"Statewide Dissemination & Sustainability of EBTs for Youth Impacted by Trauma"

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Center for Child & Family Wellness & NC Child Treatment Program
Duke Evidence-based Practice Implementation Center
Colby College Childhood Development & Behavior Conference
Meine, July 19, 2019

RELATIONSHIPS OF INTEREST
I am a full time faculty employee of Duke University School of Medicine which is a not-for-profit dedicated to providing quality health care & adjunct faculty at University of NC School of Medicine for which I do not receive salary.

Grant Funding in the last year:
SAMHSA
The Duke Endowment
US Department of Defense
NC General Assembly

OVERVIEW
• Dissemination & Implementation Strategy: NCTS Learning Collaborative Methodology for the Adoption & Implementation of EBTs
• Overview of a program roll out of TFCBT: Piloting the NC Child Treatment Program
• State funding to Build a Trauma Treatment Service Array
• Sustainability strategies:
  • through partnership with state managed care,
  • post-training platform for trainees
  • Collaboration with agencies leadership
You are working in your office, and the phone rings......

N.C. Child Treatment Program
Center for Child & Family Health
Co-Directors: Dana Hagele & Lisa Amaya-Jackson

Selected Treatments:
• Trauma Focused CBT - TF-CBT (20)
• Parent Child Interaction Therapy - PCIT (14)
• Child Parent Psychotherapy - CPP (5)
• SPRCS (4)
+Attachment & Biobehavioral Catchup - ABC (2)
• Problematic Sexualized Behavior CBT
  *Launched Fall 2019

Training Platform:
• NCTSN's Learning Collaborative on Adoption & Implementation of EBTs

Quality Assurance Standards:
• Monitor Fidelity (Adherence) + Competence + Level of Coaching Necessary
• Monitor agency, clinician, client progress & outcomes

Public Health Approach & Sustainability:
• Roster of trained providers to link children to trauma-trained clinicians
• Post-training platform

NC POP - Performance Outcome Platform
• Data Management Capture for clinician fidelity, progress monitoring & client outcomes
NC CTP: PUBLIC-PRIVATE PARTNERSHIP

Faculty and Staff
• Center for Child & Family Health
• School of Public Health, UNC-Chapel Hill
• Duke Evidence-Based Practices Implementation Center
• UCLA-Duke National Center for Child Traumatic Stress

Target Audience/Partners
• NC DMH/DD/SAS
• NC DMA (Medicaid)
• Managed Care Organizations (MCOs)
• Agencies/clinicians
• SOC support agencies

Pilot to Policy:
Began with TF-CBT Learning Collaboratives 2006-2009 Pilot on

Co-PIs
• Dana Hagele, MD, MPH - UNC Pediatrics
• Lisa A. Jackson, MD, MPH - Duke Child Psychiatry
• (Rebecca Socolar, MD, MPH) - UNC Pediatrics

Assessment & TF-CBT Trainers
• Donna Potter, LCSW
• Letia Kent, LCSW
• Lisa A. Jackson, MD
• Emasina Briggs-King, PhD
• Shannon Davis, PhD
• George Acu, PhD
• Kelly Sullivan, PhD
• Robert Murphy, PhD

Funders:
• The Duke Endowment
• NC Governor’s Crime Commission
• KB Reynolds
• NC Division of MH/SA/DD

S$ FUNDING S$

2006-09: TF-CBT Learning Collaborative Pilot in select (underserved) counties w/ evaluation for Statewide roll-out
Funders:
• The Duke Endowment
• NC Governor’s Crime Commission
• KB Reynolds
• NC Division of MH/SA/DD

2009-13: PCIT Pilot Learning Collaborative & Training for NC & SC
• The Duke Endowment

2009-13: Yearly “bare bones budget” funding
(NC Division Social Services; MCO, Tuition)

2013 – Present: $1.8 Million annually-recurring appropriation from the NC General Assembly for array of treatment models
NCCTS LEARNING COLLABORATIVE ON ADOPTION & IMPLEMENTATION OF EBTS

