Looking Back, Moving Forward: The History & Current State of Evidence-based Intervention In Pennsylvania

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EXECUTIVE SUMMARY

Nearly two decades ago, the Pennsylvania Commission on Crime and Delinquency (PCCD) began a deliberate effort to bring effective violence prevention programs to communities across the Commonwealth. Through a variety of efforts Pennsylvania has created an infrastructure intended to support the adoption, implementation, and success of select evidence-based programs where they are needed. This infrastructure includes a cross-system Resource Center for Evidence-based Prevention and Intervention Programs and Practices. In 2008, with funding from PCCD and the Office of Children, Youth, and Families (OCYF), the Penn State EPISCenter was established, with the primary goal of advancing high quality implementation, impact assessment, and sustainability of a menu of evidence-based programs identified by the Resource Center, in order to maximize the positive impact for youth, families, and communities.

Evidence-based intervention programs (EBIs) play an important role in the state’s initiative to reduce dependency, delinquency, youth violence, and substance abuse. Programs such as Functional Family Therapy (FFT), Multisystemic Therapy (MST), and Multidimensional Treatment Foster Care (MTFC) provide effective intervention for youth who exhibit behaviors bringing them in contact with the juvenile justice and child welfare systems.

In FY 2011/2012, a total of 3,650 Pennsylvania youth were served by EBIs. The vast majority of these youth were referred by the child welfare and juvenile justice systems, and 60% were at imminent risk of placement, according to the providers who served them. With the support of EBIs, 88% of these youth remained in their communities and 87% had no new offenses at the time of discharge. It is estimated that the state saw an immediate savings of over $16 million related to diversion from placement across the three programs and will experience an economic benefit of $71.4 million resulting from crime reduction due to the use of these programs.

While Pennsylvania has seen a strong return on its investment in EBIs, providers report immediate threats to sustainability that are resulting in significant financial losses for many programs. If left unaddressed, the inevitable result will be program closures and fewer evidence-based options for serving high-risk Pennsylvania youth. Current challenges include underutilization of services, delays in the start of services, administrative requirements that draw from providers’ limited resources, and difficulty accessing adequate funding to cover all aspects of the service.

These challenges are interrelated in complex ways and would be most effectively addressed through collaboration between state leaders, counties, and providers to identify creative and systemic solutions. Policies and regulations that provide a comprehensive approach to supporting the sustainability of EBIs statewide are needed.
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HISTORY OF PENNSYLVANIA’S EBP INITIATIVE

Nearly two decades ago, the Pennsylvania Commission on Crime and Delinquency (PCCD) began a deliberate effort to bring effective violence prevention programs to communities across the Commonwealth. Through a variety of efforts – PCCD grants, transition to Medical Assistance funding, Special Grants from the Office of Children, Youth, and Families (OCYF), and the establishment of the Resource Center for Evidence-Based Programs and Practices – Pennsylvania has created an infrastructure intended to support the adoption, implementation, and success of select evidence-based programs where they are needed.

Goals of the Initiative

- **Preventing** dependency, delinquency, youth violence, and substance abuse to the greatest degree possible (thus reducing the number of individuals who come in contact with the juvenile justice and adult criminal systems).
- **Intervening effectively** with youth for whom primary prevention is not sufficient (thus reducing further penetration into the criminal justice system).
- **Allowing communities flexibility** to select the strategies that will best meet local needs.
- **Providing accountability** and ensuring that scarce resources are used efficiently.

Time-Line of the Initiative

**1994**  **Communities That Care comes to Pennsylvania:** Under the Ridge administration, PCCD, in collaboration with the Juvenile Court Judges Commission, began funding Communities that Care (CTC) as part of a statewide effort to disseminate the model in Pennsylvania. As a public health approach, CTC represented a new model for the way communities and service systems could address youth mental health and behavior problems.

**1996**  **Blueprints for Violence Prevention are identified:** Alongside the Colorado Division of Criminal Justice, Centers for Disease Control and Prevention, and Office of Juvenile Justice and Delinquency Prevention, PCCD provided initial funding for a project at the Center for the Study and Prevention of Violence at the University of Colorado to identify programs that had evidence of meeting the first two goals noted above. The result was the nationally-recognized Blueprints for Violence Prevention Model Programs and Promising Programs. The Model Programs, selected from hundreds reviewed, initially included seven prevention programs and three intervention programs that met explicit and rigorous criteria for evidence of
effectiveness. The criteria include well-designed research studies demonstrating reduction in violence, delinquency, and/or substance use; sustained effects at least one year beyond the end of treatment; and evidence of success at multiple sites.

1998  **The Prevention Research Center evaluates the CTC process:** PCCD approached the Prevention Research Center at Penn State University to conduct a process study of the Communities That Care (CTC) initiative in Pennsylvania. Mark Feinberg, Mark Greenberg, and colleagues found that 1) creating and maintaining well-functioning community prevention coalitions was challenging, particularly since communities had little guidance or expertise on which to draw, and 2) while communities were able to follow the initial steps of the CTC model, they struggled with identifying, funding, and implementing evidence-based programs to address their identified community needs.¹

**PCCD begins funding Blueprints Model Programs:** PCCD established grants to communities wishing to implement evidence-based programs, which addressed one of the challenges noted in the Prevention Research Center evaluation of Communities that Care implementation. With the Evidence-based Program Initiative, Pennsylvania became the first state to fully adopt the Blueprints for Violence Prevention.

In 1999, PCCD awarded its first of many grants for Functional Family Therapy (FFT). The first Multisystemic Therapy (MST) grant was awarded in 2000 and Multidimensional Treatment Foster Care (MTFC) in 2002. Grant funding provided start-up monies that could be used to pay fees to the model disseminators, staff salaries, and other operating expenses, essentially paying the programs’ expenses while they served youth. From 1999 to 2008, grant periods varied from 2 – 4 years. When grants ended, many programs transitioned to county funding, with county juvenile justice or child welfare systems paying for services. Payment arrangements, which varied from county to county, included fee-for-service funding, case-funding, and program-funding.

**Implementation research was just beginning:** While a number of evidence-based programs had been identified, little was known about effective implementation or sustainability of programs. The Prevention Research Center at Penn State was involved in research on this topic – now referred to as Type II Translational research – early on.

