

A Longitudinal Study of State Strategies and Policies to Accelerate Evidence-Based Practices in the Context of Systems Transformation

Take Away Points

- The use of evidence-based practices (EBPs) for the treatment of substance use disorders is gradually becoming widespread. However, widespread implementation mostly favors psychological interventions. Between 2007 and 2009, states reported increased implementation of psychosocial interventions and the use of methadone, but limited use of screening and brief interventions and other medication assisted treatments.
- While states have opted to promote EBPs by requiring or encouraging providers to deliver these practices with existing contract funds, only five states have legislative mandates requiring EBPs for substance use disorders.

The Issue

Recent policy developments, including the Affordable Care Act of 2010, necessitate the integration of substance abuse treatment with primary care and the need for evidence-based practices (EBPs) that incorporate best research evidence, clinical expertise and patient values. State governments are appropriate entities for promoting EBPs in the treatment of substance use disorders and each state has dedicated Single State Authority (SSA) charged with overseeing substance abuse treatment services. However, little is known about states' strategies for improving access to EBPs, and the extent of (and changes in) EBP implementation across the states.

Source

Rieckmann T, Abraham A, Zwick J, Rasplica C, & McCarty D. (2015). *Health Services Research*, 50 (4), 1125-1145.

Study Methods and Design

The study was designed to describe state agency efforts to promote implementation of three EBPs: screening, brief intervention, and referral to treatment (SBIRT), psychosocial interventions (PIs), and medication-assisted treatment (MAT). The researchers employed a longitudinal mixed method study using semi-structured interviews and surveys to solicit data from SSA administrators on their strategies for influencing and promoting implementation of the EBPs publicly funded systems of care. Participants were 51 SSA directors/designees (representing the 50 states and Washington, DC) who completed an initial rapid assessment interview in 2007 and follow-up interviews in 2008 and 2009. Data collection focused on status of EBP implementation and strategies to increase adoption and implementation of EBPs (i.e., SBIRT, PIs and MAT). The survey asked respondents to rate the implementation and adoption of these EBPs using 5-point Likert type scales which were dichotomized (1-3 vs. 4 or 5) to examine widespread implementation. The survey/interview also asked about the presence of EPB language in direct and indirect state contracts (including competitive grants), and organizational structure, authorization/licensure, treatment provider funding, regulations and legislation, and staff functions. Descriptive statistics were used to summarize survey items while qualitative data from the interviews were coded and analyzed for emerging themes.

Key Findings and Limitations

- Significant increase in widespread implementation of psychosocial interventions and medication assisted treatments over the three years while there were no changes in SBIRT.
 - Between 2007 and 2008, there was a double fold increase in the number of states reporting widespread implementation of psychological interventions and MAT.
 - From 2008 to 2009, Motivational Interviewing/Motivational Enhancement Therapy (MIT/MET) was the only psychological intervention with significant increase in widespread implementation and there were no changes in the implementation of medication assisted treatments
 - As of 2009, there was wide availability of psychological interventions (Cognitive Behavior Therapy, MIT/MET and the ASAMPPC were available in at least 71% of the states) while MAT (including Methadone, Disulfiram and Smoking cessation) was widely implemented in less than a third of the states.
- Use of state legislation to promote EBPs was uncommon. Only five states (Oregon, North Carolina, Alaska, Wisconsin and Idaho) reported legislative mandate for EBP implementation.
- Funding for SBIRT is balanced primarily across all four sources (general funds, Medicaid, Federal Block Grants, and other grants); PIs were funded primarily through state general funds and federal block grants; and approximately three-fourths of states relied on state general funds and Medicaid to fund medication assisted treatments.
- States used contract language as a common lever for EBP implementation. States with direct contracting were significantly more likely to include EBP-related contract language in 2007 and 2008.
- States face similar changes to EBP implementation including limited/lack of funding and workforce and staffing needs. Facilitators of EBPs include partnerships with primary care providers and professional development for staff and providers.

“Health care reform and implementation of parity in coverage increases access to treatment for alcohol and drug use. Science-based substance abuse treatment will become even more crucial as payers seek consistent quality of care.”

The study is not without limitations. For example, the data collection instrument was modified during the three year study, hence the unavailability of data for all key variables (e.g., individual EBPs) and inability to examine trajectories of change. Also, data collection coincided with the early phase of the 2008 economic recession hence the need for further studies to examine if the observed trend has continued or changed.

Final Thoughts

- State agencies are important for impacting the use of EBPs and needed changes at the provider level with the overarching goal of improving client outcomes. States can improve the quality of care for SUDs by providing access to, and emphasizing the use of EBPs.
- Despite the increased implementation of psychosocial interventions and MAT (specifically, the use of methadone), there is still the need for states to ensure consistent access to these services.
- With the ongoing shifts in health care environment, SSAs are likely to assume greater involvement in the administration of Medicaid funding for the treatment of SUDs.