Financing Strategies to Promote Evidence-Based Practice Implementation and Sustainment:

Examples from Behavioral Health

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VA HRS&D Cyberseminar

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Presentation Overview

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- Background
  - Strategies for financing implementation and sustainment
  - Financing evidence-based practices in behavioral health
- Studying financing strategy outcomes
- Tailored selection of financing strategies
- Implications and future directions

Evidence-based practices (EBPs) are complex and costly

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Often designed and tested without considering real-world implementation

Costs include service delivery, training, quality assurance, care coordination, and supplies

Limited, fragmented funding is a major challenge to sustainment

Financing Strategies Help Offset EBP costs

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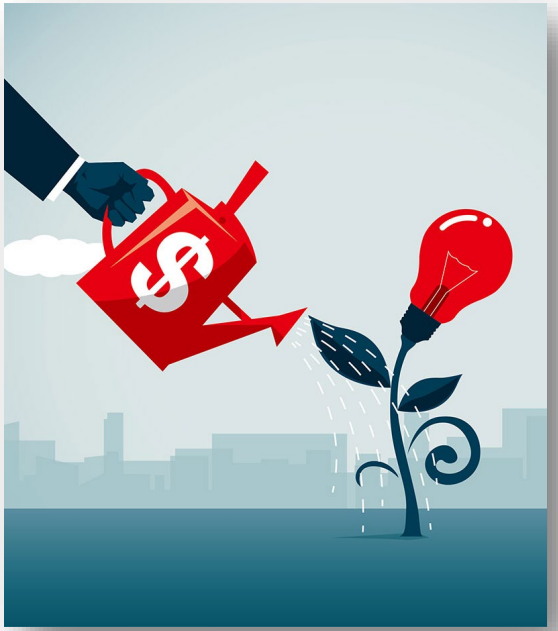
- **<u>Financing strategies</u>** help organizations and systems secure financial resources to pay for:
  - Initial EBP implementation
  - Long-term EBP sustainment

  Examples: grants, contracts, fee-for-service payments, pay-for-performance, donations, local taxes

- Service administrators, policymakers, and EBP developers need more research-based guidance on how to invest in EBPs through financing strategies



Financing EBPs in Behavioral Health

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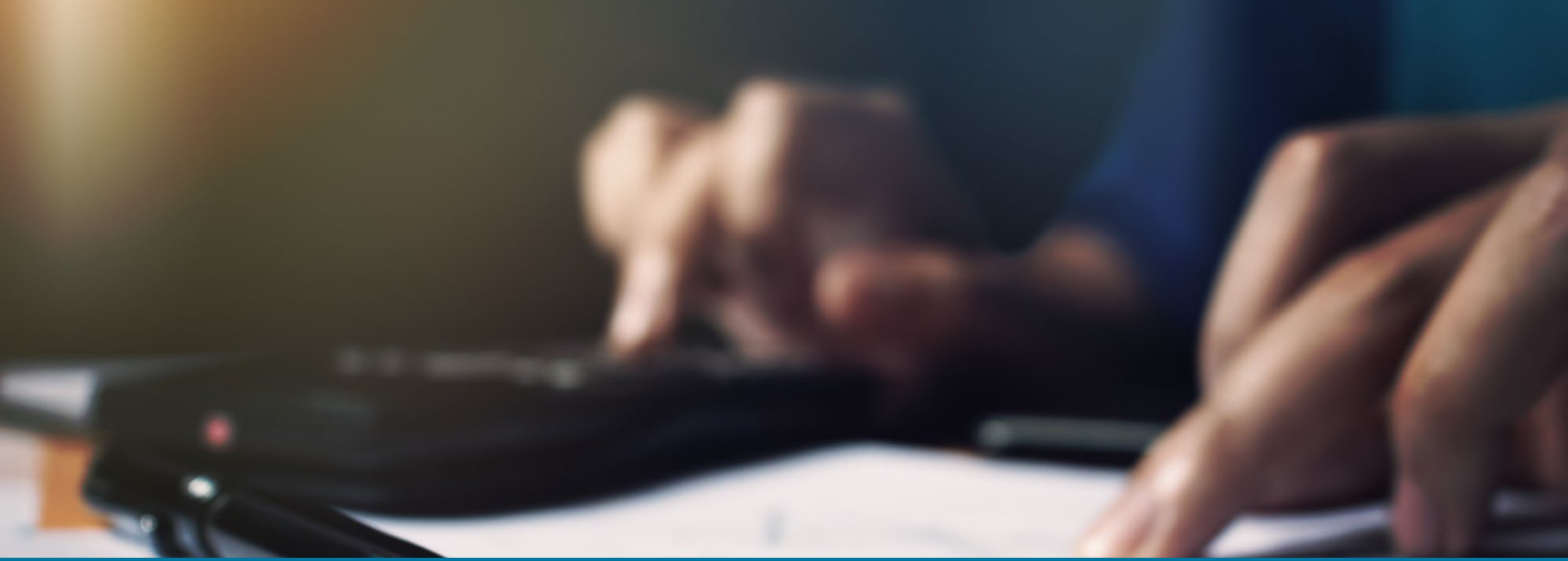
- Compilation of 23 financing strategies studied with behavioral health EBPs (Dopp et al., 2020[a]) based on a scoping review
  - Mental health and child welfare were the most commonly studied settings
  - All descriptive studies – no implementation or service outcomes reported
- North et al. (2023[b]) updated the compilation based on feedback from youth mental health system representatives:
  - Surface-level modifications to 15 strategy names/definitions (65%)
  - Participants had limited familiarity with most strategies
  - Even the most relevant strategies rated only somewhat available, feasible, and effective for sustaining EBPs
- U.S. policy has chronically under-invested in behavioral health service delivery (and by extension, implementation) – with major equity implications



