REPORTING EVIDENCE-BASED PRACTICES FOR CHILDREN’S MENTAL HEALTH:

WASHINGTON STATE GUIDELINES
HISTORY
In 2007, WA State Legislature passed House Bill 1088 establishing the Evidence Based Practice Institute (EBPI). The Institute serves as a statewide resource to promote high quality mental health services for children and youth in WA State.

MISSION
To improve the health and well-being of children. We accomplish this mission by collaborating with our policy and practice partners to conduct research syntheses, co-develop policies and programs and build organizational capacity.
Webinar Presenters

Dr. Sarah Walker
Director of the Evidence-Based Practice Institute in the Department of Psychiatry and Behavioral Sciences at the UW School of Medicine

Dr. Georganna Sedlar
Assistant Professor in the Department of Psychiatry and Behavioral Sciences at UW School of Medicine
Use ‘Chat’ function for technical/logistical questions that come up during the presentation OR to answer presenters’ questions.

Use ‘Raise Hand’ function to ask content related questions verbally – you will have to be unmuted.

Use ‘Q&A’ function to send your written content related questions at any time.
Why Evidence-Based Practices (EBPs)?

- Mental health disorders, particularly depression, are the most prevalent and costly healthcare needs in the world.

- Not all treatments are the same.

- Some approaches outperform others in effectiveness, leading to quicker recovery and saved costs.
Why collect information on EBPs?

- **Performance Monitoring**
  Provide feedback to sites about the use of the most effective practices to encourage more consistent use.

- **To create a Learning Health Care System**
  Monitor how the use of EBPs compares to other aspects of usual care in real time and in the real world.
Current performance monitoring efforts inadequate

- No system has truly cracked the nut of monitoring EBP in real time for children’s mental health services.

- Reporting on practices and outcomes is inconsistent across sites.

- Previous attempts rest heavily on administrator tracking of staff training – high margin of error for representing actual therapeutic practice.
A challenge of reporting is the lack of fit between many tested programs and real world complexities.

All EBPs specify a length of treatment, e.g., 12 weeks. This is generally an unrealistic standard for community mental health practices with an average of 3 visits or a treatment characterized by stops and starts that require a period of reassessment and reengagement.

Consequently, when asked to report if they are doing an EBP, providers may be unsure when they are “eligible” to count what they are doing.
We do not have the infrastructure to do full quality reviews to ensure “fidelity” to programs. Hence, we are interested in monitoring practice that demonstrates three capacities:

1. **AWARENESS** of effective practices
2. **ABILITY** to use effective practices
3. **INTENT** to use effective practices
Determining EBP

Checklist to determine whether a clinical encounter is EBP:

- **Training:** The provider has received an interactive training by an approved training entity.

- **Consultation:** The provider is up to date with the consultation requirements of the training entity.

- **Treatment Plan:** The provider lists the brand name or generic model and at least one essential clinical element consistent with the model in the client treatment plan.

- **Progress Notes:** The provider lists at least one essential or approved clinical element in the progress notes for the indicated client session.
Approved training entities include:

- Developers of specific interventions; OR
- Training organizations that cover the common clinical elements of a treatment category.

Both types of training entities are listed in the Code Tables for the mental health diagnosis areas:

<table>
<thead>
<tr>
<th>Treatment Types</th>
<th>Program and Training Entity</th>
<th>R/EBP Code</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harborview CBT+ Learning Collaborative</td>
<td></td>
<td>148</td>
<td>Training Entity</td>
</tr>
<tr>
<td>University of Washington CE Certificate in EBP</td>
<td></td>
<td>148</td>
<td>Training Entity</td>
</tr>
<tr>
<td>University of Washington MA in Applied Child and Adolescent Psychology</td>
<td></td>
<td>148</td>
<td>Training Entity</td>
</tr>
</tbody>
</table>

*Trainings must include an interactive component in which the trainee receives some level of skills assessment and is judged to be competent in delivering the treatment.*
Eligible training entities include:

- The trainer has expertise in the treatment area and/or is certified by a training entity listed in the Guides;

- If a trainer cannot point to a history of training on the topic area, the EBPI will review training curricula to ensure the training covers the essential and allowable elements of the clinical practice type in a structured format;

- Training received during graduate education must include a structured approach to a treatment category (e.g., CBT for Anxiety) that covers essential and allowable elements with supervised practice.

