MANAGING ENTITIES AS VEHICLES FOR THE DELIVERY OF EVIDENCE-BASED PRACTICES

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Or, Using Managing Entities (MEs) to overcome barriers to the delivery of Evidence Based Practices (EBPs)

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A very brief overview of MEs

- An entity providing certain network management functions.
  - Contrast between a network as a panel and a network as a system of care.
- Network as panel
- Network as system of care
- Typical ME functions: CQI, network development, contract management, utilization management, design and management of clinical pathways
- More info: http://www.fadaa.org/resources/networks/faqnetwork.pdf

About EBPs

- "Interventions that have shown consistent scientific evidence of being related to preferred client outcomes." *ATTC Networker*, Spring 2004
- Twenty year lag in most fields
  - Substance abuse is within the normal "needs improvement" range
- Avoid the definition trap
  - "Manualized" treatment needed to establish research reliability
  - Yet "manualized" treatment with defined lengths of stays and sessions can be the new cookie cutter

Key concepts

- Experimental designs
  - Random assignment, Double Blind for Drug Studies
  - Controlled
- Meta analysis

Needed scanning and sources of information

- What are the EBPs and what evidence supports them?
- How do you implement EBPs?
- Coming soon, in 2007, The National Registry of Evidence-based Programs and

Practices (NREPP),: http://www.nationalregistry.samhsa.gov/

Some sources

- The Cochrane Collaboration: "Produces and disseminates systematic reviews of healthcare interventions . . ." http://www.cochrane.org/index.htm
- National Guideline Clearinghouse(NGC)
  - A public resource for evidence-based clinical practice guidelines.
  - Go to http://guideline.gov/ and enter search terms
  - Among others, leads to CSAT's Treatment Improvement Protocols (TIPs)
- The National Center for Biotechnology Information (**NCBI**)
  - *Entrez* the search and retrieval system used at the National Center for Biotechnology Information for the major databases, including PubMed
  - http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?DB=pubmed
  - (enter keywords and "meta analysis"

Also scan

- NIDA: www.nida.nih.gov/
- NIAAA: www.niaaa.nih.gov/
- Robert Woods Johnson Foundation: www.rwjf.org/
- ATTC: http://nattc.org/index.html

National Quality Forum (NQF)

- EBP workgroup funded by the Robert Woods Johnson Foundation
- Results published in 2005
- See report at
  http://www.rwjf.org/portfolios/resources/grantsreport.jsp?filename=049909.htm&iaid=131
- Nineteen stakeholder experts identified:
  - 7 core treatment practices supported by sufficient scientific evidence
  - 4 attributes of high-performing SUD treatment programs
  - 5 barriers to the adoption of evidence-based treatment practices.

Among the core treatment practices

- EBP Psychosocial Intervention
  - motivational interviewing (MI);
  - motivational enhancement therapy (MET);
  - cognitive behavioral therapy (CBT);
  - structured family and couples therapy;
  - contingency management (or as motivational incentives); community reinforcement therapy
  - 12-step facilitation therapy.

Also among the core treatment practices

- Pharmacotherapy
    - All patients with SUDs should be assessed, and, if appropriate, pharmacotherapy should be initiated.
        - Although not all are good candidates for it
        - For appropriate patients, however, there is solid evidence that pharmacotherapy
    - Provided in addition to, and directly linked with, psychosocial treatment.

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Also among the core treatment practices

- Recovery/Chronic Care Management
- Patients treated for SUDs should be engaged in longterm, ongoing management of their care.

(Note: Italics indicates items that are supported by networks)

Attributes Required of Programs (Capable of EBPs)

- *Supervision of staff to ensure that practices are being properly administered. Continuous staff development and measurement of staff competence.*
- Staff communication
- *Presence of (or access to) medical and nursing staff with a set of core clinical competencies in SUDs care, especially in pharmacotherapy.*
- *Coordination of Care -- coordinated across levels and sites*
- Programs must strengthen their ability to engage patients in self-management as part of the ongoing support of recovery
- Financial incentives, legal requirements, regulatory oversight and program accreditation requirements must be redesigned to become consistent with the model of care outlined by the core practices.

Structural barriers

- *The non-existence of networked providers.*
- *The inability to share data among payors.*
- *The need for data systems that can share clinical information among providers.*
- Movement of patients back and forth from the public to the private sector for care as their insurance eligibility changes.
- *The isolation of programs/providers, especially if they are not connected with state/national associations.*
- The lack of a single state authority to support the implementation of evidence-based practices.

