SB5732

Evidence Based Practices (EBP)Workgroup
Final Report

May 2, 2014

EBP Workgroup Members

Marc Bollinger	Southwest WA Behavioral Health RSN
Maria Monroe-DeVita	Washington Institute for Mental Health Research & Training (WIMHRT), University of Washington
Linda Grant	Evergreen Manor
Gretchen Bruce	King County
Roxane Waldron	Washington Association of Community and Migrant Health Centers
Lisa Utter	NAMI-WA
Rick Weaver	Central Washington Comprehensive Mental Health
Wendy Tanner	Washington Community Mental Health Council
Stephanie Lane	Washington State University
Roy Walker	Washington Association of Area Agencies on Aging (W4A)
Mark Snowden	Harborview Medical Center, University of Washington
Pamala Sacks	Juvenile Justice & Rehabilitation Administration (JJRA)
Eric Nicholson	Juvenile Justice & Rehabilitation Administration (JJRA)
Anne Shields	Community Health Plan of Washington
Jan Ward Olmstead	American Indian Health Commission for Washington State
Marna Miller	Washington State Institute for Public Policy (WSIPP)
Britt Anderson	SEIU- Mukilteo E&T
Margaret Soukup	King County Mental Health Chemical Abuse & Dependency Services
Carrie Horwitch	American College of Physicians
June Bredin	DSHS- Developmental Disabilities Administration
Jayleen Harland	Molina Healthcare of Washington
Yolanda Lovato	DSHS- Behavioral Health and Service Integration Administration
David Reed	DSHS- Behavioral Health and Service Integration Administration
Julia Greeson	DSHS- Behavioral Health and Service Integration Administration
Greg Endler	DSHS- Behavioral Health and Service Integration Administration
Kara Panek	DSHS- Behavioral Health and Service Integration Administration
Daniel Lessler	Health Care Authority (HCA)
Charissa Fotinos	Health Care Authority (HCA)
Stefanie Zier	Health Care Authority (HCA)

Background

As part of SB5732, the Washington State Legislature commissioned the Washington State Institute for Public Policy (WSIPP) to develop an inventory of evidence-based, research-based, and promising practices for adult behavioral health. Largely replicating the methods used via HB2536 to establish a similar inventory for prevention and intervention services for children and juveniles in the child welfare, juvenile justice, and mental health systems, WSIPP will designate adult behavioral health programs and practices as "evidence-based" or "research-based" as established from a review of the research literature. "Promising practices" will be designated based on review by a panel of experts at the University of Washington; this panel reviews and scores applications submitted by community behavioral health providers and/or their service coordination entity or by WSIPP when research evidence is not sufficient to qualify a program as evidence- or research-based using the same criteria as were established for the HB2536 inventory.

The SB5732 Evidence-Based, Research-Based, and Promising Practices Inventory for Adult Behavioral Health will become one of several similar lists of such programs and practices in Washington State, including the previously mentioned list developed out of HB2536, as well as an inventory for evidence-based and research-based programs in adult corrections. Similarly, DSHS has established an evidence-based program list for substance abuse prevention and mental health promotion services. This list is based on established criteria within the Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Registry of Evidence-based Programs and Practices (NREPP).

Overview

Given the fact that the Evidence-Based, Research-Based, and Promising Practices Inventory for Adult Behavioral Health will not be completed until after the EBP Workgroup's recommendations have been made and the charge of this Workgroup is not to make recommendations on specific programs and practices, this report will focus on two recommendation areas: (1) ***program and practice selection*** (i.e., how to choose programs and practices listed on the Inventory) and (2) ***program and practice implementation*** (i.e., how to get selected programs and practices up and running).

Guiding Principles

The EBP Workgroup recommendations focus on ***practical***, ***sustainable,*** and ***recovery-oriented,*** strategies for behavioral health agencies and service coordination entities, taking into account differential approaches to supporting individual clinician ***practices*** (e.g., Cognitive Behavioral Therapy - CBT) as well as team-based or multiple clinician ***programs*** (Integrated Dual Disorder Treatment - IDDT).