⚠ Does not count: Internal training (e.g., by a supervisor not certified by an EBP) or external training from someone with insufficient clinical expertise (e.g., no record of previous clinical work or supervision in the training category).
CONSULTATION REQUIREMENTS

- Consultation, as specified by the program, must be up to date in order to report a manualized EBP.

- Ongoing consultation, following the initial period of training and observation, is not required for the generic treatment categories.
# Codes for EBP Treatment Programs

## Attention-Deficit/Hyperactivity Disorder (ADHD)

<table>
<thead>
<tr>
<th>Treatment Types</th>
<th>Program and Training Entity</th>
<th>R/EBP Code</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent Behavioral Therapy (PBT) with or without child</td>
<td>Barkley Model</td>
<td>003</td>
<td>WSIPP 2019, R-based</td>
</tr>
<tr>
<td></td>
<td>Child Life and Attention Skills (CLAS)</td>
<td>200</td>
<td>Evans et al. 2014, L1</td>
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<tr>
<td></td>
<td>Coaching Our Acting—Out Children: Heightening Essential Skills (COACHES)</td>
<td>201</td>
<td>Evans et al. 2014, L1</td>
</tr>
<tr>
<td></td>
<td>Incredible Years</td>
<td>073</td>
<td>Evans et al. 2014, L1</td>
</tr>
<tr>
<td></td>
<td>New Forest Parenting Program (NFPP)</td>
<td>181</td>
<td>WSIPP 2019, R—based; Evans et al. 2018, L1</td>
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<tr>
<td></td>
<td>Strategies to Enhance Positive Parenting (STEPP)</td>
<td>202</td>
<td>Evans et al. 2018, L1</td>
</tr>
<tr>
<td></td>
<td>Child Life and Attention Skills (CLAS)</td>
<td>300</td>
<td>Evans et al. 2018, L1</td>
</tr>
<tr>
<td></td>
<td>Plan My Life (PML)</td>
<td>301</td>
<td>Evans et al. 2018, L2</td>
</tr>
</tbody>
</table>
CONFIDENTIAL

CHILD'S NAME: Jane Doe
DATE: April 6th

PROBLEM: Afraid of large dogs
TREATMENT GOALS: Manage anxiety related to being around large dogs
TREATMENT OBJECTIVES: Utilize exposure and cognitive restructuring
CRITERIA FOR ACHIEVEMENT: Being able to be around large dogs without having a panic attack

TYPE OF TREATMENT: CBT for Anxious Children
COGNITIVE BEHAVIORAL THERAPY (CBT) FOR ANXIETY

TREATMENT FAMILY DESCRIPTION

Cognitive behavioral therapy focuses on the interrelationship among thoughts, feelings, and behaviors, and is based on the premise that changes in any one domain can improve functioning in the other domains. CBT focuses on challenging and changing unhelpful or inaccurate cognitions (e.g. thoughts, beliefs, and attitudes), changing behaviors, improving emotional regulation, and the development of personal coping strategies that target solving current problems. CBT approaches for anxiety include imaginal and in vivo exposure, psychoeducation, and creating opportunities for new learning about the client’s ability to tolerate anxiety/distress, cognitive restructuring, and coping skills (e.g., relaxation skills training).

