

Key Considerations for Prevention Plan Section VI

Last updated on 4/15/2021

This document reflects responses gathered from the [State, child welfare leadership staff, other Family First work groups, readiness assessment, stakeholder engagement], to inform planning and decision-making for STATE's implementation of the Prevention provision of the Family First Prevention Services Act.

Section VI: Evaluation Strategy and Waiver Request

Section Consideration Questions	Content Development	Next Steps for Information Gathering and Decision-Making with Stakeholders
Overall approach to evaluation and CQI of preventive programs		-
Evaluation or CQI strategy for proposed interventions: <ol style="list-style-type: none"> 1. Evaluation waiver request (if applicable) and justification 2. Approach to process evaluation 3. Approach to outcome evaluation 4. Approach to cost evaluation (optional) 5. Details on how CQI will be tailored to each intervention (timeline, data collection, 		-

measurement and monitoring mechanisms, collaboration with model developer)		
--	--	--

The below pages provide excerpts of other states' submitted prevention plans that detail their approaches to section VI (updates evolving quarterly as new plans are submitted, or submitted plans are revised and approved). For more information contact us at FamilyFirstChapin@Chapinhall.org.

Table of Contents

Arkansas - Approved	4
Maryland - Approved	13
Washington, DC - Approved	26
Utah - Approved	37
Virginia - Submitted.....	48
West Virginia - Approved.....	56
Alaska - Submitted	66
Kansas - Approved	77
Kentucky - Approved.....	78
Nebraska – Approved.....	114
Washington, State - Approved	119
North Dakota - Approved	149
Colorado - Submitted.....	168
Maine - Submitted.....	177
Oregon - Submitted.....	182



Arkansas

Status: Approved

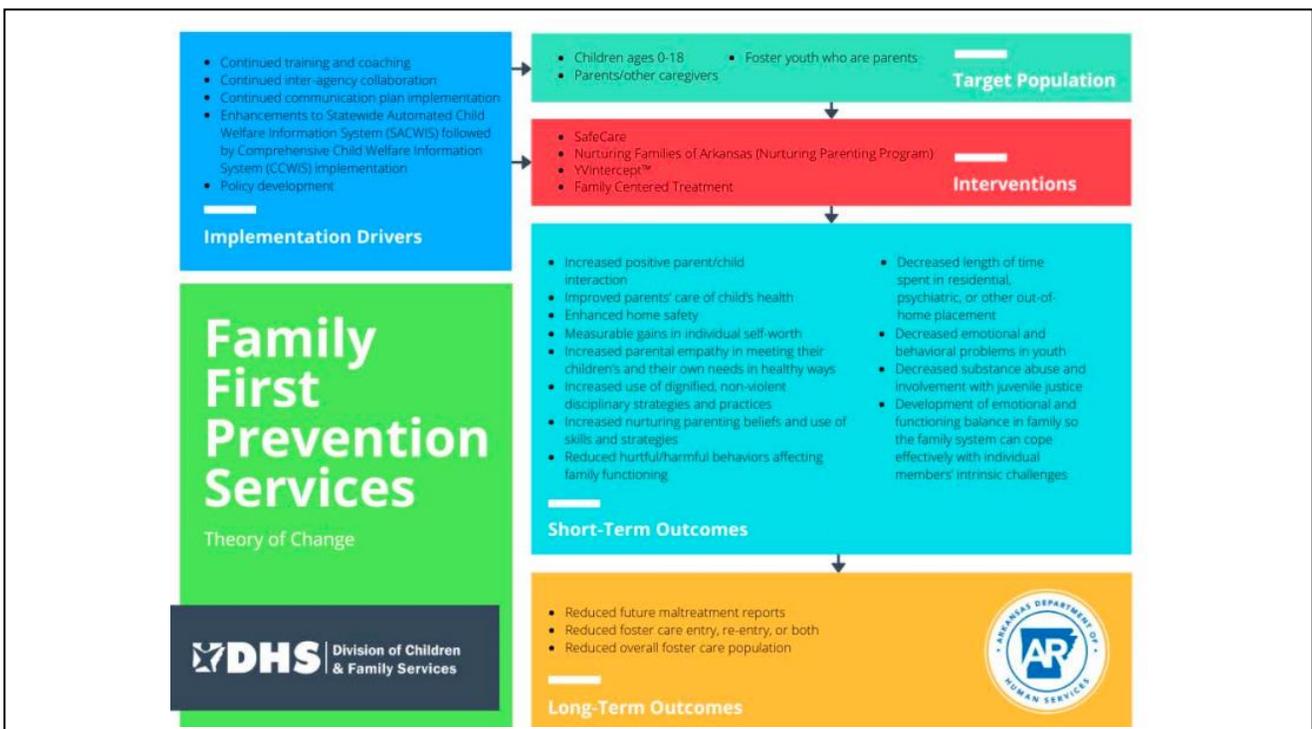
Section VI: Evaluation Strategy and Waiver Request

Evaluation Strategy and Waiver Request Pre-Print Section 2

The Family First Services and Prevention Act requires that each program listed in a State’s Five-Year Title IV-E Prevention Program Plan have a well-designed and rigorous evaluation strategy, unless granted a waiver from HHS. HHS may waive this requirement if they deem the evidence of the effectiveness of the practice to be profound and the state to meet the continuous quality improvement standard regarding the practice.³¹ DCFS is not requesting a waiver for any services at this time.

Theory of Change

DCFS’ theory of change asserts that families who are struggling with mental health conditions, substance abuse, the lack of parenting skills and problematic family dynamics due to deficits in the five protective factors (Nurturing and Attachment, Knowledge of Parenting and Child Development, Parental Resilience, Social Connections, Concrete Support, and Social and Emotional Competence of Children)³² are at greater risk for child abuse and neglect and are at greater risk of their children being brought into care. Therefore, if DCFS provides families whose children are at risk of being brought into foster care with services that address these core issues then family functioning will improve, less children will enter foster care, and children can remain safely in their home. While DCFS has services that address mental health and substance abuse issues the first phase of Family First implementation really focuses on parenting skills and the protective factors.



Evaluation

DCFS has contracted with an independent evaluator, The University of Arkansas for Medical Sciences (UAMS), to conduct a well-designed and rigorous outcomes evaluation of all programs listed under its initial In-Home Parenting strategies. This includes SafeCare, each Intensive In-Home Services (IIHS) program, Intensive Family Services (IFS - although, IFS will not be included in the evaluation until SFY2021, and Nurturing Parenting Program/Nurturing Families of Arkansas (NPP/NFA). The major objectives of this evaluation are to determine if each service is successful in reducing the removal of children into foster care, reducing maltreatment and subsequent maltreatment, and reducing future involvement with the child welfare system with the overall goals of improving child safety, permanency, and well-being. As implementation expands more programs will be added to the evaluation strategy either through an amendment to the current contract or through an additional procurement process.

As outlined above, DCFS will use the outcomes evaluation, conducted by UAMS, and the results from the CQI process, conducted by PCG to examine all of its in-home parenting interventions collectively to help guide decisions about implementation, expansion, and monitoring outcomes. Special focus will be given to Family Centered Treatment (FCT) as it is the main prevention program for which DCFS is requesting Family First claiming.

Family Centered Treatment Evaluation Plan

As detailed in the California Evidence-Based Clearinghouse for Child Welfare (CEBC)³³, FCT is a strengths-based, trauma informed, and evidence-based family preservation model that provides services to families directly in their homes. FCT is designed for families faced with disruption or dissolution of their family. FCT targets families with members at imminent risk of placement into (or needing intensive services to return from) treatment facilities, foster care, group or residential treatment, psychiatric hospitals, or juvenile justice facilities. As such it provides services to children/adolescents who have one or more of the following: adjustment disorder, post-traumatic stress disorder (PTSD), attention-deficit hyperactivity disorder (ADHD), oppositional defiant disorder, depression, mood disorder, bipolar, disruptive behavior, abusive and neglectful family situations, exposure to violence and domestic violence, and involvement in juvenile crime. It also provides services to the parents/caregivers of these children and parents who experience domestic violence and/or substance abuse.

FCT has six main goals and treatment services typically last 4-6 months:

1. Enable family stability via preservation of or development of a family placement
2. Enable the necessary changes in the critical areas of family functioning that are the underlying causes for the risk of family dissolution.
3. Bring a reduction in hurtful and harmful behaviors affecting family functioning.
4. Develop an emotional and functioning balance in the family so that the family system can cope effectively with any individual member's intrinsic or unresolvable challenges.
5. Enable changes in referred client behavior to include family system involvement so that changes are not dependent upon the therapist.
6. Enable discovery and effective use of the intrinsic strengths necessary for sustaining the changes made and enabling stability.

UAMS will conduct a rigorous quantitative outcomes evaluation using a quasi-experimental design. The research questions specific to FCT will be:

Child Safety Outcomes

1. Will families served by FCT have reduced entry into foster at 6, 12, 18, and 24 months following completion of the intervention as compared to a propensity matched comparison sample?
2. Will families served by FCT have reduced entry into foster care during the treatment period for FCT and propensity-matched non-FCT families? The sample for this research question will include families who were not involved with FCT as a reunification case.
3. Will families served by FCT have reduced true findings and/or open cases after program closure at 6, 12, 18, and 24 months following completion of the intervention as compared to a propensity-matched comparison sample?

Permanency Outcomes

1. Will families served by FCT have increased permanency at 6, 12, 18, and 24 months following completion of the intervention as compared to a propensity-matched comparison sample? The sample for this research question will include families who were involved with FCT as a reunification case to see if FCT families were more likely to be reunified than propensity-matched non-FCT families.

Well-Being Outcomes

2. Will families served by FCT have increased family functioning from entry into to exit from protective services as compared to a propensity-matched comparison sample?
3. Will families served by FCT have increased well-being from entry into to exit from foster care compared to a propensity-matched comparison sample of children who were reunified with their family? The sample for this research question will include families who were involved with FCT as a reunification case to see if FCT supported the child's well-being compared to propensity-matched non-FCT children.

Outcomes Measures

Extracts of quantitative case data from CHRIS, DCFS' case management system, will be used to measure all outcomes in the evaluation of FCT. CHRIS extracts will be generated semi-annually. CHRIS data include family and child characteristics and FFPSA candidacy definitions. CHRIS data also includes case outcomes and dates of relevant case outcomes. The specific dates which will be used in the FCT evaluation include the date of a true finding, and dates of reunification and/or subsequent removal. Family Service Workers also enter intervention information into CHRIS including the date of referral for FCT and other in-home parenting interventions (used to identify and appropriate comparison condition), date of program inception and completion, and whether the family was successful in meeting program goals. The dates of program referral, start, completion, and successful completion of program goals will be verified with billing data which is closely monitored for accuracy.

