A Statewide EBP Scale-Up Project: The Children's Administration-University of Washington EBP Partnership

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Washington State Department of Social & Health Services
CA Children's Administration

UW Medicine
SCHOOL OF MEDICINE

Public systems are using increasingly sophisticated, methods to support EBP use in "real world" practice.

- Increasing awareness of role and expectations regarding EBPs
- Growing evidence base for effective interventions and approaches
  - Increasing programmatic options for public systems
  - Reducing the gap between what is known to be effective and problems for which we need effective solutions
- State legislation focused on EBP continue to proliferate
- New federal initiatives
- Establishment of "implementation science" as a field of applied research

Public child welfare systems may be particularly amenable to application of EBP

(Chaffin & Friedrich, 2004; Barth, 2008)

- **Child welfare systems are accountable for explicit outcomes:**
  - Reduced rates of future abuse
  - Placement stability
  - Improved home environments
  - Improved child functioning

Public child welfare systems may be particularly amenable to application of EBP

- **Clarity of the child welfare mission and outcomes:**
  - Aids design of effectiveness research studies, and thus the identification of new EBPs
  - Facilitates selection of programs likely to achieve these outcomes.
  - Guides the development of federal initiatives to promote relevant EBPs
    - E.g., Initiative to Improve Access to Needs-Driven, Evidence-Based Mental and Behavioral Health Services in Child Welfare grant program (Administration for Children Youth and Families).
  - Facilitates maintenance and use of clearinghouses and inventories (e.g., California Evidence Based Clearinghouse for Child Welfare www.cebp4cw.org)

Public child welfare systems may be particularly amenable to application of EBP

- **Large-scale programmatic initiatives are often used to purchase defined services found to impact core CW outcomes, e.g.:**
  - Behavioral health interventions for parents (Anger management, substance abuse, parent training programs, e.g., IY, PCIT)
  - MH interventions for children and youth (depression, anxiety, and sequelae of trauma, e.g., TFCBT)
  - Programs directed at improved safety and prevention of abuse and neglect (e.g., SafeCare, Homebuilders)

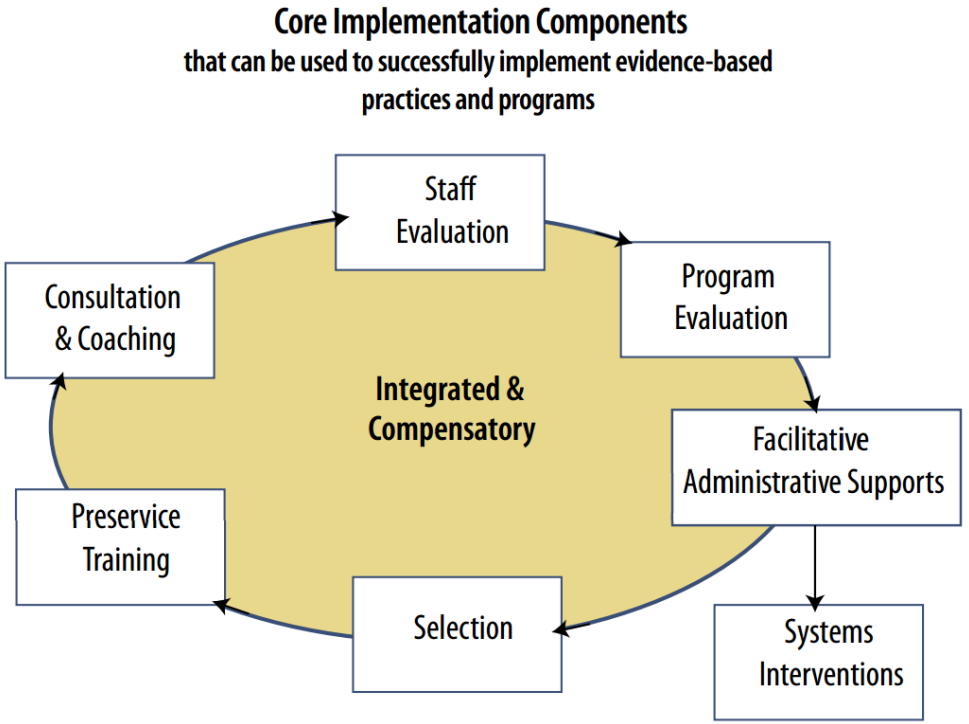
Large scale programmatic initiatives are conducive to EBP

- **Requests for qualifications and contract language may identify**
  - Specific research-based interventions to be delivered and/or
  - Stipulate that services used must be based on evidence for effectiveness
- **Centralized procurement and programmatic initiatives are conducive to ensuring presence of implementation supports:**
  - Use of manuals
  - Broad-based training and coaching
  - Consistent fidelity monitoring
  - Development of other program- or system-wide implementation supports.

Concrete support is needed for EBP implementation in public system EBPs

(Fixsen et al., 2005)

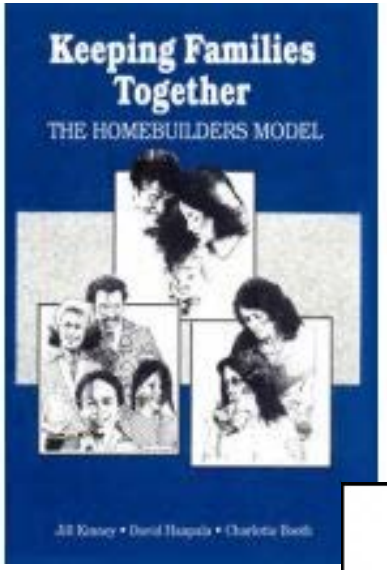
- **Provider selection**
  - Organizational level
  - Individual level
- **Training, consultation, and coaching,**
- **Staff evaluation and fidelity monitoring**
- **Program evaluation**

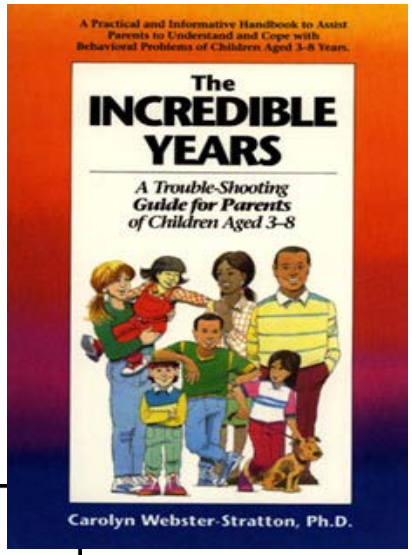


Washington State Children's Administration

- Child welfare arm of the Washington Department of Social and Health Services (DSHS)
- CA's mission is to protect abused and neglected children and provide services that will support families and communities in keeping children safely in their homes whenever possible
- CA has prioritized 7 prevention and intervention evidence- and research-based programs relevant to child welfare outcomes
  - Reduction in child abuse and neglect
  - Reduction in out-of home placement
  - Improvement in child safety
  - Placement stability
  - Safely maintain children in their own homes.
- Children's Administration contracts with agencies across the State to deliver the services to the children and families it serves.

