Report to the Legislature

Evidence-Based and Research-Based Practices
Updates and Recommendations

Engrossed Second Substitute House Bill 2536, Section 3
Chapter 232, Laws of 2012

December 30, 2014

Washington State Department of Social and Health Services

Department of Social and Health Services

Behavioral Health and Service Integration Administration (BHSIA)

Children's Administration (CA)

Juvenile Justice and Rehabilitation Administration (JJ&RA)

and

Washington State Health Care Authority

Health Care Authority (HCA)

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EXECUTIVE SUMMARY

Engrossed Second Substitute House Bill (E2HB) 2536, Section 3, passed by the 2012 Legislature, states:

(3)(a) By December 30, 2013, the department and the health care authority shall report to the governor and to the appropriate fiscal and policy committees of the legislature on recommended strategies, timelines, and costs for increasing the use of evidence-based and research-based practices. The report must distinguish between a reallocation of existing funding to support the recommended strategies and new funding needed to increase the use of the practices.
(b) The department shall provide updated recommendations to the governor and the legislature by December 30, 2014, and by December 30, 2015.

This update was requested by the Legislature to examine the continued expansion of Evidence-based and Research-based practices (E/RBPs) within the state-run systems serving children and youth in Washington.

This multi-system review of the implementation of E/RBPs highlights successes and common challenges in reaching the legislative goal of substantial increases in the use of E/RBPs.

Areas that require additional attention continue to include E/RBP fidelity monitoring; increased costs of delivering E/RBP services; on-going training; data/quality assurance; and addressing the unique needs of Medicaid and Tribal populations.

It should be noted that increased and sustained implementation of E/RBPs will require new infrastructure investments. To support this effort, it is recommended that the legislative and executive branches continue to focus on:

- Flexible fidelity monitoring that focuses on improving outcomes for children and youth;
- Cost implications of ongoing implementation, including training, for providers delivering E/RBPs;
- Quality Assurance/Improvement with a focus on improving outcomes by enhancing data collection and analysis to inform decisions and future direction; and
- Promising practices that meet the needs of special populations.

A great deal of work still needs to be done to accomplish the Legislature's intent that mental health, child welfare, juvenile justice and health care authority services delivered to children and youth be primarily evidence-based and research-based. These child-serving agencies are committed to continuing the work with adequate infrastructure funding.

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Department of Social and Health Services and Health Care Authority
Updates and Recommendations

INTRODUCTION

In accordance with E2SHB 2536, the Department of Social and Health Services (DSHS) and the Health Care Authority (HCA) present this update and recommendations for increasing the use of Evidence-based and Research-based practices across the child serving systems of child welfare, juvenile justice, and children's mental health services. The report includes progress on the delivery of Evidence-Based and Research-Based practices and continued needs recommended for:

- Substantial increases in Evidence Based (EBP) and Research Based Practices (RBP) (collectively E/RBPs) throughout Washington's Child Serving Systems.
- Cost
- Fidelity
- Cultural Responsiveness
- Future work in examining Core Elements

The report provides information regarding how DSHS Behavioral Health and Service Integration Administration's (BHSIA's) Division of Behavioral Health and Recovery (DBHR), Children's Administration (CA), juvenile courts, the Juvenile Justice and Rehabilitation Administration's (JJ&RA) Juvenile Rehabilitation, and the Health Care Authority (HCA) plan to increase the use of evidence based, research based and promising practices.

While Tribal Governments still remain open to the idea of implementing E/RBPs, they reserve the right as sovereign nations to be exempt from E/RBP legislative requirements. Their concern is based on the fact that there have not been a sufficient number of E/RBPs for American Indian and Alaska Native populations.

INVENTORY OF EVIDENCE-BASED, RESEARCH-BASED AND PROMISING PRACTICES

A defined structure has been established to regularly review the Washington State Institute of Public Policy (WSIPP) list of Evidence-Based, Researched-based, and promising practices that involves conducting a meta-analysis of the research, applying the standard of heterogeneity, and cost benefit. This yearly review will generally keep programs in the same categories but has been known to periodically change a program from one category to another.

September 2014
Inventory of Evidence-Based, Research-Based, and Promising Practices
For Prevention and Intervention Services for Children and Juveniles in Child Welfare, Juvenile Justice, and Mental Health Systems

Budget area	Program/intervention	Manual	Current definitions	Suggested definitions	Cost-beneficial	Reason program does not meet suggested evidence-based criteria (see full definitions below)	Percent minority
Child Welfare	**Intervention**						
	Family Search and Engagement	Yes	P	P	N/A	No rigorous evaluation measuring outcome of interest	N/A
	Fostering Healthy Futures	Yes	◉	◉	N/A	Single evaluation	56%
	Functional Family Therapy (FFT) for children in the child welfare system	Yes	P	P	N/A	No rigorous evaluation measuring outcome of interest	N/A
	Including Fathers - Father Engagement Program	Yes	P	P	N/A	No rigorous evaluation measuring outcome of interest	N/A
	Intensive Family Preservation Services (Homebuilders)	Yes	●	●	Yes (100%)		48%
	Multisystemic Therapy (MST) for children in the child welfare system	Yes	◉	◉	N/A	Heterogeneity/Single evaluation	18%
	Other Family Preservation Services (non-Homebuilders)	Varies*	P	⊘	No (0%)	Weight of evidence	68%
	Parent Child Assistance Program	Yes	P	P	N/A	Weight of evidence	N/A
	Parent-Child Interaction Therapy	Yes	●	●	Yes (100%)		33%
	Parents for Parents	Yes	P	P	N/A	No rigorous evaluation measuring outcome of interest	N/A
	Partners with Families and Children	Yes	P	P	N/A	No rigorous evaluation measuring outcome of interest	N/A
	Pathway to Reunification	Yes	P	P	N/A	No rigorous evaluation measuring outcome of interest	N/A
	Safecare	Yes	◉	●	Yes (99%)		44%
	Prevention						
	Circle of Security	Yes	P	P	N/A	No rigorous evaluation measuring outcome of interest	N/A
	Healthy Families America	Yes	●	◉	No (46%)	Benefit-cost	73%
	Kaleidoscope Play and Learn	Yes	P	P	N/A	No rigorous evaluation measuring outcome of interest	N/A
	Nurse Family Partnership	Yes	●	◉	Yes (71%)	Benefit-cost	51%
	Other Home Visiting Programs for At-Risk Parents	Varies*	●	◉	No (47%)	Benefit-cost	50%
	Parent Child Home Program	Yes	◉	◉	No (33%)	Benefit-cost	64%
	Parent Mentor Program	Yes	P	P	N/A	No rigorous evaluation measuring outcome of interest	N/A
	Parents and Children Together (PACT)		P	P	N/A	No rigorous evaluation measuring outcome of interest	N/A
	Parents as Teachers	Yes	●	P	No (50%)	Benefit-cost/Weight of evidence	52%
	Promoting First Relationships	Yes	P	P	N/A	No rigorous evaluation measuring outcome of interest	N/A
	Safe Babies, Safe Moms	Yes	P	P	N/A	No rigorous evaluation measuring outcome of interest	N/A
	Triple P (system)	Yes	◉	●	Yes (99%)		33%

Key:
● Evidence-based
◉ Research-based
P Promising
⊘ Produces null or poor outcomes
See definitions and notes at the end of the inventory.

