

Implementation and Long term Sustainability with FFT

Findings of FFT sustainability study with 7-15+ year old FFT sites

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First...

- ▶ We want thank and recognize the 330 sites, in 45 states and 11 countries abroad who provide FFT
- ▶ And particularly to the 100+ long sustaining FFT sites
- ▶ And those who participated in the study

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Elements of successful start up and

Share results of study of FFT sites that have sustained (7+ to 15 years)

- ▶ Domains
- ▶ Constants
- ▶ Areas of flexibility
- ▶ Confirmation of things we felt were critical
- ▶ ..and some surprises too

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FFT site attrition rates are refreshingly low

- ▶ Last three years site 1.7% of sites closed.
 - Extremely low referrals
 - Little relationship with referral source
 - Louisiana-14 sites, 10 new in last two years, champions and supportive Medicaid rate
 - State level changes/re-bidding or program changes
 - CT one site
 - And Florida...
- ▶ During last five years lost 3.8% of sites
- ▶ 96% retention

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Themes...

- ▶ While we might have in some cases accidentally did things that lead to FFT being sustained in a community, **sustainability is not an accident.**
- ▶ **How we begin has everything to do with where we end up**
- ▶ While we heavily emphasize information on outcomes with families, **data on youth/family change is even more important to sustainability than we thought.** Outcomes lead to sustainability.
- ▶ **Regardless...Implementation" (or "putting into effect") has an ongoing nature.**
 - No program in practical terms reaches stasis (some equilibrium that doesn't require attention). Service systems, therapists, teams, organizations are too dynamic.

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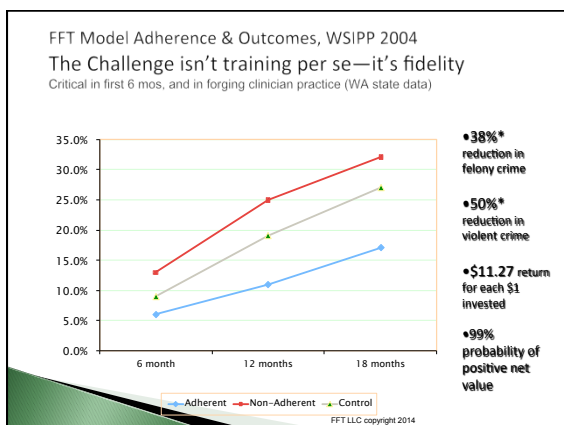
1999...Fidelity and outcomes

- ▶ Replicate therapist practice in evaluations and thus replicate the outcomes of those evaluations at community sites. **Or adherence.**
 - "Train, evaluate, close project" VERSUS lasting practice change that achieves consistent outcomes.

FFT LLC creates apparatus to support **ongoing** fidelity...

- Training and consultation protocol.
- Monitoring, assessing and correcting practice via assessment and web based protocol
- Creating internal infrastructure to do this

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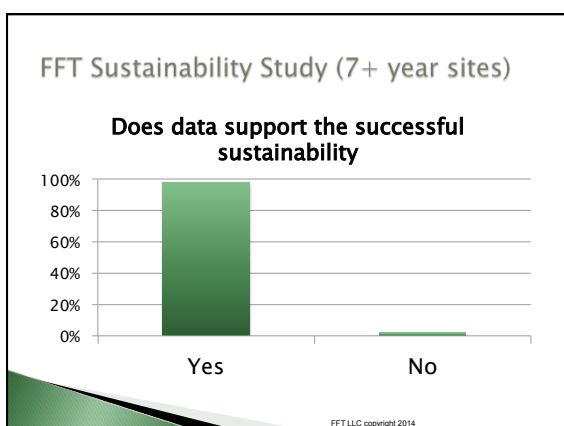
Fidelity part two

Learning from WA state: fidelity = outcomes
A lot of pressure so that

by 2007 such an emphasis on the methods to understand/assess practice became an overemphasis

- ▶ Losing the central fact that fidelity IS *actual practice*
 - Example: a good behavior change progress note is different (though perhaps linked) to doing an excellent behavior change session/s.
- ▶ Separate **clinical adherence** from **dissemination adherence**. Dissemination adherence may help us understand clinical fidelity but it's not the same thing.