Financing Strategy Outcomes:

Examining reach rates from federal grants

Adolescent Community Reinforcement Approach

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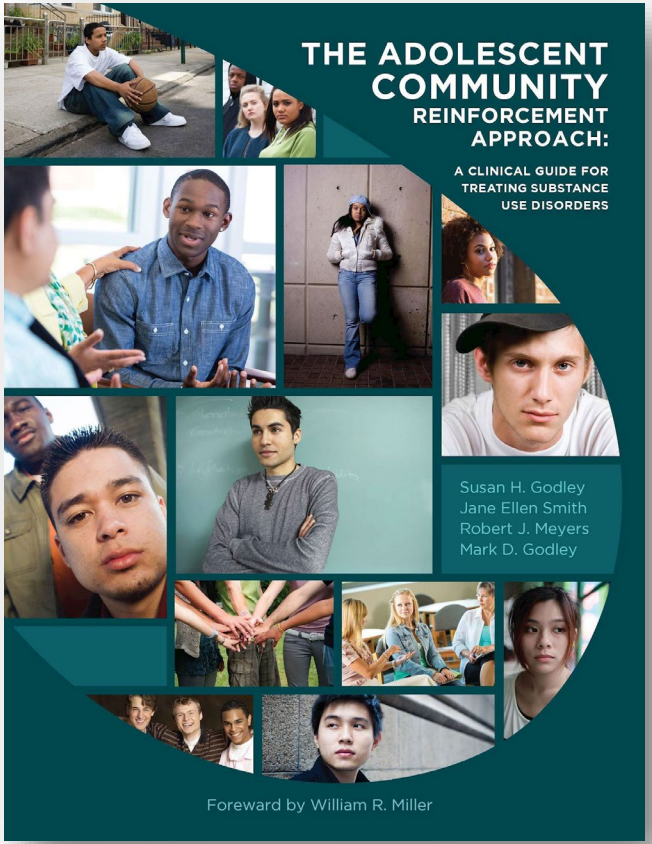
Overview

- Exemplar EBP for youth substance use treatment
- Mainly individual treatment, with some caregiver/family sessions
- Can be delivered in the office or home/community (including telehealth)
- Procedures can be flexibly ordered and repeated as needed
- Guided by overall principles (e.g., harm reduction)

Federal implementation efforts

- Led by SAMHSA Center for Substance Abuse Treatment (CSAT)
- Organization-focused grants awarded 2006-2010 to treatment organizations
- State-focused grants awarded 2012-2017 to state SUD service agencies
- Goal of state-focused grants was to enhance reach and sustainability with state infrastructure