For the entire list please click on the link below:

Inventory of Evidence-Based, Research-Based and Promising Practices-September 2014

TRIBAL GOVERNMENTS FEEDBACK

In honoring the unique government to government relationship between the State of Washington and Tribal Governments and Recognized American Indian Organizations, DSHS and HCA have updated the tribes on the status of E2HB 2536. The following encapsulates relevant information from the 2013 legislative report and information shared by the Tribal leaders during this process:

- There are limited evidence-based, research-based and promising practices that have been tested in tribal communities. The differences in Washington's tribal communities (urban, rural and frontier) adds another level of complexity to finding E/RBPs that have been adequately normed for tribal communities.

- Acknowledgement that Tribes know what works best in a Tribal community and that a pilot project or study that works in one Tribal community may not necessarily be easily replicated in another. Each tribe in Washington has its own rich and unique history, culture and traditions.

- The Tribes have a strong interest in looking at current Tribal practices and pursuing them as promising practices. Through this process, they seek modalities that will fit within the current Tribal Health system and make adjustments as necessary to keep the core practice.

- Challenges with continuity and consistency exist within the development of E/RBPs.

- Tribes experience the same, if not more, challenges in workforce development necessary to meet the needs of tribal communities.

In collaboration with the Tribes, DSHS and HCA will begin to explore Core Elements (see page 24) in implementing effective E/RBP programs for tribal youth to ensure the research based components of the models will meet the cultural and spiritual aspects unique to each Tribe.

CONCERNS EXPRESSED IN IMPLEMENTING EVIDENCE-BASED AND RESEARCH BASED PRACTICES

- **Cost** — There are serious implications around the costs associated with increasing the availability and use of E/RBPs within DSHS and HCA. The costs associated with increasing a workforce trained in E/RBPs and supporting their fidelity were not provided for in the initial legislation and subsequently were not addressed. Additional funding will be required to make meaningful advancement in increasing the use of E/RBPs.

- **Fidelity** — Stakeholders have expressed the need for increased and improved guidance, support, and financial infrastructures to support the ongoing task of fidelity monitoring. Because there is no funding allocated to fidelity costs, many

administrations use direct service funding to purchase fidelity and quality assurance.

- **Cultural Responsiveness** — Stakeholders are concerned that not enough focus has been given to the cultural appropriateness of E/RBPs. The Department plans to work with model developers in examining, adapting and/or exploring promising practices. Work needs to continue with engagement of youth and families, diverse communities and the Family Youth System Partner Round Tables (FYSPRTs) throughout the process. The Department is working with the community to support recruiting a diverse workforce able to effectively deliver services that meet the diverse cultural, family, and individual needs of the populations we serve. This includes the ability to respect and serve families where there is diversity in religion, sexual orientation, gender identity and expression, language, race, ethnicity, urban/rural, socioeconomic status and culture.

BEHAVIORAL HEALTH AND SERVICES INTEGRATION ADMINISTRATION (BHSIA)

In the 2013 Legislative Report, *Evidence-based and Research-based Practices, Strategies, Timelines and Costs*, BHSIA set a goal of 45 percent of children/youth enrolled in a Certified Mental Health Agency (CMHA) be treated with an E/RBP by the end of 2019.

As indicated in Table A, BHSIA has set out a six-year plan beginning in 2013, to increase the use of E/RBPs provided to children/youth by stepping-up the target by 15 percent each biennium (7.5 percent each year). The year in Table A will cover January through December. As indicated in Table B, benchmarks will also be measured biennially. Looking at data at this level will allow BHSIA to track progress towards the goal and whether adjustments must be made in practice, data collection, reporting, or the goal itself prior to the close of the biennium (COB).

Year	COB %
2014	7.5%
2015	15%
2016	22.5%
2017	30%
2018	37.5%
2019	45%

Table A

Biennium	COB %
2013-2015	15%
2015-2017	30%
2011-2019	45%

Table B

(Note: Projected increases for the current biennium are dependent on funding set forth in the T.R. v. Quigley and Teeter decision package as well as Federal Block Grant dollars.)

Progress and Challenges

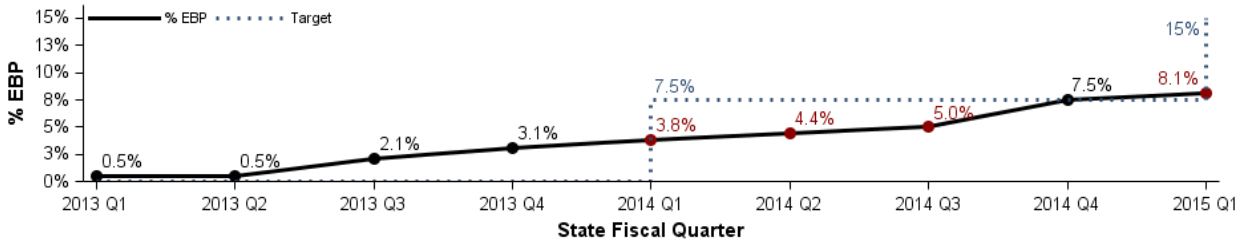
In 2013, at the request of the legislature, BHSIA established a way for RSNs to report E/RBPs through ProviderOne and placed reporting requirements in Regional Support Network (RSN) contracts. A great deal of concern from both RSNs and CMHAs persisted around the definition of "fidelity" and what was required for certification purposes. BHSIA used this feedback to revise the Service Encounter Reporting Instructions (SERI) (pg. 87-88), which removed the certification of fidelity requirement and clarified how and when to report E/RBPs. The removal of fidelity language does not negate the need for fidelity, but instead allows RSNs to report only on the E/RBPs being provided. Future work will be done in partnership with the University of Washington, RSNs and CMHAs in developing a fidelity requirement that will look toward a more simplified approach in attesting and/or certifying adherence to fidelity.

A great deal of work has been done by RSNs and their provider networks to begin the tracking necessary to report on the delivery of E/RBPs to children and youth. Table C summarizes the work as of 10/30/2014:

- 5 of 11 RSNs have met the 7.5% bench mark
- The state at 8.1% has exceeded the 7.5% benchmark BHSIA has established.

