Facilitated Discussion Notes
Evidence-Based Practices
April 24, 2014

Below are notes distilling the comments made by participants during a Facilitated Discussion of this topic. Generally, the comments are listed in the order in which they occurred. Redundancy with respect to comments has not been eliminated. This information will be combined with input from other sources and will inform development of Connecticut's Children's Behavioral Health Plan. If you have comments about these notes, please email project staff at: info@plan4children.org.

General Notes

- Hosted by Advanced Behavioral Health
- Location: Middlesex Corporate Center, Middletown, CT
- Approximately 24 people in attendance

Question 1: Strengths

Access to EBPs

- In the public sector, CT is fortunate to have a variety of models available; a lot of access to EBPs for certain populations of youth and families
- Access to EBPs is helpful to families
- CT has some of the largest implementations of EBPs in the country, and even the world
- In the case of MDFT, all children, it's not just those who are DCF-involved can access
- More options for community-based care

Funding for EBPs

- A good degree of Medicaid reimbursement for EBPs;
- Most other states do not have as many resources available for EBPs as Connecticut
- DCF has been the champion of many EBPs, but good collaboration across state agencies, especially CSSD, in funding and sustaining EBPs; partnership between all parties involved has been very helpful for sustainability
    - Co-contracting between and among state agencies has helped ensure consistent implementation of EBPs and has created some important efficiencies
- DCF and other state agencies have funded studies of whether EBPs are working, led by agencies like CHDI and ABH
- Blending state agency, philanthropic, and other dollars to fund EBPs

The Importance of Various EBP Supports

- DCF has been able to support non-profit providers with ongoing costs of sustaining EBPs (training, consultation, QA)
    - Without the financial support from DCF, many agencies would not be able to implement EBPs with fidelity

    - Training, consultation, QA helps maintain the programs and supports teams implementing EBPs
- CT has learned from EBPs that QA and other supports are very important, and we have been able to include those supports in a number of non-EBP models
- Intensive training opportunities (e.g., Learning Collaborative) help clinicians sustain the skills that they learn in a particular EBP over time

Supporting Innovative and Promising Practices

- CT has benefited from continual development of new programs
- Pilots and innovations have also been robust in CT
- DCF has been willing to fund pilot programs in areas of need where an EBP does not exist; they have, in many cases, also supported the service delivery and the program evaluation of those pilot programs

Collaboration and Coordination for Delivery of EBPs

- There are meetings between state agencies, non-profits, and model developers to enhance the system and support implementation and sustainability of EBPs
- DCF has been the champion of many EBPs, but good collaboration across state agencies, especially CSSD, in funding and sustaining EBPs; partnership between all parties involved has been very helpful for sustainability
    - Co-contracting between and among state agencies has helped ensure consistent implementation of EBPs and has created some important efficiencies
- A network of supports across many agencies providing the same model, for QA, training, and peer support/learning. The shared knowledge that comes with collaboration has been helpful

Workforce Development Opportunities Specific to EBPs

- Mental Health Transformation grant made it clear that there was a workforce development need and it led to an initiative to train graduate students about intensive in-home EBPs.
    - DCF has sustained funding for those efforts past the MHT Grant period
- Younger clinicians who are trained in an EBP, even if they leave, they take those skills to their next position which likely helps families
- Supervision is very important for ensuring fidelity, training the workforce in EBPs

Outcomes of EBPs

- EBPs have helped reduce the number of kids who have needed to be in placement and in residential programs; keeping them in-state; helps keep kids at home
- Utilization of in-home EBPs has helped reduce the number of youth in inpatient hospitalization
- More funders (state and philanthropic) are looking for results, which supports EBP movement
- Recidivism in courts has also gone down dramatically, as has the number of youth entering the system; this is due, in part to EBPs

- Most, but not all, EBPs involve the whole family (parent comment). Family-orientation EBPs have had a potential impact on siblings as well.