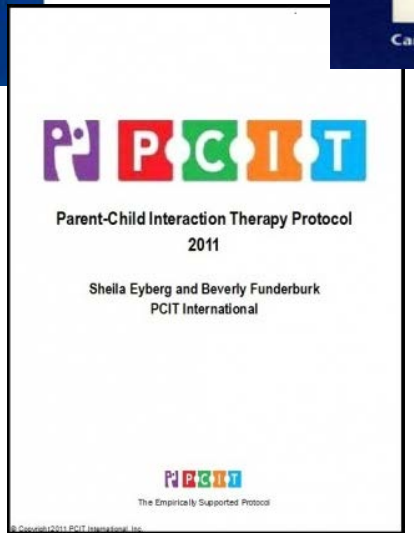
CA's Priority EBPs were selected based on their alignment with core outcomes





SafeCare
Stronger Families | Brighter Futures

Project Keep
Keeping Foster & Kinship Parents Supported



Triple P
Positive Parenting Program
for every parent

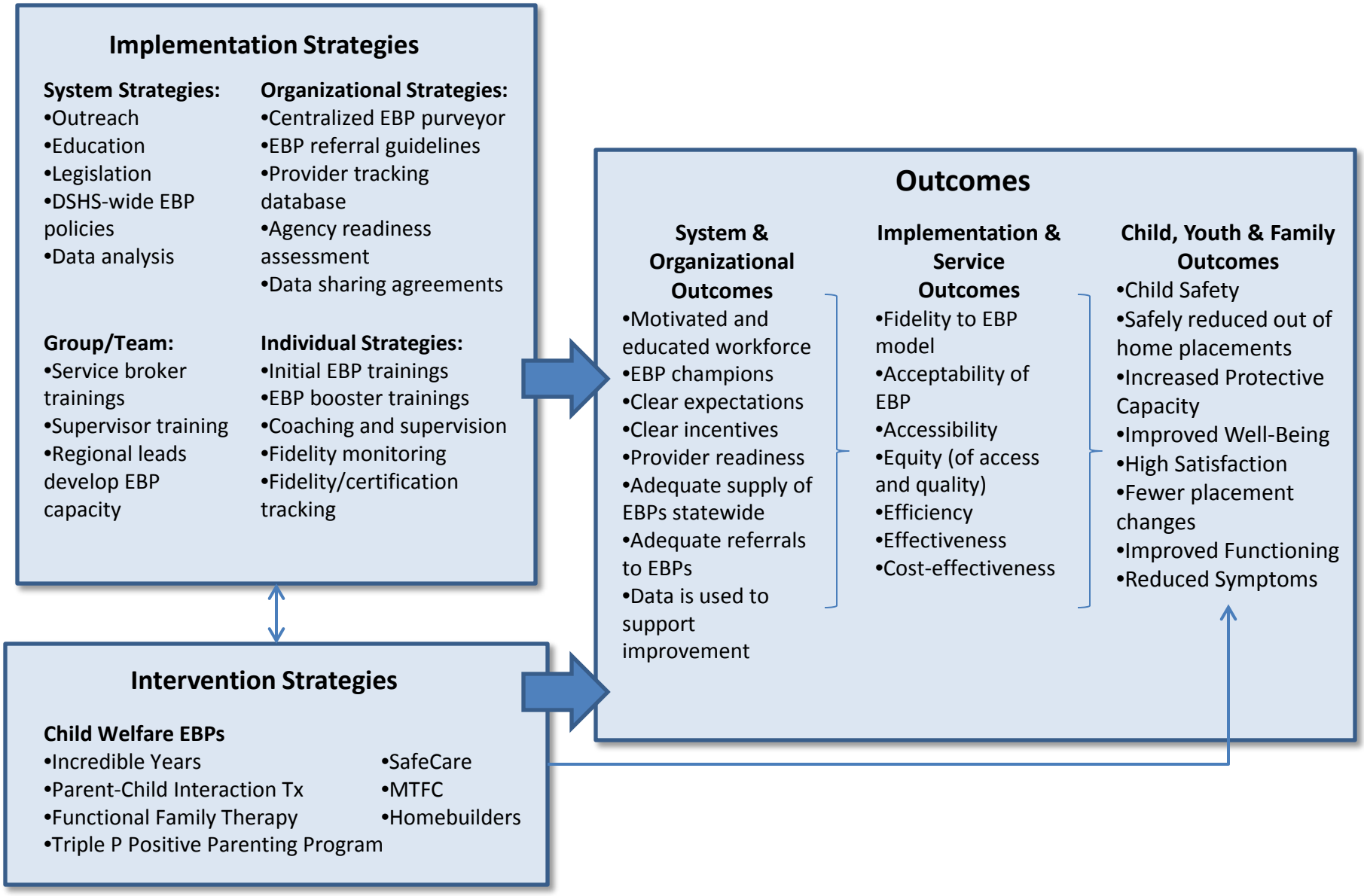
Multidimensional Treatment Foster Care®
An evidence-based solution for youth with behavioral problems, their families, and their communities

FFT Functional Family Therapy
Evidence Based. Cost Effective. Sustainable. Family, Youth & Culture Sensitive.

Children's Administration – University of Washington EBP Partnership

- Beginning in 2012 the Children's Administration collaborated with the University of Washington Division of Public Behavioral Health and Justice Policy to:
  - Oversee and administer provider trainings on core EBPs
  - Conduct fidelity monitoring and quality assurance for providers contracted to provide the selected EBPs
  - Conduct outreach and develop implementation support materials as needed to facilitate appropriate referrals and model adherent EBP use
- The CA-UW EBP Partnership is guided by a conceptual model based on the conceptual model of implementation research developed by Proctor et al. (2009)
  - The model distinguishes but links key implementation processes and outcomes

Theory of Change for the CA-UW EBP Partnership Regarding Use of Evidence-Based Practices



Specific strategies and products that extend from the conceptual model

- Establishment of a single EBP "**intermediary purveyor organization**"
- The "**Guidance Tool**"
  - Detailed set of EBP referral guidelines for use by CA social workers
- The "**Toolkit**" – Provider fidelity tracking database
  - Facilitates compliance and provision of technical assistance
- Structured EBP **readiness assessment**
  - Used by Children's Administration regional staff persons during contract negotiations
- EBP **Staff Selection Guide**
  - Includes a Pre-Training Agreement signed by provider agency rep in advance of EBP training
- Outreach and education to supervisors and staff
- Data analysis and use of information to inform programming
  - E.g., differential rates of EBP use across regions