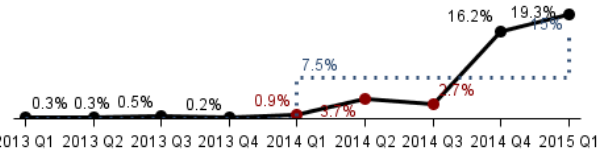
Youth Mental Health Consumers Receiving Evidence Based Practices

Unduplicated Count of Youth (under 21) by Regional Support Network and State Fiscal Quarter



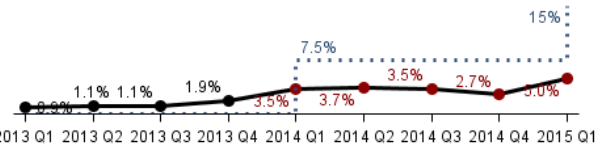
Statewide

Chelan Douglas



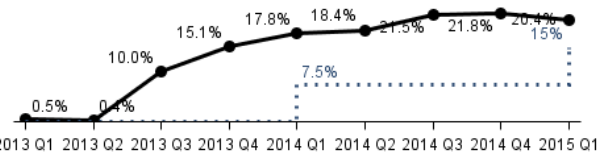
RSN

Grays Harbor



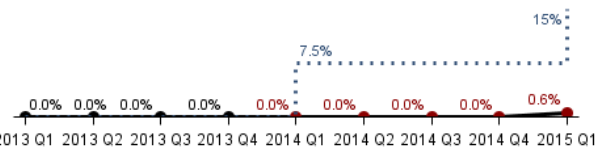
RSN

Greater Columbia



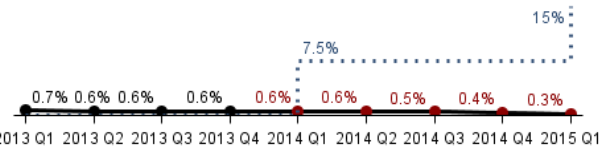
RSN

King County



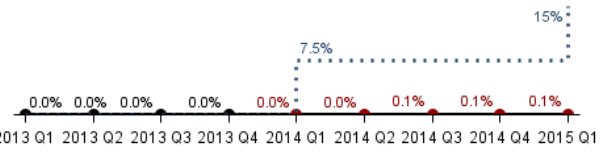
RSN

North Sound Mental Health

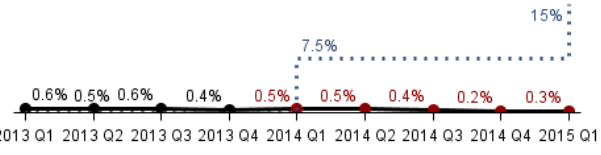


Administration

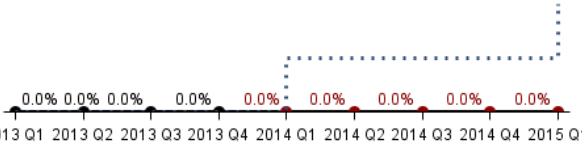
Southwest Behavioral



Health

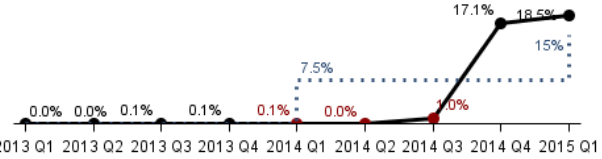


Peninsula RSN

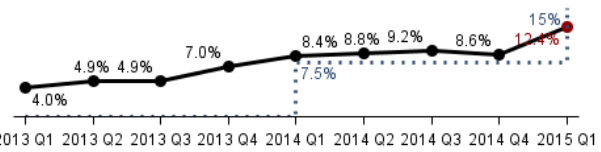


OptumHealth

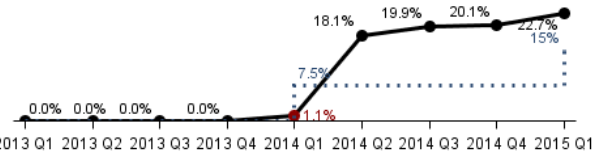
Spokane County RSN



Thurston-Mason RSN



Timberlands



RSN

NOTES: Most RSNs reported EBP services only for participants receiving services to fidelity through July 2014. Consumer age determined by month of service.
Sources: ProviderONE paid claims and CIS program data | AHQuA\Aaron\MH Youth EBP 20140421.sas | Run date: 30OCT14

Table C

Note: The dotted blue trend line represents the incremental goal set forth by BHSIA in the 2013 Legislative report [Table A and B]

Challenges remain with reporting and BHSIA has heard the following as obstacles in reporting E/RBP data within service encounters:

- **Blended funding** — RSNs have reported that many of the E/RBPs that are delivered within their service structure are not solely funded by Medicaid dollars. Instead there is a blended funding structure that incorporates county treatment sales tax dollars, grants and even private dollars in providing these practices. In response, BHSIA provided guidance that if any Medicaid dollar is spent in the use administering an E/RBP those services shall be counted.

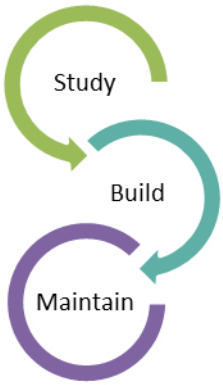
- **Delays in sharing contract requirements with providers** — Communication with providers around the need to collect and report E/RBPs could have been improved. Lack of RSN clarity about how to identify E/RBP elements or level of fidelity needed added to this delay. DBHR continues to work with RSNs to clarify definitions, funding concerns, and contractual obligations. Improvements have been and continue to be made.

- **Electronic Medical Records (EMRs)** — Many RSNs and providers have expressed challenges around establishing and/or updating EMRs. The complexity of both makes it difficult adapt to changing reporting requirements.

- **Policy** — RSNs are concerned with the possibility of E/RBPs being reported without additional legislative funding. This would misrepresent the complex landscape of services and funding structures which requires additional funding to deliver services within the intent of E2SHB 2536.

Updates on Study, Build and Maintain

BHSIA in partnership with the University of Washington, is in the Study Phase of a three phase process looking into the understanding, building, and sustainability of E/RBPs. Work on a GAPS Analysis and a True Cost Study will allow for informed anchoring of E/RBPs within the behavioral health system.



Study — Examine the landscape of current services and 'gaps' within children's behavioral health and the 'true cost' impacts on provider agencies when implementing E/RBPs.
Build — Informed by the study, select, endorse and operationalize practices into the current service array to build capacity across the entire state.
Maintain — Develop a cost structure to fund implementation and sustainable support of needed infrastructure.