The Family Advocacy and Support Tool (FAST) assessments are designed for use with the entire family. AR uses the FAST tool within 30 days of protective services case initiation and completes the tool every 3 months. The Arkansas FAST includes multiple indicators of family functioning, including collaboration and supportive relationships among family members, communication and role appropriateness, family conflict and safety, financial resources, housing condition, and residential stability. In addition to general family functioning, the Arkansas FAST includes multiple indicators of the child's status, including relationships with caregiver and others, health status, mental health status and adjustment to trauma, cognitive skills and educational status, and self-regulation and interpersonal skills. Items identified as a '0' are often strengths that can be used in strength-based planning. Items rated a '1' should be monitored and preventive efforts might be indicated. Items rated a '2' or '3' are actionable and should be addressed in the intervention plan.

The Child and Adolescent Needs and Strengths (CANS) assessments are used in Arkansas with youth in out of home placements, with two unique tools created to assess the strengths and needs of children and youth, one for those ages 0–4 and a second for those five years of age and older.

The general method of analysis for determining the success of FCT on outcomes of interest will be a prospective cohort analysis. Each case is measured from a defined starting point that is relevant to the outcomes being analyzed, for example, referral of a case to FCT. From this point in time, prospective data were analyzed to determine whether the outcome occurred within specified time frames as described in the research questions above.

Statistical techniques and quasi-experimental methods

In addition to descriptive and bivariate analyses, the evaluators will make use of a variety of nonexperimental analytic techniques to measure the impact of these services. As in most applied policy research, researchers are generally unable to randomly assign some populations to receive the policy interventions and others to a control group. In the absence of experimental methods, we look to quasiexperimental methods.

Propensity matched analyses will be used to examine each of the outcomes noted above. To reduce selection bias, FCT children will be matched with non-FCT children based on 1:1 propensity matching, as follows. First, a logistic regression model will be fitted to estimate the probability of a child being assigned to the FCT intervention using the child's demographics, mother's demographics, parent and family characteristics used to determine candidacy, and geographic and socioeconomic indicators. These independent variables specifically included the child's gender and age, the mother's race/ethnicity, the number of children in the household, candidacy reasons, and past history or open protective services support, and two indicators based on the family ZIP-code, the rural-urban commuting area code (RUCA) and the ZIP-code-level median household income. Median household income quartiles will be derived from assigning the family address a median household income based on the ZIP-code in which they resided at the time of referral.

A greedy matching algorithm will then be used to match FCT children (cases) and non-FCT children (controls) based on a 1:1 match of those with identical or near identical model-derived propensity to be in the FCT group. The SAS procedure `proc psmatch` will be used to perform both the estimation of propensity score and matching. Exact match may be made on some key characteristics (gender, race/ethnicity, candidacy, and RUCA) if it leads to an improvement of overall balance across covariates. All statistical analyses will be performed using the SAS system for Windows.

To test the association of FCT enrollment and outcomes, UAMS will fit outcome-specific generalized linear models using the SAS `proc glimmix` procedure. Matched pairs will be accounted for in individual generalized linear models by using random variable indicator for the matched-pairs dyad. An intent-totreat design will be used to test differences in outcomes. If sample sizes are sufficient, additional sensitivity analysis may be conducted to subsample FCT participants who successfully completed the intervention. FCT service delivery report data, including dosage/completion data, will be drawn from child/family-level service delivery report data that contracted providers are required to produce and submit to DCFS. Where sufficient service delivery data exists, the preferred method for coding of service delivery data will be as an ordered or continuous variable, specifying dosage from zero to full completion of the intervention. In this way, evaluators will be able to determine the extent to which partial completion of an intervention may impact the intended outcome, as well as allowing for within-group comparisons.

Sample

As described, FCT will be provided by two contractors for services in a total of 28 counties. St. Francis ministries has implemented FCT in 15 counties in the Northern and Eastern parts of Arkansas. Youth Advocate Programs (YAP) will be implementing FCT in an additional 13 counties in the Northern and Southern parts of Arkansas.

Eligible families are those with children aged 0-18. Referrals to FCT are provided from DCFS based on candidacy guidelines. The most common candidacy reasons for referral will include items 2, 3, 4, 5, 6, 11, 12, 13, and 17 as outline in Table 5. The two providers, St. Francis and YAP, will serve approximately 350 families (or an estimated 840 children³⁴) annually. St. Francis and YAP are contracted to serve 121 and 130 families per year, respectively.

According to the DCFS Annual Report Card for SFY 2019³⁵, there were 5,5054 families (12,320 children) in protective services and another 652 families in supportive services. Of the children who began receiving in-home protective services cases one year prior to SFY 2019, six percent experienced a true report of maltreatment within one year. Children ages zero to five made up nearly half (48%) of children involved in in-home protective services cases at the end of SFY 2019.

Power Analysis

UAMS performed a calculation to determine the power to correctly reject null hypothesis, given sample sizes and minimum effect of differences between FCT (treatment/intervention) and non-FCT populations (control) to conclude success of the intervention. UAMS chose to determine power based on reported effects of FCT. UAMS computed a priori power analyses, (using G*Power 3.1.9.4)³⁶, to determine the required sample size given our expected effect sizes. To obtain the expected effect sizes, UAMS used data

reported for FCT in the state of Indiana in which there was a significant difference in family dissolution, with families in FCT significantly more likely to remain intact than non-FCT families (55.61% vs. 39.04%; $d=.34$). They also opted to determine the necessary sample to detect a smaller difference in which families in FCT were less likely to repeat true findings at 6 months post-intervention than non-FCT families (1.68% vs. 4.35%; $d=.16$), which was not significant.

Based on chi-square test analysis, power estimate of at least 0.80, and alpha level of .05, the total sample would have to be 141 to detect the larger effect ($d=.36$) and 635 to detect the smaller effect ($d=.16$). Computing sensitivity using the same assumptions (power=0.80, alpha=.05), our estimated sample of 700 could detect an effect size $d=.15$. UAMS also computed the effect size for a smaller sample (250 matched pairs), a total sample of 500 could detect an effect size $d=.18$. Therefore, even if the sample is smaller than anticipated, we should be able to detect effects that are small to moderate in size.

Challenges and Limitations

There are limitations to the proposed evaluation. The sole reliance on administrative data for outcomes of the current study is one limitation. There are some mechanisms in place at the state level to ensure the correctness and completeness of data. Area supervisors review candidacy with family service workers to ensure the correct candidacy reasons are included in the case files. There is also a nightly verification of social security numbers (SSN) of individuals with open cases, which can be used to correct the SSNs within the file and to ensure unduplicated case numbers for analysis. That said, there are limited resources to conduct data cleaning of individual data elements. As such, there will likely be some data loss due to out of date or range values. The UAMS evaluation team will work with DCFS to correct data elements obtained during the semi-annual data extraction. For example, there are opportunities to identify out of range dates, such as those that occur in the distant past or the future, which will be done to maximize data correctness. It is also possible that enhancements to CHRIS may be required to facilitate documentation. In this case, this may result in a lack of available data and a backlog of information that would require retroactive data entry.

The FAST tool provides opportunities to document changes within families; however, the assessment windows on which Arkansas administers the tool are not directly tied to additional interventions. The FAST is conducted within 30 days of protective services case initiation and completes the tool again every 3 months. Therefore, the use of this tool does not necessarily reflect the beginning and end of FCT services, but rather more closely replicates the beginning and end of protective services.

An additional limitation is inherent in the quasi-experimental design. Randomization is the best method for concluding causation. While propensity matching has strengths for application in child welfare settings, it is possible that unmeasured confounding variables may be present, which would lead to biased results. Another limitation of our proposed analytic plan may be our ability to identify a fully matched comparison population. Clearly, the children/families referred to FCT are a selected group. It is unclear from the sampling whether a matched comparison group within the counties.

An additional limitation is inherent in the quasi-experimental design. Randomization is the best method for concluding causation. While propensity matching has strengths for application in child welfare settings, it is possible that unmeasured confounding variables may be present, which would lead to biased results. Another limitation of our proposed analytic plan may be our ability to identify a fully matched comparison population. Clearly, the children/families referred to FCT are a selected group. It is unclear from the sampling whether a matched comparison group within the counties where FCT is available will be possible to produce. While FCT will not be available in the quantity to serve any eligible family, there are additional services available within the counties served, including other evidence-based programs. If it is not possible to identify a comparison group within the 28 counties in which FCT is available, we will propensity match for a control group within the state, matching on the characteristics described above and on ZIP-code computed RUCA and income to identify a matched sample of families where FCT was not available within the state. Further, power analysis are based on the full sample of families for whom FCT is expected, analyses for subsamples appear sufficiently powered to demonstrate a small effect in the intent to treat design, but large attrition from the FCT intervention may create samples for research question 2 or 3 that are powered for moderate to large effects.

Evaluation Team

The University of Arkansas for Medical Sciences (UAMS) is contracted to develop and implement the evaluation. All personnel are employed by UAMS in the College of Medicine's Department of Family and Preventive Medicine (DFPM), Research and Evaluation Division. Dr. Lorraine McKelvey, Associate Professor, leads the evaluation team. Dr. McKelvey earned her doctoral degree in Developmental Psychology specializing in Applied Developmental Science from Michigan State University. Dr. McKelvey has home visiting research for nearly two decades. She was a member of the research consortium of the national Early Head Start Research Project; a co-investigator of the Pew Charitable Trusts' HV Campaign project that examined the elements of home-based EHS services most related to improved child outcomes: and conducted research of a home visiting program for teen parents using the Healthy Families America (HFA) model. Dr. McKelvey is the lead evaluator for the Arkansas' Maternal, Infant, and Early Childhood Home Visiting programs (HFA, Parents as Teachers, Home Instruction for the Parents of Preschool Youngsters, and Following Baby Back Home) and SafeCare.

See Table 6 for which services will be formally evaluated, for which DCFS is considering requesting waivers for in the future, and which services DCFS will claim FFPSA funding. Information in Table 6 assumes waiver approval for transitional payments until rated on the Title IV-E Prevention Services Clearinghouse and assumes implementation of service occurs on schedule. Adjustments will be made accordingly.