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¹ Prevention programs target the general population or at-risk youth to prevent problems from developing, often through skill-building and strengthening protective factors, while intervention or treatment programs are designed to ameliorate problems that have already developed. The three evidence-based intervention programs (EBIs) identified as Blueprints Model Programs are Functional Family Therapy (FFT), Multisystemic Therapy (MST), and Multidimensional Treatment Foster Care (MTFC). These programs serve adolescents who exhibit serious behavior problems or delinquency and all have been shown through research to result in lower rates of recidivism, reduced substance use, improved behavior, and decreased out-of-home placement when compared to alternative treatments.
2005 - Medical Assistance began funding FFT and MST: Around 2005, a significant funding shift at the state level directly impacted funding for the evidence-based interventions (EBIs). Through a process called the Integrated Children’s Service Initiative (commonly referred to as M.A. Realignment), the Pennsylvania Department of Public Welfare asked counties to identify programs that were being paid for with county funds but were eligible for Medical Assistance (Medicaid). In other words, counties were asked to identify treatment programs for which counties were currently paying so that those programs, if they met state requirements, could become enrolled in and paid for by Medical Assistance (M.A.). Attorney Richard Gold, acting as a consultant to DPW, worked with counties and providers throughout the transition. MST and FFT programs were soon identified as treatment programs eligible for M.A. funding. In 2005, two FFT providers and two MST providers were approved for M.A. funding. Within two years this number increased to 8 FFT providers and 10 MST providers.

During this time, a statewide transition to HealthChoices occurred, with all 67 counties implementing a mandatory managed care program for Medical Assistance recipients. In Pennsylvania, each of the 67 counties now contracts with one of five Behavioral Health-Managed Care Organizations (BH-MCOs) that manage the administration of M.A. Consequently, the rate and manner of reimbursement for services and certain policies and procedures vary from county to county.

2007

PCCD funding for EBIS ends: PCCD awarded its final grants for EBIs. Because other funding had become available for the three intervention programs (FFT, MST, and MTFC), they were removed from the list of programs that could receive EBP Grants from PCCD.

Medical Assistance begins funding MTFC: In November 2008, OMHSAS granted its first approval for M.A. funding of the treatment components of MTFC. MTFC was slower to transition to M.A. funding than the other EBIs, as the state worked to ensure compliance with federal regulations that allow M.A. to be used only for treatment costs. Counties continue to pay for the room and board and foster care components of MTFC, while the treatment costs are covered by M.A.

OCYF establishes Special Grants for EBIs: Richard Gold was appointed Deputy Secretary of the Office of Children, Youth, & Families. He carried his belief in evidence-based practices and the positive impact they could have on families to his new position. In FY 2008/2009 OCYF established Special Grants for evidence-based interventions. Special Grants are requested by counties as part of their annual Needs Based Plan and Budget and are earmarked for one or more EBIs identified by the county. These funds can be used to cover a range of expenses associated with the program. Special Grants were intended to play an important role in filling funding gaps, such as paying for services to begin while a youth obtains prior authorization for M.A. funding, paying for services for youth who were not M.A.-eligible, or covering costs that
are not allowable under M.A.. Furthermore, by requiring a much lower county funding match than items in the general county budget, Special Grants were designed to make EBIs an attractive alternative to existing services that do not have the same evidence of effectiveness.

The Resource Center for Evidence-Based Prevention and Intervention Programs and Practices is established: The Resource Center, which is managed by PCCD, is tasked with promoting and coordinating the use of research-based practices to address public health issues in Pennsylvania. The Resource Center brought together the various entities that were becoming involved with EBPs to work collaboratively and coordinate efforts. Its current membership includes leaders from the Pennsylvania OMHSAS, OCYF, Department of Education, Department of Drug and Alcohol Programs, and Liquor Control Board; the Juvenile Court Judges Commission; the Council of Chief Juvenile Probation Officers; and PCCD. The Resource Center Steering Committee meets quarterly to establish priorities, review progress, and discuss new data on the implementation and impact of EBPs.

Through a 4-year grant awarded in 2008, the Resource Center was initially comprised of two components 1) the Evidence-Based Prevention and Intervention Support Center (EPISCenter) at The Pennsylvania State University and 2) the Quality Improvement Initiative (Qii) managed by the National Center for Juvenile Justice. The Qii was aimed at identifying promising juvenile justice programs and practices that have not yet been rigorously evaluated, while the EPISCenter focused on supporting the dissemination and implementation of a menu of specific evidence-based programs.

2012  The Resource Center is funded for another grant cycle: July 2012 marked the beginning of a second 4-year grant for the Resource Center. Under the current grant, the EPISCenter is the primary entity responsible for carrying out the activities of the Resource Center. Responsibilities of the EPISCenter include supporting community prevention coalitions, supporting select EBPs, and improving the quality of juvenile justice programs and practices.

Human Services Block Grants are piloted in 20 counties: Human Services Block Grants consolidate several lines of funding to a county, including Special Grant funds, into a single appropriation in an effort to provide counties great flexibility in how funds are used locally. Twenty counties are participating in the pilot, which began July 1, 2012.
FUNDING OF EBIs

Currently, funding for EBIs in Pennsylvania comes from two primary sources: Medical Assistance and county funding. County funding may take the form of Special Grants or come from Human Services Block Grants. On occasion, counties use monies from the county needs-based budget. Knowledge of these funding streams provides a context for understanding EBI implementation in Pennsylvania.

**Medical Assistance (M.A.)**

With just one exception, every EBI program currently operating in Pennsylvania is M.A.-enrolled. FFT, MST, and MTFC are approved for M.A. funding under the umbrella of Behavioral Health Rehabilitation Services and fall into the category of “outpatient wraparound mental health services not currently on the M.A. fee schedule.” (The M.A. fee schedule establishes rates and billing codes for services that are identified in Pennsylvania’s State Plan.) As such, the EBIs are governed by a regulatory bulletin, Medical Assistance Bulletin 1153-95-01, that identifies a number of requirements for program eligibility:

- Submission and approval of a service description by the Office of Mental Health and Substance Abuse Services (OMHSAS).
- Provider holds a base mental health license (i.e., outpatient psychiatric clinic, partial hospitalization, or family based mental health services license).

When MST and FFT programs were first targeted for M.A. funding, several providers (who had begun implementation under funding from PCCD) did not hold the base mental health license required by Pennsylvania to enroll in and be funded by the M.A. system. This obstacle was addressed through waivers granted by the Secretary of the Pennsylvania Department of Public Welfare to individual MST and FFT programs, noting that the close oversight and certification provided by the national model disseminators served as an assurance that the program would meet acceptable treatment standards, comparable to the assurance provided by a state-issued license. Furthermore, as part of this process programs that receive waivers undergo annual site reviews by OMHSAS, comparable to a licensing visit, and the continuation of a waiver is dependent on the outcome of the review.

MTFC providers must hold both a base mental health license and a Community Rehabilitation Residential Host Home license from the OMHSAS, in addition to the foster care license required by the Office of Children, Youth, & Families. OMHSAS has not granted waivers to MTFC providers, primarily because the national model disseminator’s involvement with a site decreases significantly once a site obtains certification, limiting the amount of clinical oversight provided.