- Provides framework where clinical training & organizational capacity to deliver EBT are addressed simultaneously.
- Adapted from IHI* Breakthrough Series Collaboratives to promote best practices in medicine
- Bridge gap between knowledge & practice
- Address Agencies’ Goals to Delivery of EBT by improvements in:
  - Clinical Competence of EBT
  - Family & Child Engagement specific to EBT
  - Organizational Readiness/Capacity
- Service implementation strategies steered via
- Progress metrics at agency, clinician, client level

The National Center for Child Traumatic Stress (NCCTS) Learning Collaborative Model

STATES THAT HAVE USED NCTSN LEARNING COLLABORATIVES
NORTH CAROLINA LEARNING COLLABORATIVES:
Key Points Supporting Implementation into Services

- 12 Month Intensive -- 3 (2-Day, Face to Face) Learning Sessions
  - Training on Assessment for good treatment planning & Outcomes
  - TF-CBT clinical training

- 3 Action Periods (delivering treatment & LC activities)
  - 10 hours of individualized clinical consultation (fidelity & skills coaching)
  - 1-hour/month group calls
  - Peer Support Groups & Internet Discussion Boards
  - Agency Senior Leader Track promotes Implementation & sustainment
  - Improvement (Small tests of change)

- Performance Outcome Platform (NC POP) – training data capture system

- Agency Networking

- State EBT Stakeholders Breakthrough Series

BUT DOES IT WORK?

LC strong vehicle to address implementation, intensive training (raising skill level) and fidelity adherence in adopting mental health EBT into agency practice.

5. Hanson, Rochelle, Saunders, Ralston, et al. (2018)

NCTSN LCs promotes sustainability:
• Treatment retention
• Treatment integrity
• Therapists continue to practice
• Agencies report continued supervision and fidelity monitoring

WHAT IS

COLLABORATIVE GOALS FRAMEWORK ON THE ADOPTION AND IMPLEMENTATION OF EBTS

- Document, refined by a diverse Expert Panel
  - Defines Collaborative’s Mission, Goals & Objectives
  - Acts as a Roadmap or “Change Package”
  - Includes an organizational assessment to rate baseline and then a series of benchmarks across multiple domains
**GOALS ACHIEVED!**

- Children screened for referral to TF-CBT using standard assessments
- Therapists who provide therapy to traumatized kids receive training
- Therapists who provide TF-CBT receive ongoing training/consultation
- Therapists who provide TF-CBT implement the model with fidelity
- Progress of children is evaluated using standardized assessments

**IMPROVEMENTS MADE...**

- Clinical competence in delivering TF-CBT
- Child & caregiver engagement in TF-CBT
- Organizational practices that support implementation of evidenced-based practice

**EPIS Framework**

- Exploration
- Preparation
- Implementation
- Sustainment

**Implementation Science Elements Addressed w/ in NCCTS Learning Collaborative Model on Adoption and Implementation of EBTs Listed by EPIS Stages Of Implementation**

**Exploration Phase**

1. Consideration of an appropriate coaching model
2. Use of technology to integrate practice into care
3. Data monitoring capacity at practitioner & agency level
4. Practitioner attitudes to EBT
5. Use of technology to integrate practice into care
6. Challenges to training within service delivery structure
7. Implementation process as part of variance of treatment outcomes
8. Composition, including implementation champions
9. Use of technology to integrate practice into care
10. Appropriate selection of EBT for population & gap in best practice

**Preparation Phase**

1. Use of technology to integrate practice into care
2. Challenges to training within service delivery structure
3. Implementation process as part of variance of treatment outcomes
4. Use of technology to integrate practice into care
5. Appropriate selection of EBT for population & gap in best practice
6. Use of technology to integrate practice into care
7. Challenges to training within service delivery structure
8. Use of technology to integrate practice into care
9. Challenges to training within service delivery structure
10. Use of technology to integrate practice into care