Table 6 Evaluation Type

Intervention	Category	CQI - (Evaluation Waiver- future consideration)	Formal Contracted Evaluation	State CQI and Contract Monitoring	Claiming FFPSA
SafeCare	In-Home Parenting		✓	✓	
Nurturing Families of Arkansas (NPP)	In-Home Parenting		✓	✓	
Intercept	In-Home Parenting		✓	✓	
Family Centered Treatment	In-Home Parenting		✓	✓	✓
Home Builders	In-Home Parenting		✓	✓	
TF-CBT	Mental Health			✓	
PCIT	Mental Health	✓		✓	
CPT	Mental Health	✓		✓	
Child Parent Psychotherapy	Mental Health	✓		✓	
Functional Family Therapy	Mental Health	✓		✓	

Intervention	Category	CQI - (Evaluation Waiver- future consideration)	Formal Contracted Evaluation	State CQI and Contract Monitoring	Claiming FFPSA
Arkansas Cares	Substance Abuse			✓	
MI (DCFS Staff)	Substance Abuse			✓	

DCFS is committed to continuous quality improvement through contract monitoring, evaluation, and CQI. Each contract is overseen by a program manager or an Assistant Director. SafeCare, Intensive In-Home Services (IIHS), IFS, and NFA are all monitored by the In-Home Program Manager. Through initial implementation of Intensive In-Home Services, monthly meetings with the providers are held to discuss implementation barriers and successes. Feedback from field staff is incorporated into these monthly meetings. Providers must also submit a certification of compliance each month along with a monthly report. The information provided in the monthly report is changed as needed to ensure the right information is being reported. Along with the monthly reports, each IIHS provider must submit semiannual and annual reports on the outcomes they are achieving. Regular provider meetings are also held with SafeCare, IFS, and NFA: NFA is a monthly meeting; SafeCare is every other month, and IFS is every quarter. All counseling contracts are monitored by the DCFS Assistant Director of Mental Health. The DCFS substance abuse contracts are monitored by the DCFS TDM Program Manager. DCFS is poised to use the feedback from the evaluation and CQI to improve program implementation, DCFS practice, and refining processes.



Maryland

Status: Approved

Section VI: Evaluation Strategy and Waiver Request

Evaluation and Continuous Quality Improvement Strategy

Family First requires that each program in the Prevention Plan have a well-designed and rigorous evaluation strategy, unless a state is granted a federal waiver of the requirement. While we are seeking this waiver for all of the five reimbursable programs at this time, Maryland intends to continue to further its research to practice agenda related to prevention services. Maryland will work with the evaluation team at the UMB/SSW to ensure that evaluation or continuous quality improvement (CQI) efforts identified for each evidence-based program in the Prevention Plan are implemented. DHS/SSA contracts with UMB/SSW to support its current CQI and evaluation activities. The UMB/SSW has extensive experience supporting several of the interventions in this plan and more generally in providing key technical assistance.

Evaluation Waivers for Well-Supported Interventions

Maryland is seeking an evaluation waiver for all of the programs for which we are requesting title IV-E reimbursement at this time. A waiver is permitted for an evidence-based program designated at the well-supported evidence level by the Clearinghouse if the evidence of effectiveness of the practice is deemed compelling and the continuous quality improvement requirements of Section 471(e)(5)(B)(iii)(II) are met. We are requesting waivers for Healthy Families America (HFA), Nurse Family Partnership (NFP), Functional Family Therapy (FFT), Parent Child Interaction Therapy (PCIT), and Multisystemic Therapy (MST), as identified in Table 4. See Appendix E for Maryland’s official evaluation waiver requests for well-supported interventions.

Table 4. Evaluation or requested CQI per evidence-based program

Type	Evidence-Based Program	Planned/Future Evaluation	CQI (evaluation waiver request)
Parenting	Healthy Families America		✓
	Nurse Family Partnership		✓
	Nurturing Parenting Program <i>(not currently title IV-E reimbursable)</i>	✓	
Mental Health	Family Centered Treatment <i>(not currently title IV-E reimbursable)</i>	✓	
	Functional Family Therapy		✓
	Parent Child Interaction Therapy		✓
	Multisystemic Therapy		✓
Substance Use Disorder	Sobriety Treatment and Recovery Teams <i>(not currently title IV-E reimbursable)</i>	✓	

Compelling Evidence Review for Healthy Families America

The evidence in favor of the use of HFA as a means of promoting positive family dynamics and reducing the risk of foster care placements in Maryland is compelling enough to warrant a waiver. This request for a waiver of the evaluation requirement for Healthy Families America is based on the following:

1. HFA has been shown to be efficacious in a wide variety of geographic locations, suggesting wide applicability,
2. HFA has demonstrated flexibility and favorable outcomes among children of various cultural backgrounds and with underlying problems, suggesting wide applicability, and
3. HFA has demonstrated effectiveness with one or more target populations that shares characteristics with one or more target populations in Maryland.

HFA is efficacious in a wide variety of geographic locations, suggesting wide applicability. The Clearinghouse identifies a number of well-designed studies demonstrating the efficacy of HFA to cultivate and strengthen nurturing parent-child relationships, promote healthy childhood growth and development, and enhance family functioning by reducing risk and building protective factors in a variety of geographical locations, including Alaska (Duggan, Berlin, Cassidy, Burrell, & Tandon, 2009; Cluxton-Keller et al., 2014), Hawai'i (El-Kamary et al., 2004; BairMerritt et al., 2010; McFarlane et al., 2013), New York (Rodriguez, Dumont, Mitchell-Herzfeld, Walden, & Greene, 2010; Kirkland & Mitchell-Herzfeld, 2012; Lee, Kirkland, Miranda-Julian, & Greene, 2018), and Oregon (Green, Tarte, Harrison, Nygren, & Sanders, 2014; Green, Sanders, & Tarte, 2017; Green, Sanders, & Tarte, 2018). HFA's effectiveness in this diverse array of geographic locations indicates the model's wide applicability and suggests that it will also produce positive outcomes in Maryland.

A closer analysis of two key studies of HFA further illustrates two different, successful approaches to utilizing HFA to cultivate and strengthen nurturing parent-child relationships, promote healthy childhood growth and development, and enhance family functioning by reducing risk and building protective factors. First, in their study of Healthy Families Oregon, Green et al. (2018) found that HFA participation was associated with fewer gaps in health insurance coverage and with completion of more well-baby visits and immunizations—and that the magnitude of the program's effect grew with longer lengths of participation. Lee et al. (2018) conducted a randomized controlled trial of Healthy Families New York for a subgroup of mothers who had at least one substantiated child protective services report before enrolling in the program. They found that by the child's seventh birthday, mothers enrolled in HFA were as half as likely as mothers in the control group to have been substantiated for child maltreatment.

The immense body of literature demonstrating HFA's efficacy in a variety of geographical locations suggests the intervention would be successful in Maryland, as well.

HFA has demonstrated flexibility and favorable outcomes among children from various cultural backgrounds and with underlying problems, suggesting wide applicability. In addition to demonstrating favorable outcomes in multiple geographical locations, HFA has been found to be effective for families across a variety of cultural backgrounds and among children with various underlying problems. For example, Barlow et al.'s (2006) study assessing the impact of HFA on pregnant American Indian adolescents demonstrates that mothers in the intervention compared with mothers in the control group

had significantly better outcomes, including higher parent knowledge scores and scoring significantly higher on maternal involvement scales. Blair-Merritt et al.'s (2010) work also demonstrates HFA's treatment effect among mothers who reported instances of intimate partner violence, concluding that those who received HFA services reported lower rates of physical assault victimization and significantly lower rates of perpetration relative to the control group. Lee et al. (2009) found HFA to be effective for families across a variety of cultural backgrounds by demonstrating HFA's effectiveness in reducing adverse birth outcomes among socially disadvantaged pregnant women, two-thirds of whom were black or Hispanic.

Based on HFA's well-established track record producing positive outcomes for children and families with diverse cultural backgrounds and underlying problems, DHS/SSA posits that HFA is widely applicable. Therefore, DHS/SSA believes HFA can be effective across the myriad socio-cultural backgrounds and among children with a range of underlying problems in Maryland.

HFA has demonstrated effectiveness with one or more target populations that shares characteristics with one or more target populations in Maryland. HFA has been proven effective for improving outcomes in its target population, pregnant and parenting families with young children. This target population also aligns with the characteristics of Maryland's Family First target population. Family First identifies pregnant and parenting foster youth as a uniquely eligible population for preventative services. Maryland's administrative data reveal that 83 pregnant and parenting young people were in foster care on June 30, 2018, with 49 dependent children. DHS/SSA believes this number does not account for all youth in foster care who are pregnant or parenting as there is some inconsistency across local departments in reporting this circumstance and how such young people receive parenting supports. Moreover, Maryland's foster care entry rate is nearly four times as high for children under age one than for children overall. It is clear that HFA's target population aligns well with the characteristics and needs of the children and families who will be service through Family First in Maryland.

Compelling Evidence Review for Nurse-Family Partnership

Considerable evidence exists to support using Nurse-Family Partnership (NFP) in Maryland as a way to improve pregnancy outcomes and women's health, promote early childhood development, build parenting capacity, and strengthen the economic well-being of mothers. This evidence is strong enough to merit a waiver. This request for a waiver of the evaluation requirement for NFP is based on the following:

1. NFP has been shown to be efficacious in a wide variety of geographic locations, suggesting wide applicability,
2. NFP has demonstrated flexibility and favorable outcomes among children of various cultural backgrounds and with underlying problems, suggesting wide applicability, and
3. NFP has demonstrated history of success with its target population of pregnant which shares characteristics with the target population in Maryland.

NFP has been shown to be efficacious in a wide variety of geographic locations, suggesting wide applicability. The Clearinghouse review of NFP assessed a variety of well-designed studies to understand the program's effectiveness of improving the well-being of first time mothers and their children. Through randomized controlled trials, various studies have revealed NFP's effects on parent and child outcomes in a variety of locations, contexts, and populations (e.g. Olds, 2002; Olds et al., 2004; Matone et al., 2012; Olds

et al., 2014; Mejdoubi et al., 2015; Robling et al., 2016). Of the seven highest rated studies and evaluations assessed by the Clearinghouse, two focused on NFP application in the United Kingdom and the Netherlands (Mejdoubi et al., 2015; Robling et al., 2016) and two assessed NFP's effectiveness in the United States, focusing on implementation in Colorado, Tennessee, New York, and Pennsylvania (Olds, 2002; Matone et al., 2012; Thorland, Currie, Wiegand, Walsh, & Mader, 2017). All studies have demonstrated NFP's success with participants from a range of ethnicities, racial backgrounds, education levels, and marital status. Its universal application strongly suggests that it would be effective in Maryland to improve health and well-being outcomes for first-time, young mothers and their children from low-resource homes.