Overall Project Design

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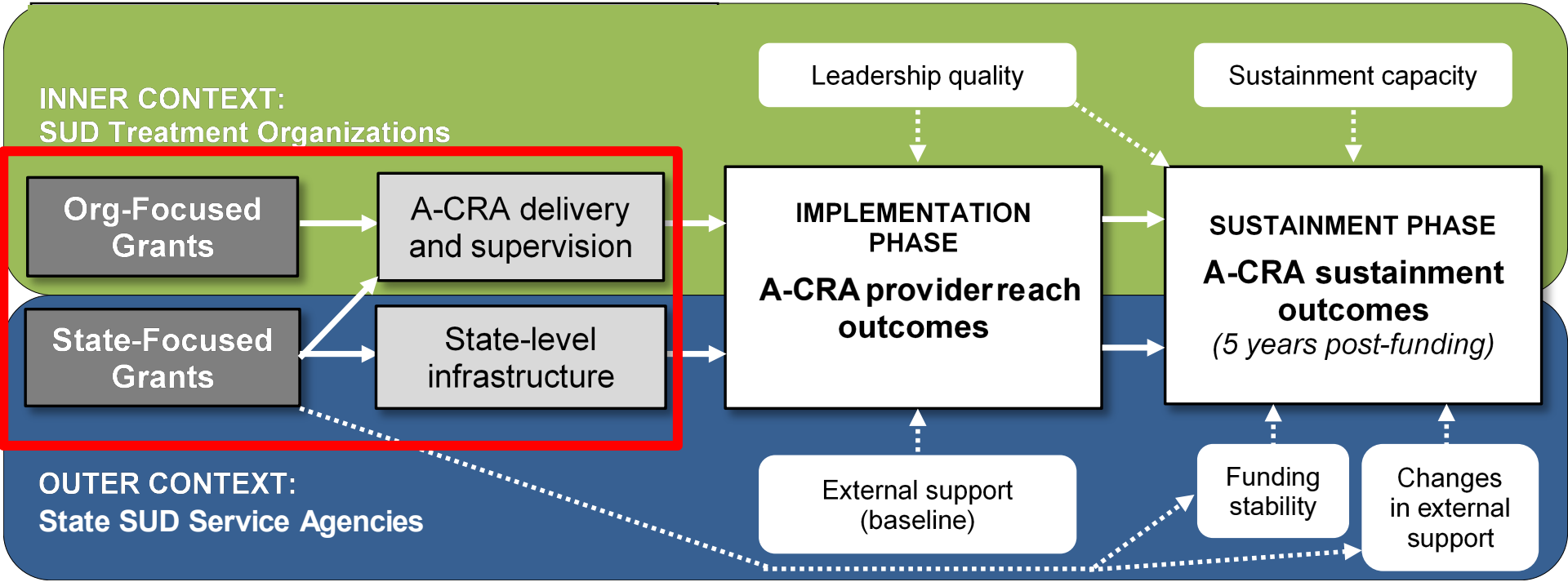

Org-focused grant data: NIAAA grant R01AA021217 (Hunter, PI)

State-focused grant data: NIDA grant R01DA051545 (Dopp, PI)