Evidence-Based Practice Guidance Tool

	PROGRAM CHARACTERISTICS				CLINICAL CONSIDERATIONS*				ADDITIONAL CONSIDERATIONS FOR SERVICE	
	Age of Youth	Program Type	Venue of Care	Frequency & Duration of Care	Family Needs	Family Discipline	Child Functioning	Capacity to Support a Safety Plan	Decision Points	Expected Outcomes
Incredible Years (IY)	Birth to 8	Group based parent training	School and office-based	Weekly sessions lasting 10- 18 weeks	• Needs support managing difficult child behaviors. • Parents in need of positive, nurturing, non-violent parenting strategies.	• Concerns about parent-child relationships. • Caregiver(s) frustrated but uses self-control, discipline may be inconsistent, lacks effective management.	• Child has behavior problems. • Child provokes dangerous reactions in caregivers.	LOW	• Parent good candidate for group training (would like being with other parents; may not need individual coaching) • Okay that parent is coached without the child	• Increase appropriate parenting skills • Increase appropriate parental discipline • Improve parent-child relationship • Decrease in child behavior problems
Parent Child Interaction Therapy (PCIT)	Ages 2 to 8	Parent training	Office-based and home-based	Weekly sessions lasting 12 to 16 weeks	• Needs support managing difficult child behaviors. • Needs one-on-one parenting coaching on a weekly basis. • Parents in need of positive, nurturing, non-violent parenting strategies.	• Caregiver(s) frustrated but uses self-control. • May have negative feelings toward child. • May use violence or threats to control behavior, lacks effective management.	• Child has behavior problems. • Child provokes dangerous reactions in caregivers.	LOW-Office based MEDIUM-Home based	• Parent has access to their child to practice skills in between sessions • Child can be transported to PCIT sessions (as parent needs to practice in session with one child)	• Increase appropriate parenting skills • Increase appropriate parental discipline • Improve parent-child relationship • Decrease in child behavior problems • Reduction in re-occurrence of physical abuse reports
SafeCare	Birth to 5	Parent training with a focus on neglect related issues	Home-based	Weekly sessions lasting 18 to 20 weeks	• Parents need help creating and maintaining a safe home environment. • Needs to learn how to care for the children when sick or injured. • Parents in need of basic parenting skills/support.	• Families experiencing neglect related issues such as medical neglect or environmental neglect. • Parents learn basic parent-child interaction skills and providing children with rules and consequences.	• Targets typically developing children exhibiting none or mild behavior problems.	MEDIUM	• Caregiver predominantly needs services to treat neglect • Children who were neglected are young (0-5 age range)	• Increase parents' understanding and management of child illness and injuries • Increase home safety. Improve and enhance parenting skills
Family Functional Therapy (FFT)	Ages 10 to 18	Youth and family therapy	Typically home-based	Weekly sessions lasting 15 to 20 weeks	• Needs support managing difficult pre and teenage behaviors. • Some monitoring and safety concerns.	• Caregiver(s) not effectively monitoring pre/teenage youth. • Moderate to high family conflict, youth is displaying some high risk behaviors.	• Adolescent has behavior problems. • Self-destructive behavior • Provokes dangerous reactions in caregiver	MEDIUM	• An adult caregiver is able to consistently participate with the youth • Other family members also can be involved (when another adult(s)'s involvement is needed to solve problem) • Helpful for high conflict situations	• Decrease in youth disruptive behaviors • Increase parenting skills and appropriate disciplining • Increase in youth academic and social competence • Increase supportive family communication • Reduction in youth substance use • Increased placement stability
Homebuilders	Birth to 17	Family preservation services	Intensive home-based intervention	Therapists are on call 24/7. Services range between 30 to 45 days	• Needs intense support managing child behaviors (40-50 hours a week) in the home to manage family conflict, maintain child placement and/or serious safety concerns.	• Caregiver(s) need immediate, intense support with not using physical discipline, maintaining child in home and meeting youth's basic physical and emotional needs.	• Child behavior problems • Lack of behavioral control • Provokes dangerous reactions in caregiver	HIGH	• Child must be placed with the referred caregiver • Intense support for a short period of time is needed (vs. longer term, less intense support)	• Parents ability to safely care for this child is increased • Child can remain safely in the parent's care • Connection of families to community resources • Reduction in lengthy out of home placement • Reduction in new referrals
Positive Parenting Program (Triple P)	Standard: Ages 2 to 12	Parent Training	Home, community, or office based	Weekly sessions lasting 1 to 15 weeks	• Needs individualized support managing typical developmental transitions and/or dealing with significant behavioral challenges. • May need improvements in the parent-child relationship.	• Caregiver(s) frustrated, may occasionally lose self-control, discipline may be inconsistent, and lacks effective management. • May use violence or threats to control behavior.	• Range from typical developmental challenges to behavioral problems • Provokes dangerous reactions in caregivers.	LOW-Office based MEDIUM-Home based	• Caregiver would benefit from a more individualized parenting plan • Triple P can be provided without the child present • Allows a less intensive option (i.e., fewer than 10 weeks) for caregivers with less intense need	• Increase appropriate parenting skills • Increase appropriate parental discipline and behavior management • Improve parent-child relationship • Decrease in child behavior problems

* Clinical considerations are intended to match domains from the Children's Administration Family Assessment so that information from this assessment can guide program selection.

Incredible Years

Age of Child	Reasons to Refer	Venue of Care	Frequency & Duration of Care	Expected Outcomes	General Capacity to Support a Safety Plan

• Birth and 6 months for baby group
• 9 months and 2 years for BASIC toddler group
• 2 and 8 years for the preschool BASIC group
	• Family Needs
	  ▪ Parents in need of positive, nurturing, non-violent parenting strategies.
	  ▪ Needs support managing difficult child behaviors.
	• Family Discipline
	• Child Functioning
		Office-based	Weekly sessions lasting 10-18 weeks	• Increase appropriate parenting skills
				• Increase appropriate parental discipline
				• Improve parent-child relationship
				• Decrease in child behavior problems
					LOW - No contact with family in the home, No afterhours support for the family

Referral Form & Provider

- Provider information: R1 | R2 | R3
- Referral form

More Tools

- Decision Points
  - Parent good candidate for group training (would like being with other parents; may not need individual coaching). Okay that parent is coached without the child.
- Parent handout
- Referral form
- Developer website
- Restrictions
- Videos of service
- Program supports
  - **NO** after-hours support
  - Provides transportation to families needing
  - On-site supervision for the children of group participant
  - A meal is provided at each training
- Service Element
- 17 Safety Threats
- Features of service
  - Initial Contact - within three (3) days of receipt of referral
  - Classes are weekly
  - Provider contacts the family at least once per week outside the group session
  - Monthly service summary reports to social worker
  - Three types of IY classes
    - 2 and 8 years for the preschool BASIC group
    - Birth and 6 months for baby group
    - 9 months and 2 years for BASIC toddler group

SafeCare®

Age of Child	Reasons to Refer	Venue of Care	Frequency & Duration of Care	Expected Outcomes	General Capacity to Support a Safety Plan
• Birth to 5	• Family Needs • Family Discipline • Child Functioning	Home-based	Weekly sessions lasting 18 to 20 weeks	• Increase parents' understanding and management of child illness and injuries. • Increase home safety. • Improve and enhance safe parenting skills.	**Medium** - provided in the home, provider reviews safety plan each week, no after hours support for the family