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SUSTAINABILITY

- ▶ The context in which therapists operate and are supported doesn't just impact but **ALLOWS** fidelity (outcomes) and sustainability
- ▶ 1999-2003
 - focus on creating a **welcoming "noise-free" environment** for FFT practice (which has a more immediate **proximal** focus)

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Larger scale sustainability efforts (07-14)

- ▶ Increasing focus on state/nationwide support and data systems for FFT (i.e. CA, FL, PA, MD, Wash DC, WA, Maine, Norway, NL)
- ▶ Increased focus on providing aggregate data and focused QI data
- ▶ CDT process in CA retain 45 out of 50 sites over 11 years
- ▶ Increased experimentation with complimentary case management systems (FFP) to create a more supportive context
- ▶ Diversify funding (medicaid)
 - A word about Medicaid: it can help, or erode, or take us off model...it depends which state you operate in

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As a training organization... (07-14)

- ▶ Simply understand dissemination better
 - Highly skilled consultants and trainers
 - Avg of 9.6 years experience in doing FFT, supervising, consulting with other sites, and training
 - Work at and are selected from the 1000+
 - Staff dedicated to funding issues, particularly Medicaid
 - Always clinically grounded by Jim Alexander and Mike Robbins
 - Increasingly organized statewide systems
- ▶ Stronger and more responsive use of data
 - With therapists, teams, multiple teams, states and nations
 - All without losing clinical responsiveness
 - Addition of Behavior change modules fitted to FFT

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Pre-implementation (07-14)

- › Implementation targets: therapists, agency, referral/funders
- › Lay groundwork for sites "owning" the responsibility for their program from the beginning
 - Transparency, about opportunities AND challenges
 - Site set up decisions within a range of choices
 - Increasing role of local site in guiding fidelity/practice, with FFT taking steps back as local infrastructure/outcomes grow
- › In some ways early implementation is an attempt to **buy time** for the local FFT project to create
 - Enthusiastic, credible and well skilled FFT therapists, supervisors, and programs
 - To develop outcomes FFT to share with funders, referral sources, the agency and the community

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Key Pre-Implementation Areas

- › Agency understanding and support of FFT clinical practice, philosophy, data and QI
 - Clinician and team choices
- › Referrals—appropriate and reliable
- › Solid history of or commitment to relationships with funders and referral systems
- › Creating multiple feedback loops (between FFT team, Training, Agency, Larger systems)

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A word about referrals (07-14)

- Critical throughout but particularly in first year
- Referral systems/agent that understand FFT and operate in ways that support the FFT practice
 - › Working with families
 - › Completion based on FFT model
 - › Not saturating families with too many referrals alongside FFT (or ones that work against FFT).
- › Appropriate and ample #s referrals
 - More families→more opportunities to apply FFT→more opportunities for success→builds confidence and motivates
 - WA state data: first six months is vital. Forged core fidelity (or not).

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FFT Sustainability Study

- ▶ Gathered data from 46 teams that have been successfully implementing FFT 7+ year to 15 years
- ▶ Respondents were team leads or administrators
- ▶ Question domains:
 - Team (therapists, supervisors)
 - Referrals
 - Funding
 - Agency/Organization (culture, incentives, support)
 - Data utility

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Results of Survey

- ▶ Based on the responses, this presentation will focus on:
 - Core elements needed for long-term sustainability
 - Implementation elements that are constants (firm) and elements that are flexible to unique agency characteristics
 - Surprising (and not surprising) findings

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Therapist/team key findings

- ▶ Almost 90% MA level or higher
- ▶ 92% have caseloads between 10-15
- ▶ Almost 80% of supervisors carry caseloads of 3 to 10, with 26% carrying btw 7 and 10
- ▶ 78% have team sizes between 3 and 5 therapists
- ▶ Equal number of full and part time therapists, but only one team with just part time therapists

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Therapist/team key findings (2)

- ▶ Top therapist characteristics to create a lasting program
 - Confidence (85%)
 - Flexibility with schedule (77%)
 - Experience with home-based services (36%)
 - New to the field (25%)
 - High experienced therapists (18%)
 - Experience with EBTs (12%)
- ▶ 84% have specific job hiring practices and
- ▶ 75% have specific FFT job descriptions

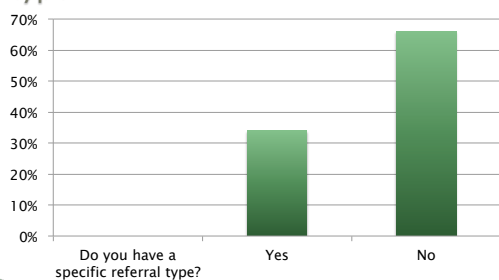
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Referrals key findings