Overall Project Design

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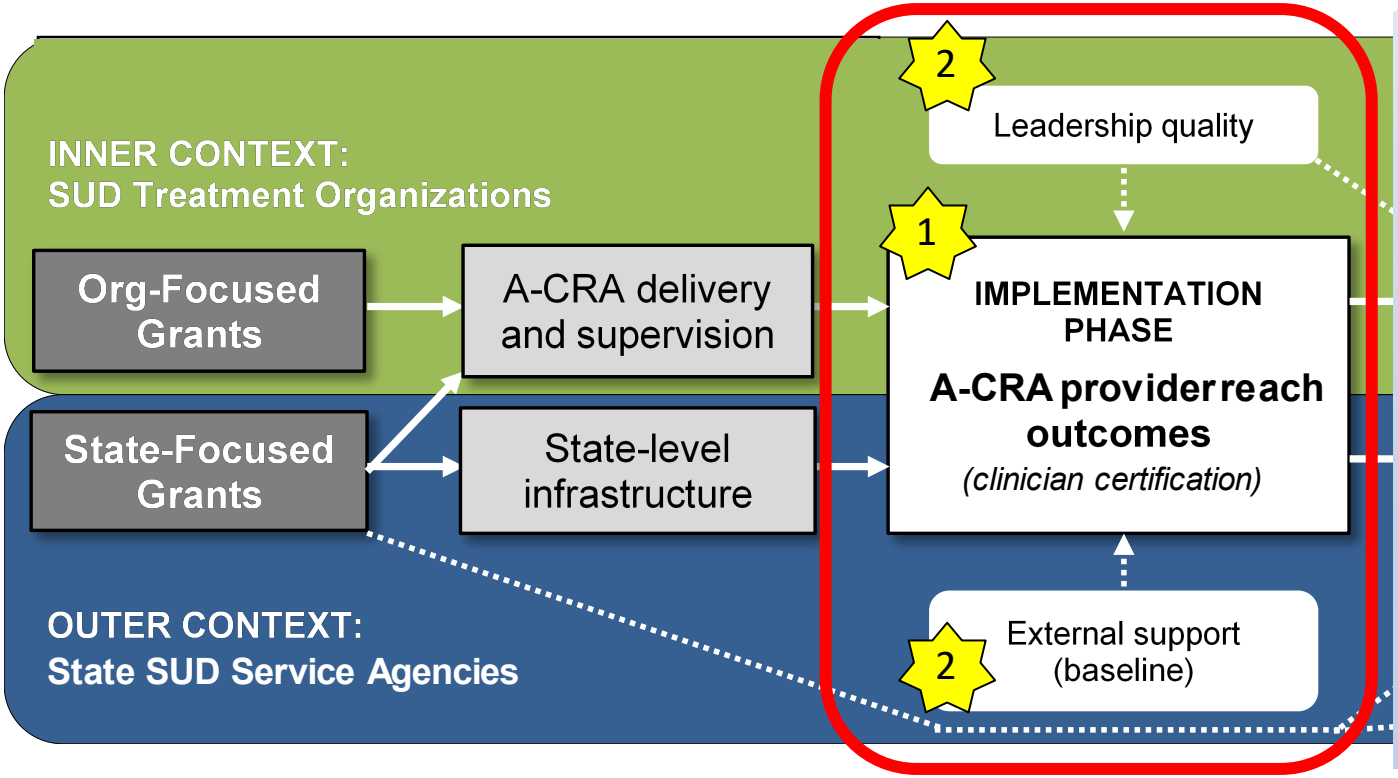

(1) How did rates of providers completing A-CRA certification differ by grant type?

(2) What factors influenced A-CRA certification rates?

Org-focused grant data: NIAAA grant R01AA021217 (Hunter, PI)

State-focused grant data: NIDA grant R01DA051545 (Dopp, PI)

A-CRA Certification Process

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3-Day Initial A-CRA Training

Clinicians:

~1 year post-training:

Consultation Calls

+

Fidelity review of recorded A-CRA sessions

First-Level Certification: Pass 9 core procedures

Full Certification: Pass all 19 procedures

+ TAY Certification: Adds two procedures for transition-age youth (TAY) to First-Level and Full Certifications

Required for independent delivery of A-CRA

Supervisors:

~1 year after starting supervisor certification:

Fidelity review of recorded A-CRA supervision (as supervisor)

Supervisor Certification: Pass three competencies for supervision

Certification Rates per Org, by Grant Type

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Certification type	Organization-focused grants (82 orgs from 27 states)	State-focused grants (82 orgs from 18 states)
Any	27% more of trained providers were certified	← these differences are not present for "demonstration" sites, which functioned similarly to org-focused grantees
First-Level	23% more of trained providers were certified	
Full	No difference	
Supervisor	No difference	
TAY	Unable to test due to small sample (only 1 in 5 orgs did TAY training)	

Interviews with Providers and State Administrators

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- Completed 0-4 years post-grant
- Provider interviews
  - 94% of organizations
  - 1-2 representatives per org
  - 39% clinician, 28% supervisor, 33% both
- State admin interviews
  - 100% of state-focused grant recipient agencies
  - Individual or group interviews
- We coded interview responses to identify common barriers and facilitators to implementing A-CRA
- Providers also completed surveys, but survey measures did not predict certification outcomes

Barriers (B) and Facilitators (F) to A-CRA Certification

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- State-focused grantee orgs experienced…
  - More challenges with lack of fit (B)
  - Complex dynamics with state leadership support (B/F)
  - Shifting community priorities about adolescent substance use (B)
  - Benefits of state-organized funding and training (F)