Referral Form & Provider

- Provider information: R1 | R2 | R3
- Referral form

More Tools

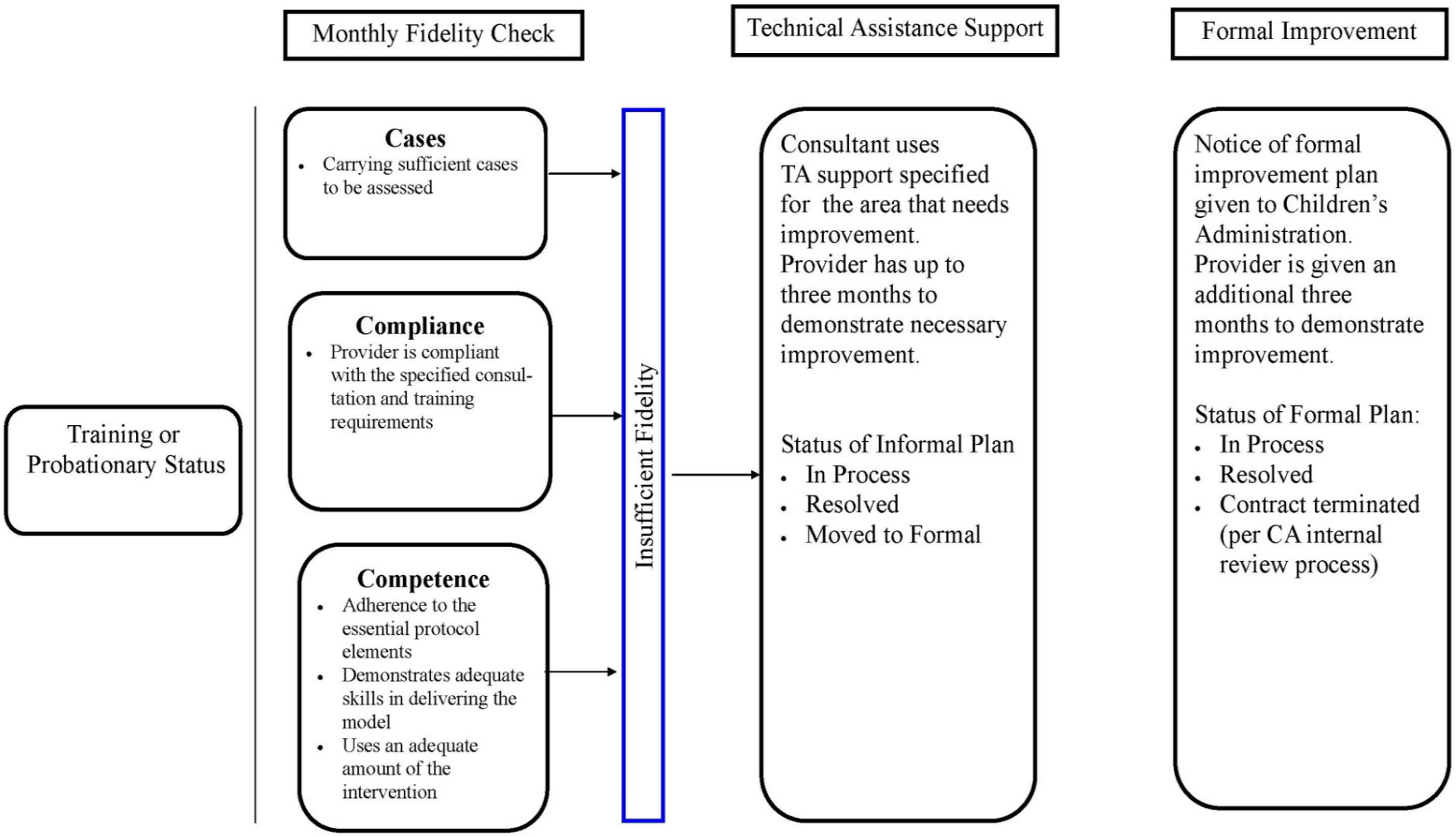
- Decision Points
- Parent handout
- Referral form
- Developer website
- Restrictions
- Videos of service
- Program supports
- Service Element
- 17 Safety Threats
- Features of service

Parent Child Interaction Therapy (PCIT)

Age of Child	Reasons to Refer	Venue of Care	Frequency & Duration of Care	Expected Outcomes	General Capacity to Support a Safety Plan
• Ages 2 to 7	• Family Needs • Family Discipline	Office-based and home-based	Weekly sessions lasting 12 to 16 weeks	• Increase appropriate parenting skills • Increase appropriate parental discipline	**Low** - Office-based **Medium Low** - Home-based, no after hours support for the family

CA-UW EBP Cross Program Fidelity Reporting

Incredible Years, SafeCare, PCIT, Triple P



EBP Roster | Public Behavioral Health & Justice Policy - Windows Internet Explorer
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Evidence-Based Mental Health in Washington State

Treatments that are proven to work

Child Welfare Evidence-Based Practice Toolkit

The Evidence-Based Practice toolkit is a centralized resource for marketing the EBP expertise of providers and managing fidelity information for programs. The toolkit is a joint effort of the University of Washington Division of Public Behavioral Health and Justice Policy's Evidence-Based Practice Institute and Children's Administration of the Department of Social and Human Services.

The toolkit serves a dual purpose. Providers receive recognition for EBP expertise on a publicly available website that can assist in marketing efforts to increase referrals. In addition, trainer/consultants for the EBPs listed below will use the toolkit to enter and retrieve fidelity information that will be used to develop quality assurance reports for Children's Administration. Efforts are also underway to assess providers' interest in accessing the toolkit as a repository for screening and progress information on individual clients to track client progress over time.

To be eligible for an account on the toolkit, providers must be working for an agency contracted through Children's Administration to provide one or more of the following evidence-based practices to child welfare children and families:

- SafeCare, a weekly, home based training program for parents of children birth to five;
- Incredible Years (IY), a weekly group-based parent-training program for children birth to 8;
- Parent-Child Interaction Therapy (PCIT), a weekly parent-training program for children 2-7 that can be delivered in an office or home setting; and
- Positive Parenting Program (Triple P), a weekly parent-training program for children 2-12 that can be delivered in the home, community, or office setting.

Who has access to the database?

The public will be able to access a list of providers who meet fidelity criteria for one of the above programs. This list is termed the "roster." The public will not be able to see any specific fidelity or compliance information associated with the provider. The roster includes the provider's name and contact information along with the EBPs he/she provides.

EBP service providers will be able to login, update their profiles on the roster, and obtain information about EBPs (e.g., updates on fidelity requirements).

Washington State EBP trainers and consultants will access the toolkit to enter training and fidelity monitoring information. The database will allow for direct entry of fidelity information obtained through video or audio reviews, consultations, and coaching.

Login to the Toolkit

EMAIL:

PASSWORD:

Forgot Password?

REMEMBER ME

Login

Need an account? Email a request

Done Internet 100%

Toolkit For Evidence-Based Mental Health Providers in Washington State

Treatments that are proven to work

PROVIDER: [redacted]

EBP STATUS: Accredited Triple P Provider

ACTIVITY MONTH: March 2013

Enter the month of activity that this report pertains to.

I) Cases

DOES THE PROVIDER HAVE SUFFICIENT CASES TO MAKE AN ASSESSMENT ABOUT FIDELITY?

YES NO

II) Compliance

Since the last review...

ATTENDANCE CALENDAR

Apr 2012	May 2012	Jun 2012	Jul 2012	Aug 2012	Sep 2012	Oct 2012	Nov 2012	Dec 2012	Jan 2013	Feb 2013	Mar 2013
✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗

DID THE PROVIDER COMPLY WITH THE SPECIFIED CONSULTATION REQUIREMENTS (IN PHONE OR IN PERSON)?

YES NO

DID THE PROVIDER COMPLY WITH SPECIFIED SUPERVISION REQUIREMENTS (E.G. PEER, GROUP, OR INDIVIDUAL)?

YES NO

III) Competence

Since the last review...

TO YOUR KNOWLEDGE, DOES THE PROVIDER ADHERE TO THE ESSENTIAL PROTOCOL ELEMENTS AS OUTLINED BY THE MODEL?

YES NO

TO YOUR KNOWLEDGE, DOES THE PROVIDER DEMONSTRATE ADEQUATE SKILLS IN DELIVERING THE MODEL?

YES NO

TO YOUR KNOWLEDGE, DID THE PROVIDER USE AN ADEQUATE AMOUNT OF THE INTERVENTION FOR THE TIME BEING RATED?