NFP has demonstrated flexibility and favorable outcomes among children of various cultural backgrounds and with underlying problems, suggesting wide applicability. Research has continuously shown a positive association between NFP use and favorable behavioral health, well-being, and education outcomes for new mothers and their children from a variety of races, ethnic backgrounds, education level, and marital status. Maryland is especially interested in implementing NFP to support low-resource, first-time mothers. In 2016, Maryland's teen pregnancy rate (women between the ages of 15 and 19) was approximately 15.9 births per 1,000 (HHS, 2018). While lower than the national average of 20.3 births per 1,000, approximately 45 percent of mothers under the age of 20 were non-Hispanic, black women (Health and Human Services, Office of Population Affairs, 2016). With this in mind, interventions to support pregnant and parenting youth in Maryland must be universal and applicable to a variety of racial and ethnic populations. All the studies included in this justification assessed NFP's impact in racially diverse study populations and demonstrated NFP's effectiveness.

Even more compelling is NFP's demonstrated flexibility in adapting to a variety of contexts and cultures. First developed in the United States by Dr. David L. Olds in 1977 (Nurse-Family Partnership, 2019), NFP has grown over four decades to be implemented in 41 states. It has even been adapted to serve young women and their children in the United Kingdom and the Netherlands (Mejdoubi et al., 2015; Robling et al., 2016). In the Netherlands context, it was successfully translated into Dutch and culturally adapted as an intervention that systematically addresses risk factors during prenatal and early infancy period. NFP's continued effectiveness in child and parent outcomes, even when adapted and translated to fit certain cultural contexts, further demonstrates that it is likely to be applicable in Maryland's context without compromising core elements of its design.

NFP has demonstrated history of success with its target population of pregnant which shares characteristics with the target population in Maryland. Randomized controlled trials in the United States showed success in achieving favorable outcomes for children's development and maternal health through higher breastfeeding and immunization rates. Breastfeeding is known to support positive health outcomes for both mothers and their children, including child cognitive and sensory development and lowered risk of common childhood illnesses and reduced likelihood of diabetes and lowered risk of ovarian and breast cancer in mothers (Stuebe, 2009). In a 2017 NFP evaluation, researchers from the Nurse-Family Partnership National Service Office, the Colorado School of Public Health, Chapin Hall at the University of Chicago, and the

University of Chicago found that first-time mothers receiving home visits from nurses through NFP were significantly more likely to breastfeed and maintain breastfeeding at 6 and 12 months compared to their counterparts (Thorland et al., 2017). The study also found that the children of NFP participants were significantly more likely to be up to date on immunizations at 6 months compared to the control group. Over three-quarters of the women included in this study's population were less than 22 years old, with over half 19 years old and younger, from urban and rural settings. Given Maryland's desire to implement NFP for young, first-time mothers across its rural and urban county environments, similar to this study's population, it is reasonable to assume that mothers and children receiving NFP in Maryland would achieve similar health and well-being outcomes through improved breastfeeding and immunization rates.

In addition, NFP has demonstrated effectiveness for young mothers with certain health risk factors. While these families are considered low risk of entering foster care, they may exhibit certain behaviors, such as alcohol and tobacco use, that can put them at risk of developing additional medical and behavioral health needs. A 2012 study found the relationship between NFP and tobacco use cessation during pregnancy to be particularly strong (Matone et al., 2012). Pregnant women who smoked and were recipients of NFP were more likely to quit smoking by the third trimester than that their counterparts in the control group. While smoking tobacco does not carry the same health risks or addictive qualities as other controlled substances, it does raise a compelling question if NFP application can have similar effects supporting young mothers with substance use disorders. NFP's model is built on the premise that nurses visiting young mothers in their homes can build trust with families, serve as a parenting resource, and provide a support network. For mothers struggling with addiction and facing the challenge of caring for substance-exposed newborns, NFP nurses could support mothers seeking treatment and monitor newborns for additional health concerns. This is especially pertinent in Maryland as DHS/SSA hopes to implement NFP in families with substance-exposed newborns.

Prior success with pregnant and parenting youth in low-resource settings and long-term effects. The program has been especially successful for single, welfare-eligible mothers living in highly disadvantaged neighborhoods in urban areas. Substantial evidence is available to demonstrate NFP's longer-term effects on child development outcomes and child cognitive functioning in low-resource families, even after nurse home visits have stopped. Researchers followed up with study participants six years after they had received the NFP intervention when children were between six and nine years old (Olds et al., 2014). The evaluation found that children born to low-resource mothers from the NFP intervention group had improved behavioral functioning, better receptive language, and sustained attention in early childhood and at school entry, compared to the control group. In addition, this group was found to use fewer therapeutic services before the age of six and were less likely to be enrolled in special education or remedial services during the first three years of elementary school. While the strength of NFP's effects generally lessened by the time children were six years old, the program's sustained impact on child development outcomes for two to four years after nurse home visits stopped is compelling for Maryland as it looks to implement NFP with pregnant and parenting youth in low-resource settings.

From the evidence outlined above for NFP, it is clear that an evaluation of NFP, a well-supported evidenced-based practice, is not necessary for Maryland's five-year prevention plan. Multiple studies across the United States and globally demonstrate NFP's effectiveness supporting pregnant and parenting youth to improve competent parenting, parent and child health outcomes, child development, and safety.

With this in mind, DHS/SSA finds that current CQI measures and processes will provide sufficient monitoring and evaluation of NFP's implementation in Maryland.

Compelling Evidence Review for Functional Family Therapy

More than 30 years of clinical research shows that FFT has positive outcomes for youth from diverse ethnic and cultural backgrounds, including but not limited to significant and long-term reductions in youth re-offending and substance use; significant effectiveness in reducing sibling entry into high-risk behaviors; high treatment completion rates; and positive impacts on family communication, parenting, and youth problem behavior; and reduction of family conflict. FFT been identified as an evidence-based model (or equivalent rating) on several nationally recognized EBP registries, and has been rated as a well-supported program on the Clearinghouse. An evaluation waiver is requested for FFT is requested due to evidence of the following:

1. FFT has been shown to be efficacious in a wide variety of geographic locations, suggesting wide applicability, and
2. FFT has demonstrated effectiveness with one or more target populations that shares characteristics with one or more target populations in Maryland.

FFT has been shown to be efficacious in a wide variety of geographic locations, suggesting wide applicability. FFT has been successfully implemented across a range of community-based settings and child-serving systems (e.g., Alexander & Parsons, 1973; Alexander, Pugh, Parsons, & Sexton, 2000; Alexander, Waldron, Robbins, & Neeb, 2013). For example, studies reviewed by the Title IV-E Clearinghouse demonstrated a moderate or high degree of effect on target populations in locations as diverse as the United Kingdom, New Jersey, Washington State, and New York City. Across these studies, effects were shown for young people residing in rural, suburban, and urban settings. Moreover, research demonstrates FFT's effectiveness with racially diverse target populations. Whereas much literature demonstrates effectiveness with white youth (Barnoski, 2002, 2004), a subset of studies demonstrate positive effects among predominantly Latino and African American youth (Darnell & Schular, 2015). In summary, the effectiveness of FFT across diverse geographic settings and with racially diverse target populations suggests that it is likely to work across Maryland's geographically diverse localities and racially diverse target population.

FFT has demonstrated effectiveness with one or more target populations that shares characteristics with one or more target populations in Maryland. FFT has been shown to be effective with target populations similar to those served by Maryland under Family First, and to improve outcomes that reflect key reasons why youth in Maryland enter foster care.

According to the Title IV-E Clearinghouse, multiple studies have demonstrated significant evidence that FFT is effective in addressing youth substance use (Slesnick & Prestopnik, 2009), delinquent behavior (Barnoski, 2004; Darnell & Schuler, 2015), and behavioral functioning (Sexton & Turner, 2010; Celinska, Furrer, & Chang, 2013). These outcomes are highly relevant to Maryland's Family First target population, as

criteria for imminent risk include Children and Youth with current Department of Juvenile Services involvement, youth substance use disorders. Moreover, child substance abuse is contributes to 7% of removals in Maryland, and 10% in Baltimore, the state's largest jurisdiction that also has one of the highest foster care entry rates statewide. Child behavior contributes to 15% of removal statewide, and 8% of those in Baltimore. Due to the alignment of FFT's target population and youth targeted through Family First in Maryland, as well as FFT's demonstrated effectiveness to address outcomes shown to be significant contributors to foster care entry statewide, DHS/SSA is confident that this program will produce positive effects in Maryland.

Compelling Evidence Review for Parent-Child Interaction Therapy

There is compelling evidence in favor of using PCIT to reduce the risk of foster care placements, and promote positive family dynamics and healthy parenting, and improve child behavioral health in Maryland. Furthermore, the weight of this evidence prompts the DHS/SSA to request a waiver from the Family First evaluation requirements for PCIT. This waiver request is based on the following:

1. PCIT has demonstrated flexibility and favorable outcomes among children of various cultural backgrounds and with underlying problems, suggesting wide applicability,
2. PCIT's target population has a high degree of relevance to the Family First target population in Maryland.

PCIT has demonstrated flexibility and favorable outcomes among children of various cultural backgrounds and with underlying problems, suggesting wide applicability. PCIT has demonstrated positive outcomes for children and families of multiple ethnicities, languages, and cultural backgrounds. For example, randomized clinical trials have shown positive outcomes for Mexican-American children and their families in the United States (McCabe & Yeh, 2009), Chinese families in Hong Kong (Leung, Tsang, Sin, & Choi, 2015), children and adolescents in Norway (Bjorseth & Wichstrom, 2016), and children and families in the United States (Solomon, Ono, Timmer, & Goodlin-Jones, 2008). This evidence suggests that PCIT is highly effective across a wide variety of geographic and cultural contexts, and therefore is also likely be effective with the diverse children and families throughout the state of Maryland. Moreover, PCIT has been shown effective for children with a wide range of underlying problems and psychological needs, such as ADHD (Leung, Tsang, Ng, & Choi, 2017), autism (Solomon et al., 2008), mental retardation (Bagner & Eyberg, 2007), and disruptive behavior (Abrahamse, Junger, van Wouwe, Boer, & Lindauer, 2016). PCIT has also had significant success with children who have experienced maltreatment (Thomas & Zimmer-Gembeck, 2011). Research demonstrated that the core components of PCIT are widely applicable. These results suggest that PCIT is likely to be effective for a range of children and families in Maryland as well.

PCIT has a high degree of relevance to the Family First target population in Maryland. According to the research reviewed by the Clearinghouse, PCIT is particularly effective in bringing about improvements in child emotional and behavioral health. Child emotional and behavioral health problems are prevalent in many child welfare system's in-home and foster care populations, but are particularly prominent in Maryland's caseloads. As described in Maryland's Prevention Plan, parents, caregivers, and children who have complex psychological and behavioral needs are vulnerable for entry into foster care. This group makes up approximately 15% of foster care entries. Families with prior child welfare experience, many of whom have had history with child maltreatment, are another target population described in the Prevention

Plan. Because of PCIT's demonstrated effectiveness addressing one of the most prevalent problems contributing to foster care entries in Maryland, DHS/SSA believes that it will be highly effective in the state.