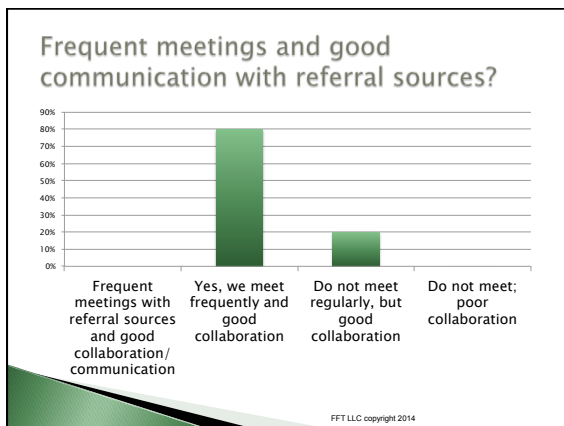
- ▶ Referral types/sources are robust, reflecting the dexterity of FFT across multiple systems
- ▶ 65% use multiple referral sources
- ▶ High levels of collaboration with referral sources, reflecting engagement of systems in FFT
- ▶ Utilization typically high
- ▶ But there is on-going need to assure referrals
 - 65% feel they have *consistently* adequate referrals

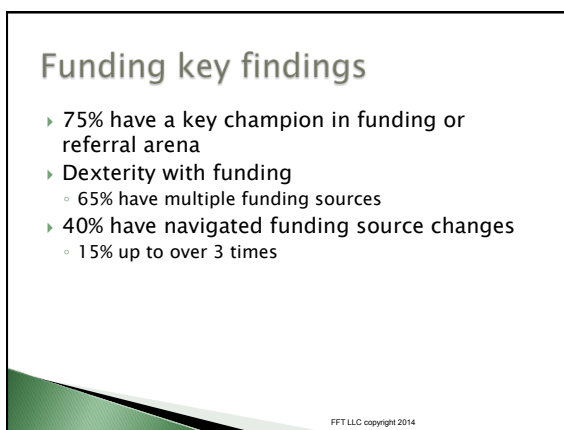
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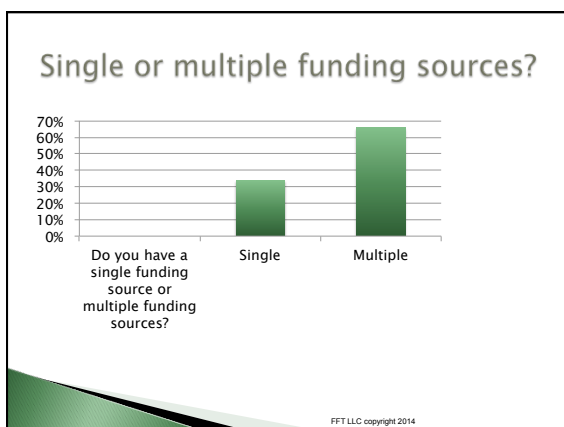
Do you have a specific referral type?

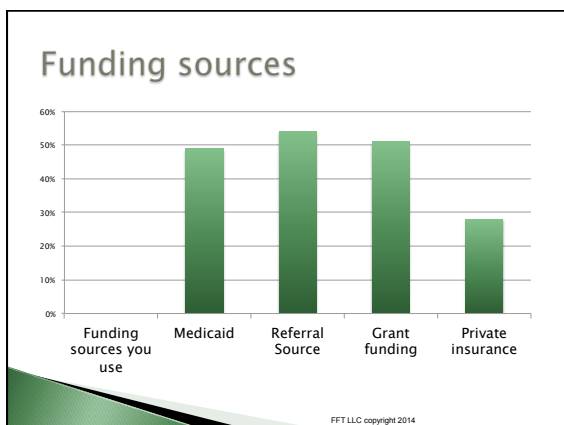


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- ### Agency/organizational key findings
- ▶ While less than 20% provide specific incentives for strong FFT performance, over 80% engage in FFT team building activities
 - ▶ Over 90% of agencies express a strong commitment to EBPs
 - ▶ 78% provide other EBPs—they are not just FFT but believers in EBPs
- FFT LLC copyright 2014