ESSENTIAL CLINICAL ELEMENTS FOR TREATMENT PLANS

a. Exposure

Description: Exposure is a practice to decrease anxiety associated with thoughts related to worry, objects or situations that are not dangerous. The child learns through practice to tolerate facing up to non-dangerous thoughts, objects or situations until the anxious feelings decrease or can be tolerated.

b. Cognitive Restructuring

Description: Cognitive restructuring involves teaching children how thoughts can influence anxiety and helping them come up with more accurate and helpful thoughts.
**CONFIDENTIAL**

<table>
<thead>
<tr>
<th>CHILD'S NAME:</th>
<th>Jane Doe</th>
<th>TYPE OF TREATMENT:</th>
<th>CBT for Anxious Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE:</td>
<td>April 6th</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PROBLEM:</td>
<td>Afraid of large dogs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TREATMENT GOALS:</td>
<td>Manage anxiety related to being around large dogs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PROGRESS NOTE:**

- Reviewed Homework with client
- Provided psychoeducation to parent about anxiety
- Planned exposure for next session
ALLOWABLE CLINICAL ELEMENTS FOR PROGRESS NOTES

a. Exposure

_Description:_ Exposure is a practice to decrease anxiety associated with thoughts related to worry, objects or situations that are not dangerous. The child learns through practice to tolerate facing up to non-dangerous thoughts, objects or situations until the anxious feelings decrease or can be tolerated.

b. Cognitive Restructuring

_Description:_ Cognitive restructuring involves teaching children how thoughts can influence anxiety and helping them come up with more accurate and helpful thoughts.

c. Psychoeducation for Children

_Description:_ Psychoeducation is providing information to children about anxiety and the CBT based model for treatment.

d. Psychoeducation for Caregivers

_Description:_ Psychoeducation is providing information to caregivers about anxiety and the CBT based model for treatment.

e. Relaxation

_Description:_ Teaching the child through modeling and practicing the difference between being relaxed and tense and how to induce a state of relaxation using breathing, tensing and relaxing muscle groups, guided imagery, and mindfulness.
LET'S PRACTICE WITH SOME CASE EXAMPLES
CASE EXAMPLE 1

Jane is a 10 year old female who enters treatment for issues related to being separated from her mom. She struggles with intense anxiety at school after being dropped off and has poor attendance as a result.

Ms. Helper is assigned to this case and has her first session with Jane. Jane’s screening scores indicate a diagnosis of separation anxiety and Ms. Helper wants to use CBT for Anxiety.

Ms. Helper is writing up her paperwork, including the treatment plan and progress note for today’s session. When she goes into her agency’s EHR to bill for today’s session, she remembers that she needs to have the correct training to provide the service. She was trained through an in-house training from a colleague who has treated a number of anxiety cases.
WHAT SHOULD SHE DO?
## ANXIETY, OCD AND RELATED DISORDERS

<table>
<thead>
<tr>
<th>Treatment Types</th>
<th>Program and Training Entity</th>
<th>R/EBP Code</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Behavioral Therapy (CBT) for anxiety, OCD and related disorders</td>
<td>Acceptance and Commitment Therapy (ACT) for children with anxiety</td>
<td>151</td>
<td>WSIPP 2019, R-based</td>
</tr>
<tr>
<td></td>
<td>Cool Kids</td>
<td>032</td>
<td>WSIPP 2019, R-based</td>
</tr>
<tr>
<td></td>
<td>Coping CCB</td>
<td>035</td>
<td>WSIPP 2019, R-based</td>
</tr>
<tr>
<td></td>
<td>Coping (Multisystemic Therapy) for anxiety and related disorders</td>
<td>157</td>
<td>WSIPP 2019, R-based</td>
</tr>
<tr>
<td></td>
<td>Coping (Multisystemic Therapy) for anxiety and related disorders</td>
<td>158</td>
<td>WSIPP 2019, R-based</td>
</tr>
<tr>
<td></td>
<td>Get Lost Multisystemic Programme</td>
<td>320</td>
<td>Comer et al. 2019, L2</td>
</tr>
<tr>
<td></td>
<td>FRIENDS Program</td>
<td>321</td>
<td>Comer et al. 2019, L2</td>
</tr>
<tr>
<td></td>
<td>Effective Child Therapy/Society of Clinical Child and Adolescent Psychology</td>
<td>151</td>
<td>Training Entity</td>
</tr>
<tr>
<td></td>
<td>Harborview CBT+ Learning Collaborative</td>
<td>151</td>
<td>Training Entity</td>
</tr>
</tbody>
</table>
CASE EXAMPLE 2

Same case . . .