GAPS Analysis Update

A report issued in November 2014 by the University of Washington provides a preliminary analysis of diagnoses for children and youth on Medicaid from the DBHR state billing database (ProviderOne). The following percentages reflect diagnoses for Medicaid children and youth:

- Depressive Disorders (32%)
- Anxiety Disorders (21%)
- Adjustment Disorders (11%)
- Trauma/PTSD (9%)
- Conduct Disorders (9%)
- ADHD (6%)
- Bipolar Disorders (2%)
- Psychotic Disorders (1%)

The following disorders were diagnosed less than 2% in the Medicaid population:

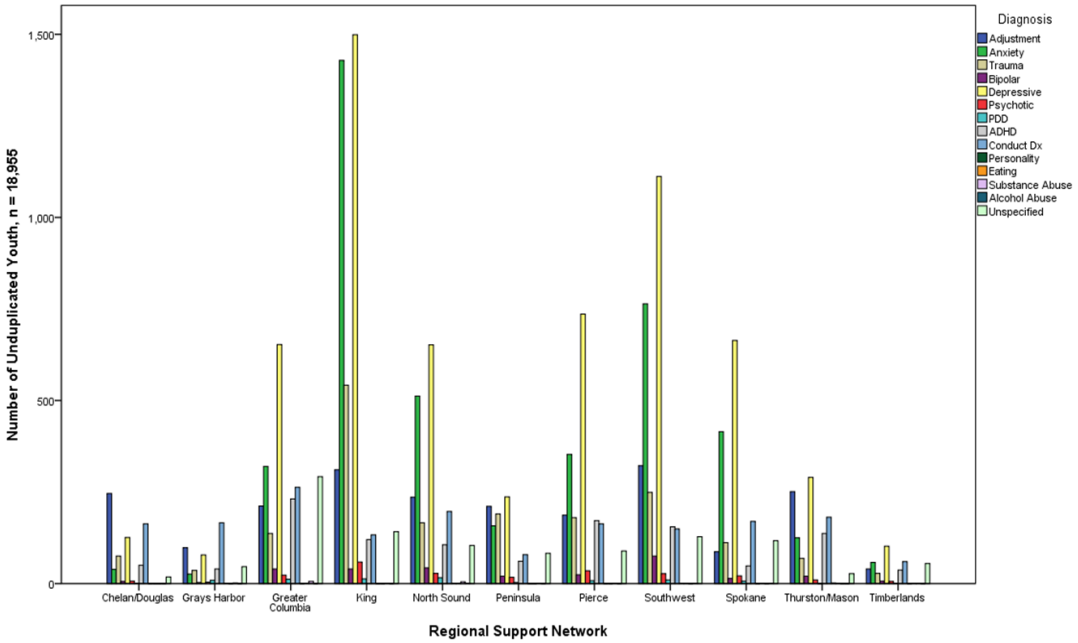
- Pervasive Developmental Disorder
- Personality Disorders
- Substance Abuse
- Alcohol Abuse

These diagnostic categories reflect the prevalence of diagnosis within the Medicaid system and not in the general population.

The diagnosis does not necessarily reflect the child or youth's primary diagnosis used to authorize care or met the Access to Care requirements. Diagnosis can reflect the diagnosis at the time of the service.

Significant variation among RSNs in diagnostic prevalence is also observed, pointing to the need to examine this variation and understand how it impacts program implementation and capacity planning.

Primary Diagnosis by Regional Support Network



Diagnostic Category by Diagnosis for Principle Diagnosis at Intake, Unduplicated Counts of Youth (0-20). FY2013

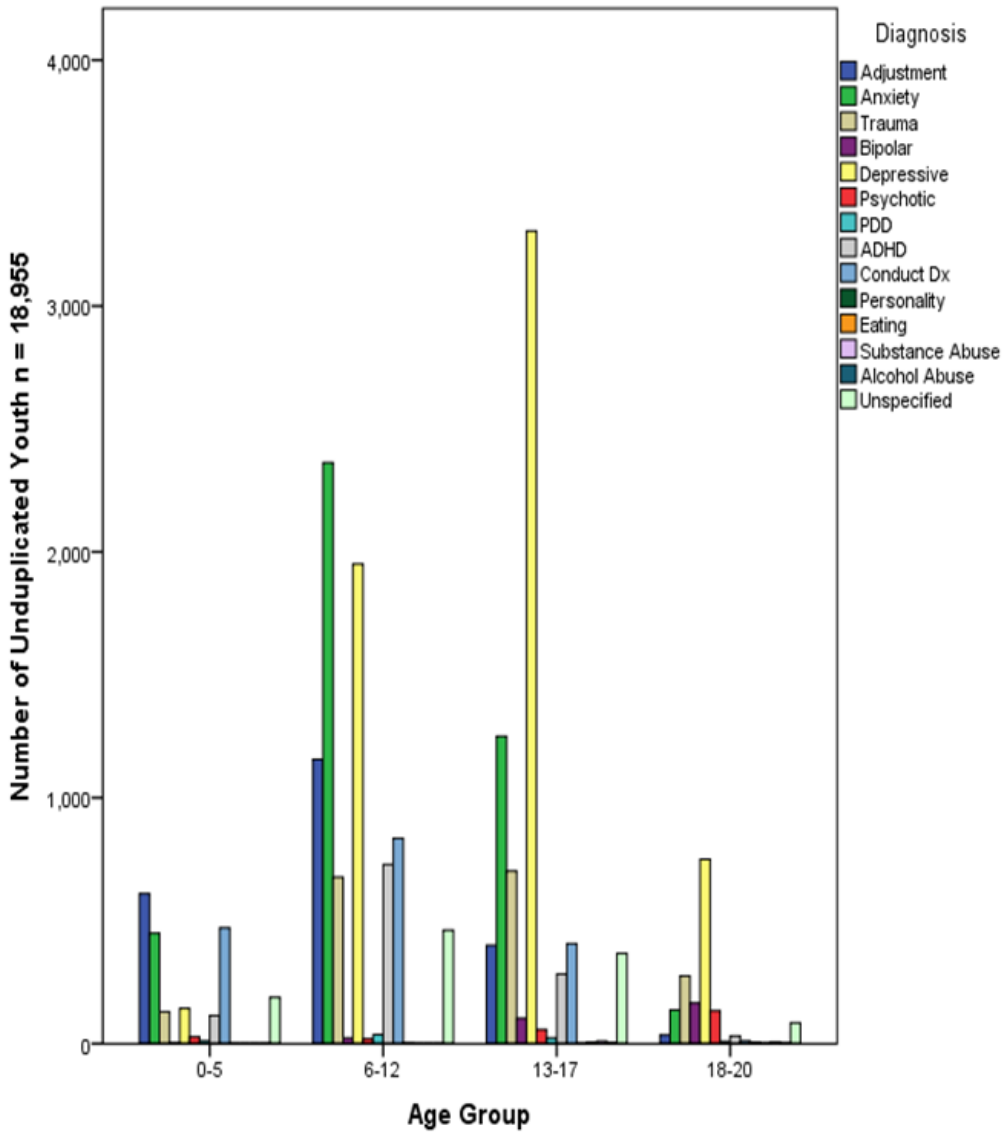
Diagnostic Categories by Regional Support Network