- Org-focused grantee orgs experienced…
  - More strengths in strategic planning (F)
  - Federal support that was intensive (F) but burdensome (B)

Barriers and Facilitators to A-CRA Certification

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- Org-focused grantee orgs experienced…
  - More strengths in strategic planning (F)
  - Federal support that was intensive (F) but burdensome (B)

"One of the difficulties with A-CRA … is that there is a big component of getting kids involved in more pro-social activities. There's a lot of barriers to that culturally and otherwise and financially for folks…"

State-focused, provider

Barriers and Facilitators to A-CRA Certification

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- State-focused grantee orgs experienced…
  - More challenges with lack of fit (B)
  - Complex dynamics with state leadership support (B/F)
  - Shifting community priorities about adolescent substance use (B)
  - Benefits of state-organized funding and training (F)
- Org-focused grantee orgs experienced…
  - More strengths in strategic planning (F)
  - Federal support that was intensive (F) but burdensome (B)

"Part of planning was also to work with state [legislature and departments] to let them know about [A-CRA] and seek longer-term state-based funding for these services. … to advocate for this model as being paid for in full."

Org-focused, provider

This study is now published!

(Dopp et al., 2023[c])

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Dopp *et al. Implementation Science* (2023) 18:50
https://doi.org/10.1186/s13012-023-01305-z

Implementation Science

RESEARCH **Open Access**

Check for updates

Comparing organization-focused and state-focused financing strategies on provider-level reach of a youth substance use treatment model: a mixed-method study

Alex R. Dopp[1*], Sarah B. Hunter[1], Mark D. Godley[2], Isabelle González[1], Michelle Bongard[1], Bing Han[3], Jonathan Cantor[1], Grace Hindmarch[1], Kerry Lindquist[1], Blanche Wright[1,4], Danielle Schlang[1], Lora L. Passetti[2], Kelli L. Wright[2], Beau Kilmer[1], Gregory A. Aarons[5] and Jonathan Purtle[6]

Tailored Selection of Financing Strategies:

A new strategic planning tool

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Background/rationale and specific aims

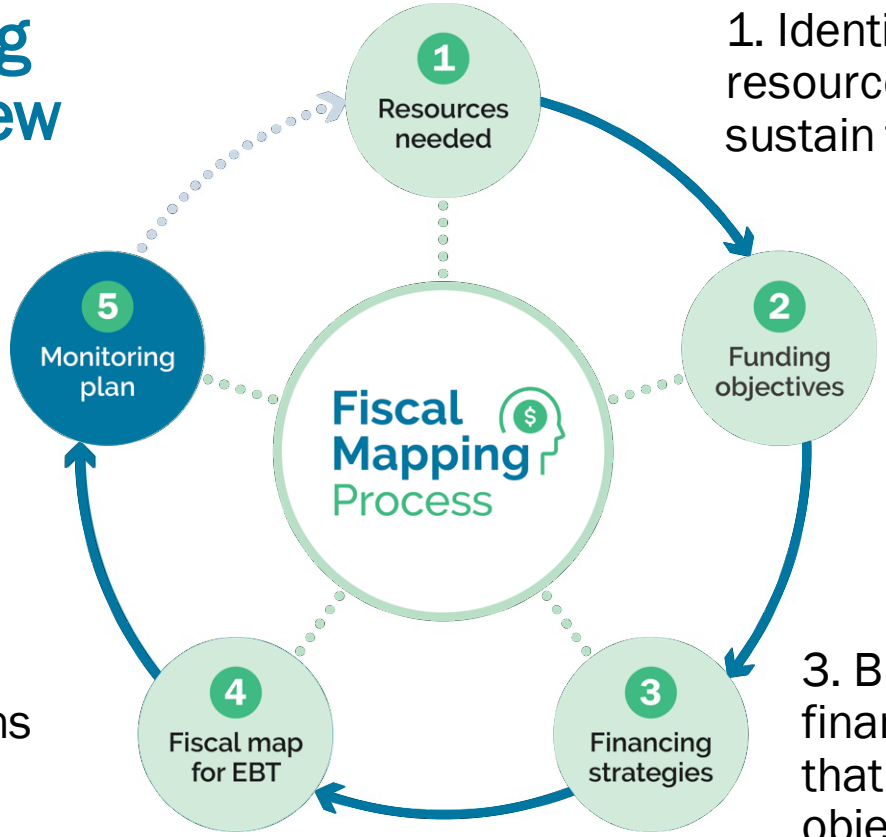
AIM 1

To develop a process that will guide strategic planning efforts for financing EBP sustainment