Financial Barriers

- The availability and adequate funding
- *Benefit structures and restrictive benefit management*
- *Billing issues, billing codes do not exist for some core practices*
- Payment models that do not include reimbursement for quality management.

The lack of available "essential community services."

Barriers around the Knowledge Base of the SUDs treatment system involve:

- The lack of standardized professional curricula for SUDs treatment, for both primary and specialty care providers.
- The lack of standardized clinical nomenclature related to SUDs symptoms and treatment.
- *Bias among some providers towards abstinence-only treatment.*
- The need to build the evidence base through new research and to improve dissemination of existing knowledge.
- *The ability of programs to apply new knowledge, to make changes in practice that reflect the evidence.*

Potential staff-related barriers include:

- *The willingness of providers to participate in the implementation of new care practices, if providers are not included in the development of these implementation plans.*
- The retention of qualified staff

Some things about contingency Management

- Described by NIDA Deputy Director as our most powerful tool for the treatment of stimulant dependence
- Positive reinforces for contracted behaviors
    - Usually negative drug screens, can be others, such as attending 12 step meetings
    - If drug screens, timing is key, once weekly for short acting
- Reinforcers
    - Cash, although can be seen as problematic
    - Also chances for prizes, points for retail items
- Recommend: review of lots of studies and develop contingencies and rewards Source for 64 studies: Cork Foundation: **http://www.projectcork.org/bibliographies/data/Bibliography_Behavioral_Contingencies.html**

Pharmacotherapy

- Buprenorphine: opioid detox, maintenance
  - Compare favorably to methadone in results
- (Those needing structure may do better with methadone)
- Disulfiram: widely used, efficacy is mixed.
- Naltrexone: reduces relapse rates and quantity of drinking.
- Acamprosate enhances abstinence and reduces drinking rates.
- Also combined naltrexone and acamprosate

Quick examples of how networks can help

- Continuous staff development
  - Examples of Florida networks
- Coordination of care
- Access to pharmacotherapy
- Structure for contingency management

Case rates and how case rates can help

- Case rate: purchaser pays the provider a single rate for contractually-specified care for a recipient's:
  - episode of care
  - level of care
  - care delivered for a period of time, usually one year.

Examples of case rates

- A rate for all contracted services needed for a client for the year.
- A type or episode of service care at a given level, such as detoxification, residential, intensive outpatient, or low-intensity outpatient.
- Reinforces efficient care without relying on external reauthorization systems.
- Single case rate for an episode that begins at one level and continues through other levels.
- Can be adjusted according to client profile and service features.

Case rates and networks

- Networks allow for the broad application of case rates
- How case rates can support EBPs
- Incentives
- Means to fund items without codes

		How Networks May Help
EBP Psychosocial Interventions	MI; MET; CBT; structured family and couples therapy; 12-step facilitation	• Shared staff development (Florida models) • Shared importation (Minkoff example) • Others:
	Contingency management	• Establish infrastructure for tracking, rein forcers across providers, locations • Others:
Pharmaco-therapy	Assess, reassess all patients	• Clinical pathways • Uniform assessments • Others:
Recovery/ Chronic Care Management	Long term, ongoing management of their care	• Establish structure for long term involvement • Others:
Attributes Required of Programs	Supervision to ensure that practices are properly administered.	• Shared supervision • Peer review • Others:
	Continuous staff development.	• Shared staff development (Florida models) • Others:
	Medical staff with competencies in SUDs care, especially in pharmacotherapy.	• Arranging for network-wide access • Others:
Addressing the barriers	The non-existence of networked providers.	• Networks formed • Others:

		How Networks May Help
	The inability to share data among payors.	• SunCoast model: networks become the level at which this occurs • Others:
	The need for data systems that can share clinical information among providers.	• Networks as platforms to share clinical data • Others:
	The isolation of programs/providers.	• Networked providers sharing training resources • Others:
	Benefit structures and restrictive benefit management	• Opportunities for flexible payment systems • Others:
	Billing issues, billing codes do not exist for some core practices	
	Bias among some providers towards abstinence-only treatment.	• Network designs that put decision making on highly trained, unbiased clinicians • Clinical pathway • Networked providers sharing training resources • Peer reviews • Others:
	The ability of programs to apply new knowledge, to make changes in practice that reflect the evidence.	
	The willingness of providers to participate in the implementation of new care practices, if providers are not included in the development of these implementation plans	