- **Practical** – While there are likely to be numerous programs and practices listed in the upcoming Inventory, we recognize that the entities responsible for selecting and implementing them need useful strategies that can be applied in real-world settings.

- **Sustainable** – Similarly, recommendations focus on long-term implementation and integration vs. rapid start-up and limited follow-up. Recommendations aim to ensure buy-in across stakeholders and a training and implementation approach that can be integrated within organizations' ongoing supervisory and quality improvement practices.

- **Recovery-oriented** – At the heart of all recommendations are the values of recovery, resiliency, self-determination, and a person-centered approach. The process of selecting and implementing programs and practices should be consumer-driven, and inclusive of the people served within the adult behavioral health system. The programs and practices selected and implemented should further align with and reinforce these values.

Programs and Practices: Selection Considerations

Programs and practices will be selected from the Inventory across a range of types of programs, including mental health, substance use/chemical dependency, co-occurring mental health and substance use, and integrated primary care. We recommend a two-pronged strategy for selection based on a combination of statewide and regional service needs:

1. **Statewide level:** We recommend that the Washington State Department of Social and Health Services (DSHS) and Health Care Authority (HCA) prioritize ***one*** *to* ***two*** programs and practices to be implemented statewide in areas where they have been identified as a need to enhance mental health, substance use, co-occurring disorder, or integrated primary care programming and outcomes. We further recommend consideration of culturally relevant programs/practices as part of this statewide selection.

2. **Regional level:** We recommend a regional prioritization process of ***three*** *to* ***five*** programs and practices to be implemented based on local needs. In order for the selection process to honor local voice, we recommend program and practices be identified by a range of local community stakeholders, including consumers, families, service providers, service coordination organizations, and other service system stakeholders (e.g., the Family Youth System Partner Round Table [FYSPRT] may be a useful model by which to make such selection decisions and to ensure they represent local need).

Prioritization of programs and practices at both levels may be guided by the following selection considerations, noting that any one program or practice may align with several of these listed considerations. These considerations are listed in no particular order. They have not yet been prioritized since they may be different at the State and regional levels. We recommend a prioritization process at each level to make best use of these considerations.

1. **Alignment with core outcome domains:** We recommend selection of programs and practices in which outcomes are aligned with Results Washington and the State's strategic plans. For example, core metrics for the DSHS Behavioral Health and Service Integration Administration (BHSIA) have included access, engagement and retention, consumer and workplace safety, and employment.

2. **Identified service gaps in the system:** The detection of service gaps will help to identify and select programs and practices across the system. We recommend examination of the

following at the state and local level: (1) Who isn't being served or served well with existing practices and programs right now? (2) What kind of programs or practices would best meet the needs of these people?

Several methods may help to address these questions. A gaps analysis using methods similar to those of the Division of Behavioral Health and Recovery's (DBHR) Children's Mental Health team and the University of Washington's Evidence Based Practice Institute (EBPI) related to implementation of HB2536 would offer a more strategic approach to systematically identifying those gaps in mental health, substance use, co-occurring disorder, and integrated primary care programming needs across the system. Service gaps may be further identified based on where Washington State stands related to system gaps identified at the national/federal level by the Department of Justice (DOJ) and Olmstead-related lawsuits and settlements in various states (see cases by issue: http://www.ada.gov/olmstead/olmstead_cases_by_issue.htm). For example, states found to retain people in mental health facilities due to limited options in less restrictive settings have been mandated to expand and enhance mental health service capacity in integrated community settings for people with serious mental illness (e.g., crisis services, assertive community treatment [ACT], supported housing, residential services, supported employment).

