small Group participants stressed that the development of clinical, evidence-based guidelines is a necessary precursor to any work that is done to link EBPs to purchasing strategies. The development of such guidelines has been completed in Iowa and Oregon (see attached case studies). Explicit activity to garner consensus on what research and client outcome data is prioritized and actually deems an SUD treatment service an "EBP" enables state purchasers to develop strategies to mandate that quality or standard of service.

While the federal government, through recent Substance Abuse and Mental Health Administration (SAMHSA) and National Institute on Drug Abuse (NIDA) initiatives is engaged in the dissemination of information on EBPs and scientifically based treatments, the burden is primarily on state agency officials to specify individualized criteria regarding their use.[1] For example, when an Iowa Single State Agency direction charged the Iowa Practice Improvement Collaborative (PIC) with developing a "plan for ensuring that community based treatment agencies use(d) EBPs," a set of 13 criteria for EBPs were developed. Practice standards included such concepts as validation by one randomized clinical trial, "demonstrated effectiveness in several replicated research studies," "manualized or sufficiently operationalized for staff use," and "well accepted by providers and clients."[2] Only a few states have undergone an explicit process to establish similarly comprehensive criteria.

The Small Group participants engaged in a lengthy discussion about the definition of "evidence-based practices." Small Group participants cited a lack of consensus about how to precisely define "evidence-based practices." Participants raised questions about how much evidence constitutes enough for the practice to become promising or proven. Participants cited EBPs that have been identified by NIDA. One participant acknowledged the lack of clarity associated with the phrase and cited an upcoming government project that would more precisely define what is required for a practice to be described as "evidence-based." In addition, a number of participants noted that there are

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[1] In 1999, NIDA published a guide "Principles of Drug Addiction Treatment" describing 12 "efficacious scientifically based treatment approaches" to substance abuse treatment services including modalities such as relapse prevention, supportive-expressive psychotherapy, and motivational enhancement therapy. The NIDA, in concert with SAMHSA, currently is engaged in the NIDA/SAMHSA-ATTC Blending Initiative to disseminate information on current evidence based treatment interventions. Recent work includes technical assistance on "Buprenorphine for Non-Physician Providers" and the "Addiction Severity Index." Furthermore, the Northeast Addiction Technology Transfer Center Network (funded through SAMHSA) catalogues EBPs on its website at http://www.ireta.org/attc/projects_nida_best_practices.htm.

[2] Iowa Consortium for Substance Abuse Research and Evaluation. *Evidence-Based Practices: An Implementation Guide for Community Based Substance Abuse Treatment Agencies*. University of Iowa, Spring 2003.

practices being used in the field of SUD treatment that are known by providers to be effective and suggested this body of knowledge also be recognized. Some participants also highlighted the evolving nature of EBPs, emphasizing that as science continues to develop, EBPs will reflect this development.

Ambiguity in defining EBPs in SUD treatment stems from the fact that the efficacy of services is often analyzed in multiple realms: for its strength in randomized clinical trials, for its applicability across population subsets, and for its practical feasibility in service environments. State agencies' own prioritization of these goals can significantly effect its perception of the suitability of particular treatment modalities and the strength of its commitment to hold treatment service providers to a particular standard of service.

Type of Purchasing Levers

Within Medicaid and the managed care marketplace, there are numerous leverage strategies that can be used by state purchasers. The environmental scan revealed that states are primarily promoting the use of EBP in SUD treatment by employing the following types of levers:

I. **Standardization of Criteria:** Basic articulation of criteria for EBPs, the utilization of the regulatory process, and passage of legislation.
II. **Contractual Requirements:** Specification in the bidding process through Request for Proposals (RFPs).
III. **Performance Incentives:** The use of rewards (i.e., funding, training, space, equipment, services) that can be awarded to programs through the contracting process or other mechanisms.

I. Standardization of Criteria

The standardization of procedures is a mechanism that is being used by a few state purchasers to explicitly direct SUD service providers to administer treatment based on EBPs. Some states have developed explicit criteria describing EBPs, as well as incorporated precise specifications for the utilization of EBPs by service providers into regulations and legislative language.

Information gathered indicates that at least one state, Oregon, has passed legislation requiring the use of EBP by SUD treatment providers. Oregon's legislation goes into effect July 1, 2005 and requires 25 percent of state funding to be spent on EBP programs. The statute states that this percentage requirement will increase to 50 percent in 2007 and 75 percent in 2009. The statute states that compliance with this requirement will be considered in the state appropriations process.

This legislation also specifies the EBP criteria. It defines an evidence-based program as one that (a) incorporates significant and relevant practices stemming from scientifically based research, and (b) is cost effective. "Scientifically based research" is defined as:

(a) Employing systematic, empirical methods that draw on observation or experiment;
(b) Involving rigorous data analyses that are adequate to test the stated hypotheses and justify the general conclusions drawn; and
(c) Relying on measurements or observational methods that provide reliable and valid data across evaluators and observers, across multiple measurements and observations, and across studies by the same or different investigators.[3]

A number of states (North Carolina, Wyoming, and Texas) indicate that their state regulations now require the utilization of EBP in some fashion. This ranges from a requirement that only EBP can be used, to language requiring that a specific percentage of programming must be evidence-based. Some states identified the requirement that American Society of Addiction Medicine (ASAM) criteria (or modified ASAM criteria) be utilized as an example of this approach.[4]

Wyoming's experience in mandating inclusion of EBPs in SUD treatment services provides an example of a more general approach to prioritizing a standard of care. In March 2002, the governor of Wyoming signed into law HB59, a comprehensive plan to address the state's substance abuse needs by adopting research-based standards for treatment and prevention programs. This legislation called for the Wyoming Department of Health's Substance Abuse Division to collaborate with the state's Departments of Education, Corrections, Family Services and Workforce Services, and members of the public to develop these research-based standards through a process which included conducting numerous public informational meetings throughout the state.

As stated in Wyoming Department of Health's Substance Abuse Division, "Rules and Regulations for Substance Abuse Standards," these regulations seek, "to establish standards for community substance abuse prevention and treatment services and provide that a full continuum of quality, research-based, best practice substance abuse services be made available to Wyoming citizens."[5]

Language related to EBP has also been incorporated into North Carolina's new definitions of SUD treatment services. During the 2001 legislative session, the North Carolina legislature passed a law that requires the State and localities to reform the state mental health system, which includes substance abuse services. As a result, all service providers will be required to use EBPs in order to be in compliance.

II. Contractual Requirements

Numerous publications assert that a primary way states and other public purchasers can increase their leverage is by constructing a contract between the public purchaser and the

[3]Chapter 669 Oregon Laws 2003, Section Three.
[4] Although not included in the scope of this project, state requirements related to the utilization of EBPs are prevalent in the area of substance abuse prevention. Lessons learned from this experience would appear to have application to the area of substance abuse treatment.
[5] The Wyoming Department of Health, Substance Abuse Division's Rules and Regulations for Substance Abuse Standards, Chapter 16, http://sad.state.wy.us/Text/Docs/SAD_59.pdf

provider that specifically states the provider's obligations.[6] The contracting process provides an opportunity for the state to address many issues, including client protection, licensing and credentialing requirement of staff, and the handling of client complaints.[7] In addition, the contract presents a unique opportunity for public purchasers to address barriers that members of special populations such as juveniles or criminal offenders face.[8] Given that providers will be legally bound by the promises made in this contract, public purchasers should be extremely thoughtful and thorough in determining which provisions they should incorporate into the contract.[9]

The environmental scan suggested that the contract procurement process creates the first and best opportunity to develop specific goals and benchmarks for performance measurement, which can include process outcomes, such as EBP, to ensure that providers offer high quality services.[10,11]

Addressing these issues early on in the contractual process will foster a discourse between the state and the provider on how the provider intends to operationalize the requirements of the contract in accordance with best-evidence practice. The entire contractual process, including the bidding process if that occurs, offers public purchasers an opportunity to put forth provisions that will ensure a heightened level of quality of these services.

Delaware (see attached case study) includes guidelines for the utilization of EBPs in its bidding process for SUD treatment services. Service providers responding to the State Request for Proposals are required to describe the evidence-based models that they will employ throughout their treatment programs (i.e., transtheoretical model, motivational enhancement strategies, cognitive-behavioral techniques, etc.).

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[6] "Purchasing Managed Care Services for Alcohol and Other Drug Treatment: Essential Elements and Policy Issues," CSAT's TAPS 16, 1995; Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers," CSAT's TAPS 16, 1998

[7] "Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers," CSAT's TAPS 16, 1998; American Managed Behavioral Healthcare Association, http://www.ambha.org/Reports/quality.htm

[8] M. Kenesson, "Medicaid Managed Care: Outreach and Enrollment for Special Populations." Center for Health Care Strategies.
http://www.chcs.org/usr_doc/outreach_and_enrollment.pdf

[9] "Contracting for Public Mental Health Services: Opinions of Managed Behavioral Health Care Organizations," Prepared for the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), by the Lewin Group; http://www.mentalhealth.org/publications/allpubs/SMA00-3438/default.asp

[10] While not specific to EBT, the literature suggests that by developing outcome measurement systems and setting quantifiable goals, public purchasers will be able to determine whether there has been improvement in the four critical areas concerning client access to treatment, the comprehensiveness of services, the number and quality of consumer protections and the ability to decrease administrative costs. "Purchasing Managed Care Services for Alcohol and Other Drug Treatment: Essential Elements and Policy Issues," CSAT's TAPS 16, 1995. "Using Performance Measurement to Improve the Quality of Alcohol Treatment," Primer Six of the "Ensuring Solutions to Alcohol Problems" Series, The George Washington University Medical Center,
www.resourcesforrecovery.com/resourcesforrecovery/EnsuringSolutionsPrimeronPerformanceMeasurement.pdf; "Monitoring Treatment Outcomes and Managed Care: Promise and Challenge for the AOD Field," CSAT Treatment Information Exchange Communiqué, 1998. http://www.treatment.org/Communique/comm98M/treatment.pdf

[11] A. Lyle and J.P. Weiner, et al., "Cost and Quality Trends in Direct Contracting Arrangement," Health Affairs, January/February 2002.