YES NO

Save Cancel

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Toolkit For Evidence-Based Mental Health Providers in Washington State

Treatments that are proven to work

CA Fidelity

Copy CSV Excel PDF Print

Filter: Triple P | Mar 2013 **Search:**

PROVIDER	AGENCY	CONSULTANT	OVERALL FIDELITY ASSESSMENT	CASES	COMPLIANCE	COMPETENCE	PLAN	NOTES
	Brigid Collins	Suzanne Kerns	Meets fidelity	Carrying sufficient cases to be assessed	Yes	Yes	None	
	Brigid Collins	Suzanne Kerns	Meets fidelity	Carrying sufficient cases to be assessed	Yes	Yes	None	
	Brigid Collins	Suzanne Kerns	Meets fidelity	Carrying sufficient cases to be assessed	Yes	Yes	None	
	Brigid Collins	Suzanne Kerns	Meets fidelity	Carrying sufficient cases to be assessed	Yes	Yes	None	
	Brigid Collins	Suzanne Kerns	Meets fidelity	Carrying	Yes	Yes	None	

Readiness Assessment

Section 1: Background information and General EBP Readiness

Script: First, I am going to ask you a few questions that will help us
agency and what kind of support or help your agency might need t

1. How did your agency become interested in providing EBPs?

2. Which EBP or EBPs are you interested in providing? (e.g., SafeCar

3. I'm interested to learn about the EBPs your agency currently pro

   a. How many staff and on what EBPs?

   EBP 1: _____N Staff: _____N
   EBP 2: _____N Staff: _____N
   EBP 3: _____N Staff: _____N
   EBP 4: _____N Staff: _____N

      i. If you have or do now provide EBPs service, w
      for ensuring compliance with fidelity monitori
      historic fidelity status of your staff?

4. What is the background of the staff who would implement new E

   a. What is their experience with specific interventions, evidence

Section 2: Adequacy of preparation and readiness to implement the EBP

Script: Thank you for providing that information about your organization. Now I would like to ask you a few questions about your plans for implementing your chosen EBP[s].

9. Can your agency manage the requirements of an intensive training plan? For example, can it release clinicians for an initial training of up to 40 hours, give them time and backfill for ongoing training, consultation, and supervision, and so forth?

10. EBPs often require the time of a support staff for implementation (e.g., food ordering, materials se up, telephone engagement with parents, and setting up video or audio recording of sessions). Can you tell me about your agency's capacity to help with these kinds of logistical details of EBP program delivery?

11. EBPs often require having sessions regularly audio or video recorded and reviewed by experts in [the selected EBP]. How do you think the clinicians in your agency would respond to this requirement?

12. Please describe how your agency has presented its plan for implementing [the selected EBP] to staff that may be expected to implement it.
    (***If prompts are needed***): Have you informed them of the idea and described the expectations of clinicians? Have you solicited and addressed any concerns?

SCORING MATRIX FOR EBP READINESS ITEMS – SECTIONS 1-2

This section of the questionnaire is to be completed by the interviewer administering the assessment immediately following the interview. Please circle the most appropriate score, based on the answers provided by the respondent to the open-ended interview questions.

Section 1: Background information and General EBP Readiness

EBP Readiness items	Rating scale
1. The agency currently implements behavioral health EBPs	0 = no EBPs 1 = one EBP / several staff 2 = 2 or more EBPs / many staff
2. The experience of staff and supervisors is adequate to implementing child specific EBPs	0 = Not at all 1 = Somewhat 2 = Definitely
3. The agency has staff (coaches, supervisors) who are certified to aid in the implementation of EBP	0 = none 1 = one 2 = 2 or more staff are certified to supervise/coach
4. The agency's clinicians like using EBPs (because of their structure, because they have been found to work, etc.)	0 = none/few clinicians or no/little support 1 = half of clinicians or some support 2= most or all clinicians; clear/universal support
5. The agency's clinicians consider research evidence for effectiveness more important than clinical experience and judgment	0 = most or all clinicians prefer clinical judgment 1 = around half of clinicians prefer clinical judgment, the other half research evidence 2 = most or all clinicians base decisions on research evidence
6. The agency's leadership explicitly and repeatedly expresses support for and promotes use of EBP	0 = no specific examples 1 = 1-2 examples of how leadership supports and promotes 2 = 3 or more examples of leadership support
7. Clinicians in the agency routinely use standardized assessment (SA) procedures (e.g., to screen for trauma, identify targeted clinical conditions, and/or measure client progress)	0 = Few clinicians or infrequent use of SA procedures 1 = About half of clinicians or some use of SA 2= Most or all clinicians; very consistent use of SA
8. The agency consistently collects evaluation data (e.g., on client outcomes and perceptions) and uses it to improve its programming	0 = Few or no examples of evaluation 1 = Agency conducts some evaluation but few examples of how it is integrated for CQI 2 = Agency consistently collects and uses data

Staff Selection Tool

Staff Selection Guidelines for Evidence Based Practices (EBPs) and Pre-Training Agreement for Participating Provider Agencies

Washington State Children's Administration
University of Washington Evidence Based Practice Institute

Evidence-based practices (EBPs) are manualized interventions that have been proven by research to work. Children's Administration is currently seeking to increase utilization of E that facilitate short-term outcomes such as improving parenting skills and reducing safety factors, and long-term outcomes such as permanency and prevention of abuse and negle

If your agency is contracted to implement an EBP selected by Children's Administration– as SafeCare, Incredible Years, PCIT, Triple-P, FFT, or Homebuilders – you will periodical have the opportunity to choose staff to attend trainings on these programs.

Careful selection of staff is critically important to the success of EBPs, and to the s investment of resource in EBPs. Practitioners who are chosen must have appropriate c background and education. Equally if not more important, their values, attitudes, and preferences of staff must "fit" well with the EBP. Finally, they must be committed to applyi their new skills in practice.

For these reasons, C.A. expects participating providers to (1) attend to the 10 points listed below in selecting staff who will be trained, and (2) sign a pre-training agreement that atte having completed this staff selection process.

As you select staff who will be trained on EBPs, consider the following questions. ***Ideally, you consider a practitioner for EBP training, the answer to all of these questions w "Yes." If not, you may want to consider whether she or he is an appropriate candid***

1. Have you interacted with your staff person about this upcoming EBP training oppo and **confirmed their interest and enthusiasm**?

2. **Have you confirmed that your staff person will be able to deliver the EBP to welfare families for at least one year post training?** The C.A. views these train an investment in the child welfare workforce that will help in meeting the needs of children and families it serves.

3. **Does your staff person have the required educational background for this E** Most CA contracts require trainees to have at least a bachelor's degree. For Incre Years, PCIT, SafeCare, Triple P, and Homebuilders, it is also recommended that trainees have some background and/or understanding of child development and o experience working with families.

4. **Does your staff person like to take on new challenges or enjoy learning abou ways of working with children and families?** To learn a new EBP, the practitio have to embrace an opportunity to learning and practicing a new approach. EBPs require extensive training, coaching, and monitoring and will work better for practit

5. **Does your staff person enjoy learning intervention strategies in a variety of ways?** All EBP trainings consist of both didactic and practice elements. It will be important for your staff to be comfortable with role playing during training and to conducting role playing with parents and their children to teach them new skills.

6. **Is your staff person open to following a manual?** All evidence-based programs have a manual that practitioners must follow in order to ensure families are being provided with an effective version of the program. Staff must feel comfortable with using a manual as they learn and practice using the EBP.

7. **Will your staff person agree to video-taping or audio recording their sessions?** Many EBPs require this for certification in the intervention and to monitor practice.