As detailed above, the literature makes a strong case for the flexibility and efficacy of PCIT for children and families from a wide array of cultural backgrounds and underlying problems. Moreover, the target population for whom PCIT has been found effective aligns with the needs and characteristics of children and families targeted through Family First in Maryland. Therefore, DHS/SSA requests an evaluation waiver for PCIT.

Compelling Evidence Review for Multisystemic Therapy

There is compelling evidence in favor of using MST to decrease engagement in delinquent activity, promote youth behavior change, and reduce the risk of out-of-home placements for youth and adolescents in Maryland. The weight of this evidence DHS/SSA to request a waiver from the Family First evaluation requirements for MST. This evaluation waiver request is based on the following:

1. MST has been shown to be efficacious in a wide variety of geographic locations, suggesting wide applicability, and
2. MST has demonstrated effectiveness with one or more target populations that shares characteristics with one or more target populations in Maryland.

MST has demonstrated flexibility and favorable outcomes across geographic locations and contexts. Studies have demonstrated the effectiveness of MST across geographic locations. For example, studies have demonstrated positive outcomes for MST in the Netherlands (Asscher et al., 2014), England (Fonagy et al., 2018), Norway (Ogden & Halliday-Boykins, 2004), and the United States (Johnides, Borduin, Wagner, & Dopp, 2017). MST has also been shown effective in a range of settings, including community mental health (Henggeler, Melton, Brondino, Scherer, & Hanley, 1997) and juvenile justice systems (Weiss et al., 2013). MST's effectiveness across geographic locations and contexts suggests its wide applicability, and suggests that it will also be effective in Maryland.

MST has demonstrated effectiveness with one or more target populations that shares characteristics with one or more target populations in Maryland. MST has been shown to be extremely effective at improving conduct among youth and adolescents with behavior problems, including antisocial and violent behaviors (Henggeler et al., 1997; Jansen et al., 2013), justice system involvement (Schaeffer & Borduin, 2005; Weiss et al., 2013), and substance abuse (Henggeler et al., 1991). Child behavior problems contribute significantly to foster care entry in Maryland, as child behavior contributed to 14% of entries and child substance abuse contributed to 7% of entries.² Moreover, Maryland is specifically targeting these populations through Family First. As described in Maryland's Prevention Plan, target populations include children and youth who are involved with the Department of Juvenile Services who are at risk of entering an out-ofhome placement, children with substance use disorders, and children with complex psychological or behavioral needs. Because of the alignment between MST's target population and the children and families who Maryland will serve under Family First, DHS/SSA believes that MST will be highly effective in Maryland.

In conclusion, MST has been validated as an effective means of improving outcomes among groups that bear great similarity to two target populations in Maryland. A large body of literature supports it as an intervention with violent juvenile offenders, juvenile delinquents, and youth with antisocial behavior and chronic conduct problems, suggesting it will be effective in Maryland. Furthermore, because research presents strong evidence for the flexibility and efficacy of PCIT to improve outcomes for children and families in varied geographic locations and settings, and for target populations are aligned with those of Maryland's Family First target population, DHS/SSA believe that MST will be highly effective in Maryland. Therefore, DHS/SSA requests an evaluation waiver for PCIT.

CQI Strategy

DHS/SSA will partner with the Institute and the Maryland Department of Health (MDH), Maternal and Child Health Bureau to continue and enhance CQI strategies for the well-supported evidence-based programs included in Maryland's Prevention Plan (i.e. HFA, NFP, FFT, PCIT, and MST). Each service will be continuously monitored to ensure fidelity to the practice model, to determine outcomes achieved, and ensure that information gleaned from the continuous monitoring efforts will be used to refine and improve practices. Specific CQI processes for each well-supported intervention is as follows:

Healthy Families America and Nurse Family Partnership

Both home visiting EBP models, HFA and NFP, are overseen by the MDH as the managing entity of MIECHV grants to local implementing agencies. MDH's CQI framework supports quality services so programs can better meet the requirements of their respective home visiting models and, ultimately, ensure that the maximum number of families can achieve the highest level of success. MDH employs a CQI Consultant who is responsible for the implementation of CQI activities among the MIECHV funded home visiting sites. CQI activities include quarterly monitoring of CQI projects, training and technical assistance.

MDH utilizes the Lean Six Sigma strategies which are an introduction to tools, techniques, and methodologies that empower and encourage improvement. These strategies take a deeper dive into the lenses of providing quality work for better public health outcomes. Strategies learned assist the CQI leads to better problem-solve and identify frameworks for improvement. CQI efforts are localized, ensuring that each program is able to identify the performance successes and challenges, and implement plan-do-study-act cycles that are tailored to their specific context. Fidelity is monitored directly with the model purveyors, HFA and NFP, and periodically verified by MDH.

A Data and Fiscal Program Administrator collects quarterly data from each local implementing agency and analyzes child and family outcomes, service use and capacity. MDH and DHS/SSA have a data sharing agreement to support sharing data on the child welfare history and involvement of families served in the home visiting programs. MDH and DHS/SSA are refining these data sharing agreements and developing memoranda of understanding (including with local agencies as appropriate) to share service, fidelity and outcomes data proactively and align CQI activities related to the families served through this Prevention Plan.

Functional Family Therapy

Both DHS/SSA and DJS contract with The Institute to assist with implementation and CQI/evaluation efforts. Further, DHS/SSA and DJS have implementation teams at the State and local levels that regularly (monthly and quarterly) review data, monitor performance, identify solutions for implementation challenges, and identify opportunities to enhance implementation, sustainability, and outcomes, using a continuous quality improvement approach. These teams include referring agency staff, provider staff, as well as other stakeholders who can contribute to successful implementation (e.g., from the Local Management Boards or Core Service Agencies).

The Institute receives data extracts from FFT, LLC on treatment-specific data, including fidelity indicators as well as additional implementation data from providers. The implementation data includes information regarding the referral process and other data elements useful to support CQI. Both data sets are collected monthly, merged, reviewed for potential errors and/or missing data, and cleaned with providers, if necessary. The data are compiled into monthly, quarterly, annual, and ad hoc reports that summarize utilization, fidelity, and outcomes (including child welfare and juvenile justice involvement) on an annual basis, among other data elements. The implementation teams use this data in regular meetings to inform implementation monitoring. Technical assistance staff from FFT LLC and The Institute assist stakeholders to assess implementation data and other qualitative information to devise strategies and make program/practice improvements as needed. The Institute also coordinates Learning Collaboratives for referring agencies, providers and other stakeholders, organizing agendas geared towards strengthening FFT practice and implementation across the State.

Parent Child Interaction Therapy

Under previous initiatives, The Institute worked with PCIT International to establish a logic model, data collection template, and data reports that support model implementation and fidelity monitoring. Like other models, SSA established local and state implementation teams who review the data as well as feedback from the PCIT Master Trainer and stakeholders to assess implementation and devise strategies to improve/enhance implementation, as needed. The Institute uses procedures for compiling, cleaning, analyzing, and reporting the data, so that it informs implementation monitoring efforts. Institute staff, along with the PCIT Master Trainer, also provide technical assistance on implementation and organize PCIT Learning Collaborative meetings to bring stakeholders together with the goals of increasing awareness and education of PCIT as well as supporting potential expansion.

Multisystemic Therapy

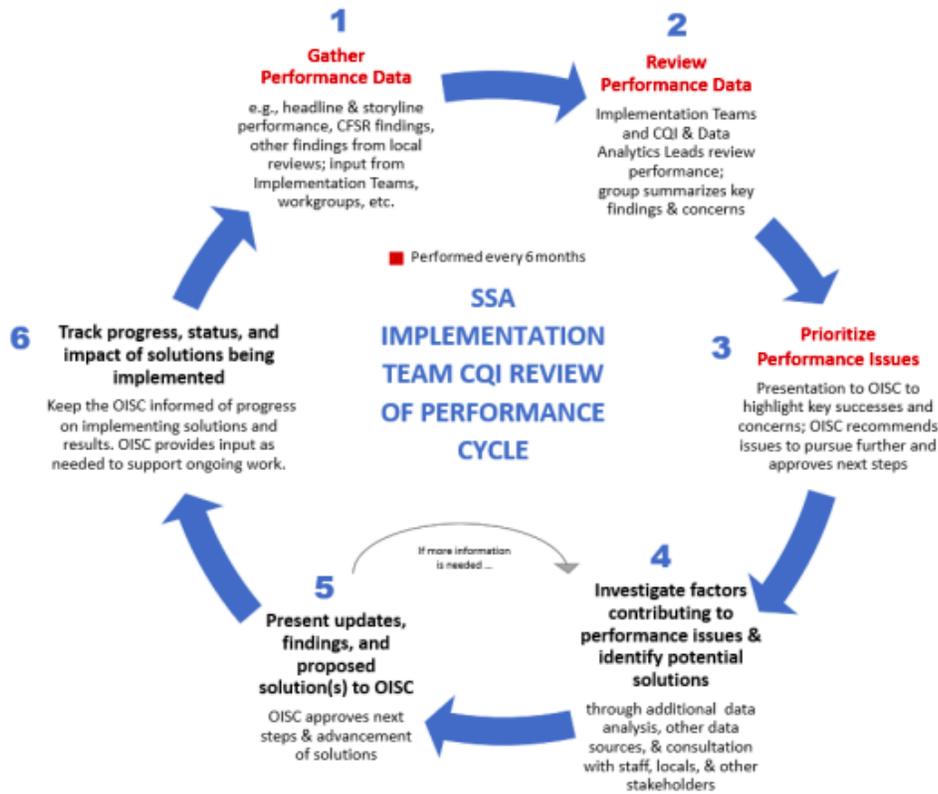
Both DHS/SSA and DJS contract with The Institute to assist with implementation and CQI/evaluation efforts. Further, both DHS/SSA and DJS have implementation teams at the State and local levels that conduct monthly and quarterly reviews of the data, monitor performance, identify solutions for implementation challenges, and identify opportunities to enhance implementation, sustainability, and outcomes, using a continuous quality improvement approach. These teams include referring agency staff, provider staff, as well as other stakeholders who can contribute to successful implementation (e.g., from the Local Management Boards or Core Service Agencies).