Washington has done a significant amount of research since 1998 to identify those indicators which most effect treatment success. The indicator found to be most significant is length of stay in treatment (retention). As a result, the State of Washington has included specific language in their contracts with substance abuse service providers requiring them to develop a plan to improve their client retention rate as well as their treatment completion rate. The State then provides consultation and oversight to encourage and support accomplishment of these requirements.

Texas requires that service providers utilize National Registry of Effective Prevention Programs (NREPP) –listed prevention programs and that treatment providers follow the Texas EBP for treatment based on the Texas Christian University Treatment Process Model.[12] Implementation challenges have included providing sufficient lead-time for implementation and related training.

III. Performance Incentives

A review of current practice reveals the use of five primary types of incentives: financial payments (pay-for-performance), relief from regulatory requirements, competitive bidding process advantage, infrastructure support (including free training in EBPs), and recognition for providing evidence-based care. The writings that discuss the use of these motivational enhancements do not do so in the context of promoting EBPs, but usually as a way to engage providers in research efforts. [13]

Performance measures can be linked to various incentives, either rewards or penalties, to encourage providers to meet these goals.[14] A recent panel of national policy experts on improving the quality of substance abuse services determined that rewarding provider results through incentive-based contracts is the best way to improve the quality of treatment.[15] By identifying which areas need work and then drafting a contract with strong incentives to encourage the provider to address these particular deficiencies, researchers and policy experts argue that providers will then deliver higher quality services.[16] While this panel did not define what results should be rewarded, the use of EBP could be one result garners an incentive.

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[12] www.ibr.tcu.edu

[13] "Research Utilization and Managing Innovation in Rehabilitation Organizations" p.19; Zweben et.al. in the Journal of Psychoactive Drugs p.194, and "Conducting Trials in Community Settings: The Provider Perspective" p.198.

[14] "Enhancing Resources for Recovery: Strategies and Examples" Dennis McCarty, Eldon Edmundson, Carla Green, Bentson McFarland, Center for Substance abuse Research and Policy Studies, Oregon Health Policy Institute; Patrick Lanahan, Alicia Smith, Resources For Recovery National Program Office, Technical Assistance Collaborative, Inc., September 2003. http://www.resourcesforrecovery.org/policy/StateReports.pdf; "Establishing the feasibility of performance measures for alcohol and other drugs," Deborah W. Garnick, Margaret T. Lee, Mady Chalk, David Gastfriend, Constance M. Horgan, Frank McCorry, A. Thomas McLellan and Elizabeth Levy Merrick, Journal of Substance Abuse Treatment, Volume 23, Issue 4, December 2002, pp. 375-385.

[15] Join Together National Policy Panel on Quality of Treatment for Substance Use Disorders, 2003. Panel recommendations are published at http://www.jointogether.org/sa/files/pdf/quality.pdf, papers of panel experts can be found at http://www.jointogether.org/sa/action/dt/strategies/improvement/panel/topics.

[16] "Rewarding Results: Improving the Quality of Treatment for People with Alcohol and Drug Problems," Join Together National Policy Panel Recommendations, Quality of Treatment for Substance Use Disorders, 2003. http://www.jointogether.org/sa/files/pdf/quality.pdf; CHCS Purchasing Analysis Guide in preparation for the CHCS Purchasing Institute for Resources for Recovery: State Practices that Expand Treatment Opportunities; Center for

For example, by first identifying a weakness, such as a low rate of initiation, measured by whether the client received treatment services within two weeks of diagnosis, the contract can incorporate a provision that gives the provider a financial reward for improving this rate of initiation by a certain percent in a defined period of time. [17] Some of the authors do caution that purchasers should take care in determining which measures to attach the financial incentives to, in order to ensure that other equally important areas without these incentives receive enough attention.[18]

A number of states indicated that they are using incentives to improve service provider behavior in general. A few states indicated that they currently are using, or are planning to use, financial incentives to promote treatment strategies, that result in improved client engagement in the treatment process and client retention in treatment. For example, Delaware uses a more direct approach of contracting and payment to improve performance and outcomes by rewarding:

- Engagement/Utilization – Provider ability to increase admissions and client engagement.
- Active Participation – Client attendance at a set number of treatment sessions. The number varies according to the state of treatment.
- Program Completion – Client participation, abstinence, and achievement of treatment goals. For example, if a client completes treatment, providers are given $100 per client up to $10,000.

Arizona has not instituted incentives specific to the utilization of EBPs but has developed incentives to improve performance. Arizona has looked at mechanisms for incentivizing agency behavior such as timely claim submission and the achievement of provider network development goals. Preliminary recommendations include:

- Items for inclusion should not be new but already required of Arizona's Regional Behavioral Health Authorities (RBHAs) and providers.
- Performance measures should be well defined and measurable with the measures already incorporated into the data system.

Health Care Strategies, Inc., Technical Assistance Collaborative, Inc., The Robert Wood Johnson Foundation; guide prepared by Mercer, July 2003.
http://www.chcs.org/usr_doc/substance_analysis.pdf; "Understanding the Purchase of Outcome in Substance Abuse Treatment," William E. Ford, Ph.D. for the National Council on Alcoholism and Drug Dependence Committee on Benefits, June 2000.
http://www.ihs.gov/MedicalPrograms/Alcohol/purchase.pdf

[17] "Ensuring Solutions to Alcohol Problems" Series, The George Washington University Medical Center, www.resourcesforrecovery.com/resourcesforrecovery/EnsuringSolutionsPrimeronPerformanceMeasurement.pd

[18] "Using Performance Measurement to Improve the Quality of Alcohol Treatment," Primer Six of the "Ensuring Solutions to Alcohol Problems" Series, The George Washington University Medical Center, www.resourcesforrecovery.com/resourcesforrecovery/EnsuringSolutionsPrimeronPerformanceMeasurement.pdf; "Partners in Planning: Consumers' Role in Contracting for Public-Sector Managed Mental Health and Addiction Services," Volume 10, SAMHSA's Managed Care Technical Assistance Services, Prepared by the Judge David L. Bazelon Center for Mental Health Law and the Legal Action Center, April 1998. "Selection Incentives in a Performance-Based Contracting System," Y. Shen, Health Services Research, Volume 38, Number 2, pp.535-552, April 2003

- Performance measures should be reflective of the agencies' experience and primarily within their control.
- Meaningful performance incentives should be established with contractors' input about what is meaningful to them.

Other recommendations emphasize the need for a partnership approach to increase potential success; sufficient resources to maintain the financial incentives over time; and the importance of timely payment of financial awards.

Officials from the State of New York indicate that they are in the early stages of conducting a study that will link financial incentives to program achievement of established performance outcomes. Performance measures to be utilized include:

- Retention rates;
- Completion rates;
- Abstinence rates; and
- Employment rates.

Although the state acknowledges that the incentives are not directly related to the utilization of EBP, it is their intent to share with their service providers relevant EBPs that have been identified either through their own studies or in the literature.

Washington uses contract language that provides for rewards and penalties for effective provider service utilization management. The director explained this incentive system requires a long-term approach based on a well developed data system and good relationships with the service provider system. Identified implementation challenges include:

- Avoiding inappropriate or unnecessary provider bankruptcies;
- Avoiding loss of service capacity;
- Avoiding establishment of arbitrary performance benchmarks;
- Need for ongoing data analysis and monitoring;
- Attention to case mix adjustments; and
- Avoiding inappropriate use of data (i.e., provider report cards).

The use of data was shown to be an integral element in the evolution of quality programming. In Delaware, the substance abuse agency prioritizes the continual use of data that is produced to evaluate the program—for clinical and programmatic outcomes, as well as those related to drug arrests and employment. The agency will be working with Dr. McLellan on Concurrent Recovery Monitoring to analyze key domains using monthly data. They will be monitoring data on provider case-mix to watch for creaming (the selection of clients with a higher likelihood of success in treatment). Texas has been using the Behavioral Health Integrated Provider System (BHIPS), an internet-based data collection system housing policy, provider, and patient level variables for analysis of SUD treatment service effectiveness.

The panel of national policy experts noted that the process of implementing a system of rewards can lead to the closure of programs. Programs with unstable infrastructures and fiscal constraints might be unable to implement new practice or demonstrate results. Rewarding programs that perform well might result in funds being taken away from poorer performing programs. The panel adds that implementing incentives suddenly and inflexibly also can lead to program closure, and treatment availability could decrease. The panel also notes that if incentives are phased in and if smaller, unstable providers combine with larger programs, availability of treatment can be preserved.[19] However, this is an issue of concern for states. North Carolina, for example, revealed in an interview, that implementing financial penalties in a manner that does not have a negative impact on clients was one of the major challenges it faced.

A number of Small group participants also cautioned that incentives can, in certain settings, have unintended consequences. Meeting participants stressed the need to develop mechanisms to assess the effectiveness of the use of incentives and purchasing levers, and to reveal any negative unintended effects they may cause so that improvements can be made. One suggestion for future research entailed a more comprehensive assessment of the intended and unintended consequences of incentives.

Incentives to Promote Specific EBPs

Activity specifically directed at the utilization of incentives to promote EBPs was reported to be limited and preliminary. Many of the individuals interviewed for the environmental scan spoke in terms of "moving in the direction" of using incentives to support the utilization of EBPs but generally cited activity which related to the use of incentives in a broader context. EBPs are not necessarily cost effective, and unfounded mandates create significant challenges in maintaining fidelity. Some small group participants noted that to insure fidelity, incentives, particularly financial incentives, are needed.