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*The exception is an MTFC site run by Venango County Children and Youth Services which is grant-funded by PCCD until June 30, 2013. Because the county does not hold a base mental health license, it has not been eligible for Medical Assistance reimbursement.*
In order for a youth to receive M.A. funding for one of the three EBIs, services must be *prior authorized* by the appropriate BH-MCO or the OMHSAS Fee-For-Service program. The youth must meet eligibility criteria in the program’s OMHSAS-approved service description and any criteria adopted by their BH-MCO, as well as the following:

- Evaluation by a psychologist or psychiatrist to establish medical need for the service. This includes a psychiatric diagnosis.
- Treatment planning by an interagency service planning team (ISPT) with representation from all systems with which the youth is involved. The team must recommend the service as well as identify treatment goals.

In some regions, processes have been put in place to expedite the start of services under M.A. funding. Specifically, some BH-MCOs pre-certify services based on a service prescription signed by a psychologist or physician, but the youth must obtain a full evaluation and an ISPT must be convened within a certain time frame (4-6 weeks) in order for funding to continue.

Billing Medical Assistance also requires that providers comply with state regulations and policies pertaining to billing, documentation of services, hiring, training, and so forth.

**Special Grants**

As noted above, Special Grants for EBIs were implemented by the Office of Children, Youth, and Families beginning in FY 2008/2009 to supplement Medical Assistance funding and fill funding gaps. Counties must request this funding on an annual basis.

At an October 2010 forum to identify current challenges faced by EBIs, providers and county stakeholders noted confusion regarding how Special Grant funds were to be used. In response, OCYF partnered with OMHSAS, PCCD, and JCJC to issue a letter clarifying the purpose of the funds, what the funds can pay for, and what information should be included in contracts between County Children & Youth Agencies and providers. The letter is available on-line at [http://www.episcenter.psu.edu/resources/DPW](http://www.episcenter.psu.edu/resources/DPW)

The number of counties accessing Special Grant funding is illustrated in the figure on the next page. The number of counties requesting funding and the total amount awarded increased dramatically from FY 2008/2009, the first year such funding was available, to FY 2009/2010. However, the number of counties and amount awarded then decreased in FY 2010/2011, likely due to program closures and counties having requested newly available funding without clear processes for utilizing the monies or without fully understanding what was required to implement an EBI. The decrease in the total amount awarded was also due largely to under spending by counties in the previous year combined with a protracted state budget impasse. The number of counties requesting funding increased the following two periods. **In each fiscal year, counties’ actual expenditures have been significantly less than the funding**
awarded (ranging from $1.2 million to $3.5 million). Actual expenditures for FY 2011/2012 have not been finalized.

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**Number of Counties Receiving Special Grant Funds for an EBI**

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Number of Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY '08/09</td>
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<tr>
<td>FY '09/10</td>
<td>54</td>
</tr>
<tr>
<td>FY '10/11</td>
<td>49</td>
</tr>
<tr>
<td>FY '11/12</td>
<td>53</td>
</tr>
<tr>
<td>FY '12/13 (Requested)</td>
<td>56</td>
</tr>
</tbody>
</table>

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**Special Grant Funding: Awards & Expenditures**

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Awards</th>
<th>Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2008/2009</td>
<td>$5.5</td>
<td>$2.7</td>
</tr>
<tr>
<td>FY 2009/2010</td>
<td>$8.6</td>
<td>$5.1</td>
</tr>
<tr>
<td>FY 2010/2011</td>
<td>$5.7</td>
<td>$4.5</td>
</tr>
<tr>
<td>FY 2011/2012</td>
<td>$6.4</td>
<td></td>
</tr>
</tbody>
</table>
**Human Services Block Grant**

As of July 1, 2012, the Human Services Block Grant is being piloted in 20 counties, 16 of which have at least one EBI program in place. The Human Services Block Grant consolidates several lines of county funding, including Special Grants, into a single appropriation to the county. It does not include the Behavioral Health HealthChoices Program (managed care for Medical Assistance) or the County Child Welfare Needs Based Budget.

The Block Grant is intended to give counties greater flexibility to meet local needs. It is unclear how the shift to Block Grants may impact EBIs. Special Grant funds created a direct financial incentive for counties to utilize EBIs, by requiring counties to match only 5% of funding from the state and earmarking money in county budgets specifically for EBIs. On the other hand, because Special Grants make available designated monies for an EBI, counties are often reluctant to utilize other sources of county funding once a Special Grant has been exhausted, and counties must plan funding over a year in advance, making it difficult to respond in a timely manner to needs that emerge.

Counties participating in the Human Services Block Grant pilot are:

- Allegheny
- Beaver
- Berks
- Bucks
- Butler
- Centre
- Chester
- Crawford
- Dauphin
- Delaware
- Erie
- Franklin
- Fulton
- Greene
- Lancaster
- Lehigh
- Luzerne
- Tioga
- Venango
- Wayne
THE EPISCENTER

The Evidence-based Prevention and Intervention Support Center (EPISCenter) was established in 2008 as a component of the Resource Center for Evidence-based Prevention and Intervention Programs and Practices. The EPISCenter, which is housed within the Prevention Research Center (PRC) at Penn State, is funded by the Pennsylvania Commission on Crime and Delinquency (PCCD) and the Office of Children, Youth, and Families.

History of the EPISCenter

The role of the EPISCenter may be best understood by looking back at its evolution, beginning with the early partnership between the PRC and PCCD. As noted in History of Pennsylvania’s EBP Initiative, the relationship between these two entities dates back over a decade to the late 1990’s when the PRC conducted an evaluation of the Communities That Care initiative and Drs. Greenberg and Feinberg noted that communities often struggled with selecting and implementing evidence-based programs that would meet their areas of need.

When PCCD began funding evidence-based programs, communities often had questions and needed assistance related to implementation. In response, in 2001 PCCD contracted with the Prevention Research Center to fund one full-time equivalent whose job it was to provide technical assistance to PCCD grantees. Over the next six years, based largely on data collected by the PRC, this technical assistance became more focused.

Around the same time, the PRC conducted an evaluation of the strengths and weaknesses of the EBP Initiative, administering surveys to existing grantees. In November 2002 the PRC presented its findings and recommendations to PCCD. The PRC identified several areas of need:

- Better understanding of program logic models by grantees, so that sites do not make program adaptations that compromise outcomes.
- Better access to training and follow-up technical assistance (TA), particularly program-specific TA.
- Local measurement of implementation quality.
- Learn more about what programs look like “in the trenches” and the characteristics that impact quality implementation and program sustainability beyond the grant period.