AIM 2

To evaluate preliminary impact of the process on EBP sustainment in youth behavioral health treatment organizations

Fiscal Mapping Process overview



1. Identify the resources needed to sustain the EBP

2. Specify objectives for obtaining needed resources

3. Brainstorm financing strategies that can meet objectives

4. Select and use the best-fit financing options to meet all funding objectives

5. Monitor financial viability of the EBP and update the fiscal map as needed

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Published tool (Dopp et al., 2023[d]) is available at RAND.org:
https://doi.org/10.7249/TLA2678-1

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Study design and timeline: 12-month pilot test

Evidence-based treatments of focus

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PCIT

- SAMHSA best practice for child disruptive behavior problems
- PCIT treats:
  - Children ages 2-7
  - Primary caregiver(s)
  - Includes families w/ history of abuse/neglect, trauma, disruption, dev disability
- Direct coaching of parent with child using one-way mirror (or telehealth)
- Average 14 – 16 sessions, completion is assessment-driven

TF-CBT®

- SAMHSA best practice for child and adolescent PTSD treatment
- TF-CBT treats:
  - Children ages 3-18
  - All types of traumas
  - With or without parental participation
  - In varied treatment settings
- Provides education, skills, and safe setting to process trauma memories
- Average 8 – 24 sessions

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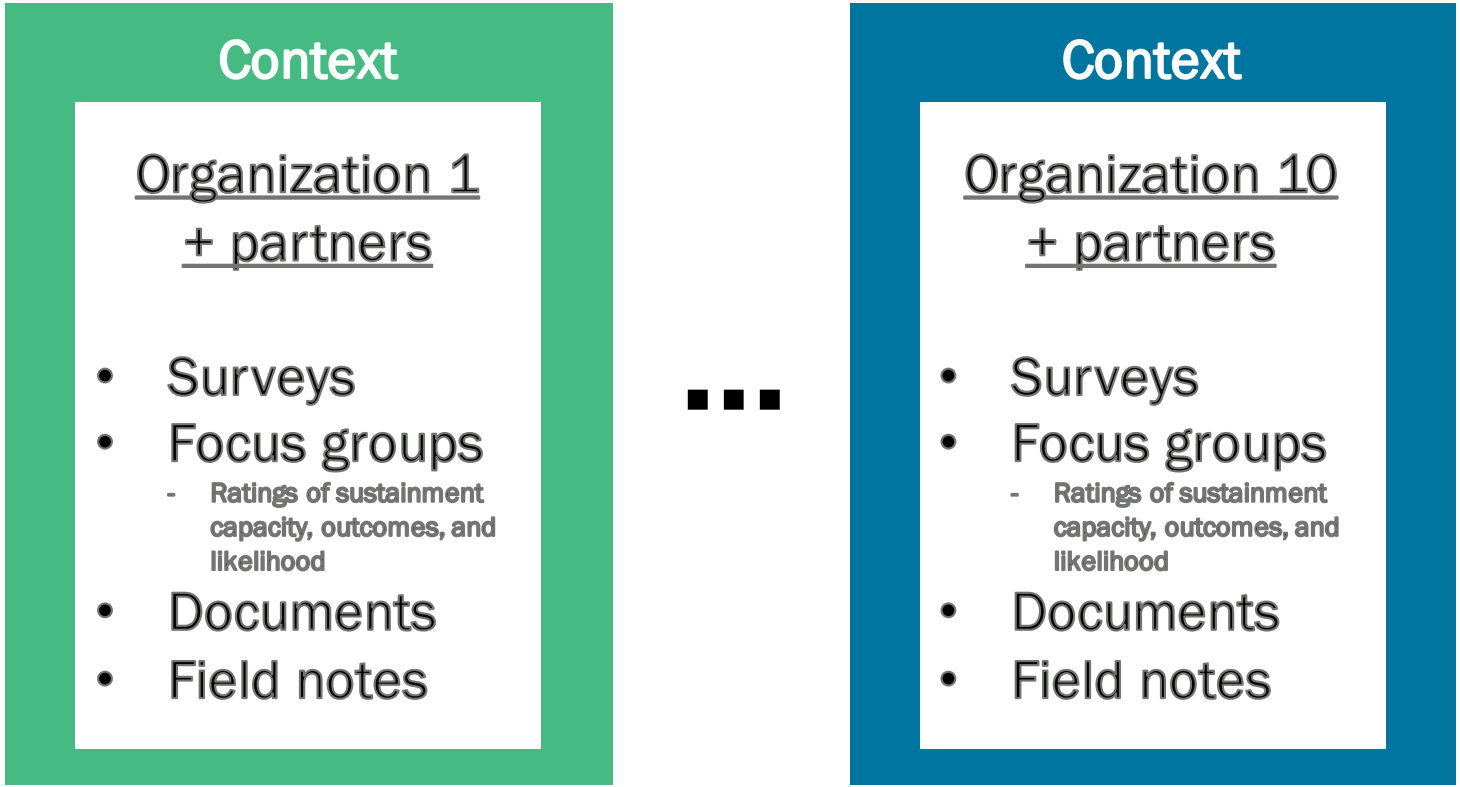
Comparative Case Study Methods
(mixed methods, qualitative + quantitative)