The Massachusetts Medicaid Program is currently implementing a pilot program that provides for increased substance abuse service reimbursement rates contingent upon implementation of EBPs (see attached case study). Arizona, Delaware, and Washington have included *specific* incentives promoting the utilization of EBP in the state competitive bidding process.

In New York and Florida, state purchasers have instituted awards programs to recognize community agencies utilizing EBP. These award programs involve a partnership between the state and the addictions service provider association. For example, Florida's Best Practices Awards is a partnership between the Florida Department of Children and Families and the Florida Alcohol and Drug Abuse Association. This competitive program provides both cash awards and public recognition to programs selected for their use of an

[19] "Rewarding Results: Improving the Quality of Treatment for People with Alcohol and Drug Problems," Join Together National Policy Panel Recommendations, Quality of Treatment for Substance Use Disorders, 2003. http://www.jointogether.org/sa/files/pdf/quality.pdf; at p.3.

evidence-based practice. A panel of experts in the delivery, administration, research, and evaluation of substance abuse services selects the award recipients.

Some motivational enhancements do not necessarily involve the use of contracts, such as providing personnel, hardware, and training resources. For example, state officials in Iowa were interested in supporting the implementation of Motivational Interviewing. Funding was provided to pay for all direct training expense for service providers. Follow-up and consultations also were provided.

Collaboration of Multiple Funding Entities and Creative Funding Options

Small group participants noted that the system of SUD treatment financing can serve as a barrier to broader implementation of EBPs if multiple funding streams and multiple payors are involved and require different practices and the use of different outcome measures. Increasing collaboration between state agencies and Medicaid programs could maximize scarce funds and to further enable providers to improve quality of care. Coordination and collaboration between state and county agencies can also eliminate some of these barriers.

Formulating a single contract with a provider that encompasses two or more funding entities enables the purchasers to concentrate their bargaining power and achieve better results. Counties and localities could work to better pool their information to avoid duplicative administrative costs.[20] This also could enable the multiple purchasers who are party to the contract to save costs by centralizing their outcome measurement systems or by pooling resources to submit more competitive proposals. This model also could be used whenever multiple agencies have a direct interest in the care of a client, such as an agency specializing in juveniles working with the state agency with jurisdiction over substance abuse treatment for juveniles or greater collaboration between the state departments of justice and the substance abuse agencies for criminal offenders in need of treatment.

By forming informal work groups among members of relevant state agencies, researchers, clinicians and stakeholders, state purchasers can maximize their bargaining power with vendors. More formal collaboration between the agencies of different states involved in the public purchase of substance use disorder treatment services could also be helpful for a more standardized exchange of ideas and strategies.

In addition, states could better share how they are improving quality within their own systems and how they utilize federal funds. States with similarly sized populations or those facing similar barriers in the purchase process could collaborate on how best to utilize and coordinate funding streams for Medicaid and non-Medicaid services, and how

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[20] "Sub-State Purchasing of Managed Behavioral Health Care: An Analysis of County-Level Managed Care Contracts," Center for Health Services Research and Policy, The George Washington University Medical Center, Prepared for SAMHSA, October 1999. http://www.gwhealthpolicy.org/downloads/behavioral_health/reports/County-level%20Study%201199.pdf.

to optimize the use of certain funds such as the Medicaid Rehabilitation Option, the Substance Abuse Prevention and Treatment Block Grant and Medicaid waivers.[21] States also can work together to identify other cost measures.

Some researchers argue that the federal government should take the lead in helping states to create additional levers for the purchase of substance use disorder treatment services.[22] The federal government could establish pilot programs that would enable states to more fully develop some of the above-identified leverage points (such as more effective outcome measurement systems or additional resources to reward providers for achievement.)

Involving Service Providers in the Culture of Change

A number of state leaders interviewed for the environmental scan emphasized the importance of obtaining service provider buy-in. This also was a major theme that emerged from discussions of the Small Group. Participants emphasized that coordination and cooperation among providers and between providers and state agencies is essential as states develop and implement purchasing levers. Participants discussed the need to focus on culture change at the provider level to ensure buy-in for quality enhancing practices such as EBPs.

Several participants suggested that providers could be used as a resource to create change. Small group participants emphasized that the vast majority of providers are motivated by the ideal of improving the quality of services and achieving positive outcomes for clients. There may be "spark plugs" and "fertile ground," even at "one-shot events" with providers such as at conferences and within provider associations. Many participants said that SUD treatment is a discipline with a tradition of "peer to peer" discussion and that broader implementation of EBPs will be most effective by capitalizing on that tradition. Efforts to engage the field at the grass roots level are often contingent upon the innovation within one or two state agencies.

Service providers interviewed were generally supportive of incentives to support the implementation of EBP. They did, however, raise a number of general concerns. Some individuals noted that attaching a financial reward to improved outcomes could create a disincentive to treat more difficult clients, since it would be harder to achieve positive results. Addressing "case mix" as part of this process was perceived as critical to avoid this unintended consequence. Others noted the data related to the use of incentives for

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[22] "Rewarding Results: Improving the Quality of Treatment for People with Alcohol and Drug Problems," Join Together National Policy Panel Recommendations, Quality of Treatment for Substance Use Disorders, 2003; "Negotiating the New Health System: Findings from a Nationwide Study of Medicaid Primary Care Case Management Contracts," Informed Purchasing Series' Working Paper, Sara Rosenbaum, Alexandra Stewart, Colleen Sonosky, June 2002; "Value-Based Purchasing: Can Medicare be the Spark," Changes in Health Care Financing and Organization, March 2004,www.hcfo.net/topic0304.htm.

better outcomes could potentially be misused by creating overly simplistic service provider “report cards.”

Finally, participants highlighted the need for further training and technical assistance in the use of EBPs. One participant recounted workforce competency, availability, and burn-out as major issues in her state; there was a general sense that many SUD treatment programs may not have enough provider staff with expertise in the use of EBPs that states want to implement. Provider associations could be useful partners for the states in building this expertise.

The Broader Context of Purchasing Strategies Aimed at Assuring Quality

In examining the potential areas for increased activity, the broader health care field provides some models of purchasing behavior relevant to quality enhancement work aimed at SUD treatment services—specifically with regard to the use of incentives and the construction of delivery systems that mandate a particular standard of care. Successful efforts in other service systems may provide some insight into how leverage can be gained to improve quality of care.

General health care initiatives using incentives serve as basic models of innovation for SUD treatment service purchasers. The *Local Initiative Rewarding Results* project is using health plan provider and member performance incentives to increase participation in well care and improve related health outcomes. A Community Health Network of Connecticut initiative to improve EPSDT participation rates is using “friendly” competition and weekly “prizes” for overall staff effort. A Partnership Health Plan initiative to ensure appropriate asthma medication usage among members uses physician/staff training on asthma education, personalized beta-agonist reports for physician practices, and recognition in quarterly newsletters.

Systems-integration models, in other fields such as children’s mental health, also provide examples of how purchasing levers can be used to ensure a heightened quality of services and incorporate EBPs. For example, in *Comprehensive Family-Focused Care (CFFC),* the recently instituted initiative for Medicaid-eligible children and adolescents with serious emotional disorders (SED) in Massachusetts, mechanisms to promote clinical quality using accepted standards of care include direct supervision of purchased services by the community agency serving as the care manager, as well as explicit standards of care developed by the Massachusetts Behavioral Health Partnership (the managed behavioral healthcare organization) for the network of specialty services.

Under *WorkFirst New Jersey*, a Comprehensive Social Assessment (CSA) screening tool is used for all beneficiaries receiving cash assistance for 12 months or longer and multi-disciplinary teams from numerous systems are deployed to coordinate care and assist beneficiaries with identified barriers in accessing social services. This aspect of *WorkFirst New Jersey* programming has been instrumental in expanding the access to and quality of SUD treatment options for beneficiaries with barriers to employment.

A number of Small Group participants highlighted the role that managed care organizations can serve as a vehicle for quality enhancing programming. Participants noted that the field of prevention is more fully driven by model programs and EBPs than the treatment system. Several Small Group participants suggested that the field look to the mental health care and medical care systems for examples of programs that support EBPs. Other participants suggested that states may want to investigate further collaboration with the private sector. In addition, some small group participants suggested that they should look to a business model for guidance, which would involve determining the return on investment from the promotion of EBPs, as well as the economic benefits to other agencies and the broader social impact.

Within the provider community, some formal provider networks do exist, usually as a result of the growth of managed care. Some meeting participants questioned whether a push toward the further development of networks would allow for continued diversity among providers. Some participants expressed concern that small, community-based providers may be at risk, especially if the EBPs focused on pharmacotherapy and other practices based more on a medical care model. Other participants noted, however, that SUD treatment providers' experience dealing with a hard-to-reach population might be a skill that larger integrated health care networks would find valuable. Further research on the role of provider networks in influencing quality of care and how to develop levers that purchasers and plans would use to motivate the use of networks was suggested.

Process Issues

In this review of current practices, the need for innovation in the utilization of levers is apparent. The environmental scan indicated that there is generally a low level of state activity in promoting EBPs in SUD treatment services through purchasing levers. State purchasing patterns incorporate the use of levers such as standardization of procedures and performance incentives, with varying levels of sophistication and with varying degrees of linkage to EBPs. In some instances state purchasers have linked incentives to EBPs; however, this trend does not seem as prevalent as specification of EBPs in statutory, regulatory or contractual language. Some commenters indicated that requiring implementation of EBP was the most effective mechanism, while other emphasized a more collaborative, partnership-oriented approach.

The literature, interviews, and participants in the Small Group Consultation all stressed the need for implementation of EBPs to be a component of an ongoing, long-term process rather than an isolated activity. The environmental scan makes clear that the process of improving quality of treatment, whether through the implementation of performance measures or utilization of EBPs, is an incremental one. Focus group participants also emphasized the importance of incremental change through long-term, gradual investment. This perspective would appear to support the utilization of incentives that have the capacity to reward incremental changes and can be adjusted as needed.