The PRC recommendations included visits to grantee sites, more active and coordinated TA, building relationships with model developers, and applying existing research findings.

Over the next five years, the PRC continued to provide assistance to grantees, utilizing data to direct and focus that TA. It also continued to refine its survey of sites, which has evolved into the web-based Annual Survey of Evidence-based Programs (ASEP). The ASEP is administered to past and current PCCD grantees and provides valuable information about the factors impacting program sustainability.
In 2007, PCCD issued a request for proposals for a center that would support the Evidence-based Initiative in Pennsylvania through proactive technical assistance and data collection for providers of evidence-based programs. The grant was awarded to the EPISCenter, a new project housed within the Prevention Research Center. The grant is managed by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) and overseen by the Resource Center Steering Committee for Evidence-based Prevention and Intervention Programs and Practices.

**Goals & Activities of the EPISCenter**
The EPISCenter has the primary goal of advancing high quality implementation, impact assessment, and sustainability of a menu of evidence-based programs identified by the Resource Center, in order to maximize the positive impact for youth, families, and communities.

To this end, the EPISCenter works to:
- **Direct outreach and advocacy efforts** at federal, state, and community levels to foster recognition of the value and impact of proven prevention and intervention programs.
- **Provide training and technical assistance** to communities to improve implementation quality, promote the collection and use of program impact data, and foster proactive planning for long-term program sustainability.
- **Develop resources and facilitate peer networking** to disseminate current prevention science research and promote effective practice.
- **Conduct original research** to inform more effective practice, dissemination, and implementation of evidence-based programs.

**The Framework**
The EPISCenter understands its partnership with state partners, local practitioners, and researchers using a conceptual model that builds upon the Interactive Systems Framework developed by Wandersman and colleagues. (See Figure 1 on next page.)

In this expanded model, the EPISCenter serves as the bridge between systems that conduct research and synthesize this knowledge into interventions (such as the Prevention Research Center); practitioners and providers that deliver services to youth and families; and the macro-system of funders and policy-makers (such as Pennsylvania’s Resource Center Steering Committee). Thus, the EPISCenter plays a fundamental role in connecting science to policy and practice, by utilizing the most current research when providing technical assistance to providers and facilitating the use of input from researchers and practitioners to guide policy and funding decisions.

A more detailed explanation of this framework can be found in a 2011 journal article by Brian Bumbarger and Liz Campbell.
Figure 1. Conceptual model for the EPISC Center.

**Technical Assistance for Evidence-based Interventions**

During its first four years, the EPISC Center responded to almost 3,000 technical assistance (TA) requests and provided over 200 trainings in support of Communities That Care and the 11 evidence-based programs on its menu. Staff also conducted 400+ site visits and consultations to PCCD grantees, many culminating in formal TA plans. The EPISC Center website, which had over 27,000 visits from January 2010 to June 2012, has grown to include a large number of program-specific resources that can be accessed by communities and providers.
EPISCENTER staff who support the 8 prevention programs work primarily with PCCD grantees and have collaborated with program developers to create tools that grantees can use to ensure quality implementation and monitor adherence to the prevention models.

Because the three intervention programs (EBIs) — Functional Family Therapy, Multisystemic Therapy, and Multidimensional Treatment Foster Care — are treatment models with a high degree of clinical oversight from national entities responsible for dissemination and are no longer funded by PCCD, the support provided by the EPISCENTER to these programs has a different emphasis. The assistance requested by EBI providers often relates to data collection, understanding state policies and regulations, navigating relationships with county stakeholders and Behavioral Health Managed Care Organizations, accessing funding, and handling the administrative requirements associated with M.A. funding. The EPISCENTER has contact with all 27 providers currently implementing EBIs in Pennsylvania, all of whom attend regularly scheduled networking meetings.

Support to the EBIs includes:

- **Provider networking meetings**, primarily held face-to-face but also including phone conferences. These meetings are designed to facilitate information-sharing, provide opportunities for training, and identify challenges experienced by providers so that problem-solving can occur. Meetings occur regularly, with the frequency and format tailored to the unique needs and desire of each provider group.
- **Site visits and consultations** are provided to all PCCD grantees (there is currently one remaining grantee for MTFC) and to other providers as needed.
- **Technical assistance** to providers and communities regarding implementation. TA takes a variety of forms, from sharing of resources to facilitating meetings with county stakeholders to problem solve barriers to program sustainability.
- **Development of resources and reports**, which are available on-line. Resources range from FAQs and logic models for each program to reports of EBI outcomes and the impact of EBIs on placement rates in Pennsylvania.
- **Facilitating conversations between model disseminators and state partners**. For instance, the EPISCENTER facilitated meetings between the OMHSAS Children’s Bureau and FFT Inc. to develop a treatment plan template and sample treatment plan requested by providers. The treatment plan was then presented to providers at a networking meeting, with opportunity for questions and discussion.
**EBI Data Reporting & INSPIRE**

The EPISCenter has developed a web-based data collection and reporting system called INSPIRE to assist EBI providers with collecting and analyzing data on implementation quality and client outcomes. INSPIRE (INtegrated System for Program Implementation and Real-time Evaluation) serves two important functions:

- Provide sites with a system for collecting, storing, and analyzing client- and program-level data, facilitating the process of data reporting to the state.
- Provide consistent, reliable, and valid statewide data on program implementation and outcomes. Data from INSPIRE can be aggregated across sites and across programs to provide state funders and policy makers with valuable information about the quality and overall impact of Pennsylvania’s investment in EBIs.

INSPIRE was launched in the spring of 2011. The EPISCenter engages in a number of activities related to providers’ use of INSPIRE and quarterly data reporting:

- Initial and on-going training for INSPIRE users.
- Technical assistance for questions ranging from log-in difficulty to identifying the reason for a data error to interpretation of reports.
- The development of resources to aid providers with data collection and understanding the INSPIRE system. Each program has a web-page devoted to INSPIRE resources, including a general FAQ, User Screen Guides, reporting protocols, data collection worksheets, and an explanation of how outcomes are calculated in the INSPIRE Data Highlights Report. An example can be found at [http://www.episcenter.psu.edu/node/163](http://www.episcenter.psu.edu/node/163).
- Coordination of quarterly reporting from all sites.
- Creating statewide reports that highlight the impact of FFT, MST, and MTFC in Pennsylvania.

More information about INSPIRE can be found in the on-line FAQ at [http://www.episcenter.psu.edu/sites/default/files/ebp/FAQ%20for%20INSPIRE%202012.pdf](http://www.episcenter.psu.edu/sites/default/files/ebp/FAQ%20for%20INSPIRE%202012.pdf)
EBI IMPACT IN PENNSYLVANIA

The impact of evidence-based interventions in Pennsylvania is presented in three areas: youth outcomes, impact on placement rates, and cost savings.