Ms. Helper is assigned to this case and wants to use CBT for Anxiety.

Ms. Helper is writing up her paperwork, including the treatment plan and progress note for today’s session. When she goes into her agency’s EHR to bill for today’s session, she remembers that she needs to have the correct training to provide the service. Recently, she was trained through the training entity, CBT+. 
## Anxiety, OCD and Related Disorders

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<td>WSIPP 2019, R-based</td>
</tr>
<tr>
<td></td>
<td>Cool Kids</td>
<td>032</td>
<td>WSIPP 2019, R-based</td>
</tr>
<tr>
<td></td>
<td>Coping Cat</td>
<td>035</td>
<td>WSIPP 2019, R-based</td>
</tr>
<tr>
<td></td>
<td>Coping Cat/Koala book based model</td>
<td>157</td>
<td>WSIPP 2019, R-based</td>
</tr>
<tr>
<td></td>
<td>Coping Koala</td>
<td>158</td>
<td>WSIPP 2019, R-based</td>
</tr>
<tr>
<td></td>
<td>Get Lost Mr. Scary Programme</td>
<td>320</td>
<td>Comer et al. 2019, L2</td>
</tr>
<tr>
<td></td>
<td>FRIENDS Program</td>
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<td>Comer et al. 2019, L2</td>
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<td></td>
<td>Effective Child Therapy/Society of Clinical Child and Adolescent Psychology</td>
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<td></td>
<td>Harborview CBT+ Learning Collaborative</td>
<td>151</td>
<td>Training Entity</td>
</tr>
</tbody>
</table>
TREATMENT PLAN
Community Health Clinic of Washington

Client Name: Jane  Date: Jan 20, 2020
Primary Diagnosis: Separation Anxiety  Type of Treatment: CBT for Anxious Children

Presenting Problem: Experiences separation anxiety at school

Treatment Goals: Manage and reduce anxiety related to being separated from mom

Treatment Intervention:

1. Teach Jane how to use coping skills when she starts to experience anxiety

2. Work with Jane to identify her range of anxiety when being separated from mom and monitor this weekly to see when it is highest and lowest.
WHAT DO YOU THINK?
COGNITIVE BEHAVIORAL THERAPY (CBT) FOR ANXIETY

TREATMENT FAMILY DESCRIPTION

Cognitive behavioral therapy focuses on the interrelationship among thoughts, feelings, and behaviors, and is based on the premise that changes in any one domain can improve functioning in the other domains. CBT focuses on challenging and changing unhelpful or inaccurate cognitions (e.g. thoughts, beliefs, and attitudes), changing behaviors, improving emotional regulation, and the development of personal coping strategies that target solving current problems. CBT approaches for anxiety include imaginal and in vivo exposure, psychoeducation, and creating opportunities for new learning about the client’s ability to tolerate anxiety/distress, cognitive restructuring, and coping skills (e.g., relaxation skills training).