Before states employ levers to require the use of certain practices, the literature, interviews, and participants in the Small Group Consultation stressed the importance of

sufficient lead-time for implementation and the importance of partnership between programs and other stakeholders in the developmental process. Delaware spent five to seven years developing a contracting process that connected payment to performance. Although consumers were not involved, the Delaware Division of Mental Health and Substance Abuse did seek feedback from providers on setting standards for payment and thresholds. There were SSA/provider meetings every two to three months to obtain feedback on the standards. Additionally, implementation was phased-in over the course of a 12-month period.

Leadership for change was identified as possibly the most critical determining factor. Participants pointed to the importance of an individual taking the leadership role to nurture the process of change and provide consistent support over time to organizations dealing with the upheaval that change can bring. The key leadership position for SUD treatment providers is most likely the program director, the manager of treatment activity, yet this position often suffers from high turnover. Constancy also is needed in the state agencies that will implement purchasing levers. State agency leadership often changes as a result of the political process, and long tenures in these leadership positions are rare. Some meeting participants noted that the SUD field must learn the science of innovation.

Four State Profiles

Oregon, Massachusetts, Iowa, and Delaware have made significant advances in the utilization of levers to promote evidence-based practice (EBP) in substance abuse disorder treatment. The profiles in Appendix I offer information that will be of assistance to other states that are considering or are moving forward with plans to utilize levers to promote the use of EBP.

The profiles were intended to:

1. Provide an overview of the states' utilization of levers and EBP including the state's motivation to employ levers for promoting the use of EBP;
2. Detail the participants involved and the processes used by states in designing and implementing their plans to promote EBP;
3. Discuss the challenges the states encountered in implementing their plans;
4. Summarize lessons from the states, including the unintended consequences of financing and delivery strategies that promote EBPs;
5. Include provider feedback on the states' efforts;
6. Where applicable, examine models for involving consumers in the development of quality-enhancing substance use disorder treatment;
7. Where applicable, identify mechanisms for assuring that racially and ethnically diverse consumers and providers are represented at all levels; and
8. Examine the use of MOUs and/or joint contracting models in cross-agency purchasing of treatment services.

Lessons Learned from Profiled States

There clearly is significant diversity among the four states regarding their approach to the implementation of Evidence-Based Practices and the utilization of levers, resulting from the differences in the state environment. However, there are a number of common themes and things learned across the states:

- The implementation of EBPs and the associated use of levers is occurring not in isolation but in the context of the larger, extremely challenging state government environment with multiple priorities.
- Rather than an isolated project implemented with a radically new approach, the implementation of EBPs and utilization of levers in most cases is done utilizing an already existing structure and philosophy related to the role of service providers and other stakeholders.
- The existence of long-term, stable leadership within the state agency is a positive contributor to progress.
- The existence of a positive, long-term relationship with service providers is critical to success.
- The great majority of service providers demonstrated strong support for system change aimed at improving the quality of services to their clients.
- Utilization of outside expertise is a significant contributor to success.
- Success of this initiative requires a long-term commitment to training, supervision, and oversight.
- To a certain degree, significant service system changes must be accompanied by parallel changes in the state agency internal system.
- The implementation of EBPs requires a multi-year process. Recognizing that it is a process, incentives to bring about change are a valuable tool.

Recommendations for Further Research

The environmental scan and the Small Group Consultation identified five areas that need further attention and research:

1. States need help to develop Memoranda of Understanding (MOU) across state government agencies representing various funding streams as a means of expanding collaboration, maximizing funding, and incentivizing quality improvement. The current system of financing SUD treatment was repeatedly cited as an obstacle for the implementation of EBPs or broader quality improvement. Expanding collaboration between state agencies would maximize funding and incentivize quality improvement.
2. The unintended consequences of existing incentives needs to be more comprehensively studied to better inform state purchasers' decisions as they leverage their buying power. Several participants asserted that the existing incentives for EBPs or general quality improvement produce unintended results that are not always favorable.

3. More attention needs to be paid to ensuring that a more diverse group of providers is brought into the discussion. Small Group participants spoke of the need to conduct outreach to populations and providers to ensure that policies promoting EBPs appropriately incorporate the considerations and needs of the underrepresented. Work to identify and involve providers and provider associations with diverse and/or underrepresented populations will ensure that a broader cross-section of views is represented.
4. States need assistance in developing joint contracting models that would allow for purchasing of services across the continuum of care regardless of program ownership or management.
5. Research should be conducted on the role of consumers in improving the quality of SUD treatment, especially in supporting a chronic illness model of care. This could focus on consumer involvement in the formation and implementation of substance use disorder treatment services, highlighting the difference between the role of the consumer in substance use disorder treatment and chronic illness treatment. This would acknowledge the philosophical tensions with regard to what is "best" for the consumer, such as the tension with the responsibility entailed in the 12-Step Model versus medicalization of the disease; and tension between coerced treatment vs. programming that fosters consumer satisfaction.

Appendix I

Oregon

Overview

Oregon's approach to implementation of EBP in substance use disorder treatment is unique in that, to our knowledge, it is the only state in which the legislature has mandated the expenditure of public funds based on the use of evidence-based practices. The legislation, SB267, was passed by the Oregon legislature in 2003. The law mandates the implementation of evidence-based practice on an incremental basis with 25 percent of public funds spent on evidence-based practices in 2005, 50 percent in 2007 and 75 percent in 2009 and thereafter. The legislation defines evidence-based practice as "a program that (a) incorporates significant and relevant practices based on scientifically based research and (b) is cost effective".[23]

Members of the Oregon legislature wanted to ensure that public funds were spent on effective services that produced positive outcomes. This concern was not limited to substance abuse and mental health services but included other service areas as well. The law applies not only to substance use disorder treatment and mental health services administered by the Oregon Department of Human Services, Office of Mental Health and Addiction Services (OMHAS), but to the services administered by Oregon's Department of Corrections, Youth Authority, Criminal Justice Commission and the Commission on Children and Families.

Since the passage of the legislation, OMHAS has convened an ongoing internal workgroup as well as three stakeholder workgroups related to the implementation of SB267. To date, OMHAS has:

- Established a definition of EBP with stakeholder input. The definition is currently being updated to be consistent with the prevention and treatment EBP work being done by SAMHSA and CSAT.
- Established an evidence continuum that includes six levels. The first three levels are defined as EBP meeting the OMHAS standard.
- Reviewed practices and, to date, identified the following provisional list of ten EBPs for substance abuse disorder treatment:

    1. ASAM Patient Placement Criteria
    2. The Matrix Model: Outpatient Stimulant Treatment
    3. Methadone Maintenance

[23] The OMHAS Web Site provides access to a wealth of information regarding this initiative. Much of the material included in this report comes, with OMHAS permission, directly from that website: http://www.oregon.gov/DHS/mentalhealth/ebp/main.shtml

4. Motivational Enhancement Therapy
5. Twelve Step Facilitation Therapy
6. Cognitive Behavioral Therapy – Substance Abuse
7. Motivational Interviewing
8. Cannabis Youth Treatment (CYT) series
9. Dialectical Behavioral Therapy for substance abuse
10. Co-Occurring Disorders: Integrated Dual Diagnosis Treatment

- Created a project implementation plan that includes:
    - incentives for system change and reduction of barriers;
    - administrative rule and contract actions;
    - technical assistance and training;
    - plans for defining and measuring outcomes; and
    - communication strategies (both internal and external).

The process of planning for the implementation of EBPs has not only required OMHAS staff to invest a significant amount of time and energy, but also to commit to their internal system change. As the project manager stated: "We realized that if we expected our service providers to undergo a significant systems change, we would have to practice what we preached and undergo changes in our system to support the implementation of EBPs." [24]

Stakeholder Involvement

In interviews and documents, OMHAS has stressed its commitment to a substantial level of consumer, family, and other stakeholder involvement. OMHAS documents state, "This involvement should be sufficient to ensure that the concerns and values of these groups are reflected in the project plan, the EBP workgroups, the administrative rule workgroups, and in the final products of the EBP effort."

OMHAS has organized three stakeholder workgroups to help with the implementation of SB267:

- The Selection and Verification Workgroup works with the OMHAS internal workgroup to identify EBPs.
- The Adoption and Implementation Workgroup oversees the development of technical assistance efforts, rules and contracts.
- The Outcomes and Cost Benefit Workgroup advises OMHAS on defining and measuring outcomes.

The project manager reported that service providers and individuals in recovery are involved in all three workgroups. In addition, representatives of minority service providers also are involved. These include individuals as well organizational representatives such as the Oregon Indian Council on Addiction. According to both the

[24] Interview with Robert Miller, Project Manager, OMHAS.

project manager and a representative of the provider association, OMHAS has a history of service provider and consumer involvement.

Communication

In order to help keep stakeholders involved, the OMHAS "Project Plan to Promote the Adoption of Evidence Based Practices" includes an "external communication" section that states:

- Persons attending OMHAS stakeholder work groups will receive minutes, including meeting schedules and handouts.
- Persons attending stakeholder work groups will receive the monthly EBP summary.
- Steering committee members will provide updates at meetings of providers, the Association of Oregon Mental Health Centers, the Governor's Council on Alcohol and Drug Services, the Mental Health Planning and Management Advisory Council, the Oregon Indian Council on Addictions, and other stakeholder groups.
- The steering committee will work with stakeholder groups to find additional appropriate media opportunities to transmit information.
- The steering committee will work with DHS communications to transmit information within DHS.
- OMHAS will develop a standard EBP PowerPoint presentation to provide a general picture of the EBP efforts for a variety of audiences.