Table 5: Diagnostic Categories by Regional Support Network

Diagnostic Categories		Regional Support Networks											
		Chelan/ Douglas	Grays Harbor	Greater Columbia	King	North Sound	Peninsula	Optum Health	Spokane	Southwest	Timberlands	Thurson/ Mason	Total
Adjustment	n	246	98	212	311	236	211	187	322	87	251	40	2201
	%	33.7%	19.3%	9.7%	7.3%	11.4%	19.9%	9.6%	10.8%	5.3%	22.6%	10.1%	11.6%
Anxiety	n	39	26	320	1429	512	158	353	764	415	125	58	4199
	%	5.3%	5.1%	14.6%	33.3%	24.8%	14.9%	18.1%	25.5%	25.0%	11.2%	14.6%	22.2%
Trauma	n	75	36	137	542	166	190	180	249	112	69	28	1784
	%	10.3%	7.1%	6.3%	12.6%	8.0%	17.9%	9.2%	8.3%	6.8%	6.2%	7.1%	9.4%
Bipolar	n	6	3	40	40	43	20	24	75	14	20	7	292
	%	.8%	.6%	1.8%	.9%	2.1%	1.9%	1.2%	2.5%	.8%	1.8%	1.8%	1.5%
Depressive	n	126	78	653	1499	652	237	736	1112	664	290	102	6149
	%	17.2%	15.3%	29.8%	34.9%	31.5%	22.4%	37.8%	37.1%	40.1%	26.1%	25.8%	32.4%
Psychotic	n	7	4	23	59	28	17	35	27	21	10	6	237
	%	1.0%	.8%	1.1%	1.4%	1.4%	1.6%	1.8%	.9%	1.3%	.9%	1.5%	1.3%
PDD	n	1	9	12	13	16	3	8	10	7	0	1	80
	%	.1%	1.8%	.5%	.3%	.8%	.3%	.4%	.3%	.4%	0.0%	.3%	.4%
ADHD	n	50	40	231	120	106	61	172	155	48	137	37	1157
	%	6.8%	7.9%	10.5%	2.8%	5.1%	5.8%	8.8%	5.2%	2.9%	12.3%	9.3%	6.1%
Conduct Dx	n	163	166	263	133	197	79	163	149	170	181	60	1724
	%	22.3%	32.6%	12.0%	3.1%	9.5%	7.5%	8.4%	5.0%	10.3%	16.3%	15.2%	9.1%
Personality	n	0	1	0	0	1	0	0	1	0	2	0	5
	%	0.0%	.2%	0.0%	0.0%	.0%	0.0%	0.0%	.0%	0.0%	.2%	0.0%	.0%
Eating	n	0	0	1	0	1	0	0	1	1	1	1	6
	%	0.0%	0.0%	.0%	0.0%	.0%	0.0%	0.0%	.0%	.1%	.1%	.3%	.0%
Substance Abuse	n	0	2	6	1	5	1	1	0	0	0	1	17
	%	0.0%	.4%	.3%	.0%	.2%	.1%	.1%	0.0%	0.0%	0.0%	.3%	.1%
Alcohol Abuse	n	0	0	0	0	1	0	0	1	1	0	0	3
	%	0.0%	0.0%	0.0%	0.0%	.0%	0.0%	0.0%	.0%	.1%	0.0%	0.0%	.0%
Unspecified	n	18	46	292	142	104	83	89	128	117	27	55	1101
	%	2.5%	9.0%	13.3%	3.3%	5.0%	7.8%	4.6%	4.3%	7.1%	2.4%	13.9%	5.8%
Total	n	731	509	2190	4289	2068	1060	1948	1657	2994	396	1113	18955
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Diagnostic Category by Diagnosis for Principle Diagnosis at Intake, Unduplicated Counts of Youth (0-20). FY2013

Diagnostic Categories by Age Group



Diagnostic Category by Diagnosis for Principle Diagnosis at Intake, Unduplicated Counts of Youth (0-20). FY2013

Diagnostic Categories by Age Group

Table 6: Diagnostic Categories by Age Group

Diagnostic Category		Age Group 0-5	6-12	13-17	18-20	Total
Adjustment	n	610	1156	400	35	2201
	%	28.5%	14.0%	5.8%	2.1%	11.6%
Anxiety	n	449	2363	1250	137	4199
	%	20.9%	28.6%	18.1%	8.3%	22.2%
Trauma	n	130	677	702	275	1784
	%	6.1%	8.2%	10.2%	16.7%	9.4%
Bipolar	n	1	23	103	165	292
	%	.0%	.3%	1.5%	10.0%	1.5%
Depressive	n	143	1951	3305	750	6149
	%	6.7%	23.6%	47.8%	45.6%	32.4%
Psychotic	n	27	19	57	134	237
	%	1.3%	.2%	.8%	8.1%	1.3%
PDD	n	11	37	23	9	80
	%	.5%	.4%	.3%	.5%	.4%
ADHD	n	114	729	283	31	1157
	%	5.3%	8.8%	4.1%	1.9%	6.1%
Conduct Dx	n	471	835	407	11	1724
	%	22.0%	10.1%	5.9%	.7%	9.1%
Personality	n	0	1	0	4	5
	%	0.0%	.0%	0.0%	.2%	.0%
Eating	n	0	0	5	1	6
	%	0.0%	0.0%	.1%	.1%	.0%
Substance Abuse	n	0	0	10	7	17
	%	0.0%	0.0%	.1%	.4%	.1%
Alcohol Abuse	n	0	0	2	1	3
	%	0.0%	0.0%	.0%	.1%	.0%
Unspecified	n	188	461	367	85	1101
	%	8.8%	5.6%	5.3%	5.2%	5.8%
Total	n	2144	8252	6914	1645	18955
	%	100.0%	100.0%	100.0%	100.0%	100.0%

Diagnostic Category by Diagnosis for Principle Diagnosis at Intake, Unduplicated Counts of Youth (0-20). FY2013

The University of Washington integrates the diagnostic information obtained from ProviderOne with survey data from CMHAs. The University of Washington conducted a survey of all CMHAs in the state on the number of staff trained in specific E/RBPs as well as the funding sources for these programs. The majority of sites fund their programs through a combination of Medicaid, DBHR, HCA, CA and private sources. To be

included in the survey, sites had to have an active contract with DBHR; consequently, private providers and those funded exclusively through other public sources (e.g., CA) are not represented. E/RBPs were coded according to their ability to adequately treat a diagnostic area (A = very well, B = moderately, C = not indicated). These codes were developed based on the state inventory and an independent review of the literature.