Similar to other EBP CQI procedures, The Institute receives monthly data extracts from MST Services as well as additional implementation data from providers (e.g., more specific information regarding the referral process and other data elements useful to support CQI/evaluation in Maryland). The data sets are merged, reviewed for potential errors and/or missing data, and cleaned with providers, if necessary. The data are compiled into monthly, quarterly, annual, and ad hoc reports that summarize utilization, fidelity, and outcomes, among other data elements, for stakeholders to use in their regular meetings to inform implementation monitoring. The MST Expert and other Institute staff provide technical assistance to assist stakeholders in implementation meetings to assess data and other qualitative information to devise strategies and make program/practice improvements as needed. Institute staff also coordinate and facilitate MST Learning Collaboratives for referring agencies, providers and other stakeholders.

In addition, DHS/SSA will work with UMB/SSW and The Institute to ensure collaboration among key stakeholders in program level CQI and use of data to guide implementation strategies by: (1) convening regular meetings with the purveyors to coordinate implementation activities (e.g., training), discuss/resolve implementation issues, and plan for program changes, as needed; (2) supporting training and technical assistance for DHS/SSA, local departments, and provider partners to form and maintain implementation teams; (3) supporting the provision of on-going technical assistance to local implementation teams to use data to identify implementation challenges and to develop strategies and solutions; and, (4) supporting the development and facilitation of an evidence-based program Stakeholder Collaborative to include opportunities for public and private agencies across jurisdictions to share data, outcomes, implementation challenges, and potential strategies for improvements.

At the agency level, Maryland will integrate the data and implementation reports into its ongoing CQI processes. As noted above, CQI is carried out within DHS/SSA's Implementation Structure, an organizational structure nested within DHS/SSA in partnership with system partners, to advance key priorities in order to achieve the agency's strategic direction. Figure 3 shows the CQI cycle operationalized in Maryland.

Figure 3. SSA Implementation Team CQI Review of Performance Cycle



During the first year of Family First, the CQI cycle will focus on a review of data and information related to implementation, including but not limited to data to address the process evaluation questions noted below. This will provide SSA with a firm understanding of how evidence-based programs are being implemented, the status of implementation drivers and supports and allow for proactive management of the evidence-based programs to ensure implementation success. In subsequent years, proximal and distal outcomes will be examined, as data become available and as implementation stabilizes sufficiently to allow for outcomes assessment.

Finally, DHS/SSA engages each local jurisdiction as they participate in Maryland Child and Family Service Reviews (CFSR) with a focused discussion on the local department’s performance. This discussion focuses on DHS/SSA headline indicators related to safety, permanency and well-being, the story that provides context for that performance and the use of particular approaches interventions that may impact child and family outcomes. DHS/SSA and the local department identify areas of outstanding performance and those in need of improvement during this engagement and couple them with the local department’s MD CFSR findings to guide the local department’s improvement efforts. Additionally, Maryland anticipates that some of the children and families served by the Prevention Plan will be a part of the cases sampled to undergo a qualitative review in a MD CFSR, allowing SSA an additional opportunity to explore the contributions of prevention programs to child and family outcomes and areas for improvement.

Evaluation Strategy

DHS/SSA has mentioned three evidence-based programs in this Prevention Plan that currently are not identified as well-supported by the Clearinghouse: Family Centered Treatment, Sobriety Treatment and Recovery Teams and Nurturing Parenting Program. As previously stated, their inclusion here is to indicate Maryland's intent to include these programs in an amended Prevention Plan when they are deemed allowable by the Children's Bureau. As such a full evaluation plan is not included here. The evaluation strategy for each, if required because of their evidence level, will be designed to meet the particular circumstances of each evidence-based program. SSA will work with our evaluation partners to develop a specific evaluation plan to determine the evaluation questions, appropriate measures, indicators, data sources, and analytic approaches for each intervention that is not rated as well-supported by the Clearinghouse. Included in our evaluation strategy will be the development of a dissemination plan to share the evaluation findings.

Research Questions

SSA plans to use a mixed-methods approach to conduct process and outcome evaluations of the promising and supported evidenced based programs included in the Prevention Plan. Preliminary research questions that have been identified to drive the evaluations and our CQI efforts include:

Processes:

- To what extent was the program delivered with fidelity to the program model?
- To what extent did the service get delivered to the target population of evidence-based program?
- To what extent did targeted populations enroll and to what extent did they sustain participation?
- To what extent did DHS/SSA (and sister agencies and partners, as applicable) support implementation of the evidence-based program?

Outcomes:

- To what extent are participating children and families experiencing better mental health, substance abuse, and parenting outcomes as prescribed by each evidence-based program model?
- To what extent has the program kept a child from entering foster care within one and two years of receipt of the evidence-based program?

In addition, SSA will examine research questions that transcend individual evidence-based programs and instead examine the degree to which the state's comprehensive prevention strategy is working. These questions may include:

- To what extent is the Family First eligibility assessment and documentation process being performed consistently by workers?
- To what extent are families being referred to the right services to meet their needs?
- To what extent does SSA's preventive service array align with the needs of the target populations?
- To what extent is SSA's coordination and collaboration successful with sister agencies on individual shared cases



Washington, DC

Status: Approved

Section VI: Evaluation Strategy and Waiver Request

Evaluation Strategy and Waiver Request Pre-print Sections 2 and 4 Purpose of Evaluation

As reflected previously in this prevention plan, CFSA proposes to offer a comprehensive array of evidence-based prevention services to children and families at risk of becoming involved with the child welfare system. The legislation states that programs whose evidence of effectiveness is supported or promising will be formally and rigorously evaluated by CFSA, as outlined within this evaluation strategy. As permitted through the legislation with the approval of an evaluation Waiver, the implementation and effectiveness of well-supported programs will be assessed through robust CQI internal to CFSA rather than through formal evaluations. However, due to the existing federal funding mechanisms in place to support the existing service capacity, at the time of this submission, CFSA will be focusing on the implementation of the PAT model only for Family First claiming. As more EBPs are reviewed and approved by the Title IV-E Prevention Services Clearinghouse, the District may submit an amendment to the five year plan with a description of the updated evaluation plan. It should be noted that while CFSA will focus on PAT for Family First, in support of its city-wide prevention services evaluation and CQI strategy, CFSA will leverage evaluation and State level CQI to examine all interventions collectively, comparing outcomes against federal and local outcomes of children, youth, and families served during the first five years of the prevention plan.

The evidence-based programs that will be monitored through CQI for Family First, formally evaluated, or monitored through CQI as part of the local prevention services CQI strategy below (State level CQI) are listed below in Table 6. While information in this table assumes the accuracy of the estimated Title IV-E Prevention Services Clearinghouse ratings listed in Tables 2 and 3 above, adjustments will be made if Title IV-E Prevention Services Clearinghouse results are released that do not align with the estimates.

Table 6: EBPs Formal Evaluation or CQI Strategy*

Prioritized Interventions	CQI (<i>Formal evaluation Waiver</i>)	Formal Evaluation	State Level CQI	Claiming FFPSA
Parents as Teachers (PAT)	✓		✓	✓
Nurturing Parent Program (NPP)			✓	
Healthy Families America (HFA)			✓	
Chicago Parenting Program (CPP)			✓	
Effective Black Parenting Program (EBPP)			✓	
Transition to Independence (TIP)			✓	
YVLifaset			✓	
Motivational Interviewing (MI)			✓	
Project Connect			✓	
Adolescent Community Reinforcement Approach (A-CRA)			✓	
Recovery Coaches			✓	
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)			✓	
Multi-Systemic Therapy (MST)			✓	
Functional Family Therapy (FFT)			✓	
Parent Child Interaction Therapy (PCIT)			✓	
Parents Anonymous			✓	

Evaluation and CQI Capacity and Approach

CFSA is deeply committed to evaluating the effectiveness of the supported and promising programs we invest in through Family First and to carrying out robust CQI to understand fidelity and outcomes for well-supported programs. Moreover, we are poised to use the evidence gained through the evaluations and CQI to inform refinements to program implementation, changes to the service array, and practice improvements. As mentioned previously, lessons learned from the Waiver point to the importance of monitoring and ongoing refinement of business processes and implementation in order to maximize the impact of EBPs. Utilizing evaluation and CQI findings intentionally to improve practice and service provision will be critical to our success in carrying out the vision inspired by Family First.

Accordingly, CFSA has marshalled the following internal and external resources for completing rigorous evaluations of programs and robust CQI as part of Family First.

- Internal Evaluation Team: CFSA is currently preparing to hire Senior Evaluation Leads, specifically to design, lead, carry out, document, and communicate evaluations for supported and promising programs under Family First, as well as manage CQI for well-supported programs. These staff are expected to possess expert knowledge of evaluation design and methodology. They will sit within CFSA’s Community Partnerships Administration where they will be deeply rooted in the

programmatic aspects of Family First implementation, supporting the team's analysis using implementation science and CQI activities, while also serving as cross-functional data-analytics team in partnership with CFSA's Performance Accountability and Quality Improvement Administration (PAQIA), where they will receive direct support from PAQIA analysts responsible for generating CFSA's administrative data.