Utilization of Levers and Incentives

As indicated above, the OMHAS internal workgroup has identified the need to develop and provide incentives for system change. The committee recognized that system change occurs more quickly with incentives and supportive measures and indicated that they would be examining a number of mechanisms which include:

- Establishing priority in funding for specific EBP implementation.
- Recognizing providers who have successfully adopted EBPs.
- Subsidizing training and technical assistance for providers in the process of adopting or maintaining EBPs.

OMHAS also indicated that some administrative rules may need to be eliminated if they act as barriers to the adoption of EBPs. They indicated that they would attempt to eliminate all unnecessary rules in order to create a more efficient system and to give service providers "breathing room" to focus on implementing EBPs.

Challenges and Barriers

Project staff identified a number of challenges in implementing the use of EBPs:

- Even though the project had access to national resources and information about efforts in other states, the process of identifying EBPs was labor intensive and slow. The size, complexity, and range of services included in the service system required that a wide variety of EBPs be considered.
- The state has moved quickly toward statewide implementation of EBPs rather than begin with a pilot. OMHAS and the workgroups have had to quickly figure out how to best make use of limited resources to achieve the goals outlined in the legislation.
- It has been difficult to measure progress toward the goal of utilizing EBPs for 25 percent of publicly funded services. To date, the state has used provider self report surveys. Two statewide surveys have been conducted which indicate that the 25 percent goal has been met. Staff indicates that this progress did not surprise them as many service providers were moving towards the implementation of EBPs prior to the passage of this legislation. Information gathered from these surveys will be used as a baseline from which OMHAS can measure progress.
- Minority stakeholders had voiced concerns that EBPs, which were proven effective for general populations, would be forced on minority populations. Staff indicated that minority representatives have been sufficiently involved to see that this would not happen. In addition, staff has been successful in identifying EBPs specifically applicable for services to minority populations. Recently the OMHAS six-level evidence continuum has been revised to allow for a broader set of practices that are culturally sensitive.
- It has been very challenging to measure outcomes and cost effectiveness.

A representative of the Alcohol and Drug Programs Association of Oregon indicated many providers already had an existing understanding of EBPs, such as Motivational Enhancement and Relapse Prevention, before the legislation was passed, and this was a significant help in implementing the legislation. From their perspective, this initiative will have the biggest impact on those service providers who do not use EBPs.

However, service providers are concerned that the legislation does not address the significance of the clinical counselor/client relationship in connection with the treatment outcome. A number of Oregon service providers have implemented an increased level of clinical supervision to improve outcomes.

Lessons Learned

OMHAS staff identified a number of valuable lessons learned as they moved forward to implement SB267:

- In order to bring about change of this magnitude, it is very important to have a clear understanding of the principles of systems change.

- Focused leadership and direction is critical to continue to move the project along.
- It is important to create a project plan that identifies clear roles, responsibilities and timeframes.
- Technical assistance is very important to implementing EBPs, even more important than training.
- Sound clinical supervision is very important.

Cross-Agency Agreements

An Integrating Steering Committee with representatives of each of the agencies involved in this project meets monthly to share information, avoid conflict, and coordinate efforts to the degree possible.

To date, OMHAS has met twice with the Department of Corrections to develop an evidence-based rule for behavioral health programs operated by or funded by the Department of Corrections. Following a thorough agency management review, the rule will be reviewed by the stakeholder advisory group and then prepared for the public notice and hearing process.

Co-Occurring Substance Abuse and Mental Health Disorders

The OMHAS project plan states that they will develop a draft rule to define programs providing specialized treatment for persons with co-occurring disorders. The plan further states that "integrated mental health and alcohol/drug treatment services for this population is an evidence-based practice". A rule to define programs that serve persons with co-occurring disorders has not been drafted yet. OMHAS is rewriting and reducing the current rules, and does not want to introduce a new rule at this time.

Evaluation of the Implementation of EBPs

The OMHAS project plan states that to track the use of EBPs, OMHAS will ask funded providers to submit information demonstrating how they are delivering EBPs with a degree of fidelity. This includes tracking basic outcomes associated with the practice and identifying a process for documenting fidelity to the practice.

The project plan also states that OMHAS will cooperate with the county Community Mental Health Programs, Mental Health Organizations and fully Capitated Health Plans to obtain annual reports from providers regarding their EBP services. The reports will include a list of practices, the number of people served by each practice, and the cost associated with the delivery of each practice. Other information may include documentation of ongoing measurements of outcomes and adherence to practice principles. OMHAS will work to ensure that data collection related to EBPs takes full advantage of existing systems. Collection of EBP data will remain a factor in the modification of current information systems.

Additional Comments

The statewide implementation of EBPs in Oregon mandated by the legislature in 2003 represents a very ambitious process of systems change and has involved more than two years of work. State agency staff have made a significant attempt to involve stakeholders and to ensure that the process is transparent by providing information to all parties on contemplated change. Staff report that this initiative has ignited significant community interest in the implementation of EBPs.

Iowa

Overview

Iowa began discussions related to EBPs more than four years ago through the work of the Iowa Consortium for Substance Abuse Research and Evaluation (the Consortium). As stated in its mission, the Consortium "coordinates research and knowledge transfer among researchers, assists professionals in the field, and informs public policy makers in the area of substance abuse." In the area of EBPs, the Consortium worked with the Iowa Practice Improvement Collaborative (PIC), one of fourteen centers nationwide funded by the SAMHSA Center for Substance Abuse Treatment and devoted to bridging the gap between research and practice in the substance abuse treatment field. Working together, the Consortium and the Iowa PIC began the process of defining and identifying EBPs.

Because of the Single State Agency (SSA) leadership, knowledge and awareness of national efforts related to EBPs, particularly in the area of prevention, a new workgroup, the Statewide Knowledge Implementation Workgroup (SKIP), was created. The charge given to the SKIP was to:

- Recommend a process for the selection, implementation and evaluation of EBPs statewide;
- Make recommendations regarding which EBPs should be implemented, utilizing the above-referenced process; and
- Define "what quality treatment should look like in Iowa."[25]

During the process, the goals of increasing length of stay and improving outcomes were established. The SKIP also discussed plans for evaluating implementation of the EBPs, which included identifying fidelity and outcome measures, adapting the EBPs to meet the unique needs of the Iowa treatment system, and examining the cost effectiveness of EBP implementation**.** After its deliberations, the SKIP selected Motivational Interviewing (MI) as the first EBP recommended for statewide implementation.

Stakeholder Involvement

According to Iowa SSA Director, Janet Zwick, the SSA places a great emphasis on "collaboration with stakeholders." In keeping with this philosophy, a diverse group of stakeholders were involved in the SKIP. Members included representatives from:

- Iowa Department of Public Health (IDPH);
- Service providers, including directors, clinical supervisors and counselors;
- Community- and hospital-based treatment programs and rural and urban programs;
- Managed care organizations;

[25] Interview with Janet Zwick, Deputy Director, Director of Behavioral Health and Professional Licensure

- Corrections staff; and
- Researchers.

Utilization of Levers and Incentives

Several types of incentives were used in the implementation of the Motivational Interviewing (MI) EBP. Through the Iowa Plan for Behavioral Health, Medicaid community reinvestment funds were used to support MI training. The training was delivered through the service provider association and was provided at no cost to the participants, including travel and lodging. Response to the training by service providers was extremely positive ("more providers wanted in than we had room for…"). The training was followed by a train the trainers workshop to support the provision of supervision and feedback.

Apart from the implementation of EBPs, the Iowa Department of Public Health has utilized incentives in a number of areas for the last four to five years. These incentives include:

- Increased reimbursement rates for treating certain populations;
- Financial reward for providing services to additional clients; and
- Financial rewards for increasing the average client length of stay.

Iowa's SSA Director also indicated that the SSA recognizes service provider agencies that are leaders in the implementation of EBPs as models.

Iowa's managed care program includes incentives in its Request for Proposals. It asks managed care company applicants to identify EBPs they will be utilizing, thus creating an incentive in the competitive bidding process.

Challenges and Barriers

The Iowa SSA director identified a number of challenges they faced as they moved forward with the process for the selection, implementation, and evaluation of EBPs:

- The costs related to providing training, supervision, and feedback to counselors proved to be a significant challenge. Service providers are reimbursed based on the amount of client services provided, and thus possibly the largest related cost to an agency results from counselor time diverted from seeing clients and invested in training or supervision.
- Figuring our what data to collect to demonstrate change proved challenging.
- An appropriate level of buy in from program directors is critical to the successful implementation of the MI EBP. While program director commitment is critical, an over-enthusiastic response that does not take into account the need for gradual change can result in resistance from counselors.
- Ensuring that all service quality improvement initiatives are effectively coordinated in a consistent fashion presents a practical challenge.

According to service providers, sustaining the utilization of the MI EBP has also been challenging. This initiative has relied on a volunteer train the trainers approach. A lack of available training has hampered continued implementation of the MI EBP.

Lessons Learned

Iowa's SSA Director identified the following lessons learned as they moved forward with the process for the selection, implementation, and evaluation of EBPs:

- All levels of service provider staff need to be involved and invested, including directors, clinical supervisors, and counselors.
- Researchers must be able to effectively communicate with lay persons.
- Incentives are important, even if they are minimal.
- It is important to gather data to demonstrate change.
- Consistent SSA leadership and demonstrated commitment are critical.

Additional Comments

Iowa has had a stable, long-term leadership in the SSA Director position (as was the case in most of the states selected as case studies). This proved pivotal in the development of Iowa's use of the MI EBP. The SSA agency has a positive relationship with the service provider system based on experience. It helped the state be aware of national trends (i.e. creation of Research to Practice Consortiums) and draw down resources relevant to this area (i.e. Practice Improvement Collaborative, State Incentive Grant). Indications are that these elements may have established a foundation upon which successful implementation of EBPs could occur in Iowa.