**Implementation Phase**

1. Use of technology to integrate practice into care
2. Challenges to training within service delivery structure
3. Use of technology to integrate practice into care
4. Challenges to training within service delivery structure
5. Use of technology to integrate practice into care
6. Challenges to training within service delivery structure
7. Use of technology to integrate practice into care
8. Challenges to training within service delivery structure
9. Use of technology to integrate practice into care
10. Challenges to training within service delivery structure
NC CTP ROSTER CRITERIA FOR TFCBT CLINICIANS

1. Participation in full training curriculum
2. Take ≥ 2 traumatized child (1=sexual abuse) through TF-CBT with fidelity monitoring & documentation
3. Completion of Clinical Outcomes & online Clinician Encounter Forms

COHORT 1-2 PILOT:

Child Covariates
Client Age, Gender, Race, Medicaid Status

Clinician Covariates
Race, Age
Prior knowledge of TF-CBT
Licensed as Masters or PhD Psychologist

Child Outcome Scores
Child Depression Inventory
Child rated PTSD Total
- Re-experiencing
- Avoidance
- Hyperarousal

Parent rated PTSD (Total and subscales)
Strengths & Difficulties Q (4-10)
Strengths & Difficulties Q (11-17)

Parent Outcomes Scores
Brief Symptom Inventory (Gen Severity)

2006-09 PILOT DATA: ALL POST-TEST SCORES SIGNIFICANTLY* LOWER THAN PRE-TEST SCORES ON OUTCOMES

1. A. PTSD* Ri- Child Report
2. B. PTSD* Ri- Parent Report
3. C. PTSD* — Child Depression Inventory
4. D. PTSD* — Child Depression Inventory
5. E. PTSD* — Parent Report on Behavior* — Strengths Difficulties Q
6. F. PTSD* — Parent Report of Own Symptoms* — Brief Symptom Inventory

*p<.001

Controlling for: Client age, gender, race, Medicaid status, Clinician characteristics (age, gender, race), & prior trauma training.

Research data:
n=124 clinicians
n=310 clients
CLINICAL OUTCOMES ARE RELATED TO ACHIEVEMENT OF FIDELITY

Fidelity (adherence & competency) drives clinical outcomes!


TFCBT NATIONAL CERTIFICATION VERSUS NC’S STATE PERFORMANCE ROSTER

National Certification

- Minimal standard set out by TFCBT Developers.
- Professional licensure in home state
- 2 days of face-to-face training with approved trainer
- 8 of 12 group consultation calls over the course of 6-12 months
- Participation in an endorsed Learning Collaborative
- Use one trauma assessment measure
- Assert completion of 3 cases
- Written Examination

Rostering via NC CTP LC

- Professional licensure in home state
- 7 days of face-to-face training with approved trainer
- Action periods interspersed with face-to-face training
- 9 monthly team consultation calls & 18 bi-weekly individual consultation (coaching) calls
- Weekly documentation of clinical contact
- Completion of 2 cases w consultant-assessed fidelity
- Demonstrated competence & adherence

In NC CTP LC: “Training” versus “Training & Implementation” in TFCBT

- Covers Assessment and TFCBT Training
- Participated in training, use of role plays of the full TFCBT model.

Advanced TFCBT:
- Younger Children
- Trauma Focused Education
- Complex Trauma
- Problematic Sexual Behaviors
- Case/Mini-Sessions
- Agency Meetings
- Senior Leader Track

Monitored Performance & Outcomes

- > 2 clients
EFFECTIVENESS OF TRAINING COMPONENTS  
(JOYCE AND SHOWERS, 2002)

<table>
<thead>
<tr>
<th>COMPONENTS</th>
<th>KNOWLEDGE</th>
<th>SKILL</th>
<th>TRANSFER/USE</th>
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<tbody>
<tr>
<td>Lecture/theory</td>
<td>10%</td>
<td>5%</td>
<td>0%</td>
</tr>
<tr>
<td>Demonstration</td>
<td>30%</td>
<td>20%</td>
<td>0%</td>
</tr>
<tr>
<td>Practice</td>
<td>60%</td>
<td>60%</td>
<td>5%</td>
</tr>
<tr>
<td>Coaching</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
</tr>
</tbody>
</table>