The Gaps Analysis is using a geocoding process to map diagnostic need to zip code/census areas against the number of therapists providing services for those diagnostic needs. Separate maps of diagnostic need (Anxiety, Depression, etc.) are being produced that identify areas where therapist capacity is insufficient to meet need. We are also calculating the number of therapists needed to bring an area up to capacity within diagnostic categories.

True Cost Study Update

BHSIA in partnership with the University of Washington is also conducting a True Cost Study to identify the costs of implementing and sustaining E/RBPs. The following preliminary steps have been taken:

Survey development: A survey has been developed to determine the incremental costs associated with implementing EBPs with fidelity. The survey is aligned with implementation stages to provide information about start-up costs, early implementation costs, and longer-term sustainability costs. The additional costs associated with initiating and sustaining E/RBPs above and beyond 'usual care' will be captured. This work is being done closely with a health economist to ensure that estimates will be reliable and valid.

Pilot testing: Work has been done with a major behavioral health organization to assist with pilot testing the measure. Their feedback was instrumental to ensuring that questions were worded appropriately and assisted in learning what cost categories would be very difficult to reliably assess, thus streamlining the survey.

Development of a Technical Assistance model: Pilot testing identified the need to have a technical assistance model to support agencies and avoid unnecessary frustrations. All agencies have the opportunity to participate in brief (30 minute max) introductory Webinar. Following indication of participation, a 'technical assistance' call is scheduled with the CFO and other appropriate personnel to review the survey in detail and answer any questions. Agencies are then provided with a link to a web-based survey. This call lasts approximately one hour and the health economist is on the call as well. They are given approximately 6 weeks to complete the survey, during which time two check-ins are provided – to prompt for any further questions. Agencies are able to call or email study staff at any time for further technical assistance.

Participation: To date, 15 agencies representing 9 RSNs are currently participating in the survey. This is the minimum needed to provide cost estimates. There are several other agencies who have expressed interest in participating; it is expected that the final number of agencies will be approximately 20, with a goal of 30 in total. The current agencies represent significant geographic diversity across the state and implement a range of different EBPs of various sizes. The University of Washington is confident that they will be able to supply cost estimates that are generalizable to a range of different agencies.

Time frame: Data will continue to be collected through the end of the 2014 year. A final report will be ready by the end of March of 2015.

Next Steps moving

A great deal of work remains to grow toward the next benchmark of 15% of youth receiving E/RBPs and develop an infrastructure that is prepared and able to sustain these changes moving into the future. The following highlights activities slated to occur in 2015:

- Informed by the GAPS Analysis, create a strategic plan that systematically scales up E/RBPs with specific attention to 'target areas' that require E/RBPs to meet the needs of their population.
- Explore alignment/integration of proposed fidelity methods within specific existing practices. In partnership with the University of Washington, RSNs and providers set a course toward increasing fidelity standards over time.
- Complete the True Cost Study and share results with stakeholders and the Legislature to inform future direction in E/RBP workforce development.

CHILDREN'S ADMINISTRATION (CA)

In the 2013 Report to the Legislature on Evidence-based and Research-based Practices Children's Administration (CA) proposed two increases in the use of evidence-based or research-based services. The first proposal was a 56 percent increase in the use of existing evidence-based and research-based services, without any additional funding. The second proposal was to introduce evidence-based or research-based services to three areas of service within CA, requiring additional funding. Additional funding was not obtained and therefore CA did not move forward with any part of the second proposal.

Update to Data Reporting

Since writing the 2013 Report, CA has enhanced the data reporting tools for these services. As a result of this work, the baseline numbers have changed. The chart below identifies the new fiscal year 2012 baseline as compared to the previous number and the new Fiscal Year 2014 Projected Participants.

Practice	*Original FY2012 Baseline*	*Updated FY2012 Baseline*	*Projected Targeted Increase*	*Updated FY14 Projected Target*
Functional Family Therapy	*265*	*232*	*25%*	*290*
HomeBuilders	*558*	*584*	*5%*	*613*
Incredible Years[1]	*100*[1]	*100*	*370%*	*470*
Multi-Dimensional Treatment Foster Care	*30*	*30*	*0%*	*30*
Parent Child Interaction Therapy	*155*	*114*	*25%*	*143*
SafeCare	*241*	*182*	*25%*	*228*
Triple P	*0*	*0*	*n/a*	*200*
Total	***1,349***	***1,242***	***56%***	***1,773***

The chart below identifies that CA exceeded the target increase in the number of participants who received evidence-based and research-based services in fiscal year 2014. Some individual services had greater increase than other services. This shifting appears to be a function of CA's on-going focus to increase families being referred for the right service at the right time. Over the last year CA focused on increasing supports to assist social workers in matching children and families' needs with the right service at the right time.

Practice	*FY 2014 Projected Target*	*FY2014 Participants*
Functional Family Therapy	*290*	*277*
HomeBuilders	*613*	*752*
Incredible Years	*470*	*452*
Multi-Dimensional Treatment Foster Care	*30*	*6*
Parent Child Interaction Therapy	*143*	*138*
SafeCare	*228*	*364*
Triple P	*200*	*552*
Total	***1,773***	***2,541***

Fiscal Year 2015 Targets for Current Evidence-Based and Research-Based Practices

Historically, CA has been the sole funder of evidence-based and research-based services trainings. This has involved CA funding two to four trainings yearly for each evidence-based and research-based service CA supports. These trainings targeted both expansion and attrition in the workforce.

[1] This is a best estimate of Incredible Years utilization, based on consultation with the fidelity monitor.

This approach is costly and has inherent downsides for sustainability. Due to budget constraints and the need to have more sustainable approaches in using evidence-based and research-based services, CA has started work with the contractors who receive the trainings to find a cost sharing approach to training. This transition will require planning and collaboration between CA and the Contractors who deliver the services to families. The work to find a sustainable approach is actively happening and it will take some time to find a balanced approach. Until a more cost balanced approach is identified, CA has very limited capacity to provide EBP training.

As a result of this transition, CA anticipates a net reduction in the EBP workforce due to the lack of training. Due to this anticipated reduction, CA estimates a 15 to 25 percent reduction in the use of evidence-based and research-based services. The exact impact of attrition on each program (e.g. Triple P versus SafeCare) is not known, however, the projection of children and families to receive evidence-based or research-based services from CA in fiscal year 2015 is estimated to reduce by 20 percent, due to workforce attrition.