3. **Serving the needs of most:** We recommend consideration of programs and practices that meet the needs of the majority of people served in the public behavioral health system. For example, CBT+ was selected by the DBHR Children's Mental Health team because it includes a variety of interventions that address the needs of roughly 80% of children and youth served in public behavioral health settings (i.e., anxiety, depression, post-traumatic stress, and working with parents to address disruptive behaviors). This was established by WSIPP using state administrative data to identify service utilization patterns and diagnoses (Burley, 2009). In order to identify these service needs (including service gaps, as identified in #2 above), we recommend a similar study be conducted and expanded to the adult behavioral health service system; this is particularly important given the changing service population under Medicaid Expansion through the Affordable Care Act (ACA).

4. **Successful pilots:** DSHS and HCA have funded several pilot service programs and practices over the past several years. For example, the Screening, Brief Intervention, and Referral to Treatment [SBIRT] program, was initially implemented in hospital emergency departments and is now expanding into primary care practices in Washington State, and the Mental Health Integration Program (MHIP), in which behavioral health service providers are co-located in primary care settings so as to screen, diagnose and treat low and moderate level behavioral health needs. Similarly, several regions and agencies have implemented their own pilot evidence-based, research-based, and promising practices (e.g., CBT for post traumatic stress disorder [PTSD], anxiety and depression; Dialectical Behavior Therapy [DBT], supported employment/individual placement and support model, trauma-informed care). We recommend consideration of expansion of successful pilot programs and practices in the state, where there is still unmet need that could be addressed by those models.

5. **Targeting service integration:** Health care reform under the ACA focuses on enhancing the integration of physical and behavioral health care systems. We recommend considering programs and practices that align with integration of mental health, substance use, and/or primary care. In addition to those previously mentioned, others include Seeking Safety, which addresses trauma and PTSD among substance-using females and the Integrated Dual Disorder Treatment [IDDT] program which provides stage-based treatment for people with co-occurring substance use disorders and serious mental illness).

6. **Cultural relevance:** In recognition of the diversity and geographic heterogeneity of Washington State, we recommend consideration of programs and practices that are conducive to adaptation for diverse populations (e.g., racially or ethnically diverse, Tribes, LGBTQ, older adults) and regions (e.g., rural and frontier areas).

7. **Best value:** Given WSIPP's purview to include a cost-benefit analysis of each program listed in the Inventory, we recommend that the cost-benefit of programs and practices be taken into consideration as well as when there are lower cost alternatives at an equal value.

Similar to the process for HB2536, we recommend that the SB5732 Evidence-based, Research-based, and Promising Practices Inventory for Adult Behavioral Health serve as a "living" list that will be updated over time, building in opportunities to add and remove programs and practices from that list. This is not only true for updates to evidence-based and research-based practices, but also for promising practices, along with the provision of technical assistance for agencies and providers carrying out these practices to assist with planning to bring them to the next level of evidence.

Programs and Practices: Implementation Considerations

After programs and practices are selected, we recommend the following considerations for implementation at both the State and regional/local level.

1. **Take a developmental approach to implementation:** Implementation approaches need to take into account that not all providers will be in the same place with implementing a variety of evidence-based, research-based, and even promising practices. We recommend tailoring implementation support and resources to the agencies' and providers' level of readiness to adopt such programs. We recommend providing agencies and providers practice- and program-specific readiness aides where available in order to expedite implementation readiness.

   Similarly, getting a gauge on organizational culture and climate and the readiness of leadership to adopt and implement such programs and practices, and tailoring efforts to assist with that process will go a long way. This may include, for example, providing agency administrators and supervisors with an orientation to these models and/or including them in part or all of the start-up training in order to ensure their understanding of the models. These approaches can lead to their championing and provision of local

support for these programs and practices. A "Practical Guide for EBP Implementation in Public Mental Health" (Berliner, Dorsey, Merchant, Jungbluth, & Sedlar, 2013) is a resource that was developed specifically for agencies implementing EBPs for children and youth, but specifies similar strategies for agencies to use to address organizational climate and leadership, among a number of other core areas of implementation. This guide will be referenced throughout many of the remaining recommendations, given its utility in implementing somewhat parallel recommendations related to the Children's Mental Health team's portion of HB2536.