Youth Outcomes, FY 2011/2012

The tables and graphs below summarize INSPIRE data for the three EBIs for FY 2011/2012. More detailed analysis, including data for FY 2010/2011, can be found in outcomes summaries available on the EPISCenter website at [http://www.episcenter.psu.edu/EBIReports](http://www.episcenter.psu.edu/EBIReports).

- Across all three programs, a total of **3,650 youth** were served.
- The vast majority of referrals come from the child welfare and juvenile justice systems.
- Over 1,600 newly enrolled youth were deemed by providers to be at imminent risk of placement outside the home or, in the case of MTFC, a more restrictive placement.

<table>
<thead>
<tr>
<th>Youth Served (FY 2011/2012)</th>
<th>FFT</th>
<th>MST</th>
<th>MTFC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Providers (FFT, MST) or Sites (MTFC) Reporting</td>
<td>10</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>Youth Served</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New youth enrolled</td>
<td>1,052</td>
<td>1,610</td>
<td>22</td>
</tr>
<tr>
<td>New parents/caregivers served</td>
<td>882&lt;sup&gt;c&lt;/sup&gt;</td>
<td>1,655</td>
<td>31</td>
</tr>
<tr>
<td>Percent of youth enrolled who were at imminent risk of being placed in a more restrictive setting</td>
<td>33%</td>
<td>78%</td>
<td>59%</td>
</tr>
<tr>
<td>Total youth served (new and previously enrolled cases)</td>
<td>1,417</td>
<td>2,201</td>
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<table>
<thead>
<tr>
<th>Referral Sources</th>
<th>FFT</th>
<th>MST</th>
<th>MTFC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Welfare</td>
<td>16%</td>
<td>38%</td>
<td>53%</td>
</tr>
<tr>
<td>Juvenile Justice</td>
<td>53%</td>
<td>46%</td>
<td>42%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>8%</td>
<td>8%</td>
<td>5%</td>
</tr>
<tr>
<td>Education</td>
<td>4%</td>
<td>4%</td>
<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>19%</td>
<td>4%</td>
<td>0%</td>
</tr>
</tbody>
</table>

<sup>c</sup> For FFT the number of parents/caregivers is lower than the number of youth enrolled due to measurement issues and underreporting. Further explanation is provided in the FY 2010/2011 Outcomes Summary available at [http://www.episcenter.psu.edu/resources/PRCmainresearch/researchreports](http://www.episcenter.psu.edu/resources/PRCmainresearch/researchreports).
Youth Discharged  
(FY 2011/2012)

<table>
<thead>
<tr>
<th></th>
<th>FFT</th>
<th>MST</th>
<th>MTFC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of youth discharged(^d)</td>
<td>1,102</td>
<td>1,676</td>
<td>25</td>
</tr>
<tr>
<td><strong>Discharge Type</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrative withdrawals (as a % of total)</td>
<td>13%</td>
<td>14%</td>
<td>16%</td>
</tr>
<tr>
<td>Clinical discharges (as a % of total)</td>
<td>87%</td>
<td>86%</td>
<td>84%</td>
</tr>
<tr>
<td>Successful (as a % of clinical)</td>
<td>66%</td>
<td>72%</td>
<td>52%</td>
</tr>
<tr>
<td>Unsuccessful (as a % of clinical)</td>
<td>34%</td>
<td>28%</td>
<td>48%</td>
</tr>
<tr>
<td><strong>Average Length of Stay (in months)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For youth successfully discharged</td>
<td>3.8</td>
<td>4.6</td>
<td>7.3</td>
</tr>
<tr>
<td>For youth unsuccessfully discharged</td>
<td>3.0</td>
<td>3.8</td>
<td>3.1</td>
</tr>
</tbody>
</table>

The category of administrative withdrawals is intended to capture youth discharged prior to completing the program for non-clinical reasons that are outside of the program’s control (e.g., the family moving, loss of funding, youth is placed for an event that occurred prior to program enrollment). Pennsylvania utilizes stringent definitions of success, which vary across the three programs. “Success” is generally defined as both completion of the program and the achievement of certain goals identified by each model.\(^e\)

*When comparing data across the three programs, please note that the populations served by each program vary and therefore outcomes may not be directly comparable across the three programs.* While there is significant overlap in the populations served, particularly for FFT and MST, there may also be overall differences in the severity of the population served (as reflected in the percent at risk for placement) and client risk factors.

\(^d\) Total number of youth discharged is a sum of successfully, unsuccessfully, and administratively withdrawn youth.

\(^e\) Definitions of success are as follows. **MST:** Youth completes MST and achieves all three of the Ultimate Outcomes targeted by the model. **FFT:** Family completes the 3 phases of FFT and the youth meets the threshold for satisfactory ratings on outcome measures completed by the youth, family, and therapist. Therapist may override these ratings and indicate a positive outcome, if clinically warranted. **MTFC:** Youth moves successfully through the Point & Level system, achieves treatment plan goals, and is discharged to a less restrictive placement.
Youth Outcomes at Discharge
(FY 2011/2012)

*These outcomes are reported only for youth who were identified with this problem at enrollment. Substance use outcomes were not reported for any youth discharged from MTFC during FY 2011/2012.

Impact on Placement Rates

Over the past decade Pennsylvania has seen significant growth in the number of EBI programs, as well as an increase in the number of counties where such services are available. At the same time, the number and rate of placements have declined across all service systems – juvenile justice, child welfare, and mental health. Are these two phenomena related? Data suggests they are: **As a group, counties that adopted EBIs saw a decrease in placements over a 6-year period, while counties that did not adopt an EBI saw no change or even increases in juvenile justice and child welfare placement rates.**

More detailed information is available at [www.episcenter.psu.edu/sites/default/files/ebp/Placement%20Data%202012.pdf](http://www.episcenter.psu.edu/sites/default/files/ebp/Placement%20Data%202012.pdf) and interactive maps on the EPISCenter web-site provide a valuable tool for looking at county placement rates over the past 7 years. These e-maps can be accessed at [www.episcenter.psu.edu/emaps](http://www.episcenter.psu.edu/emaps)
Economic Benefits

It is estimated that in FY 2011/2012 Pennsylvania saw an immediate savings of over $16 million as a result of diverting youth from placement through the use of EBIs. This is based on a comparison of two cost estimates using data for youth who were clinically discharged from an EBI in FY 2011/2012:

- Potential placement costs: The cost of simply placing the 1,148 youth who were at risk of placement and not serving those who were not at risk.
- Actual service and placement costs: The cost of sending 2,427 youth through an EBI at full cost plus the cost of placement for 282 youth who were placed upon discharge.