8. **Does your staff person possess good engagement and clinical skills?** Each EBP teaches and rehearses certain skills during training, but it is important for your staff to possess basic counseling skills such as active listening, use of standardized assessment, and developing treatment plans. Because EBPs are based on such skills, an inexperienced staff person may not be the best candidate for EBP training.

9. **Does your staff person seek out supervision and input on their performance?** EBPs emphasize coaching and feedback, often based on observation of practice. An ideal trainee seeks out supervision and input on their performance, rather than avoid it.

10. **Is your staff person strengths-based?** All EBPs ask the practitioner to identify and use family strengths to overcome issues and problems affecting their ability to safely parent.

PRE-TRAINING AGREEMENT

I attest that the staff person(s) selected for the upcoming training have been screened based on the 10 criteria listed above. I am aware that only staff members who are listed on the attached roster can attend the training. If there are any changes to the list of training participants I will notify and receive approval from the CA Program Manager prior to the training.

Printed Name of Agency Supervisor	Signature	Date

Printed Name of CA Regional Lead	Signature	Date

Note: Please retain a copy of this form for your own records. In addition, please forward a completed and signed copy of this agreement as well as a roster with the names and emails of the staff member(s) who have been selected to attend the EBP training to:

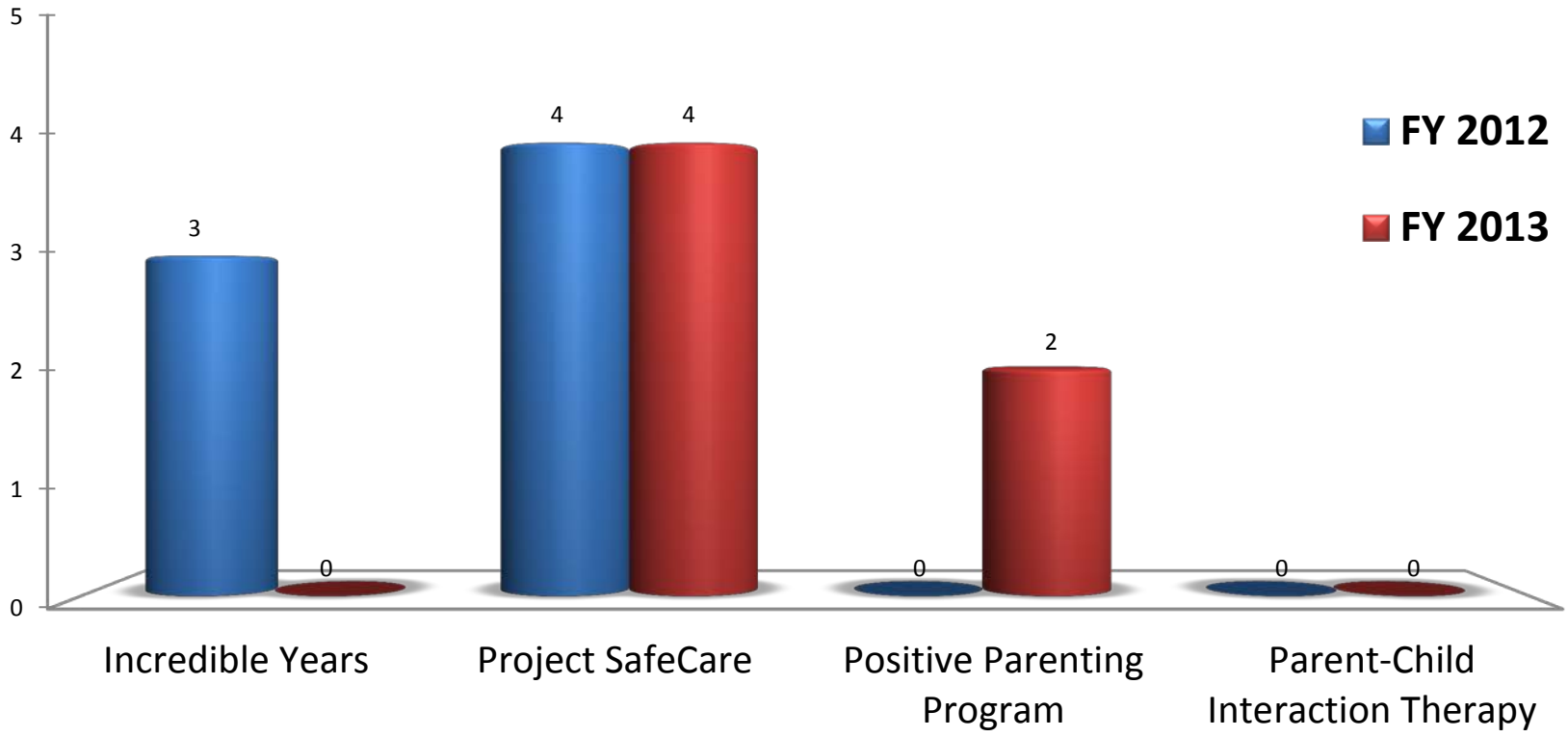
Using Data to Stay on Track

System and project (e.g., providers trained, referral and utilization)

Implementation and Service (e.g., equity of access, fidelity by region, organization, provider, EBP)

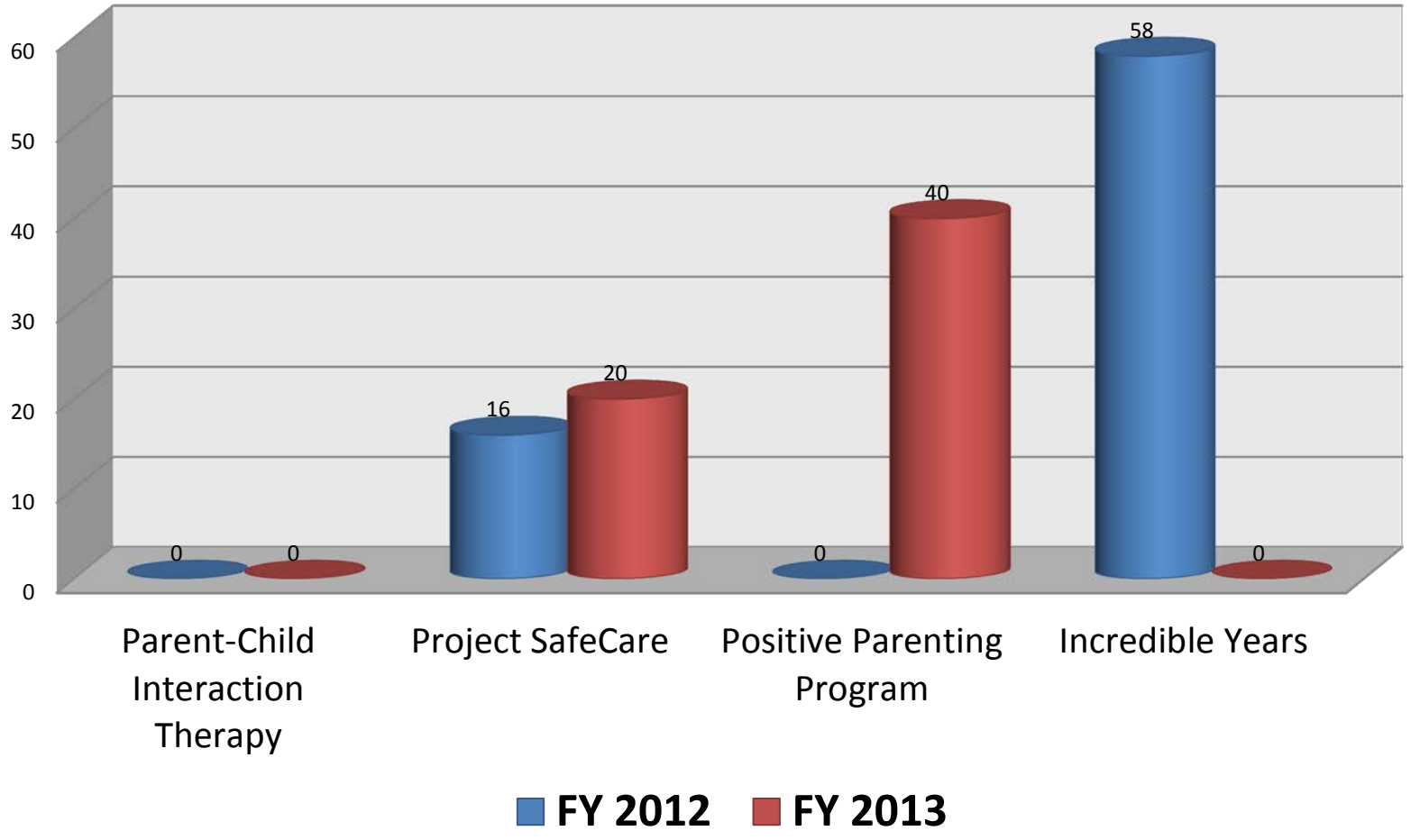
Outcomes (child and family outcomes, system outcomes)