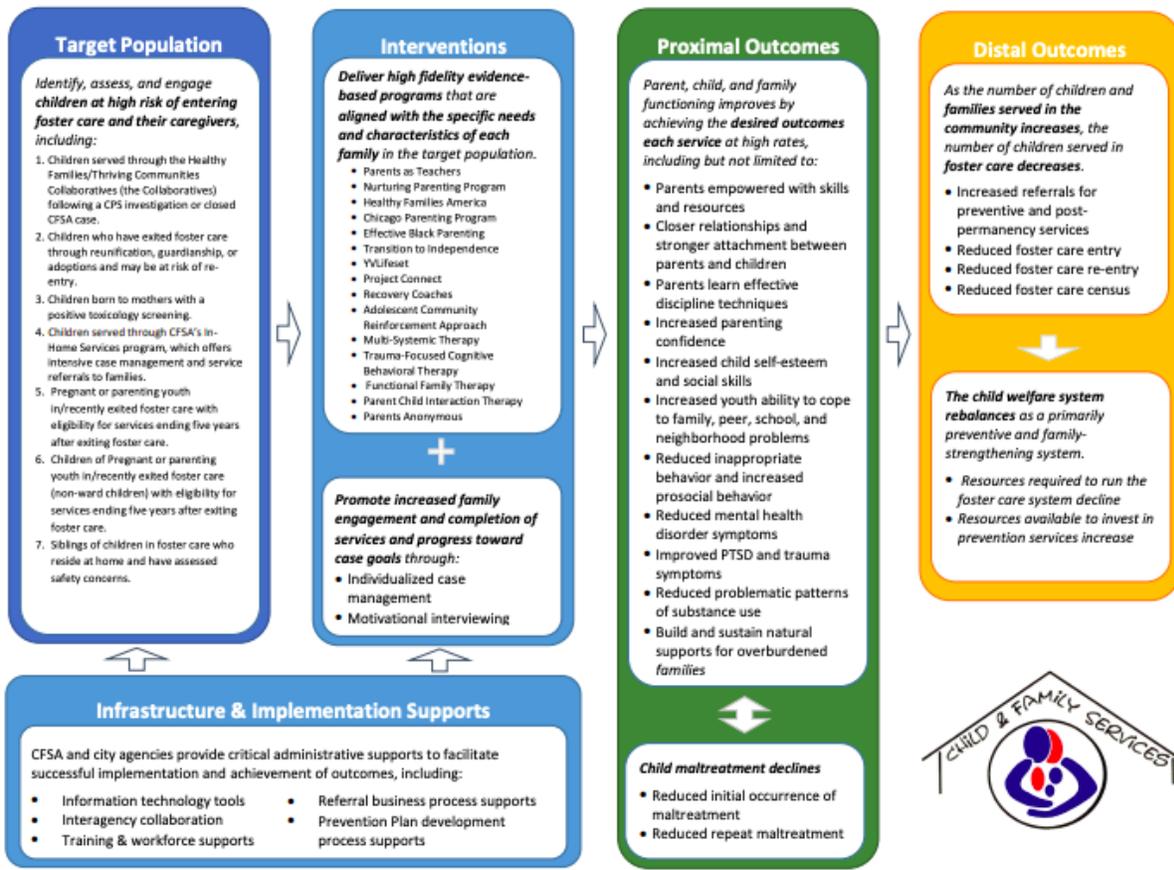
- Partnership with The Lab @ DC: A partnership with The Lab @ DC, DC's own local government think-tank specializing in agency partnerships to perform policy and program evaluations, has been formed to support identification, hiring, and ongoing development of exceptional scientific talent in the Senior Evaluation Leads.⁴⁵ The hired candidates will be affiliated with the Lab @ DC as fellows, allowing them to take full advantage of capacity-building collaboration with The Lab @ DC and leveraging The Lab @ DC resources to support building the internal structure to carry out robust evaluation and CQI operations within CFSA.
- Ongoing CQI support from Chapin Hall at the University of Chicago: Chapin Hall is currently contracted to provide support to CFSA on development and implementation of CQI systems and processes throughout 2019. As part of this support, Chapin Hall CQI experts will advise the Senior Evaluation Leads on development and launch of a CQI system that aligns and integrates Family First requirements with CFSA's broader strategic direction and State Level CQI efforts.

Theory of Change

In support of CFSA's Four Pillar strategic framework, the Agency seeks to leverage Family First funding to make investments to support family stability and preservation, to increase protective factors, to reduce risk factors for child abuse and neglect, and to ultimately prevent children from entering foster care.

CFSA's theory of change assumes that mental health conditions, substance misuse, and lack of parenting skills and knowledge can significantly diminish any parent's capacity to ensure their child's well-being and provide them with a safe, permanent home where they can thrive. Data clearly demonstrate families struggling with one or more of these challenges are more likely to experience crises that bring their children in to foster care. Therefore, if CFSA provides families whose children are at risk of entering foster care with access to an expanded array of intensive and evidence-based services in the communities where they live, as well as critical case management and motivational enhancement support to help them engage and sustain participation throughout the healing and capacity-building process, family functioning will improve, stabilization will occur, and children will enter and re-enter foster care at lower rates.

Family First Prevention Service Theory of Change, DC Child and Family Services Agency



Evaluation Design

The District does not intend to implement any allowable supported or promising practice EBPs for consideration under Family First at the time of this submission. The District will only leverage Family First funding for PAT, a well-supported model, in year one of implementation. Therefore, an evaluation description is not required at this time. As additional services are added to the Title IV-E Prevention Services Clearinghouse, the District may submit amendments to this five year prevention plan along with a full evaluation design for any supported or promising models implemented. The following high-level evaluation approach outlined in this section will be used to guide the development of a detailed evaluation design for any promising or supported programs that are submitted under a future plan amendment.

The evaluation of each supported and promising program will consist of two studies: a process evaluation and an outcomes evaluation. The targeted programs are provided across multiple agencies in the health and human services cluster and engage the family, community partners, and other systems of care. Experience has shown that regardless of policies and procedures that might be created at the system level to support activities, making sure that providers and specialists in the field are following proscribed policies and practices can often be difficult. For this reason, it is critical to remain mindful that many different parts of the child welfare system, including CFSA and its sister agencies, are involved in implementation. Consequently, while interventions must be evaluated individually, they must be evaluated

within the broader context of the child welfare landscape. The evaluation components are described below.

Process evaluation

For the process evaluation, CFSA will examine how each supported and promising program and associated administrative supports and processes were implemented within CFSA, Collaboratives, and in each of the sister agencies at multiple levels simultaneously.

Research Question 1: Was each program implemented as the model intended? CFSA will assess implementation fidelity in accordance with each program’s unique model fidelity standards. CFSA will liaise with model developers to obtain measures, specific methodology, and tools for assessing model fidelity, and develop internal processes and systems for monitoring fidelity of each program on a periodic basis. Findings will be used to inform training and supervision to ensure that the proven benefits of the model are realized through faithful implementation, and to ensure that outcomes can accurately be attributed to the model. CFSA has recent experience successfully monitoring model fidelity for both Homebuilders® and Project Connect as part of the Title IV-E Waiver and will build on that experience when establishing and carrying out monitoring protocols for the Family First programs.

Because both programs were new to the District, fidelity assessments were conducted by the national model developers (Children’s Friend) with data stored locally by the CFSA implementation and evaluation team. Where possible, CFSA will work with national model developers on conducting fidelity assessments to ensure Family First programs are implemented with fidelity. As with the Waiver, CFSA will continue to track fidelity by capturing components of training, fidelity to practice standards which include findings from annual site visits, case record reviews, and review of local documentation detailing referral criteria, caseload size and make-up, supervision sessions, and face-to-face contacts. CFSA will make recommendations on consistent fidelity tools and metrics across programs and organizations that will range from training to fidelity to practice standards. Frequency of fidelity reporting will be determined after a full inventory of all programs to be implemented is completed.

Research Question 2: To what extent did each program reach the intended target population? This component of the process evaluation will assess the degree to which families within the target population and are eligible are receiving each services (reach). This information will be viewed in the context of the overall successes and challenges of implementation and the related competency, organization, and leadership drivers that may have influenced referrals, service uptake, and service completion for each program.

Research Question 3: Did CFSA and the DC health and human services system support implementation of services in a way that optimized fidelity to the model, effective operations, and successful outcomes? The focus of a process evaluation is on the organization’s ability or capacity to support programs to reach their stated goals. The process study will periodically assess progress made citywide in implementing infrastructure and implementation supports, and the degree to which services are reaching the target population. The process study will utilize metrics built by the CQI Subgroup prior to implementation of the

programs. They will focus on system changes such as workforce (e.g., staffing configuration, training), interagency collaboration and consultation around service delivery (e.g., case handoffs, referral tracking), fidelity to the business process for developing and updating Prevention Plans, and fidelity to the business process for service referrals.

Outcomes Evaluation

The outcomes evaluation will assess the degree to which the supported and promising programs achieve the intended outcomes for children and families associated with each individual program model, as well as distal outcomes related to reduced repeat maltreatment and reduced foster care entry and re-entry. CFSA will partner with model developers for each program to determine appropriate program outcomes, associated metrics, and data collection tools and methodologies, anticipating that specific outcomes measured and tools for collected these data will vary between programs.

The research questions and designs to follow are solely initial considerations. Once hired, the Senior Evaluation Leads will work closely with experts in applied research methodologies at The Lab @ DC to draft a rigorous design. Sampling plans will also be determined by the Senior Evaluation Lead and The Lab @ DC for each program.

Research Question 4: To what extent did the evidence-based practices and other programs meet anticipated outcomes? The evaluation may utilize a quasi-experimental matched pre-test/post-test design for discharged families to determine the extent to which outcomes were met at the time of discharge. Design for enrolled participants has not yet been determined.

Research Question 5: Was there a significant difference in achievement of outcomes for the intervention group compared to a similar group from the pre-intervention time frame? Quasi-experimental design with a matched historical comparison group using propensity score matching may be utilized to understand outcomes of program participants relative to a comparable group of families from an earlier time period who did not receive the intervention.

Waiver Request

Please see Appendix C - Attachment II for each State Request for Waiver of Evaluation Requirements for a Well-Supported Practice. The requests in Attachment II align with Table 5: EBPs Formal Evaluation or CQI Requirement above.

CQI Strategy

Section 471(e)(5)(B)(iii)(II) states a prevention services and programs plan component shall include how implementation of the services or programs will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved and how information learned from the monitoring will be used to refine and improve practices. The information in this section details CQI plans for PAT and how CFSA plans to meet the continuous monitoring requirements, which will be implemented as part of year one activities under Family First. For the full CQI plan that includes specific outcomes to be achieved, data collection methods and tools, and all CQI activities related to PAT, please see Attachment V-FY19 DC MIECHV CQI Plan.

As previously mentioned, the District will leverage Family First funding to add additional capacity to the District's existing PAT program, historically funded through MIECHV. In year one of implementation, the District will work with our partner agency, DC Health to perform CQI on this well-supported model. It should be noted that there have been no adaptations to the original model, and it is presently being implemented in alignment with its first version⁴⁶. DC Health has served as the program coordinator of the MIECHV Home Visiting program in the District for nearly 10 years, inclusive of the PAT model. In that time, DC Health has developed a robust CQI plan in accordance with the MIECHV program guidelines. CFSA will partner with DC Health to leverage the robust CQI plan already established for PAT while integrating limited additional data analysis specific to child welfare as detailed below.