Another economic benefit of evidence-based intervention is related to the potential longer-term savings associated with reductions in crime, including savings related to cost to victim and cost of crime (incarceration, etc.). Based on all youth discharged from an EBI in FY 2011/2012, the total economic benefit resulting from crime reduction is estimated at $71.4 million. If we take a more conservative approach and only include youth successfully discharged during that same period, the economic benefit associated with reductions in future crime is still over $41 million.

<table>
<thead>
<tr>
<th>Program</th>
<th>Benefit-Cost per Youth (2011$)</th>
<th>Youth Discharged FY 2011/2012</th>
<th>Estimated Economic Benefit (crime reduction)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFT</td>
<td>$35,483</td>
<td>1,102</td>
<td>$39,102,266</td>
</tr>
<tr>
<td>MST</td>
<td>$18,135</td>
<td>1,676</td>
<td>$30,394,260</td>
</tr>
<tr>
<td>MTFC</td>
<td>$76,064</td>
<td>25</td>
<td>$1,901,600</td>
</tr>
</tbody>
</table>

More information about cost savings related to placement diversion and crime reduction can be found in the FY 2011/2012 Outcomes Summary at www.episcenter.psu.edu/resources/PRCmainresearch/researchreports

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† Estimated placement savings is based on data available at the time of this report and will be updated when data regarding the cost of private residential placements and average length of placement are available. Placement cost per youth is based on the average per diem for YDC/YFC placement in FY 2011/2012 (OCYF Bulletin 00-11-02). A very conservative approach of 90 days per placement was used.

§ EBI program cost per youth is based on average across providers or sites for each program, using BH-MCO rates as reported by providers and average length of stay for successful cases in FY 2011/2012. For MTFC, program cost includes room and board.

|h The estimated benefit-cost per youth was based on benefit-cost from the 2008 Prevention Research Center report, The Economic Return on PCCD’s Investment in Research-based Programs, translated into 2011 dollars using the Consumer Price Index. The 2008 report is available at www.episcenter.psu.edu/sites/default/files/resources/PCCD_Report2.pdf
A significant concern with the implementation of any EBI is sustainability. Considerable energy and resources are often dedicated to the start-up of a program. Does that investment have a short-lived return? Or have resources been invested in a program that continues to have a lasting impact on the community? Sustainability is a common challenge for any evidence-based prevention or intervention program, particularly when grant funding ends and the program must access other means of support.

The past 15 years have seen considerable strides in the dissemination, implementation, and support of EBIs across Pennsylvania. The Commonwealth expanded from a single FFT site in 1999 to 8 FFT sites, 47 MST teams, and 4 MTFC sites as of July 1, 2012. The pattern of sustainability has been different for each of the three EBIs.¹

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¹ Sustainability data is presented as of July 1, 2012.
- **Multisystemic Therapy:** Over the past decade MST has seen a steady increase in the number of teams in Pennsylvania. MST has an overall sustainability rate of 80% (47 of 59 teams). MST has generally enjoyed a high level of buy-in from county probation offices. In addition, many teams were established after M.A. funding began in 2005.

- **Functional Family Therapy:** FFT has gone through periods of growth, followed by program closures. When FFT Inc. implemented a more formal process for clinical oversight and monitoring of program fidelity, several sites that had been established using PCCD grants earlier in the decade closed. Later, sites struggled with the transition from county funding and PCCD grant funding to M.A., which culminated in nine site closures between 2008 and 2011. While the EPISCenter provided active technical assistance to several of these sites in 2010 and 2011, many were unable to overcome challenges with low referrals, inadequate revenue, county buy-in, and/or competition from other programs (most often Family-Based Mental Health Services or MST). FFT has an overall sustainability rate of 30% (8 of 27 sites).

On a positive note, many of the remaining sites have resolved significant challenges over the past 2 ½ years ago. The EPISCenter provided technical assistance to several FFT sites, developed FFT-related resources to help providers advocate for their programs, and shared the concerns of FFT providers with state partners. Some sites were successful in obtaining higher rates from their BH-MCO, increasing the rate of referrals through collaboration with their counties and outreach to other potential referral sources, and developing a mechanism for immediate authorization from the BH-MCO (therefore reducing cost to the county).

- **Multidimensional Treatment Foster Care:** Historically, MTFC sites have struggled to sustain in Pennsylvania. A spike in the number of programs in 2008 and 2009, related to programs beginning under the final PCCD grants for evidence-based interventions, was followed by a period of numerous closures. Providers have been unable to generate enough referrals to keep their programs open and to recruit enough treatment parents to place the youth who are referred. The overall sustainability rate for MTFC in Pennsylvania is 36% (4 of 11). While one new site was established in July 2012, two sites are in the process of closing.
CURRENT CHALLENGES

The section *Program Impact* highlights the many benefits experienced by Pennsylvania from the implementation of FFT, MST, and MTFC:

- Positive outcomes for youth and families served.
- Many youth are able to remain in their homes, avoiding the negative trajectory associated with placement.
- Immediate cost savings associated with diversion from placement.
- Long-term savings associated with crime reduction.

In this section we highlight the challenges currently face EBIs, which not only pose a significant threat to sustainability but also directly impact the youth served.

**Underutilization**
Data from the past fiscal year, along with reports from providers, show that EBIs are being underutilized in Pennsylvania – the number of youth served is less than the capacity that currently exists.

<table>
<thead>
<tr>
<th>Program</th>
<th>Number of Youth Enrolled</th>
<th>Estimated Annual Capacity</th>
<th>Enrollments/Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFT</td>
<td>1,052</td>
<td>1,610</td>
<td>65%</td>
</tr>
<tr>
<td>MST</td>
<td>1,610</td>
<td>2,413</td>
<td>67%</td>
</tr>
<tr>
<td>MTFC</td>
<td>22</td>
<td>80</td>
<td>28%</td>
</tr>
</tbody>
</table>

Underutilization not only impacts program viability by creating financial challenges, but also suggests that in any given community either 1) capacity is not matched to need, or 2) existing programs are not being utilized fully in spite of the benefits they could provide the community.

A number of factors may be responsible for underutilization of EBIs. One reason – delay in the onset of services – is discussed below. Additional reasons include:

- Insufficient buy-in from key local stakeholders.
- Weak mechanisms for translating the investment of county leaders into referrals from county staff.
For MTFC specifically, limits on the target population cause referrals to be turned away, and providers have difficulty recruiting a sufficient number of qualified MTFC parents so that referrals can be matched to appropriate families.