Practice	FY2014 Participants	Percent Change	FY2015 Project Target
Total	**2,541**	-20%	**2,033**

JUVENILE JUSTICE AND REHABILITATION ADMINISTRATION (JJ&RA)

In the 2013 Legislative Report, Evidence-based and Research-based Practices, Strategies, Timelines and Costs, Juvenile Rehabilitation (JR) proposed the following recommendations for increasing the delivery of Evidenced-based and Research-based programs above the baseline assessment:

- *Functional Family Parole (new funding);*
- *Functional Family Therapy (reallocation);*
- *Functional Family Therapy (new funding);*
- *Juvenile Drug Court (existing funding – not included in baseline assessment); and*
- *Evidence-based and research-based programs for Becca youth (new funding)*

Three of these proposals required new funding, which was not obtained. Therefore, JR did not move forward on those proposals. The following program update will provide information on Functional Family Therapy (FFT) and Juvenile Drug Courts.

Program Update

Functional Family Therapy (reallocation)

EBP	SFY 2012 Participants (baseline)	Projected Increase	SFY 2014 Participants	Actual Increase
FFT	641	6%	670	5%

Although the target was missed by 1%, an overall increase did occur as a result of the reallocation. The reason the target was missed was a result of two of the three .5 FTEs not being hired until the middle of the year. It is anticipated that targets will be met when all positions are filled for the entire year.

Juvenile Drug Courts

The juvenile courts, in conjunction with JR, are continuing to develop the process for juvenile drug courts to become an evidence-based program. In August 2014, a Drug Court Summit was held. Researchers from Washington State University, University of Washington, Washington State Institute for Public Policy, and the Administrative Office of the Courts (AOC), as well as members from the juvenile drug courts, JR, AOC, Division of Behavioral Health and Recovery (DBHR), and other evidence based program quality assurance specialists were in attendance.

The goal of the summit was to begin to identify a programmatic approach for all juvenile drug courts in Washington State to follow. This would involve mechanisms to collect, gather, and disseminate data of program participants; develop quality assurance measures; and enable the programs to be researched.

A survey will be sent out to all juvenile drug courts to begin gathering baseline information on all elements of each program–referral, assessment, court engagement, treatment, and continuing care.

Next Steps

Juvenile Justice Programs – Continuous Quality Improvement

Implementation of evidence-based and research-based programs requires a commitment to maintaining a program's integrity by working to remain adherent and competent in the delivery of those programs. In order to effectively increase the utilization of evidence-based and research-based programs the following core elements must be present:

- *Quality Assurance;*
- *Program Research and Analysis; and*
- *Promising Programs.*

Quality Assurance

In December of 2003, WSIPP, as directed by the Legislature, published a report titled *Recommended Quality Control Standards: Washington State Research-Based Juvenile*

Offender Programs (page 2). In their review of the implementation of research-based programs, WSIPP concluded the following:

> *Since the late 1990s, Washington has been recognized as a leader in implementing research-based juvenile justice programs. After evaluating Washington's experiences to date, one conclusion is clear: these programs work, but with one vital qualification. When the programs do not adhere to the original design, they can fail. In fact, we found that the programs can increase the recidivism rates of participants when they are poorly delivered.*

This report was the catalyst for the juvenile justices' current quality assurance structures. Every program that was listed in the juvenile justice baseline report has some form of quality assurance. Quality assurance is an ever-evolving process where data and information assist with decision making and change.

One thing is for certain, quality assurance and monitoring for fidelity takes funding and resources. Since 2004, the juvenile justice field has been building a robust system of quality assurance. This has largely been accomplished without specific funding support from the Legislature. The juvenile courts receive state funding from the Legislature. Funding for quality assurance is taken off the top of those direct service dollars before they are distributed to the juvenile courts. JR received some funding to support quality assurance for their residential programs but it was not funded at nearly the capacity at which it needs to be. Currently there are only two FTEs dedicated to providing training and quality assurance to all JR residential staff. Despite these challenges, juvenile justice understands the immense value in these efforts. However, with specific funding assistance for quality assurance more youth could be served and the quality of services received would drastically improve leading to even better outcomes for youth and families.

Fidelity and quality assurance is an integral part of the delivery of evidence-based and research-based programs. Without quality assurance and fidelity monitoring, the State's investment in these programs will not meet expectations.

Program Research and Analysis

It is essential that funding for program expansion include funds necessary to conduct research on those programs that fall into the category of promising or research based. Strong data analysis regarding youth within the juvenile justice system will improve the system's ability to select programs that work.

A broader array of well-designed and effective programs is necessary in order to respond to the needs of those youth that are not being reached by the current menu of programs. The juvenile justice system is not yet in a position to fully respond with programs designed to meet the needs of youth based on cultural differences or on differences in the complexity of youth needs.

Research Needs and Conclusions

For nearly 15 years the Washington State Legislature has been committed to the ongoing prioritization of evidence-based programming for the juvenile justice system. More

recently, pursuant to House Bill 2536, this effort has been enlarged to include a similar emphasis for different systems of care including children in the mental health and child welfare systems. With the legislature's support to date, and the work of juvenile justice agencies, Washington State is perceived as a national leader in the areas of providing evidence-based programs in juvenile justice and for the quality assurance structure created to ensure the programs are implemented and maintained to create positive results for the youth served.

The continued success of this evidence-focused juvenile justice system depends on the willingness of those who govern directional and budgetary decisions to meet the needs of the system so that it can move forward. It is time for Washington State to expand beyond implementation, maintenance and quality assurance monitoring of our programs. The next phase of our commitment includes the ability to evaluate in detail our current menu of evidence-based and research-based programs and make data driven decisions regarding possible new programs that could meet the needs of those children with whom we have yet to succeed. Without a commitment to full research support for evidence-based programs in juvenile justice, the current system of care will become outdated, unresponsive to important new information, and ultimately less successful. To continue to use funding identified for direct service of programs to support this necessary piece of the overall picture translates into fewer and fewer youth getting into programs, completely defeating the purpose of this evidence-based journey.

Currently, the funds allocated for juvenile justice evidenced-based programs are fully dedicated to program delivery and its quality assurance structure. A strong research foundation is needed that will help lawmakers determine if Washington State is maximizing its tax dollars to reduce crime. State professionals in juvenile justice, both juvenile courts and JR, identify this as an important priority.

While the current need for responsive research in juvenile justice is critical, it is only wise to see this as part of a long-term strategy that should be able to serve not only legislators and juvenile justice professionals but also those other systems of care now starting down the path of providing evidence-based programs to their consumers. All systems should be able to take advantage of a learned truth: that evidence-based programs cannot thrive on their own, creating positive outcomes for any target population without the underpinning of skilled professionals, competent providers of programs, quality assurance experts and the science of research.