Question 2: Concerns

Limited Access to EBPs among Commercially Insured

- There are still huge gaps in who can access EBPs
- Almost everything mentioned in this discussion of EBPs is only available in the public sector.
- There is a growing amount of care being provided by private practitioners that mostly is not evidence-based
- A lack of clinicians in the private sector who specifically work with children and families
- Children do not have access to the best treatments unless they get involved with state agency systems, or Voluntary Services, or unless they have Medicaid

Limited Access to EBPs Related to Other Factors

- Most EBPs are in-home; we have fewer EBPs available in routine outpatient care settings where most kids receive MH treatment
- Capacity problem; there are huge wait lists in early childhood programs;
- DCF funding may only cover town-specific regions leaving some towns without access
- Early childhood EBPs have a developmental context that needs to be addressed
- Wait Lists for Some EBPs in Community Settings
    - Getting into a CGC can be difficult due to wait list for EBPs
- Lack of child/adolescent psychiatrists in CT
- Lack of EBPs for specific populations: young children, autism, transition-aged youth, truants
- A need to educate referral sources around the range of EBPs and their differences and similarities and what would be the best match
- Kids in child welfare do not have access to EBPs

Follow-up and Continuity for Families, Within and Across EBPs

- A parent said that after the EBP was delivered, there was little evaluation or after-care that asked how the service worked for them and if they had other needs
    - Need sustained contact with families during and after the EBP is delivered
- Many families have to use multiple EBPs sequentially, and there is not great linkage across programs; information is not always shared across programs
- We need more parent and family input to share their experiences about what is working and not working with all services, including EBPs
- We need a continuum of care within an agency; providers trying to make seamless transitions but they may not have a broad range of services.
- Families transitioning from one service to another can be confused as they try to engage with multiple service providers

Ongoing Need for More and Better Outcomes Data

- Even when kids are in DCF care, they do not always have access to services that meet needs
- Even the best EBP models are not successful for all children; at the absolute best, EBPs will be helpful for 80% of children and families, but that means there are 20% that do not respond positively to EBPs (failure rates are even higher in routine care that is not EBP)
- The match of the EBP to the family is not always thoughtful or logically tied to where the evidence is strongest to meet the needs of that specific child and family
- Many models do not have a measure that assesses outcomes at the family level
- There is a need for state agencies to require the same standard of evidence for all funded services; currently there are inconsistencies in required evidence for EBP and non-EBP models

Insufficient Financing for all Elements of EBP Delivery

- Not enough financial support to offset the cost of providing EBPs (fidelity, supervision)
    - Many of the EBPs are quite costly
    - Those funds are grant dollars and they are limited, which limits ability to expand
- Insufficient reimbursement rates and payment structure is going to limit expansion
    - DCF may want to move many services to Medicaid FFS reimbursement model. If DCF moves models toward FFS, they will lose EBPs
- It can be very difficult to get CTBHP to authorize a service for Medicaid reimbursement, which makes it difficult for providers to meet an identified need

Workforce Issues

- Staff turnover and its financial implications
    - Many EBP clinicians are entry-level positions that don't pay well; well-trained clinicians are often lost to promotions, switching agencies, state agency jobs
    - An unfortunate consequence of having a range of EBPs is more movement of staff
- There is little incentive for a private practitioner to provide EBPs
    - Time involved in training and sustaining an EBP in a private practice setting, and lost revenue associated with that time, would make it virtually impossible for those clinicians to deliver an EBP
    - Even if they were interested, private practitioners can't access training for most EBPs
- Lack of diversity of clinicians in the workforce, which may contribute to racial and ethnic disparities in outcomes-- limited opportunities to have discussions in CT about disparities

<u>Question 3: Recommendations</u>

Access to EPBs among Young Children

- Screen and identify children at an earlier age for evidence-based intervention which will prevent them from utilizing treatment later on in life
- Fund and sustain EBPs for early childhood population; many of those young children will need services as they get older and earlier engagement will result in better outcomes