Competition from other services in the community. In many cases, these services are not evidence-based but have strong buy-in from referral sources.

**Delayed Start of Services**

OCYF Special Grants were initiated in order to fill funding gaps that could not be covered by Medical Assistance, including the cost of services delivered prior to M.A. authorization. In reality however, many providers report that the start of services is delayed while they await M.A. authorization for a youth. Depending on the Behavioral Health Managed Care Organization and its protocols, as well as whether a youth is covered by M.A. at the time of referral, this can take anywhere from a few days to several weeks.

The impact of service delays is significant:

- Negative impact on model fidelity, particularly for FFT and MST which are designed to start quickly (i.e., within days of referral).
- Family motivation may be highest at the time of referral. Providers report that families become more difficult to engage as time elapses between referral and the start of services.
- Referral sources opt to refer youth to services that can begin immediately rather than refer to an EBI, negatively impacting utilization and consequently the financial viability of a program.

Even when counties do fund the start of services, if funding for the EBI is not straightforward and easily accessed, referral sources may still refer to an alternative service.

**Shift in Focus to Productivity & Administrative Requirements**

There are undoubtedly benefits of Medical Assistance funding for EBIs. In contrast to time-limited grants, M.A. provides a reliable funding source for programs, and it has broadened the scope of youth that can be served to beyond those in the juvenile justice system. At the same time, the current funding structure for EBIs in Pennsylvania and the requirements associated with M.A. regulations create specific challenges for EBI providers.

Providers consistently report that these are some of the most significant obstacles to program success, as they attempt to marry an evidence-based model with state policies and regulations. The time and energy invested in meeting these requirements are costly for programs, and may demand that clinicians focus their attention on administrative issues instead of clinical ones, resulting in model drift and lower morale. When providers have difficulty meeting M.A. requirements, the future of their program can be put in jeopardy. Examples of challenges related to administrative requirements include:
**Accessing Funding:** Considerable time and resources are expended accessing funding. Some providers have moved toward only accepting referrals for youth who are already M.A.-eligible, in order to minimize costs and service delays associated with helping families access M.A. This has the unintended effect of excluding certain youth from services or at the very least delaying services until the youth becomes M.A. eligible and a provider will accept the referral.

**Productivity Emphasis:** M.A. funding in Pennsylvania utilizes either a fee-for-service approach (unit billing) or an alternative payment arrangement (typically a weekly rate in the case of FFT or MST). These funding structures are inherently based on specific productivity requirements – i.e., a therapist must provide a certain number of billable hours in order for the program to generate sufficient revenue to cover costs. While funders’ desire to ensure they are “getting what they pay for” is understandable, productivity requirements have a number of negative effects on model delivery including: staff burnout, model drift, service intensity based on productivity requirements rather than clinical need, and difficulty generating sufficient revenue when referrals are slow.

**Documentation:** Providers must document services in accordance with M.A. requirements, which go above and beyond the documentation required by the models-as-designed and increase therapist workload.

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**Financial Losses**

Pennsylvania has seen some improvement in EBI stability as communities have been provided clearer information about accessing Special Grant funds and some providers have been successful in negotiating rate increases with their Behavioral Health-Managed Care Organizations. However, *across agencies and across the three EBIs, the majority of programs report that they are losing money*. In some cases, losses are in the hundreds of thousands for a single provider. Ultimately, losses of this magnitude will result in program closures.

While in MTFC this loss appears largely a result of low program census, MST and FFT providers attribute the losses to a variety of factors, most of which have just been described:

- Insufficient referrals.
- The rate and manner of reimbursement, as well as unanticipated limits on billable activities without corresponding rate adjustments.
- The resources needed to meet administrative requirements.
- Difficulty accessing county funding for costs that are not covered by M.A. It is interesting that many providers have difficulty obtaining adequate county funding for services, while statewide Special Grant funds have been chronically under spent.

Financially sound programs generally report 1) a steady rate of program referrals, 2) a high rate of reimbursement from their BH-MCO, and 3) easy access to county funding and/or a process for expediting MA approval.
Several dynamics are worth noting with respect to funding of EBIs. First, while the three EBIs are funded by M.A. under the umbrella of Behavioral Health Rehabilitation Services (BHRS), EBIs differ significantly from traditional BHRS in Pennsylvania in important ways:

- Each model has specific guidelines regarding the number of program staff required, recommendations against EBI staff working in other programs, limits on maximum caseload, and static program costs (e.g., consultation, training, and licensing fees). As a result, unlike with traditional Behavioral Health Rehabilitation Services, providers of EBIs are limited in the extent to which they can cut program costs or reduce program size by diverting staff elsewhere when referrals are slow.
- Similarly, because staff must be extensively trained in the model, programs cannot easily make up “lost hours” by using other clinicians in the agency when an EBI therapist is ill or a position is vacant.
- Because of model requirements, EBIs must maintain certain caseloads to be model adherent. At the same time, model limits on maximum caseload prevent programs from taking on extra cases to make up for slow periods, therapist absences, or no-shows.
- Unlike other BHRS which tends to have longer length of stay, MST and FFT have a short length of stay. In this sense, the “return on investment” for resources spent accessing and managing funding is lower than in traditional BHRS. MST and FFT also serve a large number of youth outside the traditional mental health population; some providers receive many referrals for youth that do not already have M.A. and spend considerable time helping families apply for funding through the County Assistance Office.

In many communities, providers must invest considerable time and resources accessing funding and are left “eating” part of the cost of services provided. This may include case management time spent getting services approved for funding and aspects of the service that are not M.A.-reimbursable. For instance, time spent preparing for and then accompanying a family to a court hearing is not an allowable cost under M.A., but at this time no counties of which we are aware reimburse providers for court time. Similarly, while in theory counties could reimburse the time providers spend helping a youth become M.A. eligible, this rarely if ever occurs. Providers report that the frequency with which youth have lapses in their M.A. eligibility mid-treatment is increasing. Switching back and forth between county funding and M.A. during a youth’s treatment can be complicated and time-consuming, and oftentimes it simply does not happen.

While Pennsylvania has created a structure of blended funding streams with the goal of funding all aspects of EBIs, in reality the process is a complicated one that directly impacts referrals and youth access to services.
STRATEGIES FOR SUCCESS

Given the challenges faced by providers, what distinguishes providers who are thriving in the current system from those who are struggling to sustain? Below are several features of communities with successful programs. Taken alone, none of these is sufficient. In fact, these program features are strongly interrelated. With most or all of these characteristics in place, a program has a great likelihood of being financially sound, enabling it to continue serving youth and focus on quality implementation.