NC CHILD TREATMENT PROGRAM WEBSITE:  
www.ncchildtreatmentprogram.org

Find a Therapist

Provider Roster

Public access to find a trauma EBT therapist

*Hagele, A. A.; Alvord, et al. 2014*
2014 CLINICAL OUTCOMES: TF-CBT COHORT 8

PTSD Pre-Post Measures

- Pre-Treatment
- Post-Treatment

Parent rater
Child report

Increased Arousal (Child)
Re-experiencing (Child)
Total (CG)
Avoidance/Numbing (Child)
Re-experiencing (CG)
Avoidance/Numbing (CG)
Total (CG)

P<.001 on all scales

- Steinberg, Glienke, Hagele, Amaya-Jackson, Alvord et al, 2014

Anxiety/Depression Pre-Post Measures

- Pre-Treatment
- Post-Treatment

Social Phobia
Panic
Separation Anxiety
General Anxiety
Obsessions/Compulsions
Total Anxiety
Depression
Total Anxiety and Depression

P<.001 on all scales

- Amaya-Jackson, Hagele, Steinberg, Glienke, Alvord et al, 2014

Parents Own Symptoms: Pre-Post Measures

- Pre-Treatment
- Post-Treatment

Global Severity
Anxiety
Depression
Somatization

***p <.001
**p <.01
*p < .05

- Amaya-Jackson, Hagele, Steinberg, Glienke, Alvord et al, 2014
INSTITUTIONAL FUNDING AND SUPPORT

• $1.8 million annually-recurring appropriation from the NC General Assembly to support:
  • Training & Implementation of Trauma EBTs that include fidelity, outcomes, & progress monitoring
  • Tailoring the LC platform for the models in this child mental health service array
  • Necessary infrastructure supports
  • Emphasis: Outcomes, accountability & cost-savings
  • Ongoing Evaluation (not research)
• $500,000 allocation: Expand a training and treatment data exchange platform (NC POP 2.1)
• 2019 Additional DMH funds to pilot PSB-CBT platform
• 2016-2021 NCTSN dollars fund ABC dissemination

Proliferation of EBTs in Child Mental Health
EBT LISTS/REGISTRIES

**Government Site**
SAMHSA’s National Child Traumatic Stress Network
www.nctsn.org/treatments-and-practices/trauma-treatments

**State Sites**
The California Evidence-Based Clearinghouse for Child Welfare (CEBC):
www.cachildwelfareclearinghouse.org


University of Washington’s EBP Database: http://www.adai.washington.edu/ebp/

**American Psychological Association**
Division 53: www.effectivechildtherapy.com/

Division 12: www.apa.org/divisions/div12/cebc.html

CEBC Website: www.cachildwelfareclearinghouse.org

CEBC Website

Welcome to the California Evidence-Based Clearinghouse for Child Welfare

The California Evidence-Based Clearinghouse for Child Welfare (CEBC) website is designed to:

- Serve as a one-stop connection for child welfare professionals, staff, and public
  and private organizations, academic institutions, and others who are interested in
  serving children and families.
- Provide up-to-date information on evidence-based child welfare practices
- Facilitate the identification of evidence-based practices as a method of ensuring
  improved outcomes and the delivery of quality care and services.

If you see an “EBP” use this site, you may wish to read about the background of the CEBC or about the key evidence-based strategies, it will help to answer your questions. You may also be interested in our child guides, which contains many you can search the site on any go directly to over 100 tools, apps,

CEBC Website: www.cachildwelfareclearinghouse.org

CEBC Website

Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)

Scientific Rating: 1

Child Welfare System Reference Level: High

About the Program

The information in the program outline is provided by the program developer and edited to the CEBC staff. Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) has been rated to the CEB in these areas of Anxiety Treatment (Child & Adolescent) and Trauma Treatment (Child & Adolescent). Target Populations: Children with a known trauma history who are experiencing significant

Post-Traumatic Stress Disorder (PTSD) symptoms, whether or not they meet full diagnostic

criteria. In addition, children with depression, anxiety, and/or chronic medical to traumatic

exposure. Children experiencing Childhood Traumatic Grief can also benefit from the