Pilot-Testing Organizations and Representatives

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	Youth Mental Health Service Organization									
	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10
Organization type	Nonprofit	CMHC	CAC	Nonprofit	CAC	For-profit	CMHC	CMHC	For-profit	CMHC
EBP model	TF-CBT	PCIT	TF-CBT	TF-CBT	TF-CBT	PCIT	PCIT	TF-CBT	PCIT	TF-CBT
# representatives	3	3	2	3	1	3	3	2	1	3
financial manager	mixed	mixed	mixed	mixed	N	N	Y	N	Y	N
clinical manager	Y	Y	Y	N	mixed	Y	Y	Y	Y	Y
senior leader	N	mixed	Y	mixed	Y	mixed	mixed	mixed	Y	mixed
# coaching sessions	2	4	9	0	6	4	10	6	10	6
Avg coach session (min)	19.5	17.8	23.8	N/A	16.2	16.3	41.7	17.5	31.2	18.2

CMHC = community mental health center
CAC = Children's Advocacy Center

Process findings

(Dopp et al., in press[e])

(1) Tool works best for full EBP programs that also have financial sustainment needs

(2) Requires collaboration among clinical manager, financial manager, and senior leadership roles

(3) Coaching was valuable for making full use of the tool, but also difficult to prioritize

(4) Process benefits from collaboration with funding partners, but this was challenging and sensitive

This process has been beneficial as a company because it helped us

see what it really requires to have a program that pays for itself and kind of functions as its own program. That's not the way we usually do things. We have cost centers, but they're based on clinics not on programs.

- Financial Manager

Outcome findings

(Dopp et al., in press[e])

We're an agency with so many different programs and funding streams… a lot of competing needs. [By] changing conversations internally to show that there are gaps and how we're gonna fill them …this tool brings up more awareness.

- Clinical Manager

(1) Organizations that engaged with the Fiscal Mapping Process reported increased ability to strategically plan for financial sustainment

(2) Increases in self-reported strategic planning consistently led to increases in reported EBP sustainment extent/intentions

(3) Impacts were incremental and best understood over multi-year timespans

Contextual influence findings

(Dopp et al., in press[e])

(1) Youth-serving system capacities influenced the funding sources available for EBPs

(2) Organization leadership support for Fiscal Mapping set priorities for the program and team

(3) Turnover of clinicians and managers threatened capacity to deliver EBPs, creating urgent needs that were prioritized

(4) Use of Fiscal Mapping was even more challenging when organizations prioritized populations experiencing mental health inequities

(5) Representatives viewed the Fiscal Mapping Process as likely to generalize across a variety of behavioral health EBPs

We are working with private [insurance] contractors to increase the rate for PCIT. This can supplement [government payors with low rates] but we don't have that many private cases. [Organization] really focuses on underserved populations.