Delaware

Overview

For more than three years, the Delaware Division of Substance Abuse and Mental Health (DSAMH) has used contracts with their publicly-funded outpatient service providers that provide financial incentives (and penalties) for the achievement of specific performance targets related to client engagement, attendance, and successful completion of treatment. [26] Service providers responding to the State Request for Proposals (RFP) have been required to describe the EBPs that they would employ in their treatment programs.

DSAMH began to improve accountability and treatment quality by conducting a literature review, particularly the work of Dr. Thomas McLellan, PhD[27], a noted national researcher and trainer (www.tresearch.org), and the Treatment Process Model developed by Dr. Dwayne Simpson at Texas Christian University (www.ibr.tcu.edu). Following this review, DSAMH decided to focus on client engagement and retention as well as the utilization of EBPs. This decision was based on the basic principles that successful outcomes are related to 1) the length of time in treatment, 2) the amount and type of services received (dosages), and 3) evidence/research based techniques and strategies.

Delaware's State Substance Abuse Director convened an internal team of agency staff, including staff with background and responsibilities in information technology, contracting, financing, and treatment. In addition, the Director asked Dr. McLellan to participate in the plan development because of his expertise in the "chronic disease" model which places a greater focus on the provision of continuing care and recovery support services. A significant amount of preparatory time was dedicated to planning this pay for performance initiative.

Utilization of Incentives and Levers

DSAMH service provider contracts provide financial rewards on a monthly basis for:

- Engagement/utilization and active participation. Programs that exceed minimum service utilization rates and exceed three of the four active participation targets (expected attendance at a minimum number of treatment sessions) earn a five percent incentive payment.
- Program completion. Programs earn an incentive of $100.00 for each client who successfully completes treatment up to the capped contract amount.

DSAMH also includes a schedule of financial penalties in the contract. These financial penalties are implemented if a service provider agency fails to meet the minimum service

[26] Jack Kemp, Director of Substance Abuse Services, Delaware Division of Substance Abuse and Mental Health.
[27] Dr. A Thomas McLellan, Professor of Psychiatry at the University of Pennsylvania; founder and director of the Treatment Research Institute in Philadelphia.

utilization rate. DSAMH allowed a six-month grace period during which penalties were not imposed so that programs could gain experience in achieving the targets.

Concurrent Recovery Monitoring

DSAMH will soon be launching a new but related initiative, Concurrent Recovery Monitoring (CRM). DSAMH has been working with Dr. McLellan and the Delaware outpatient service providers in planning for the implementation of CRM. DSAMH expects that this initiative will develop new and innovative ways to provide continuing care that more effectively addresses the chronic needs of clients. Through CRM, DSAMH hopes to provide service providers with the technology to monitor "real time" data on how clients are progressing against SAMHSA national outcomes. When fully implemented, DSAMH will add relevant outcome measures to contracts (e.g., reductions in drug use and arrests, increased employment, etc.). DSAMH expects that financial incentives also will be added related to achievement of these outcomes.

Stakeholder Involvement

Because DSAMH intended to use a competitive bidding process, it did not involve service providers in the program development. Instead, it relied on the internal staff workgroup described earlier. DSAMH leadership met with all of the service providers soon after the Request for Proposals was completed. At that time, DSAMH negotiated measures with the service providers. Service providers indicate that the lack of opportunity to participate in the program development presented a challenge because of the short timeframe to research the RFP expectations and to respond to the RFP.

After DSAMH awarded contracts, it provided a one-day training to service provider personnel. DSAMH staff continued to meet with service providers bimonthly, which provided an opportunity for service providers to share successes as well as discuss problems and challenges relative to implementing this initiative. Providers indicate that DSAMH did respond quickly to identified implementation challenges.

Challenges and Barriers

DSAMH identified a number of challenges employing levers to promote the use of EBP:

- It was challenging to define the performance measures that would be connected to payment, ensure that there was a defensible basis in research and establish appropriate stretch targets.
- It was also challenging to define the methodology and timing for monitoring the process.
- DSAMH needed a data system that was able to meet the needs associated with the pay for performance initiative. Service providers agreed that the ability of the state data system to report on data with a high degree of accuracy was critical if payment was going to be based on that data. DSAMH has applied for a grant from the National Institute on Drug Abuse that will focus on streamlining paperwork

and bring reporting requirements more in line with the movement toward performance measurement.

- Service provider staff turnover was a barrier to successful implementation of this initiative. Service providers indicated that increased counselor training was also necessary.

Lessons Learned

The DSAMH Substance Abuse Services Director indicates that service providers have responded positively to the pay for performance initiative and that they are very engaged in the process of change. As a result, he feels this initiative has significant merit. The Director also indicates that the involvement of Dr. McLellan has been very helpful.

The involvement of Delaware service providers in The Robert Wood Johnson Foundation's "Network for the Improvement of Addiction Treatment" (NIATX) project has been identified by both DSAMH and service providers as being very helpful. The Delaware providers selected NIATX projects that would assist in meeting the performance outcome goals.

Additional Comments

Knowledge of national trends, involvement in national initiatives, and positive relationships with the service providers appear to lay the foundation for the major change represented in this type of initiative. Long-term, stable leadership also appears to be a positive contributor.

Massachusetts

Overview

Massachusetts has moved toward the implementation of EBPs for substance abuse treatment services funded by the Massachusetts Medicaid Program as well as those services funded through the Massachusetts Department of Public Health's Bureau of Substance Abuse Services (DPH/BSAS). BSAS is the designated single state authority for substance use services and the payer of last resort. Within the last year, Massachusetts has undertaken a major strategic planning process, part of which focuses on the need to ensure that public dollars invested in substance abuse treatment are used to purchase the most effective services possible. The strategic planning effort included a broad range of stakeholders such as providers, trade groups, and consumers, including people in recovery.

The Massachusetts initiative to develop a *Substance Abuse Strategic Plan* resulted from the confluence of a number of factors that forced public officials to take a fresh look at their approach to the problems related to substance abuse. Massachusetts ranks among the top five percent of states in the country for the highest rates of drug and alcohol use among adults and youth. It admits three times more individuals for detoxification from heroin than the national average, and is experiencing an epidemic of overdoses and deaths from opiates such as OxyContin and heroin.

State budget cuts over the past few years resulted in the closure of half of the community-based detoxification beds and significant reductions to other critical services. This in turn significantly reduced access to treatment and the state's rate of admission to treatment decreased by more than 14,000 compared to three years ago. The budget cuts also jeopardized the state's receipt of Federal Substance Abuse Prevention and Treatment Block Grant dollars that are vital to funding the prevention and treatment service system.

As a result, the Massachusetts Lieutenant Governor convened a series of roundtable discussions on substance abuse that involved state, federal, and local government officials. Following these discussions, the Massachusetts Department of Public Health embarked on the interagency strategic planning effort.

The Massachusetts Substance Abuse Strategic Plan is comprehensive in scope and very ambitious. Six priority areas were identified in the plan as critical to achieving the plan's vision. One of these priority areas is to "develop a system of accountable prevention, treatment and recovery support services that are:

- Evidenced-based or based on best practice (EBPs);
- Cost efficient;
- Well managed; and
- Outcomes–based."

Language related to the importance of utilizing EBPs is threaded throughout the plan, as are references to specific EBPs, i.e., brief interventions and office-based opioid treatment.

The plan further recommends the need to develop performance measures for both providers and health plans and the creation of a performance-based monitoring system that "promotes quality and accountability for desired outcomes". [28]

Significant time and effort was invested in a process of identifying EBPs with a major focus on those serving youth, including a review of the literature and site visits to programs in other states. Current efforts involve a major restructuring of the Youth Treatment System, including implementation of standardized screening and assessment procedures, as well as greater emphasis on family services and aftercare.

The Assistant Commissioner for Substance Abuse Services and Director of the Bureau of Substance Abuse Services indicated that efforts to redesign the service system also have necessitated changes within the Bureau. The agency has had to reorganize itself to move from one that funds programs to one that purchases services with a greater focus on supporting quality care. This has involved agency restructuring, hiring of staff with different skills and internal training with a primary focus on workforce development, Science-to-Service, and provider training initiatives. [29]

Stakeholder Involvement

In addition to officials from numerous governmental agencies representing health and human services, public safety and the criminal justice system, a wide range of external stakeholders were involved in the strategic plan development. This included service provider organizations such as the Mental Health and Substance Abuse Corporations of Massachusetts, Inc. (MHSACM) as well as representatives of the recovery association, the Massachusetts Organization for Addiction Recovery (MORE).

State officials indicate that overall responsiveness on the part of service providers has been positive though there have been small pockets of resistance which appear to be related to an organization's capacity to change. DPH/BSAS officials indicate that the Addiction Technology Transfer Center has been helpful in assisting some service providers to examine their readiness to change. The Bureau and ATTC have launched a Science-to Service program with a group of providers to promote their use of Contingency Planning, a NIIDA recognized EBP, as the tool to teach them how to implement change strategies within their programs.

National research and public policy resources were involved in the strategic planning process, including Dr. Tom McLellan. In addition, the DPH/BSAS Assistant Commissioner for Substance Abuse Services indicated that Massachusetts was fortunate to have the involvement of a number of local experts of national prominence, including Dr. David Rosenbloom, Director of Join Together at Boston University School of Public Health (www.jointogether.org), and Dr. Constance Horgan, Director of the Center for Behavioral Health at Brandeis University (http://sihp.brandeis.edu/cbh.html). The

[28] To obtain access to the *Commonwealth's Substance Abuse Strategic Plan,* go to: www.mass.gov/dph/bsas/bsas.htm .
[29] Interview with Michael Botticelli, Assistant Commissioner, Massachusetts Department of Public Health, Bureau Of Substance Abuse Services

Brandeis Center has recently received a SAMHSA grant to examine strategies for improving the quality of care in managed care organizations, including the use of incentives.