For children/adolescents ages 3 – 10 For parent caregivers of children ages 3 – 10

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For children/adolescents ages 3 – 10 For parent caregivers of children ages 3 – 10
Selected Treatments:
- Trauma-Focused CBT - TF-CBT (16)
- Parent Child Interaction Therapy - PCIT (10)
- Child Parent Psychotherapy - CPP (2)
- SPARCS (4)
- Attachment & Biobehavioral Catchup – ABC (2)
- Problematic Sexualized Behavior CBT
  - Launch Fall 2019

Quality Assurance Standards
- Monitor Fidelity (Adherence) + Competence + Level of Coaching Necessary
- Monitor agency, clinician, client progress & outcomes

Public Health Approach & Sustainability:
- Roster of Trained Providers to link children to trauma trained clinicians
- Post training platform

Training Platform:
- NCTSN’s Learning Collaborative on Adoption & Implementation of EBTs

Public Health Approach & Sustainability:
- Built a Data Management Capture for Clinician Fidelity, Progress Monitoring & Client Outcomes

PCIT Trainers
- Rhea Chase PhD (Master Trainer)
- Ericka Wray, LCSW  (Level 2)
- George Ake, PhD (Level 2)
- Kelly Sullivan, PhD (Level 2)
- Robin Gerwitz, PhD (Master)

Agency Senior Leader Faculty
- Improvement Advisor
  - Ashley Alvord, MPH
  - Robert Murphy, PhD

Research Evaluators:
- Karen Carmody, PhD
- Ashley Alvord, MPH

Can PCIT Dissemination be done thru Learning Collaboratives:
- Standard PCIT training: 5 days with 1 trainer and 5-6 trainees.
- LC: Up to 30 trainees plus senior leaders
- Pilot & subsequent dissemination grant: NC and SC
- More Learning Sessions days, fidelity: video review; intensive technology support

Collaborative Goals Framework:
Expert Panel of PCIT International trainers

Pilot to test Learning Collaborative Methods for PCIT
1st Learning Collaborative (ever) for PCIT

RESULTS: CLINICAL OUTCOME DATA

Fidelity
1. Average treatment integrity = 94%
2. Average DPICS* reliability (trainee’s coding compared to faculty coding) = 78%, SD = 12

Outcomes
1. Significant decrease in child behavior problems (ECBI), t(11) = 3.66, p < .01
2. Significant increase in positive parent verbalizations with child, t(11) = 2.63, p < .05
3. Significant decrease in negative parent verbalizations with child, t(11) 2.70, p < .05

* Dyadic Parent Interaction Coding System: coding parental statements as focus of intervention outcomes


-PIs: Murphy & Amaya Jackson
## 2014: Clinical Training & Workforce Development in Evidence-Based Treatments

<table>
<thead>
<tr>
<th>EBT</th>
<th>Clinician Number Initially Enrolled</th>
<th>Enrollee Retention Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>TFCBT Cohort 8 - Outpatient</td>
<td>62</td>
<td>74%</td>
</tr>
<tr>
<td>TFCBT Cohort 9 - RTC</td>
<td>54</td>
<td>94%</td>
</tr>
<tr>
<td>SPARCS Cohort 1</td>
<td>36</td>
<td>97%</td>
</tr>
<tr>
<td>PCIT Cohort 4</td>
<td>20</td>
<td>80%</td>
</tr>
<tr>
<td>CPP Cohort 1</td>
<td>40</td>
<td>97.5%</td>
</tr>
<tr>
<td>ABC pilot</td>
<td>18</td>
<td>69%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>228</strong></td>
<td><strong>87%</strong></td>
</tr>
</tbody>
</table>

Amaya Jackson, Hagele, J Steinberg, Glienke, Alvord 2014

## 2014: Clients Served by NC CTP Clinician-Trainees

<table>
<thead>
<tr>
<th>Evidence-Based Treatment</th>
<th>Number of Enrolled Clients</th>
<th>Retention Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>TFCBT - Outpatient</td>
<td>170</td>
<td>69%</td>
</tr>
<tr>
<td>TFCBT - RTC/Outpt</td>
<td>118</td>
<td>92%</td>
</tr>
<tr>
<td>PCIT</td>
<td>209</td>
<td>86%</td>
</tr>
<tr>
<td>SPARCS</td>
<td>144</td>
<td>*</td>
</tr>
<tr>
<td>ABC</td>
<td>32</td>
<td>72%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>673</strong></td>
<td><strong>85%</strong></td>
</tr>
</tbody>
</table>