ESSENTIAL CLINICAL ELEMENTS FOR TREATMENT PLANS

a. Exposure

*Description*: Exposure is a practice to decrease anxiety associated with thoughts related to worry, objects or situations that are not dangerous. The child learns through practice to tolerate facing up to non-dangerous thoughts, objects or situations until the anxious feelings decrease or can be tolerated.

b. Cognitive Restructuring

*Description*: Cognitive restructuring involves teaching children how thoughts can influence anxiety and helping them come up with more accurate and helpful thoughts.
**Client Name:** Jane  
**Primary Diagnosis:** Separation Anxiety  
**Type of Treatment:** CBT for Anxious Children  
**Service:** Family Therapy w/client  

<table>
<thead>
<tr>
<th>Location</th>
<th>Time</th>
<th>Progress Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHC</td>
<td>3:00-4:00 pm</td>
<td>Explored client’s feelings by playing emotional bingo and had him talk about each one. Client reported feeling anxious and sad. Used sand tray to work with client to explore the causes of his anxiety.</td>
</tr>
</tbody>
</table>
WHAT DO YOU THINK?
ALLOWABLE CLINICAL ELEMENTS FOR PROGRESS NOTES

a. Exposure

Description: Exposure is a practice to decrease anxiety associated with thoughts related to worry, objects or situations that are not dangerous. The child learns through practice to tolerate facing up to non-dangerous thoughts, objects or situations until the anxious feelings decrease or can be tolerated.

b. Cognitive Restructuring

Description: Cognitive restructuring involves teaching children how thoughts can influence anxiety and helping them come up with more accurate and helpful thoughts.

c. Psychoeducation for Children

Description: Psychoeducation is providing information to children about anxiety and the CBT based model for treatment.

d. Psychoeducation for Caregivers

Description: Psychoeducation is providing information to caregivers about anxiety and the CBT based model for treatment.

e. Relaxation

Description: Teaching the child through modeling and practicing the difference between being relaxed and tense and how to induce a state of relaxation using breathing, tensing and relaxing muscle groups, guided imagery, and mindfulness.
f. Cognitive Coping

*Description*: Teaching the child to use self-talk or reappraisal to overcome, manage or tolerate anxious/worry thoughts.

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g. Mood or Emotion Self-monitoring

*Description*: Self-monitoring involves teaching children to identify fear/anxiety/worry emotional states and develop a rating scale (feelings thermometer) for the intensity of the emotional state.

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h. Self-reward/Self-praise

*Description*: Self-reward/self-praise involves helping the child attend to and acknowledge efforts to face up to and handle their fears/anxieties/worries.

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i. Rewards/Reinforcement

*Description*: Caregivers acknowledge, praise or give tangible rewards to the child for taking steps towards overcoming or managing their fears/anxieties/worries.

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j. Measurement-based Care

*Description*: Measurement based care (MBC) is a care delivery approach involving the regular use of standardized measures in routine mental health care to inform treatment and to identify individuals not improving as expected and to encourage treatment changes. It may be added to or integrated with any model of practice.

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k. Motivational Interviewing

*Description*: Motivational Interviewing is a client-centered, directive therapeutic approach that focuses on helping clients resolve ambivalent feelings and discover internal motivation to change their behavior. It is a short-term therapeutic approach that is focused and goal-directed. It may be integrated with any therapeutic model.
CASE EXAMPLE 3

Same case:

Jane is a 10 year old female who enters treatment for issues related to being separated from her mom. She struggles with intense anxiety and panic attacks at school after being dropped off and has poor attendance.

Ms. Ima Helper is assigned to this case and has her first session with Jane. Jane’s screening scores indicate a diagnosis of separation anxiety and Ms. Helper plans to use CBT for Anxious Children to treat Jane’s symptoms.

Ms. Helper is writing up her paperwork, including the treatment plan and progress note for today’s session. When she goes into her agency’s EHR to bill for today’s session, she remembers that she needs to have the correct training to provide the service. She was trained through CBT+. 
# TREATMENT PLAN
Community Health Clinic of Washington

<table>
<thead>
<tr>
<th>Client Name: Jane Doe</th>
<th>Date: Jan 1, 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Diagnosis: Separation Anxiety</td>
<td>Type of Treatment: CBT for Anxious Children</td>
</tr>
</tbody>
</table>

**Presenting Problem:** Experiences separation anxiety with mom

**Treatment Goals:** Manage anxiety related to being separated from mom

**Treatment Intervention:**

1. Use cognitive restructuring to help client explore anxious thoughts and replace these with thoughts that are more helpful to managing anxiety.