2. **Tailor funding to needed resources:** We recommend several approaches to funding programs and practices prioritized at the State and regional level, taking into account the reality of limited resources in our state. For programs and practices prioritized by DSHS and HCA, we recommend state funding for start-up, ongoing training and implementation, and material resources.

   Ideally, some state resource would be dedicated to support regional and local implementation of some evidence-based, research-based and promising programs and practices; for example, if several regions decide to implement the same program, the State may coordinate and fund start-up training across the state in that particular model, given the need. Regional authorities and local agencies should also take into account local resources that may support particular program or practice implementation (e.g., $1/10^{th}$ of 1% sales tax, agency incentives for implementing models with demonstrated effectiveness) and/or examine ways to reallocate existing resources where needed (i.e., if practices aren't aligned with good outcomes, planning for re-training and implementing a more effective model in its place).

3. **Employ core EBP implementation drivers:** Much work has been done in the area of implementation science, which supports a comprehensive approach to program implementation, with a focus on clinical skills uptake, application, and sustainability (see Figure 1). We recommend application of a combination of these implementation supports, while focusing on what is practical, particularly at the agency level, where multiple evidence-based, research-based, and promising practices and programs may be implemented.

   - **Clinician Selection:** We recommend that agencies apply approaches to staff hiring that best ensure skills uptake of the programs and practices identified. These may include job announcements listing a preference for knowledge or experience in particular skills and/or program models and following up with asking for copies of certificates in those specific areas during the interview (Berliner et al., 2013), as well as conducting role-plays of practical skills within the interview. Realistic job previews (i.e., providing job applicants with accurate and detailed information about what the day-to-day work looks like) have been found to modestly improve staff retention (McEvoy & Cascio, 1985; Premack & Wanous, 1985); similarly in more intensive outreach-oriented programs, job shadowing and sitting in on team meetings to get a better sense of the work within these programs have been found to be helpful.

- **Clinician Training:** We recommend provision of start-up and booster training to clinicians, using evidence-based approaches to training, such as fewer didactics-focused presentations and more practice of specific skills. Provider agencies may want to focus on training their workforce in core clinical skills first (e.g., motivational interviewing), which can then translate to carrying out those very practices as well as provide a foundation on which other programs and practices can build. For example, training in motivational interviewing and cognitive-behavioral interventions have been recommended across a range of different programs such as Housing First, family psychoeducation, and illness management and recovery (McGovern, McHugo, Drake, Bond, & Merrens, 2013). Further, we recommend building in train-the-trainer models so that providers can sustain these practices locally over time, as well as assisting providers to develop the capacity for cross-training on various programs and practices. Agencies should ensure that clinician training manuals and resources are available at the local level to further support sustainability. See related recommendations under Learning Collaboratives (#4) below.

- **Consultation/Supervision:** We recognize that training alone is ineffective; in order to ensure skills uptake and application, it needs to be followed up with expert consultation focused on practicing the actual skills the clinicians use in their clinical work (Bond, 2007; Isett et al., 2008; Joyce & Showers, 2002; Mancini et al., 2009; Rapp et al., 2008; Rapp, Goscha, & Carlson, 2010). Consultation should also focus on local sustainability; this can be achieved by helping supervisors provide practice-focused consultation directly to the clinicians they supervise (i.e., not just talking about cases). A similar approach has been used in expert consultation to supervisors and could be applied within supervision itself (Beidas, Cross, & Dorsey, in press; Beidas, Edmunds, Marcus, & Kendall, 2012). See related recommendations under Learning Collaboratives (#4) below.