Utilization of Levers and Incentives for EBPs

DPH/BSAS

Though DPH/BSAS efforts to utilize incentives are at the preparatory stage, the Massachusetts strategic plan references the need to promote outcomes through the creation of financial incentives and includes an implementation plan specific to that subject (Strategy #5.4, page 62). To establish financial incentives to support and reward key outcomes the implementation plan will:

- Reach consensus with key stakeholders and the clinical effectiveness team on priority outcomes to target for purchase;
- Determine reimbursement models, incentive structures and performance expectations, and draft contract terms;
- Identify funding for incentives;
- Continue to investigate contract reimbursement models;
- With the Governor's Interagency Council and EOHHS Purchasing Council, create joint procurement template;
- Establish feedback mechanisms for ongoing interchange of ideas between providers and implementation team;
- Develop evaluation component and data collection capacity; and
- Implement additional measures as necessary and/or appropriate.

DPH/BSAS leadership has talked to the Director of Alcohol and Drug Services in Delaware to learn from his experience in this area.

Procurement of EBPs for Adolescent and Family Residential Services

In October 2004, the DPH/BSAS issued a request for proposals to procure a new model of Adolescent Residential Services. This new procurement was based on a program model developed by an Interagency Work Group composed of representatives from the Departments of Social Services, Youth Services and Mental Health, the juvenile justice system, and MassHealth (the state's Medicaid program). The model was based on best practices of substance use services for adolescents, and substantially changed the treatment model which now includes the following components:

- Standardized assessment and referral protocol that ensures appropriate referrals for a residential level of care.
- Centralized intake process that places appropriate clients in residential treatment and monitors intakes, discharges, bed capacity, and availability.
- Enhanced clinical capacity, including mental health services.
- Educational/tutorial services.
- Gender specific treatment.

- Developmentally appropriate treatment for adolescents.
- Specific milestones for progression through the treatment process.
- Aftercare coordination to ensure continued engagement in treatment.
- Family involvement throughout the treatment process.

When a community-based provider identifies high-risk behavior, the adolescent is evaluated using the CRAFFT instrument, a substance abuse screening instrument specifically for adolescents developed by John Knight at Boston's Children's Hospital and recommended by the Center for Substance Abuse Treatment (CSAT) as a best practice model. If the CRAFFT screen warrants it, a referral is made for a full assessment using the GAIN (Global Appraisal of Individual Needs), also an assessment tool recommended by CSAT as a best practice model. Based on the results of the GAIN, a determination is made whether the youth should be referred to residential treatment.

To support the development of these practices, DPH/BSAS has begun training with substance use providers, other Health and Human Services agency staff, school-based health center staff and court personnel on the use of the CRAFFT and GAIN. DPH/BSAS also sponsored training on evidenced-based/effective practices for youth and young adults.

The Family Residential Treatment System was also recently redesigned and procured by DPH/BSAS. After an extensive review of evidence-based programs, a decision was made to undertake a complete review of existing models. A committee comprised of staff from DPH/BSAS and the Departments of Transitional Assistance (welfare office), Social Services, MassHealth, the behavioral health managed care organization, and the Governor's Advisory Committee was established to review data, current research and literature on best practices in order to develop criteria for a comprehensive model.

Medicaid Behavioral Health

In Massachusetts, the Executive Office of Health and Human Services (EOHHS) through the Office of Medicaid manages the state's Medicaid program, while the MassHealth Behavioral Health Program component reports directly to the Commissioner of the Department of Mental Health (DMH) and is housed at the DMH. EOHHS develops Medicaid policy and MassHealth/Medicaid insurance instruments, administers the Primary Care Clinician Plan (PCCP), and contracts with managed care organizations and other payers to manage the delivery of services to MassHealth members through contracts with service providers. The Massachusetts Behavioral Health Partnership (MBHP) is the state's Medicaid managed care organization for behavioral health services for MassHealth members in the PCCP, including substance abuse treatment.

EOHHS/DMH and MBHP have both been very progressive over the past several years in identifying and instituting evidence-based and best practices through various providers and payment mechanisms. Some EBPs that were instituted after lengthy and comprehensive planning processes include *Motivational Interviewing* among Structured Outpatient Addiction Programs (SOAPs-day treatment services); *Outcomes Measurement*

by all providers under contract with MBHP; and *Outliers Management* with Acute Treatment Services (ATS/detoxification programs) to track and identify clients who are rapidly cycling through detoxification program beds, as an effort to stop the cycling and produce better client outcomes.

Motivational Interviewing

EOHHS's contract with MBHP includes Performance Incentives that are identified in collaboration with various stakeholders, including the MBHP consumer and family advisory councils. These Performance Incentives must be instituted in order for MBHP to qualify for the financial incentive. One such Performance Incentive in 2004 was use of Motivational Interviewing among SOAPs-day treatment programs. MBHP worked with Gary Rose, Ph.D. and Peter Nathan, Ph.D., nationally recognized experts in evidence-based practices to develop a training module, and then issued an open invitation to SOAP providers to participate in this initiative. This effort proved very successful for providers and clients, and since that time MBHP has further promoted the expansion of SOAP programs and continues to pay an incentive to providers who utilize the motivational interviewing technique. The SOAP providers now share a common philosophical approach to treatment.

Outcomes Measurement

On May 10, 2004, the Massachusetts Behavioral Health Partnership (MBHP) announced the planned implementation of an outcomes management and best practice initiative throughout their network of over 1,200 providers. This task was important from two perspectives: public accountability and healthcare quality. MBHP's goals for this initiative are to work with the provider community to identify best practices, identify the barriers to adopting best practices, and to promote best practices at all levels of care within its provider network.

This outcomes initiative evolved through many months of dialogue with provider associations, professional associations, and consumer advocates. All agreed that it was important to measure treatment outcomes; few agreed upon how outcomes should be measured; and all asserted that providers could not afford to bear the cost of measuring outcomes. In response to the concern about costs, MBHP was fortunate to have the support of the Massachusetts Executive Office of Health and Human Services, Department of Mental Health, and the MassHealth Behavioral Health Programs Unit in identifying savings that could be applied to rate increases that were given to nearly all network providers.

A portion of the rate increase was given specifically to pay providers for the outcomes initiative. In addition to the network-wide rate increases, MBHP created a limited fund that allowed them to subsidize their preferred outcomes instrument, the Treatment Outcome Package (TOP) published by Behavioral Health Laboratories in Massachusetts. The Partnership then offered training and technical assistance to providers.

Outliers Initiative

In April 2005, the MBHP Outliers Initiative was instituted to better address the addiction treatment needs of about 140 clients who were utilizing detoxification services from three to seven times within a 90 day period. Prior to implementation, MBHP met with the providers of detoxification services in order to define this initiative as well as to identify their specific concerns and the issues that MBHP would need to address in the pre-implementation training sessions. In general, the providers' primary concerns were the day-to-day impact of this initiative on their detoxification program operations, and their staff capacity to meet the requirements of this initiative in addition to their current workload.

MBHP met with each provider of detoxification services at each program site to conduct the training in order to address their individual staff and program's needs. They established a means by which to flag clients on their data base when they met the "cycling" criteria, so that when a detoxification program called MBHP to register the client they would be referred to a MBHP clinical manager. Although this initiative is in the earliest stages of implementation, it appears to be netting positive outcomes. Data on service utilization and client outcomes will be collected and analyzed to determine its success as a best practice.

Lessons Learned

Lessons learned from the Motivation Interviewing project include:

- The implementation of EBPs requires an ongoing commitment of resources to maintain the level of training and coaching needed and to ensure fidelity to the treatment model. In order to better support all of its EBPs, MBHP has recently hired a quality specialist whose job will primarily be to ensure that EBPs are fully supported and evaluated for fidelity.
- The implementation of EBPs requires sufficient planning as well as adequate resources for training, administrative oversight, and ongoing support. Resources allocated for training should take into consideration the high rates of staff turnover in substance abuse treatment programs. MBHP addressed this challenge through the development of trained coaches within each agency.
- Consumer involvement and provider buy-in early in the process, as well as access to the expertise of a consultant, were important to successful implementation.
- The closer the philosophical alignment of the EBP to the clinician's prior training, the greater the likelihood of EBP adoption. In this regard, it was felt that Motivational Interviewing is an EBP that lends itself to adoption because it can be learned in relatively few sessions and because it "fits" easily with most traditional substance abuse counseling methods. MI also had appeal to consumers because it tracks a treatment style that is very compatible with the principles of recovery and rehabilitation.

Cross Agency Agreements

There has been a high degree of priority related to interagency collaboration in the development of the Commonwealth's Strategic Plan. DPH/BSAS officials indicate that these interagency efforts encompassed all the human services, state, county and local correctional facilities, the judiciary and educational state agencies, and represents the first time that agency leaders at the Commissioner level have come together to focus on substance abuse. A *Governor's Interagency Council on Substance Abuse Treatment and Prevention* has been created to provide executive level leadership focusing on:

- Maximizing and aligning available resources across agencies to effectively and efficiently address substance use issues;
- Developing unified policies and strategies to drive changes in the substance abuse prevention and treatment systems across agencies; and
- Unifying the authority of the Governor's separate Alcohol and Drug Advisory Council.

Additional Comments

The Massachusetts strategic planning effort represents a major redesign of the substance abuse treatment system supported by a strong commitment from the Governor and other policymakers. The strategic planning effort has been accompanied by a significant investment by the legislature in increased funding for substance abuse treatment and prevention services.

Appendix II

Key Informant Interview Protocol

Information on the utilization of levers to promote EBP was gathered from 23 individuals representing a wide breadth of perspectives. Information was gathered through telephone interviews and e-mail from a number of state purchasers of SUD treatment, state agencies, managed care entities, SUD treatment service providers, organizations representing SUD treatment providers, and researchers. Information also was gathered from a limited number of individuals, organizations and states that had been identified as potentially having experience related to the subject of this research. Thus this environmental scan is not intended to represent a comprehensive review of all existing relevant activities.