2. Utilize exposure in small steps with client to increase client’s comfort with being separated from mom.
WHAT DO YOU THINK?
COGNITIVE BEHAVIORAL THERAPY (CBT) FOR ANXIETY

TREATMENT FAMILY DESCRIPTION

Cognitive behavioral therapy focuses on the interrelationship among thoughts, feelings, and behaviors, and is based on the premise that changes in any one domain can improve functioning in the other domains. CBT focuses on challenging and changing unhelpful or inaccurate cognitions (e.g., thoughts, beliefs, and attitudes), changing behaviors, improving emotional regulation, and the development of personal coping strategies that target solving current problems. CBT approaches for anxiety include imaginal and in vivo exposure, psychoeducation, and creating opportunities for new learning about the client's ability to tolerate anxiety/distress, cognitive restructuring, and coping skills (e.g., relaxation skills training).

ESSENTIAL CLINICAL ELEMENTS FOR TREATMENT PLANS

a. Exposure

*Description:* Exposure is a practice to decrease anxiety associated with thoughts related to worry, objects or situations that are not dangerous. The child learns through practice to tolerate facing up to non-dangerous thoughts, objects or situations until the anxious feelings decrease or can be tolerated.

b. Cognitive Restructuring

*Description:* Cognitive restructuring involves teaching children how thoughts can influence anxiety and helping them come up with more accurate and helpful thoughts.
TREATMENT PLAN
Community Health Clinic of Washington

Client Name: Jane Doe  Date: Jan 1, 2020
Primary Diagnosis: Separation Anxiety  Type of Treatment: CBT for Anxious Children

Presenting Problem: Experiences separation anxiety with mom

Treatment Goals: Manage anxiety related to being separated from mom

Treatment Intervention:

1. Use **cognitive restructuring** to help client explore anxious thoughts and replace these with thoughts that are more helpful to managing anxiety.

2. Utilize **exposure** in small steps with client to increase client’s comfort with being separated from mom.
# PROGRESS NOTE

## Community Health Clinics of Washington

<table>
<thead>
<tr>
<th>Client Name:</th>
<th>Jane Doe</th>
<th>Date:</th>
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</tr>
<tr>
<td>Service:</td>
<td>Family Therapy w/ client</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Location</th>
<th>Time</th>
<th>Progress Note</th>
</tr>
</thead>
</table>
| CHC      | 3:00-4:00 pm | Provided psychoeducation to mom about separation anxiety and effective treatment for this diagnosis. Used cognitive restructuring with client to identify her anxious thoughts about being separated from mom: “If I leave my mom she won’t come back”. Ct was able to identify an alternative thought to this: “When I leave my mom it is only for a small period of time before I see her again”.


WHAT DO YOU THINK?
ALLOWABLE CLINICAL ELEMENTS FOR PROGRESS NOTES

a. Exposure

*Description:* Exposure is a practice to decrease anxiety associated with thoughts related to worry, objects or situations that are not dangerous. The child learns through practice to tolerate facing up to non-dangerous thoughts, objects or situations until the anxious feelings decrease or can be tolerated.

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*Description:* Cognitive restructuring involves teaching children how thoughts can influence anxiety and helping them come up with more accurate and helpful thoughts.

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*Description:* Psychoeducation is providing information to children about anxiety and the CBT based model for treatment.

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*Description:* Teaching the child through modeling and practicing the difference between being relaxed and tense and how to induce a state of relaxation using breathing, tensing and relaxing muscle groups, guided imagery, and mindfulness.
# PROGRESS NOTE
Community Health Clinics of Washington

**Client Name:** Jane Doe  
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</tbody>
</table>
REPORTING USING HCA CODES

- Report one EBP code per encounter.