*Data not available

Amaya Jackson, Hagele, Steinberg, Glienke, 2014

## 2013 NC POP: Performance Outcome Platform

EBT-Specific Support Platform for Data Capture

- Web-based EBT support platform for data capture
  - TF-CBT is template
- Action Period consultation
- Client tracker on enrollment, assessments, module completion
- Fidelity (adherence/skill) monitoring
- Clinical Outcomes tracker
- Service use & cost (codes)
- (+/-) Analytics

Hagele, Glienke, Amaya Jackson, DelRosario, McMillan, Alvord et al. 2014
NC CTP: PUBLIC ROSTER OF CLINICIANS

To maintain status on NC CTP Roster:
- Clinicians need to:
  - Graduate from a model-specific learning collaborative
  - Demonstrate fidelity to the model
  - Active license in good standing

- In FY 2018, the following requirements were added:
  - Accepting referrals and/or maintaining active caseload
  - 6 EBT relevant CEU’s per 2 years
  - EBT specific clinical supervision or peer supervision
  - Completion of 2 EBT cases in previous 2 years, including monitoring of case-level fidelity and completion of pre- and post-treatment assessment.

- Currently, there are over 620 clinicians on the roster (ABC, CPP, PCIT, SPARCS, TF-CBT)
- Roster location: www.ncchildtreatmentprogram.org

ABC IN NC LEARNING COMMUNITIES

# COHORTS: 4
# TRAINEES: 68
# SENIOR LEADERS: 29
# AGENCIES: 25
  - early intervention, home visiting/parent education, child welfare, community mental health
  - # TRAINEES ROSTERED: 47 (69%)

Client Outcomes
Pre-post measures of:
- Observations of parenting
- Self-report of parenting behaviors and parenting self-efficacy
- Parent report of child social and emotional development

PARENTAL SELF-EFFICACY – ANOTHER LOOK

- 18 of 26 (67%) reported improved sense of self-efficacy.
- Let’s look closer:
  - High vs low starting groups
  - High stayed high
  - Low group increased significantly – and up to the level of the high group
2014-15 CTP Next Phase Questions: Sustainability

- How do we keep this going?
- What would incentivize Managed Care Organizations to offer enhanced Medicaid rates?
- What quality assurance mechanism are in place to “protect their investment”
  - How do they know that the trained providers stay “high quality” now that they don’t have ongoing consultation?
  - Outcomes vs fidelity as a mechanism for reimbursement
- What is best mechanism for deciding on who should get enhanced rates?

FIDELITY: IS IT KEY TO GET OUTCOMES?
Therapist Competency Ratings and Recidivism

MEASURING FIDELITY (PERFORMANCE)

- NC CTP faculty developed a TF-CBT fidelity metric (endorsed by TFCBT developers)
- Fidelity metric: 0-4 scale (< 2.0 score = “Inadequate fidelity”) 
- Multiple versions:
  - Self-administered
  - Supervisor administered
  - Coach/consultant administered
- With coaching: > 90% of trainees achieve acceptable fidelity standards
**PURPOSE OF AN EBT TIME MODEL FROM AN IMPLEMENTATION PERSPECTIVE**

- To inform agency-level logistics (e.g., scheduling)
- To determine the true cost of EBT delivery from a clinical perspective
- To inform the development of a cost model (i.e., to help determine payment mechanisms and cost)
- To better understand workforce capacity

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**HIGH-FIDELITY TF-CBT: A TIME MODEL OF CLINICAL REQUIREMENTS IN COMMUNITY PRACTICE (AGENCIES)**