- Senior Leader

Key Take-Aways

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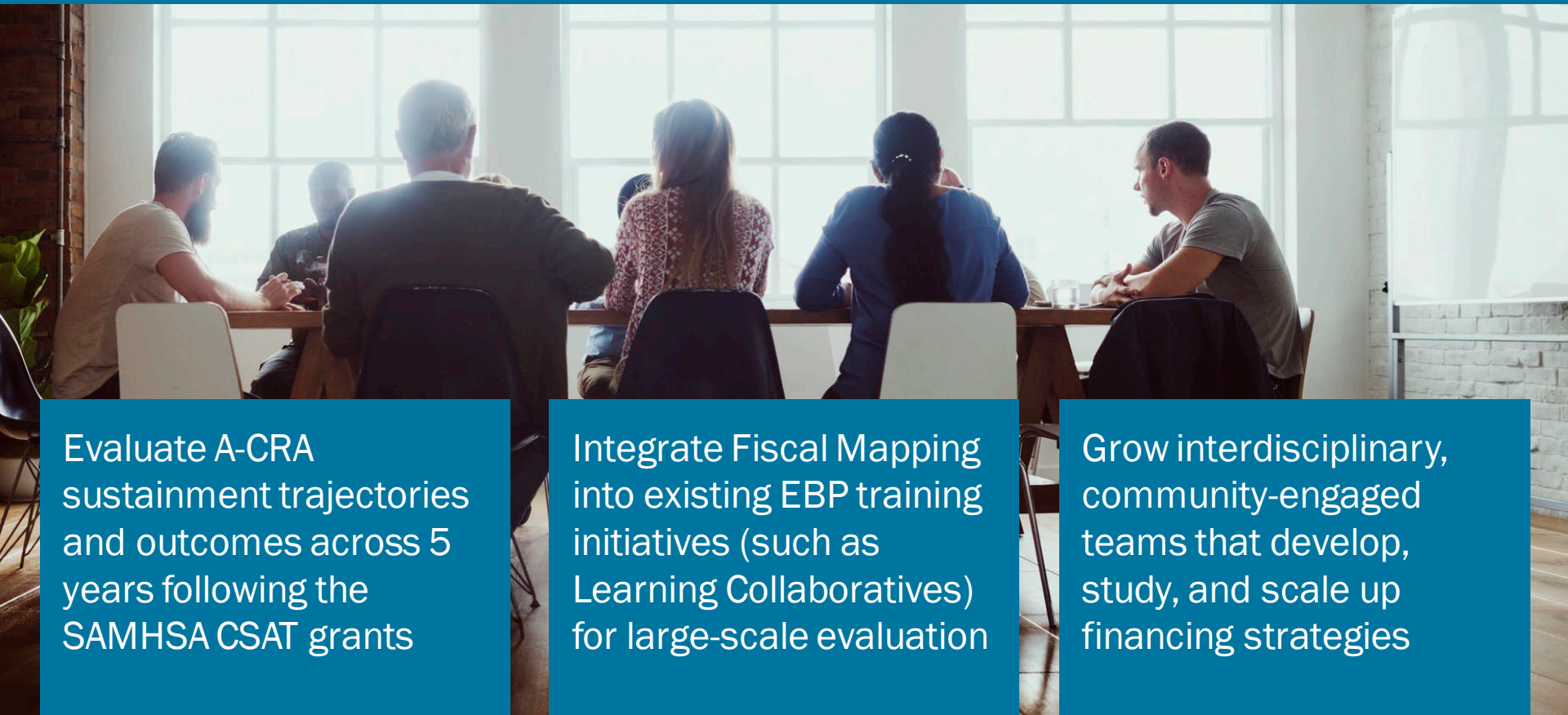
1. Financing strategies have an important, but poorly understood, role in EBP implementation and sustainment

2. Financing strategy specifications affect EBP implementation outcomes (e.g., A-CRA reach differed by federal grant type)

3. Strategic planning (e.g., Fiscal Mapping Process) can help treatment organizations navigate challenging environments for financial sustainment

Future Directions



Evaluate A-CRA sustainment trajectories and outcomes across 5 years following the SAMHSA CSAT grants

Integrate Fiscal Mapping into existing EBP training initiatives (such as Learning Collaboratives) for large-scale evaluation

Grow interdisciplinary, community-engaged teams that develop, study, and scale up financing strategies

At the end of the day…

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- Implementation is real work that adds value to service systems, but is often rendered invisible
- Organizations and systems are rewarded for avoiding formal mechanisms to compensate implementation
- The status quo is good for bottom lines, but leads to exploitation of workers and lower service quality for recipients/communities

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Questions?

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