- For Integrated Managed Care (e.g. community mental health), the EBP number must be reported as a nine-digit number beginning with ‘860’. The next three digits must represent the appropriate EBP code as outlined in the Service Encounter Reporting Instructions (SERI). The last three digits must be reported as ‘000’.

  - **Example**: CBT for Anxiety would be coded as **860151000** with **151** representing the three-digit EBP code.

* Primary care reports EBPs with a 870 code
EBP REPORTING: BHO to MCO transition

- Now under MCOs, HCA has all providers report EBP codes at the header level (2300).
  
  Previously under BHOs/RSNs, EBP codes reported at the line level (2400).

- In the 1500 form (paper version), EBP codes are reported in box 23 ("prior authorization number").

- In the 837 file (electronic version) EBP codes are reported in the 2300 REF02 field.

- Telehealth doesn’t affect EBP reporting.
**JOURNEY MAP:**

**Reporting of EBPs for children’s mental health**

**STEP 1**
Therapist documents EBP use in the EHR system using the EBP Reporting Guides.

**STEP 2**
Agency enters EBP code on an encounter/claim form.

**STEP 3**
MCOs receive EBP reporting as part of routine claims data. This is submitted to HCA (in the Expedited Prior Auth field).

**STEP 4**
HCA receives EBP data. HCA extracts and submits aggregated data to EBPI for reporting.

**Issues encountered:**
- Therapists not trained in EBPs
- Therapists not reporting EBPs
- EHR system:
  - Not set up for entering EBP codes
  - System in place but complex leading to low reporting (e.g. data analyst extracting use of EBPs and documenting as a second step)

**Issues encountered:**
- Wrong EBP codes used or entered incorrectly
- EBP codes entered in the wrong part of the form (e.g. change in location from prior to Integrated Managed Care)
- Complexity from multiple agency locations submitting from a central site (aggregated submission including data from multiple regional locations).

**Issues encountered:**
- MCOs not receiving EBP data from agencies
- MCOs not extracting EBP data correctly
- MCOs not submitting data to HCA

**Issues encountered:**
- Difficulties in extracting/aggregating EBP data at HCA for EBPI reporting:
  - Having all of the MCO ProviderOne IDs
  - HCA pulling the EBP data from the incorrect field in the encounter data (location not the same under IMC as it was prior to IMC)
PARENT BEHAVIORAL THERAPY (PBT) WITH OR WITHOUT CHILD

TREATMENT FAMILY DESCRIPTIONS

**Group or Individual Parent Behavior Training:** A training that teaches caregivers skills for managing child behaviors (e.g. differential reinforcement, use of rewards/consequences, praise) without child participation.

**Group or Individual Parent Behavior Training with Child Participation:** A training that teaches caregivers skills for managing child behaviors with the child present. This can involve live action coaching of the caregiver to enhance the caregiver/child relationship or coaching the caregivers on behavior management techniques such as differential reinforcement.

ESSENTIAL CLINICAL ELEMENTS FOR TREATMENT PLANS

a. Praise

*Description:* Parental praise involves providing the rationale regarding the value of praise, demonstrating how to use labeled praise in interactions with their child, how to praise (tone of voice), and how to identify opportunities for praise (e.g. following good behavior).

*Client-friendly description:* Therapist explains the value of praising children to parents, and then demonstrates how to praise (e.g. tone of voice), and how to identify opportunities for praise (e.g. following good behavior).
ANIMATED TRAINING VIDEO

Available at: tinyurl.com/EBPcartoon

2020

EBPI

Reporting Guides Video
FEEDBACK SURVEY

www.tinyurl.com/EBPevaluation
Email: ebpi2536@uw.edu

Website: https://www.ebp.institute/

2020 Reporting Guide: tinyurl.com/EBPcartoon

Animated training video: tinyurl.com/EBPcartoon