EBP Trainings FY 2012-2013



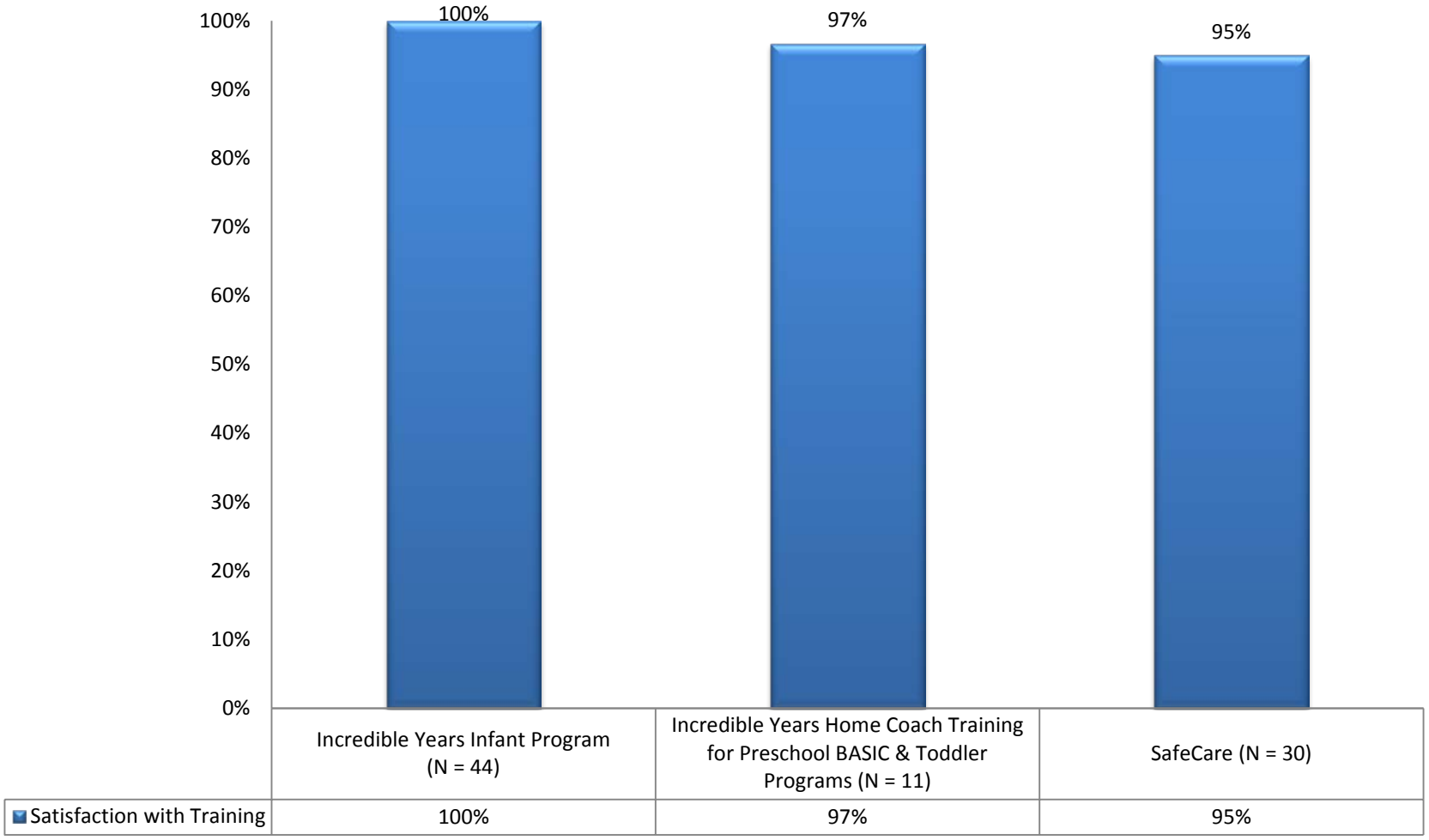
Other EBP Training Activities	# of Activities
SafeCare Coach Training	1
SafeCare Curriculum Update	2