- **Outcome Monitoring:** The most important reason that certain programs and practices are implemented is because they demonstrate positive outcomes; as such, seeing a person improve and achieve a better life is what should be the target of treatment. Some program models (e.g., Collaborative Care) focus primarily on outcome monitoring as a way to assess whether the intervention is working. Similarly, many evidence-based practices incorporate some type of brief outcome measurement as part of the practice itself (e.g., CBT for anxiety). We recommend systematic use of this approach across all programs and practices to guide clinical work at the provider level. Washington State also needs to come up with a systematic process by which providers can incorporate outcome monitoring to guide their practice, feed this information to the State, and still obtain individual and program-level reports to guide ongoing quality improvement. We recommend looking to states and organizations that have started to implement elements of such approaches (e.g., Hawaii; GroupHealth Cooperative; Berliner, Dorsey, Sedlar, Jungbluth, & Merchant, 2013).

- **Fidelity Assessment:** While outcomes are the most important, assessing how well the practice is delivered to potentially achieve those outcomes is often necessary, especially at the start of a new practice or program or when outcomes have not been achieved or are slow to develop. When applied, however, fidelity assessment feedback should be used in a systematic manner to guide ongoing clinical practice and provider competence (Bond et al., 2009; McHugo et al., 2007).

  We recommend cataloguing various approaches to fidelity assessment, listing the pros and cons, and presenting them to a variety of Washington State stakeholders (e.g., Healthy Options managed care plans, Regional Support Networks [RSNs], community providers) to have them weigh in on how fidelity will be approached across a range of programs and practices in adult behavioral health in Washington State. A similar process is currently occurring via HB2536 related to children's mental health services within BHSIA/DBHR. Additionally, key components of fidelity that are process measures (e.g., using a PHQ-9, or reviewing cases in clinical supervision in collaborative care interventions) can be monitored, and encouraged by incorporating them into pay-for-performance approaches (Unutzer et al., 2012).