- **A strong referral base.** EBIs depend on a strong, steady flow of referrals. A good referral base may be due to a number of factors: a provider’s excellent reputation; strong provider-stakeholder relationships; county stakeholders who are invested in the service; and a well-coordinated intake process within the county. For instance, some county agencies have a designated coordinator whose job it is to identify youth appropriate for referral to an EBI. Other counties have a team that meets weekly to discuss new cases with providers and assign youth to the most appropriate service. Referral sources are also motivated to refer when services can begin quickly, funding is easily accessible, and they are confident in the program’s outcomes.

- **The ability to start services quickly.** The ability for FFT and MST to start services immediately is not only attractive to stakeholders but also promotes implementation quality and enables providers to engage families when they are most receptive to services. Quick initiation of services is facilitated by a BH-MCO protocol that allows pre-certification and/or county funding of services until M.A. is authorized.

- **Accessible and adequate county funding.** Counties with a generous pot of funding that is easily accessible provide a more sustaining environment for EBIs. County funds can be used to pay for services until M.A. is authorized, fund youth who are not M.A. eligible or whose families refuse M.A., cover the cost of services when M.A. lapses, and pay for service activities that are not M.A.-
reimbursable (e.g., court-related activities, time spent assisting a family with M.A. eligibility). This is especially important in communities where many youth do not already have M.A. and in communities where the BH-MCO does not pre-certify services. Furthermore, some counties have made the conscious decision not to require youth without M.A. to apply for it, since the path to M.A. eligibility often requires a mental health diagnosis. These counties instead use Special Grant or other county funds to pay for the youth’s services.

- **A process to expedite M.A. eligibility.** In some instances, county agencies have successfully worked with the County Assistance Office to develop a plan for expediting M.A. applications for youth referred to an EBI. In addition, some providers have been able to maximize M.A. reimbursement for services by working with their BH-MCO to develop a process for accessing “retro-eligibility,” so that M.A. pays for services from the date the M.A. application is submitted to the County Assistance Office, rather than the date the application is processed. This enables the program to begin serving youth promptly, rather than waiting days or weeks until the service is authorized.

- **Administrative support.** To enable clinicians to focus on clinical work as well as use resources wisely, programs benefit from having support staff to manage administrative and case management tasks such as assisting families with M.A. eligibility, coordinating ISPT meetings, following up with the County Assistance Office regarding applications, monitoring M.A. eligibility throughout the course of treatment, ensuring documentation is completed on time, and so forth. This cost must be accounted for in the program’s budget and rate of reimbursement.

**These characteristics can be used to guide policy and support for EBIs at both the state and local levels, creating a climate that better supports EBIs across the Commonwealth.**

While many providers have successfully negotiated common obstacles by working closely with county stakeholders, significant challenges remain in many communities. For instance, while one provider was successful in negotiating a better rate after providing the BH-MCO with more information about the evidence-based model, another group of providers has been unsuccessful in convincing their BH-MCO to increase its rate of reimbursement, which has not changed in 7 years.
The EBP Initiative in Pennsylvania is now more than a decade old. An infrastructure to support the initiative, the Resource Center for Evidence-Based Prevention and Intervention Programs and Practices, has been in place for over 4 years. Pennsylvania has seen a positive impact from its investment in EBIs, as illustrated by outcome data showing good outcomes for the families served, a steady reduction in placements over the past several years, and money saved by diverting youth from placement and future reduction in crime. At the same time, there are significant challenges to program sustainability. Improvements that focus on key barriers and are informed by lessons learned will help to promote program sustainability and maximize public health impact.

1. **Take concrete and proactive steps to address the challenges faced by the programs, with the support and involvement of key stakeholders at the state level.** The challenges facing EBI programs are interrelated in complex ways and would be most effectively addressed through collaboration between state leaders and providers to identify creative and systemic solutions. A best practice guide from the state, outlining policies and processes for effectively supporting EBIs and integrating information from multiple systems (e.g., child welfare, juvenile justice, mental health), could be highly beneficial to local communities. Appendix A outlines a number of possibilities for addressing the current challenges.

2. **Create avenues for continuing to educate a broad audience of county leaders about the benefits associated with EBIs and the role counties play in ensuring implementation is a success.** This includes sharing the lessons learned over the past decade with communities. While many counties are “on board” with EBIs, others have been slower to respond or are misinformed. Counties that have developed successful ways of supporting their EBIs and have seen the fruits of their labor in terms of decreased placement rates have much to share with counties that are newer to EBI implementation or in which providers are struggling. Similarly, in some counties Behavioral Health-Managed Care Organizations have developed ways to support and collaborate with EBIs – from expediting M.A. authorization to attending clinical trainings to learn more about the models – which could be shared. Next steps should include:
   - An “EBI Forum,” similar to the one held in 2010, to share best practices and educate counties regarding their critical role in supporting EBIs.
   - Continued sharing of information through the EPISCenter newsletter for county leadership and BH-MCOs, which should focus on some of these key challenges and how counties can help.
   - Targeted TA from a team of state partners to counties that continue to place high numbers of youth, yet are underutilizing existing EBIs.
3. **Identify communities that are interested in adopting an EBI and counties where additional service capacity is needed, and provide technical assistance from the earliest stages of planning.** It has become clear that planning can play a pivotal role in the successful implementation of a program. The EPISCenter is available to provide technical assistance not only to existing EBI providers, but also to communities considering adoption of an EBI. When communities have reached out for assistance, the EPISCenter has been able to answer questions, clarify misconceptions, and provide information not only about the models being considered but also about specific considerations for successful implementation in Pennsylvania, based on experience working with EBI providers across the Commonwealth. A protocol for identifying communities in the early stages of planning would enable us to provide this support on a larger scale. Furthermore, the electronic maps developed by the EPISCenter are helping us to identify communities where placement rates are high, yet the availability EBIs is low. These counties would likely benefit from targeted outreach and planning assistance.

4. **Collect and disseminate more information about the long-term outcomes associated with EBIs in Pennsylvania.** Policy makers and funders are very interested in knowing what impact EBIs have over the long-term. The INSPIRE system, deployed in the spring of 2011, makes available to providers and to the state more reliable, valid, and consistent data about EBI utilization and outcomes. The system provides a way for programs to track and report follow-up data, but at this time few programs are consistently collecting data beyond the point of discharge, in part due to limited resources at the provider level. A multi-pronged approach would be most successful and could consist of a written policy around expectations for data collection, small grants to incentivize data collection, and training for providers around how to most effectively follow-up with clients.

By proactively addressing the current challenges facing EBIs and continuing to support communities with effective implementation, Pennsylvania can continue to experience the benefits of EBI implementation: positive outcomes for youth, responsible use of taxpayer dollars, and reducing the flow of youth into the adult criminal justice system.
CITATIONS