At a minimum, future steps to expand the menu of evidence-based and research-based programs must include costs for evaluation, data analysis and research.

Costs for these items will vary by program. Choosing which programs to prioritize for implementation will require additional data analysis about the risks and needs of youth in the juvenile justice system. Special consideration should be made for youth that appear to have needs that are not met by currently available programs.

Promising Programs

As mentioned previously, the juvenile justice field has been investing in evidence-based and research-based programs for many years. What this journey has uncovered is that not all youth can be adequately served by the menu of programs that are currently provided. After reviewing the baseline report for juvenile justice it became very clear

there are two very specific treatment areas that do not have an evidence-based or research-based treatment available: substance abuse treatment and sex offender treatment. In the juvenile courts and JR, funding for these two treatments are the only areas where treatment funding is spent on a non-evidence-based or research-based program.

The juvenile justice field needs to extend beyond what is currently available. As a result, in order to effectively implement promising programs, new funding will need to be made available to provide quality assurance and fidelity monitoring as well as funding for research and data analysis.

A sound investment is critical in order to ensure promising programs are being done with fidelity, have a research design, and a plan for evaluation.

HEALTH CARE AUTHORITY (HCA)

The Health Care Authority administers a Medicaid benefit that covers mental health services for all beneficiaries. Covered Mental Health services include:

- Unlimited visits, with clients who don't meet RSN access to care standards or are awaiting the determination whether they meet access to care standards and are bring referred to the Regional Support Network (RSN) for services,
- Medication management by a psychiatrist or psychiatric ARNP
- Psychological and neuropsychological testing
- Additional services as needed under the Early Period Screening Diagnosis and Treatment (EPSDT) Benefit

As defined in **RCW 71.34.020**, and as allowed under the Indian Health Care Act (IHCIA), mental health professionals providing services include:

- Licensed Psychologists
- Licensed Psychiatric Advanced Registered Nurse Practitioners (ARNP)
- Licensed Independent Clinical Social Workers
- Licensed Marriage and Family Therapists
- Licensed Mental Health Counselors (If they care for children, must certify they have two years of experience working with children before being enrolled as a Medicaid provider)

HCA contracts with five Managed Care plans to deliver health care services including the mental health benefit described above. Over 90 percent of Medicaid beneficiaries receive their health care services by the plans. While Medicaid does not require the services to be E/RBPs – Medicaid does reimburse for the visits in which these modalities are used to deliver mental health treatment.

Implementation and Resources

HCA developed billing procedures with the managed care plans to support collecting information on select Evidence/Research Based Practices (E/RBPs) being provided to clients under the age of 21 years old. Both Fee-For-Service (FFS) and the managed care organizations (MCOs) began tracking the modalities listed below on July 1st, 2014.

Timeline

Our goal is to capture data to reflect the practice of E/RBPs in children's mental health, including prevention and intervention services, when provided to a child covered by Apple Health's Fee-For-Service program or contracted Managed Care Plan. Information to be collected and reported includes:

- Number of children receiving E/RBP services
- Number and percentage of encounters using these services
- Relative availability of these services

In order to accomplish the Legislative mandate, HCA worked with partners across agencies and our providers to identify the modalities that are utilized to deliver mental health services to children in community mental health settings. Data is being collected about each of these targeted E/RBPs.

Programs/Coding for Mental Health Professionals*
Positive Parenting Program (Triple P) (Level 2)
Positive Parenting Program (Triple P) (Level 3)
Parent-Child Interaction Therapy (PCIT)
Cognitive Behavioral Therapy (CBT)+ for Behaviors, Anxiety and Depression
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
Bonding and Attachment via the Theraplay model (Promising Practice)
Cognitive Behavioral Therapy (CBT)
Strengthening Families Program

There was a delay in implementation as issues with some plans' systems had to be addressed and an infrastructure created for capturing the data. Tracking officially began in July, and each of the managed care plans as well as fee-for-service providers are in the process of collecting data for that quarter. Providers have a year to bill so the data is not complete at this time, however, preliminary figures to report to date are:

Provider:	Amerigroup	CCC	CHPW	Molina	UHC	FFS
Encounters:	5	0	7	1	41	117

As of this time, HCA has met all goals identified in the December 2013 report:

- Develop a billing procedure to collect information on which E/RBPs are being provided to Medicaid clients (both in the managed care organizations, and fee-for-service) using existing Provider One programming;
- Collect and record data for reporting;
- Begin the process of analysis on the information collected.

In addition, HCA will continue to monitor for compliance and use of E/RBPs. We are eager to expand the use of E/RBPs, and will endeavor to do so by using the "report card" to identify providers and compliance over time.

This report illustrates the commitment and dedication of HCA to assure clients within our sphere of care are offered appropriate, outcome oriented treatment, in the right place and at the right time. The use E/RPBs is a focus that our contracted providers are aware is a priority. Working in collaboration with our partners across agencies, the youth of Washington State are receiving quality care.

PROMISING PRACTICES WITHIN A CORE ELEMENTS LENS

DSHS and HCA support the expanded use of research and evidence based practices across services and programs and there remain considerable barriers of both cost and time to bring a promising practice up to the standards of research-based or evidence-based. DSHS and HCA are keenly aware that "one-size-fits-all" E/RBPs do not meet the needs for a meaningful segment of the populations we serve. With that understanding, work has begun to explore the feasibility and flexibility of a 'core elements' or common components approaches that may then allow promising programs to move to the category of research-based.

Core Elements within an E/RBP context allows for identifying current evidence or research based program components and finds the shared elements that create the evidence. In some situation, where effort, need, and funding are present, meta-analyses can be used to look at the impact of these core elements looking toward the strongest effects in applying core elements that translate across multiple practices and produce positive overall outcomes. This would provide structure and guidance when administering a program, but also offers flexibility to providers that may not be as easily found in a manualized E/RBP.

Exploring the practicality of Core Elements will add to the positive impact of E/RBPs, with more options to the workforce to drive overall better outcomes for the people we serve.

NEXT STEPS

DSHS and HCA will provide another update to the governor and the legislature by December 30, 2015.

If DSHS or HCA anticipate they will not meet their recommended levels for an upcoming biennium as set forth in its report, they must report to the legislature by November 1 of the year preceding the biennium. This report shall include:

1. The identified impediments to meeting the recommended levels
2. The current and anticipated performance level
3. Strategies that will be undertaken to improve performance

DSHS and HCA continue to be eager to expand the use of E/RBPs. This update illustrates the continued advancement and future opportunities where expansion and increased delivery of E/RBPs may occur. Much of our expansion/increased delivery is

dependent upon new funding directed toward resource for training, rates, and infrastructure enhancement.