Calculating Total Time Outside of Clinical Sessions

- Pre-Treatment Phase
  - Clinical intake process & assessment
  - Documentation of findings and treatment plan
- Treatment Phase - In session & out of session
  - Session (agenda) planning
  - Fidelity and outcomes monitoring
  - Clinical supervision
  - EBT Clinical Support
- Time spent on TF-CBT by Clinical Supervisor

---

**Table One: TF-CBT Total Treatment Time Estimate Summary (Case-level)**

<table>
<thead>
<tr>
<th>Clinical Activity (Case-level)</th>
<th>Treatment Time</th>
</tr>
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<tbody>
<tr>
<td>Total In-Session Activities</td>
<td></td>
</tr>
<tr>
<td>TF-CBT Specific Activities</td>
<td></td>
</tr>
<tr>
<td>General Clinical Activities</td>
<td></td>
</tr>
<tr>
<td>Total Out-of-Sessions Activities</td>
<td></td>
</tr>
<tr>
<td>Total Treatment Time (In-Session + Out-of-Sessions)</td>
<td></td>
</tr>
<tr>
<td>Ratio (In-Session : Out-of-Sessions)</td>
<td>(1.0) : (0.7)</td>
</tr>
</tbody>
</table>

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*a Assumes medium case complexity.

*b Case-level service utilization data may not provide the predefined "typical" range due to case complexity and/or implementation-related factors, yet remain clinically acceptable.

*c TF-CBT specific activities are defined per the TF-CBT manual.

*d Activities that support TF-CBT implementation and the achievement of targeted clinical outcomes.
Lessons in Dissemination & Scaling up EBTs Across States:

1. LCs (bc of empiric support on many implementation science tenets) work well for state dissemination w/ attention to Implementation, clinical performance, agency performance & client outcomes
2. Goals across collaboratives are often the same, but the process to get there depends on the makeup of teams, agencies + landscape (ex. local Medicaid rates/incentives)
3. Fidelity calls & Fidelity Monitoring (aka Metrics) With Coaching
   Fidelity (Adherence to EBT Components) + Clinical Competence + Case Complexity + (Coaching intensity)
4. Community Clinician Workforce
   -Weaker: less training, less experience, basic foundations missing
   -Incentives & accountability - “paperwork” oriented (not client outcomes)
5. Systems: Stakeholders & Brokers
   -Politics/management/System/S$$
   -Cost modeling versus time modeling
   -Landscape is changing: ex the MCOs (Medicaid) are going after the bigger businesses + Historically the ones with the poorest performing clinicians, agencies vary in resources = many are laying off staff & then contracting with them; good clinicians leaving agencies bc quality/job dissatisfaction

Amaya-Jackson, 2014

Lessons in dissemination & scaling up:

6. If you want enhanced rates for EBT: clear, consistent mechanism for accountability. Data counts.
7. Stakeholders want platforms that offer accountability for clinician performance & client outcomes.
   -Fidelity Monitoring
   -Measurement based care
8. Rosters - use them wisely, fairly, & keep them up to date to be meaningful
9. Sustainability - if you leave it up to the agencies (or anybody else) they will fail. Sustainability for ongoing performance & outcomes requires Post-Collaborative activity:
   -Advanced Training, Fidelity brushup/recalibration, & some mechanism for Monitoring for Performance & Outcomes (NC POP)

Amaya-Jackson, et al 2014

A Guide for Senior Leadership in Implementation Collaborative

- Collaboration between NCTSN, CCFH, & Duke EPIC:
- Sections include:
  - Selecting the senior leader
  - Orienting & engaging the senior leader
  - Preparing for implementation
  - Putting training into action
  - Sustaining the work

Reviewed by an NCTSN Expert Panel 9, 2016
What does it take to keep an EBT going in your agency after you have invested in significant training?

**Sustainability 9: Strategies & Application**

1. Model-specific supervision or consultation after training complete
2. Access to ongoing education in the EBT
3. Supervisor support
4. Cultivating an agency champion
5. Fidelity monitoring
6. Client outcomes monitoring
7. Ongoing leadership support for quality EBT delivery
8. Funding and adequate (enhanced) rate for EBTs
9. Training new staff