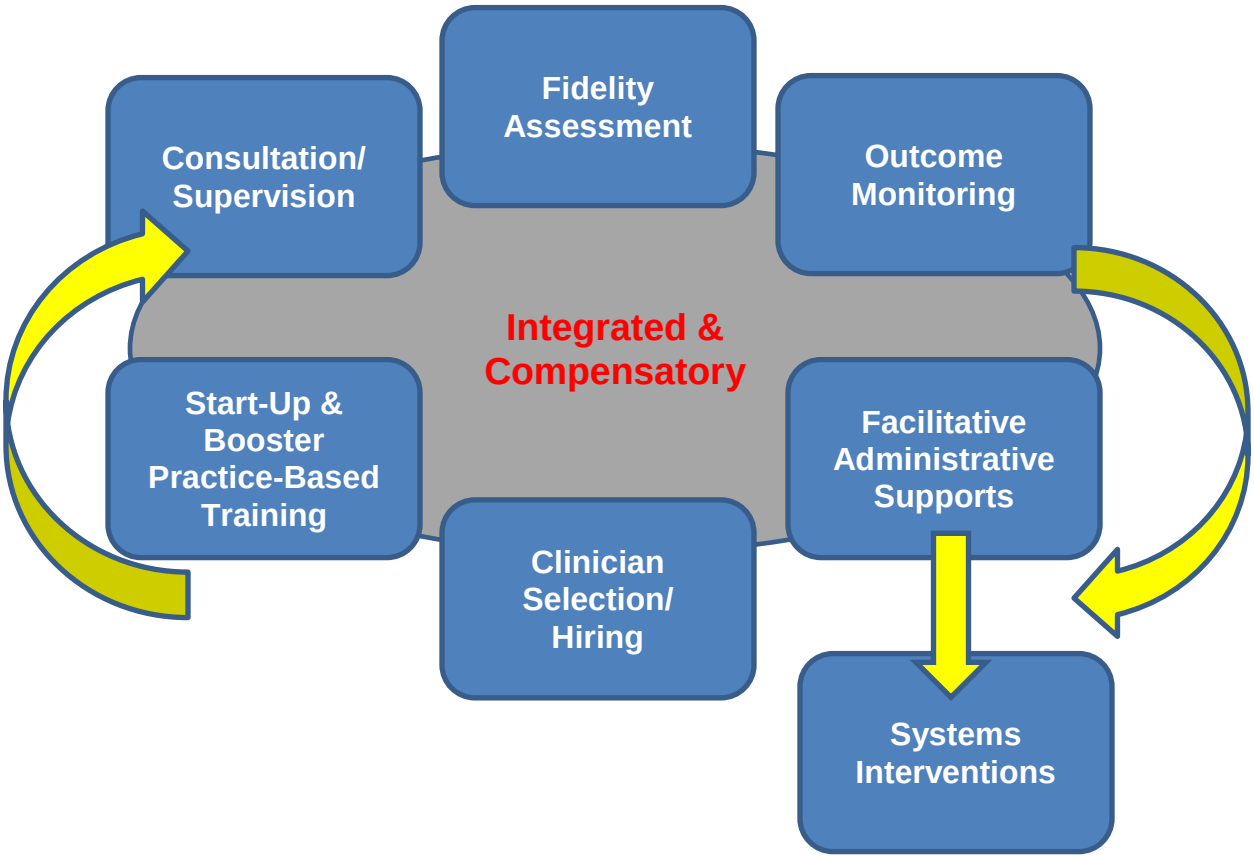
4. **Establish Learning Collaboratives:** As described in several places above, we recommend building local sustainability through supporting "EBP Champions" who may provide agency/administrative support, train-the-trainer models, supervisors who directly provide "expert" consultation focused on practicing skills, and providing a mechanism by which providers implementing similar EBPs can talk with one another to problem-solve and consult with one another through the implementation process. Further, facilitating learning in a systematic manner across teams is another emerging strategy to ensure quality implementation of programs and practices (Becker et al., 2011; Drake & Bond, 2010). Learning collaboratives generally follow the framework: (1) group learning on how to improve performance, (2) implementing new learning through practice and observing the results, (3) sharing experiences with other similar program and practice sites, and (4) coming back together to plan further practice improvement (Ovretveit et al., 2002; Wilson, Berwick, & Cleary, 2002).

5. **Structure the oversight process so that it is not duplicative**: Contract monitoring, licensing, and other types of oversight as discussed above (i.e., fidelity monitoring) are necessary to ensure the quality of services delivered. We recommend that these oversight processes be well-coordinated between State, service coordination organizations, and providers so that local providers do not experience multiple, often labor- and time-intensive, site visits that seek to assess many of the same aspects of service delivery.

Summary

In conclusion, the 5732 EBP Workgroup recommendations focus on evidence-based, research-based, and promising practices ***selection*** and ***implementation*** considerations. We recommend that program and practice selection occur at both the statewide and regional levels. Selection considerations should be prioritized at both levels. Implementation considerations should be rolled out at both the state and regional levels.

Figure 1. Core Implementation Components (Adapted from Fixsen et al., 2005)



References

Becker, D. R., Drake, R. E., Bond, G. R., et al. (2011). A mental health learning collaborative on supported employment. *Psychiatric Services, 62*, 704-706.

Beidas, R.S., Cross, W.F., & Dorsey, S. (in press). Show me don't tell me: Behavioral rehearsal as a training and fidelity tool. *Cognitive and Behavioral Practice*.

Beidas, R.S., Edmunds, J.M., Marcus, S.C., & Kendall, P.C. (2012). Training and consultation to promote implementation of an empirically supported treatment: A randomized trial. *Psychiatric Services, 63*(7), 660-665.

Berliner, L., Dorsey, S., Merchant, L., Jungbluth, N., & Sedlar, G. (2013). *Practical guide for EBP implementation in public mental health.* Lacey, WA: Washington State Division of Behavioral Health and Recovery.