Ensure Continuity of Care Within and Across EBPs

- Develop a centralized system for intake, treatment course, and discharge information so that providers can access information about families without having to ask them to repeat their story and complete the intake process over and over

Increase Awareness in Community of Availability of EBPs

- Develop systems that increase awareness among families as to which EBPs are available to them and which EBPs best match their profile and needs
- Education and public awareness to potential consumers

Address Ongoing Need for Workforce Development in EBPs

- Expand workforce through graduate education programs in EBPs
- Address the need for better cultural and linguistic competence in the workforce
    - Continue to prioritize hiring that represents the population served; especially racially and ethnically diverse and Spanish-speaking clinicians
- Explore the possibility of making BA level staff (with supervision and fidelity to treatment) eligible for reimbursement for services
    - The evidence on relation of degree to outcomes is far from clear
    - For example, BA level care coordinators or family partners who "apprentice" with EBP clinicians get great training and may go on to pursue advanced degrees
- Engage young, diverse teens in High School and recruit them to work in the MH field

Funding

- Ensure Medicaid and commercial insurance reimbursement rates that fund actual cost of care
- Shift funds away from agencies that are not living up to standards and re-invest those funds to agencies who are implementing with fidelity and achieving outcomes
- Seek Medicaid match funding (50%) that is available from the federal government for research on services that are delivered to the Medicaid population
- Use braided state agency funding to support models that combine treatment for children with treatment for parents and siblings
    - E.g., there are some services that treat parents along with children, but DMHAS does not currently contribute funding for those services
- Schools are an important setting for service delivery and they are responsible for social and emotional development; engage SDE in funding and delivering services

Data Needs

- Collect data to support the understanding that using EBPs will save money in the long run
- A more robust data system across service and programs that demonstrates the long-term cost savings to the state and the private insurance companies

    - Insurance companies understand that they won't experience the long-term benefit of EBPs because most of their members don't stay with them long-term
    - Commercial providers don't care much about prevention of outcomes that don't cost them anything; they would be convinced if they saved money on issues they end up paying for
    - State agency outcomes in terms of cost savings would be a different set of outcomes
    - Comparing costs across different models
- Look at the Washington State model and their work in examining cost savings to the public for implementing EBPs (e.g., RSVP model is doing a full economic analysis of the model, its outcomes and its cost savings).
- Expectations for certain outcomes, not just for private agencies, but for treatment provided by the state as well (e.g., DCF)
- Outcome studies should use the same methodology for all models in order to compare findings

Increase Access to EBPs among Commercially Insured

- The only way commercial insurers will cover EBPs is with legislative mandates
    - Empower DOI to require providers to cover certain services that are endorsed by the state agencies who have been implementing them
- Seek public-private insurance partnerships to fund EBPs
    - More communication between insurance providers and the state that encourages and incentivizes the insurance providers to fund EBPs
    - Certification of certain providers to deliver EBPs
    - Incentivize private insurers to cover, and build relationships with public sector
    - State could absorb costs of ongoing QA and training

Expand Understanding of what Constitutes Evidence-Based Practice

- Consider complementing the EBP models we have with interventions that are not as well-defined or scripted, but are known to improve outcomes
    - Some will be easier to implement and will generally improve outcomes
    - Needs to be rigor at measurement level to ensure we know who is improving and why
    - Avoid model drift if you strip away accountability and fidelity
- Consider measurement of symptoms in real-time which has evidence for effectiveness
- Examine practice-based evidence, recruit young researchers who study new novel programs and can move them toward EBP status

<u>Comments on the Process</u>

- A very clearly defined and time-limited discussion can curtail the process, especially with respect to coming up with solutions. Consider more time for these FDs
- Assign FD participants to the Advisory Committee to ensure follow-up on recommendations
- Send a summary of FD notes to all in attendance; offer opportunities to elaborate on notes
- Sustain these FD groups over time so they can advocate for their area