The interviews attempted to gather information related to:

- The utilization of levers by purchasers to promote the utilization of EBP;
- The effectiveness of such mechanisms;
- Unintended consequences resulting from the utilization of these mechanisms;
- Recommendations for improving the effectiveness of these mechanisms;
- The identification of other individuals with experience in this area; and
- The identification of any available literature on this subject.

As with the literature review, the information obtained through the interviews was gathered with the intent that the findings would be a beginning point for discussion by a focus group of key experts on this topic.

Ten telephone interviews were completed. They included four state SUD treatment directors, four representatives of SUD treatment providers or service providers, one regional managed care SUD treatment purchaser, and one mental health fiscal expert.

In addition to these phone interviews, information was received from six individuals via e-mail communication. These included five SUD treatment researchers and one managed care SUD treatment purchaser. Finally, with the assistance of the SUD treatment state director in North Carolina, an inquiry was disseminated to all members of the National Association of State Alcohol and Drug Abuse Directors, requesting any relevant information on this subject. Seven additional state directors responded to the inquiry, bringing the total number of state agencies from which information was received to 11.

Appendix III

Publications Analyzed in the Literature Review

"Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers," CSAT's TAPS 16, 1998.
http://www.treatment.org/taps/tap22/TAP22TOC.htm

"Purchasing Managed Care Services for Alcohol and Other Drug Treatment: Essential Elements and Policy Issues," CSAT's TAPS 16, 1995.
http://www.treatment.org/TAPS/TAP16/TAP16TOC.HTML

"Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment," CSAT's Treatment Improvement Protocol (TIP) Series, Volume 14, 1995.

CHCS Purchasing Analysis Guide in preparation for the CHCS Purchasing Institute for Resources for Recovery: State Practices that Expand Treatment Opportunities; Center for Health Care Strategies, Inc., Technical Assistance Collaborative, Inc., The Robert Wood Johnson Foundation; guide prepared by Mercer, July 2003.
http://www.chcs.org/usr_doc/substance_analysis.pdf

"Enhancing Resources for Recovery: Strategies and Examples" Dennis McCarty, Eldon Edmundson, Carla Green, Bentson McFarland, Center for Substance abuse Research and Policy Studies, Oregon Health Policy Institute; Patrick Lanahan, Alicia Smith, Resources For Recovery National Program Office, Technical Assistance Collaborative, Inc., September 2003.
http://www.resourcesforrecovery.org/policy/StateReports.pdf

"Using Performance Measurement to Improve the Quality of Alcohol Treatment," Primer Six of the "Ensuring Solutions to Alcohol Problems" Series, The George Washington University Medical Center.
www.resourcesforrecovery.com/resourcesforrecovery/EnsuringSolutionsPrimeronPerformanceMeasurement.pdf

"Rewarding Results: Improving the Quality of Treatment for People with Alcohol and Drug Problems," Join Together National Policy Panel Recommendations, Quality of Treatment for Substance Use Disorders, 2003.
http://www.jointogether.org/sa/files/pdf/quality.pdf

"Monitoring Treatment Outcomes and Managed Care: Promise and Challenge for the AOD Field," CSAT Treatment Information Exchange Communique, 1998.
http://www.treatment.org/Communique/comm98M/treatment.pdf

"Partners in Planning: Consumers' Role in Contracting for Public-Sector Managed Mental Health and Addiction Services," Volume 10, SAMHSA's Managed Care

Technical Assistance Services, Prepared by the Judge David L. Bazelon Center for Mental Health Law and the Legal Action Center, April 1998.
Not accessible on the Internet.

"Contracting for Public Mental Health Services: Opinions of Managed Behavioral Health Care Organizations," Prepared for the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), by the Lewin Group.
http://www.mentalhealth.org/publications/allpubs/SMA00-3438/default.asp

"Division of State and Community Assistance: State of the SSA's," June 2004, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

"Research Utilization and Managing Innovation in Rehabilitation Organizations," Backer, T.E., Journal of Rehabilitation, 54(2), p. 19, 1988.

"Conducting Trials in Community Settings: The Provider Perspective," Zweben et.al., Journal of Psychoactive Drugs, Volume 32 (2) p.194 April-June 2000.

"Sub-State Purchasing of Managed Behavioral Health Care: An Analysis of County-Level Managed Care Contracts," Center for Health Services Research and Policy, The George Washington University Medical Center, Prepared for SAMHSA, October 1999.
http://www.gwhealthpolicy.org/downloads/behavioral_health/reports/County-level%20Study%201199.pdf

"Understanding the Purchase of Outcome in Substance Abuse Treatment," William E. Ford, Ph.D. for the National Council on Alcoholism and Drug Dependence Committee on Benefits, June 2000.
http://www.ihs.gov/MedicalPrograms/Alcohol/purchase.pdf

"Medicaid Behavioral Managed Care: What Lies Ahead," CHCS Informed Purchasing Series' Working Paper, Sandra L. Forquer, PhD, James E. Sabin, MD, August 2002.
http://www.chcs.org/usr_doc/bhforecasting.pdf
General background piece of issues connected to Medicaid and managed behavioral health care.

"Medicaid Managed Care: Outreach and Enrollment for Special Populations," CHCS's Informed Purchasing Series," Mary Kenesson.
http://www.chcs.org/usr_doc/outreach_and_enrollment.pdf

"Contracting for Coordination of Behavioral Health Services in Privatized Child Welfare and Medicaid Managed Care"
http://www.chcs.org/usr_doc/childwelfare.pdf

"The Role of Competition in Changing Public Managed Behavioral Health Systems" CHCS's Informed Purchasing Series Resource Paper.
http://www.chcs.org/usr_doc/reprocurement.pdf

"Value Purchasers in Health Care: Seven Case Studies," DA Kindig, Milbank Memorial Fund, September 2001.

"Establishing the feasibility of performance measures for alcohol and other drugs," Deborah W. Garnick, Margaret T. Lee, Mady Chalk, David Gastfriend, Constance M. Horgan, Frank McCorry, A. Thomas McLellan and Elizabeth Levy Merrick, Journal of Substance Abuse Treatment, Volume 23, Issue 4, December 2002, pp. 375-385.

"Cost and Quality Trends in Direct Contracting Arrangement," Health Affairs, January/February 2002. Lyle A. and Weiner J.P. et al.

"Evolution in the Buyers Health Care Action Group Purchasing Initiative," Christianson J.B. and Feldman R. Health Affairs, January/February 2002.

"Resources for Recovery: State Practices that Expand Treatment Opportunities"
http://www.resourcesforrecovery.com/news/default.asp

"Negotiating the New Health System: Findings from a Nationwide Study of Medicaid Primary Care Case Management Contracts," Informed Purchasing Series' Working Paper, Sara Rosenbaum, Alexandra Stewart, Colleen Sonosky, June 2002.
http://www.chcs.org/usr_doc/negotiatingpccm.pdf

"Health Purchasing Coalitions Struggle to Gain Bargaining Clout: Small Size and Lack of Support from Health Plans are Factors," Health Care Financing and Organization: Findings Brief, June 2000, Volume 4, Issue 1.
http://www.hcfo.net/pdf/findings600.pdf

"Value-Based Purchasing: Can Medicare be the Spark," Changes in Health Care Financing and Organization, March 2004.
www.hcfo.net/topic0304.htm

"Research in Practice: Buyers Health Care Action Group Purchasing Initiative," Jon Christianson, Center for the Study of Healthcare Management, Department of Healthcare Management, February 2002.
http://www.csom.umn.edu/Assets/4193.pdf

"Cost and Quality Trends in Direct Contracting Arrangements," Alan Lyles, Jonathan P. Weiner, Andrew D. Shore, Jon Christianson, Leif I. Solberg, Patricia Drury, Health Affairs, Volume 21, Issue 1, pp.89-109, 2002.

"Selection Incentives in a Performance-Based Contracting System," Y. Shen, Health Services Research, Volume 38, Number 2, pp.535-552, April 2003.

"Consumer Guides in Managed Care," SAMHSA guide, 2000
www.samhsa.gov/mc/content/Managed%20Care%20Contracting/ConsumerGuide/P42.htm

"Health Care Quality Improvement Studies in Managed Care Settings—Design and Assessment: A Guide for State Medicaid Agencies"
www.ncqa.org/communications/Publications/additionalpubs.htm

"The Impact of Managed Care on Substance Abuse Treatment: A Problem in Need of Solution," http://www.asam.org/ppol/managedcare.htm

Five papers written by field experts who are serving on Join Together's National Policy Panel. Although none of the web-accessible reports seemed to be directly relevant to leveraging state purchasing power, they could be helpful as background pieces.

- High Quality Alcohol Treatment/Interventions Systems: Empirical Evidence Regarding the Efficacy/Effectiveness of Selected Components," John Finney, Director, Center for Health Care Evaluation, VA Palo Alto Health Care System
- "Understanding Drug Treatment Process to Improve Quality," D. Dwayne Simpson, Ph.D. Texas Christian University
- "Treatment for Substance Use Disorders: Exploring the Relationship between Treatment Training and Treatment Outcomes," Howard Shaffer, Associate Professor & Director, Division on Addictions, Harvard Medical School
- "Who Benefits from Better Drug Treatment?" Mark Kleiman, Professor of Policy Studies, University of California in Los Angeles
- "Can the National Addiction Treatment Infrastructure Support the Public's Demand for Quality Care?" McLellan AT, Carise D, Kleber HD. Can the national addiction treatment infrastructure support the public's demand for quality care? J Subst Abuse Treat. 2003 Sep;25(2):117-21.
http://www.jointogether.org/sa/action/dt/strategies/improvement/panel/topics/