Berliner, L., Dorsey, S., Sedlar, G., & Jungbluth, N. (2013). *Everyday competence and fidelity for EBP organizations: Practical guide.* Lacey, WA: Washington State Division of Behavioral Health and Recovery.

Bond, G. (2007). Modest implementation efforts, modest fidelity, and modest outcomes. *Psychiatric Services, 58(3),* 334-334.

Bond, G. R., Drake, R. E., Rapp, C. A., McHugo, G. J., & Xie, H. (2009). Individualization and quality improvement: two new scales to complement measurement of program fidelity. Administration and Policy in Mental Health and Mental Health Services Research, 36(5), 349-357.

Burley, M. (2009). *Outpatient treatment differences for children served in Washington's public mental health system* (Document No. 09-10-3401). Olympia: Washington State Institute for Public Policy.

Drake, R. E., & Bond, G. R. (2010). Implementing integrated mental health and substance abuse services. *Journal of Dual Diagnosis, 6*, 251-262.

Fixsen, D. L., Naoom, S. F., Blasé, K. A., Friedman, R. M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature* (FMHI Publication #231). Tampa: University of South Florida, Florida Mental Health Institute.

Isett, K. R., Burnam, M. A., Coleman-Beattie, B., Hyde, P. S., Morrissey, J. P., Magnabosco, J. L., & Goldman, H. H. (2008). The role of state mental health authorities in managing change for the implementation of evidence-based practices. *Community Mental Health Journal*, *44*(3), 195-211.

Joyce, B. R., & Showers, B. (2002). *Student achievement through staff development (3rd ed).* ASCD.

Mancini, A., Moser, L., Whitley, R., McHugo, G., Bond, G., Finnerty, M., & Burns, B. (2009). Assertive community treatment: facilitators and barriers to implementation in routine mental health settings. *Psychiatric Services*, *60*(2), 189-195.

McEvoy, G. M., & Cascio, W. F. (1985). Strategies for reducing employee turnover: A meta-analysis. *Journal of Applied Psychology*, *70*(2), 342.

McGovern, M., McHugo, G. J., Drake, R. E., Bond, G. R., & Merrens, M. R. (2013). *Implementing evidence-based practices in behavioral health*. Center City, MN: Dartmouth PRC-Hazelden.

McHugo, G., Drake, R., Whitley, R., Bond, G., Campbell, K., Rapp, C., & Finnerty, M. (2007). Fidelity outcomes in the national implementing evidence-based practices project. *Psychiatric Services, 58*(10), 1279-1284.

Øvretveit, J., Bate, P., Cleary, P., Cretin, S., Gustafson, D., McInnes, K., & Wilson, T. (2002). Quality collaboratives: lessons from research. *Quality and Safety in Health Care, 11(4),* 345-351.

Premack, S. L., & Wanous, J. P. (1985). A meta-analysis of realistic job preview experiments. *Journal of Applied Psychology, 70(4),* 706.

Rapp, C. A., Etzel-Wise, D., Marty, D., Coffman, M., Carlson, L., Asher, D., & Whitley, R. (2008). Evidence-based practice implementation strategies: results of a qualitative study. *Community Mental Health Journal, 44*(3), 213-224.

Rapp, C. A., Goscha, R. J., & Carlson, L. S. (2010). Evidence-based practice implementation in Kansas. *Community Mental Health Journal, 46*(5), 461-465.

Unutzer, J., Chan, Y. F., Hafer, E., Knaster, J., Shields, A., Powers, D., & Veith, R. C. (2012). Quality improvement with pay-for-performance incentives in integrated behavioral health care. *American Journal of Public Health, 102* (6), 41-5.

Wilson T., Berwick D.M., Cleary P.D. (2003) What do collaborative improvement projects do? Experience from seven countries. *Joint Commission Journal on Quality and Safety, 29,* 85-93.