Total # Providers Trained by EBP



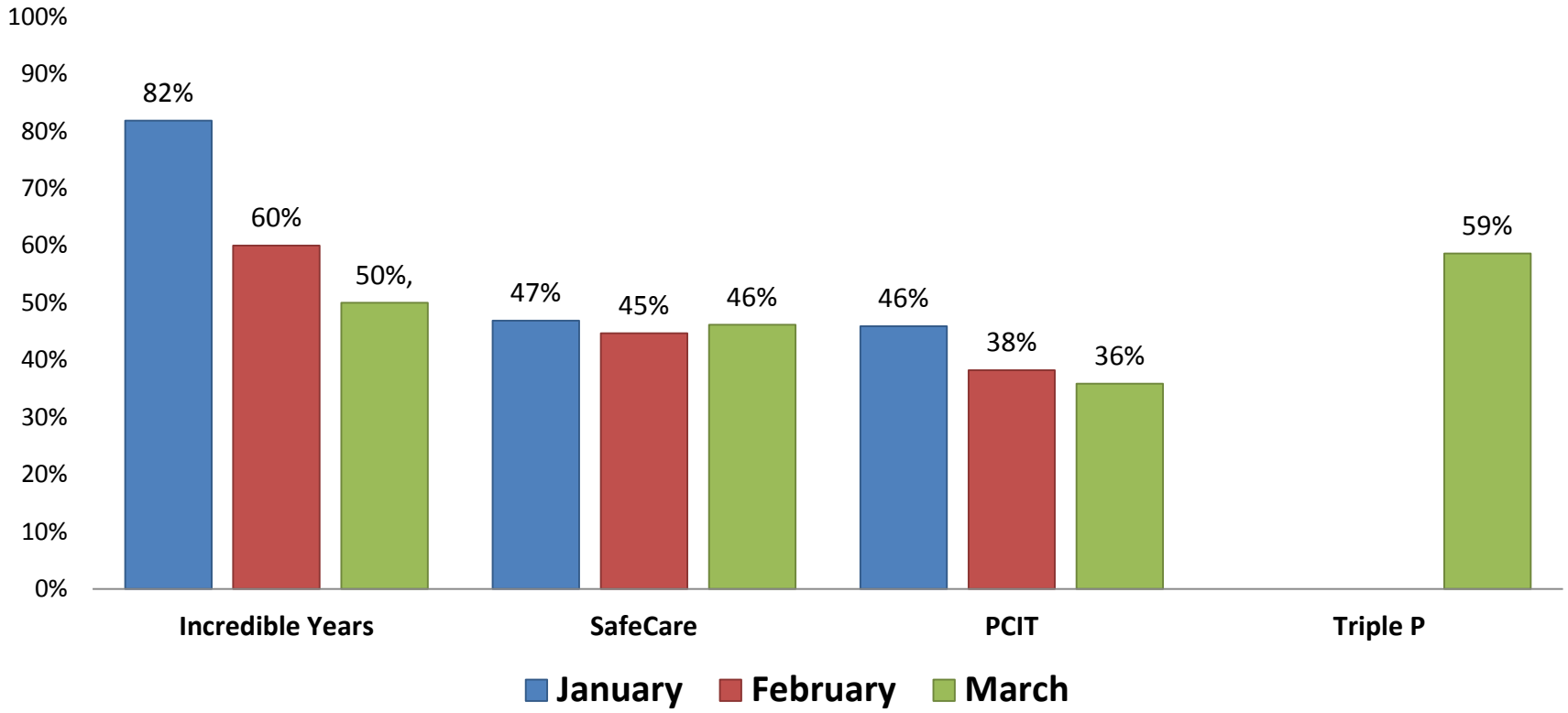
SOURCE: CA-UW EBP Partnership

Provider Satisfaction with EBP Trainings



SOURCE: CA-UW EBP Partnership

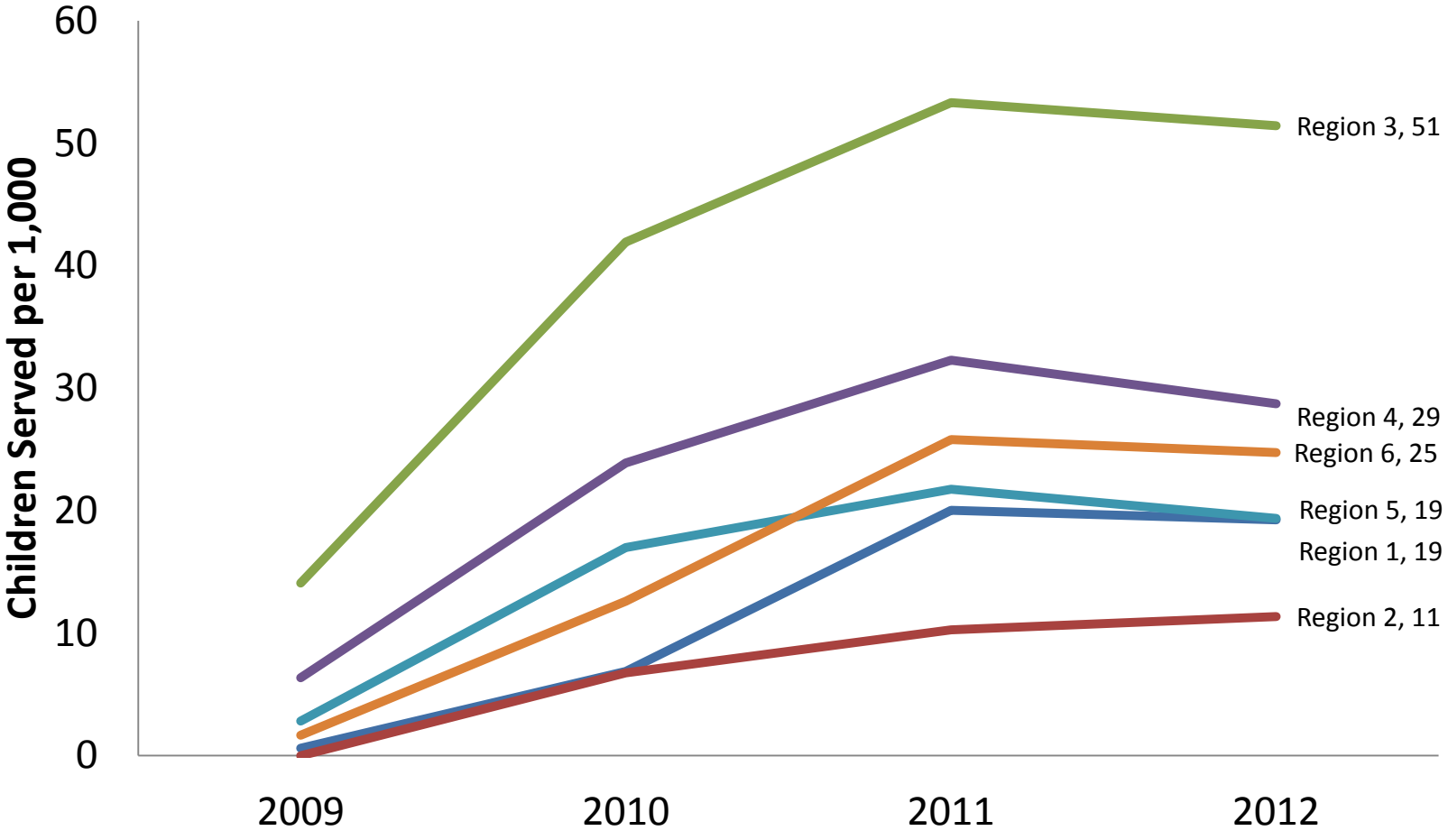
Providers Meeting Fidelity



	PCIT		IY		SafeCare		Triple P	
	Total Active	Meeting Fidelity	Total Active	Meeting Fidelity	Total Active	Meeting Fidelity	Total Active	Meeting Fidelity
January	37	17	44	36	32	15	N/A	N/A
February	34	13	65	39	47	21	N/A	N/A
March	39	14	68	34	52	24	29	17

SOURCE: CA-UW EBP Partnership

Rate of EBP Utilization by N of Children Served
DSHS Regions 2009-2012



* Rates are calculated by dividing the number of children for whom reimbursement was sought for IY, SafeCare, PCIT, and Homebuilders, by the number children with accepted CPS referrals within each region for 2011. **2012 rates do not represent all billings from May-June.**

Lessons Learned

- Central entity for coordinating training and monitoring creates opportunity for efficiencies
- Partnership model provides rich environment for reviewing data, brainstorming ideas, and developing tangible implementation supports
- Jointly developed products and resources have been well-received by child welfare leadership and staff

Lessons Learned

- Maintaining a true spirit of partnership can be challenging
  - Esp. given contractual relationship between CA and UW
- Tension can arise over delineation of roles, e.g.:
  - UW outreach role
  - Who will manage / analyze relevant data
- Different expectations of pace of change
- System is complex and doesn't transform overnight
  - EBP awareness and referral is a perpetual challenge
  - EBP services are only a small part of the enterprise of a child welfare system

Future Priorities

- Continue our emphasis on increasing appropriate referral and utilization of EBPs
- Use data more consistently to inform our efforts and evaluate our collective success
- Take on new EBP expansion opportunities as a partnership
  - e.g., development of appropriate and targeted, short-term, evidence-based models for CA's approach to implementing Family Assessment and Response (FAR)

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