CQI governance for PAT is detailed in the FY19 DC MIECHV CQI Plan:

CQI initiatives are implemented by two quality improvement teams collaboratively focused on identified areas in need of improvement at both the State and Local levels of the DC MIECHV program. The state CQI team will concentrate its efforts on the state-level system and infrastructure supports. The local CQI teams will focus on program service delivery improvements. Each team will be responsible for selecting and implementing the CQI interventions (change activities) designed to drive improvement in selected topic areas... The organizational system consists of three teams, the LIA CQI Managers Team, LIA CQI Home Visitors Team, and the DC Health CQI Team. The DC Health personnel assigned to the CQI Teams are the: MIECHV Program Coordinator and DC Health Public Health Analyst, who serve as the CQI Lead Team

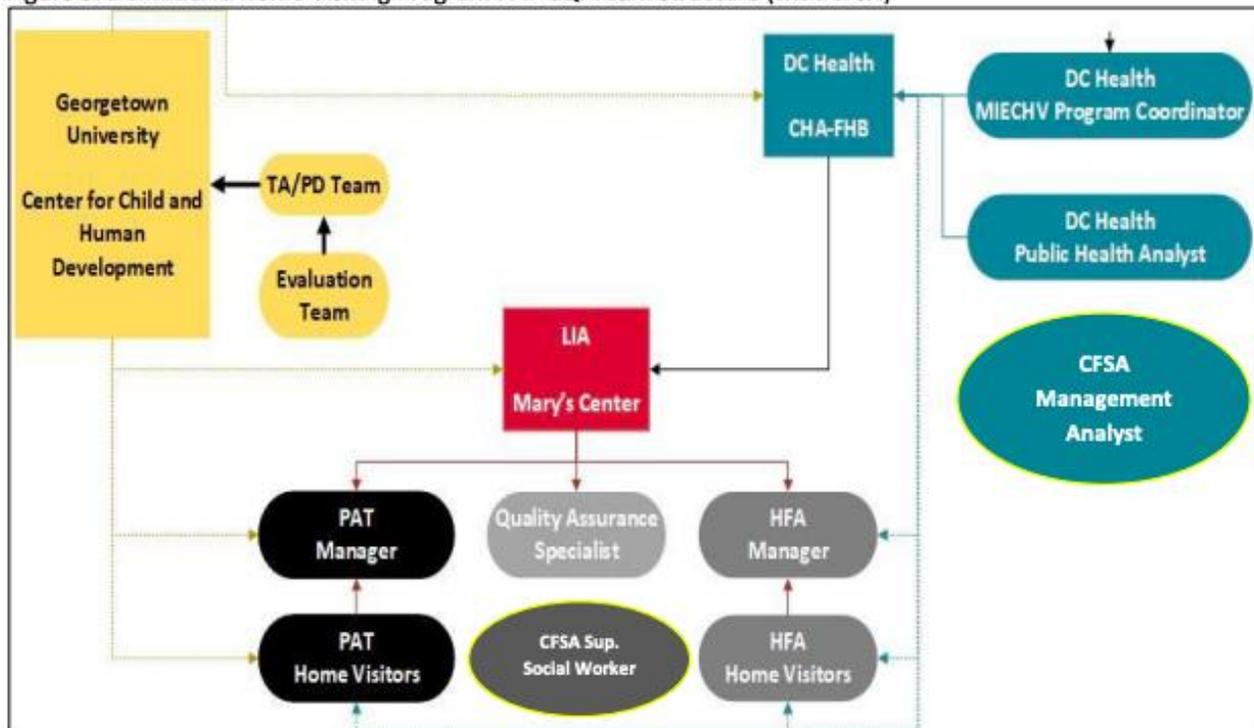
CFSA will include a CFSA social worker on the LIA CQI Home Visitors Team and CFSA CQI representative to the DC Health CQI Team. CFSA will seamlessly integrate into the already existing CQI activities and tailor them to meet the needs of the child welfare population. In addition, these CFSA staff will be charged with routinely reporting key CQI results and insights back to CFSA for oversight of the PAT program.

The integration of CFSA into the existing plan will require PDSA cycles related to 1) how CFSA social workers explain the referral and program to families, especially voluntary participation and 2) assurance that a family's participation status and results of PAT specific assessments will not negatively impact their involvement with CFSA. In addition, CFSA will analyze data to obtain subsequent maltreatment and foster care entry rates for PAT participants referred by CFSA. While these outcomes are not in the MIECHV CQI plan, they are critical for CFSA and will be integrated into CFSA's agency-level reviews of PAT performance data. Thus, the role of the CFSA CQI representative will be to develop and implement PDSA cycles related to these requirements at CFSA. The District (DC Health and CFSA) will include the following CQI structure in the FY20 MIECHV CQI Plan and all changes are contingent upon the Health Services and Resources Administration (HRSA) approval. A copy of the final FY20 MIECHV CQI Plan will be provided upon HRSA approval in February 2020.

Organizational Diagram of DC's MIECHV Home Visiting Program (PAT)

The DC MIECHV organizational system consists of three teams, the LIA CQI Managers Team, LIA CQI Home Visitors Team, and the DC Health CQI Team. The DC Health personnel assigned to the CQI Teams will be the MIECHV Program Coordinator and DC Health Public Health Analyst. The CFSA personnel assigned to the CQI Teams will be the Performance Accountability & Quality Improvement Administration (PAQUIA) Management Analyst and the Office of Youth Empowerment (OYE) and/or Entry Services Supervisory Social Worker. Figure 5 provides an overview of the DC’s MIECHV Home Visiting Program CQI Structure, updated to reflect CFSA staff’s involvement

Figure 5: DC MIECHV Home Visiting Program PAT CQI Team Structure (with CFSA)



As detailed in the FY19 DC MIECHV CQI Plan:

The DC Health CQI team will be responsible for overseeing all CQI activities. The state team will take lead, and is responsible for reviewing MIECHV data on a quarterly basis to track fidelity and progress against Benchmarks. Based on these data findings, the team will identify strategies for supporting the LIA (local CQI team) in implementing improvements...

The MIECHV Program Coordinator and DC Health Public Health Analyst (DC Health CQI Co-Leads) oversee all CQI activities. The DC Health CQI team is responsible for assisting the LIA in identifying areas for improvement. The LIA is responsible for developing the Model for Improvement Worksheet and the DC Health CQI team will provide technical assistance in the development of the Worksheet that includes the proposal for change (PDSA). Once the change has been implemented, the DC Health CQI team will schedule a teleconference to discuss the results. The LIA managers/supervisors will determine if the change will be adopted, adapted or abandon, and if another test of change is warranted. The DC Health

CQI team may offer technical assistance in helping the LIA determine the best strategy for a new test of change...

Monthly check-ins will be used to share and review data charts and analysis, when appropriate, around CQI activities to provide opportunities for team discussion and encourage requests for technical assistance where needed, as well as share progress and successes. Individualized data reports and analyses will also be shared in 1-on-1 sessions.

Designated CFSA CQI and prevention staff will join the existing team structure to contribute to all CQI activities.

Compelling Evidence of Effectiveness

Pursuant to section 471(e)(5)(C)(ii), the requirement for a well-designed and rigorous evaluation of any well-supported practice may be waived if the evidence of effectiveness of the practice is deemed compelling and the CQI requirements of Section 471(e)(5)(B)(iii)(II) are met. The District asserts the evidence of the effectiveness of PAT is both compelling and evident as supported by the Title IV-E Prevention Services Clearinghouse's Summary of Findings, which reflect findings from a dozen evaluations, as well as consistently strong local evaluations over nearly a decade in the District of Columbia.

Current studies of PAT show a significant impact on a number of outcomes vital to the child welfare system. In March of 2019, Parents As Teachers published a Fact Sheet, Prevention of Child Abuse and Neglect, reporting the following impacts of PAT on child abuse and neglect:

- In one of the largest research studies in the U.S. conducted to investigate the impact of home visiting on child maltreatment, researchers found a 22 percent decreased likelihood of substantiated cases of child maltreatment (as reported by Child Protective Services) for Parents as Teachers families compared to the non-PAT families.
- In a randomized-controlled trial of Parents as Teachers for CPS-involved families, the program was associated with a significantly lower likelihood of CPS for non-depressed mothers...
- Parents as Teachers participation was related to 50 percent fewer cases of suspected abuse and/or neglect. Parents as Teachers in Maine focusing on families with involvement with Child Protective Services, found that once entered into a Parents as Teachers program 95 percent of families had no further substantiated reports or allegations of child abuse

Additionally, a review by the Title IV-E Prevention Services Clearinghouse shows that PAT had favorable and statistically significant impacts on child safety as well as child social and cognitive functions, which are key outcomes in the District's prevention service array. The District understands the impact of caregiver well-being on overall child well-being and thus considers the positive impact of PAT on positive parenting practices to be a significant component of the effectiveness of the program. It should be noted that according to the Title IV-E Prevention Services Clearinghouse review, PAT has produced no unfavorable impacts on outcomes. A summary of this review's findings can be found in Table 7 below.

Table 7: Parents as Teachers Summary of Findings

Outcome	Effect Size ⁱ and Implied Percentile Effect ⁱ	N of Studies (Findings)	N of Participants	Summary of Findings
Child safety	0.11 4	2 (6)	4825	Favorable: 2 No Effect: 3 Unfavorable: 0
Child permanency	0.16 6	1 (1)	4560	Favorable: 0 No Effect: 1 Unfavorable: 0
Child well-being: Social functioning	0.12 4	1 (6)	375	Favorable: 3 No Effect: 2 Unfavorable: 1
Child well-being: Cognitive functions and abilities	0.13 5	2 (12)	575	Favorable: 2 No Effect: 10 Unfavorable: 0
Child well-being: Physical development and health	0.08 3	1 (3)	375	Favorable: 0 No Effect: 3 Unfavorable: 0
Adult well-being: Positive parenting practices	0.27 10	1 (1)	203	Favorable: 0 No Effect: 1 Unfavorable: 0
Adult well-being: Family functioning	-0.07 -2	2 (11)	640	Favorable: 0 No Effect: 10 Unfavorable: 1
Adult well-being: Economic and housing stability	-0.09 -3	1 (10)	366	Favorable: 0 No Effect: 9 Unfavorable:

As previously mentioned, the PAT program was originally implemented as part of DC Health’s Home Visiting program in 2010 through funding from HRSA’s MIECHV grant. Since its implementation, PAT has maintained fidelity to the model and provided outcomes data in support of effectiveness as required under the MIECHV grant guidelines. Complementing the Title IV-E Prevention Services Clearinghouse’s findings showing PAT’s effectiveness, results from The Home Visiting Evidence of Effectiveness (HomVEE) review recently published in September 2019, which reviewed the evidence of effectiveness of 21 home visiting programs, reported that most home visiting models, including PAT, had favorable impacts on primary measures of child development and school readiness and positive parenting practices. The study also showed that PAT participants sustained favorable impacts for at least one year after beginning the program⁵³. Additionally, as the child welfare community moves toward studying implementation science and understanding the facilitators of successful program implementation, CFSA recognizes the need for interventions that not only guarantee sustainable and favorable outcomes, but also interventions that demonstrate successful program implementation at the local level. The HomVEE report provides evidence that minimum standards for fidelity have been met in the areas of supervision, frequency of visits, pre-service training, use of fidelity tools, and an established system for fidelity monitoring, furthering CFSA confidence in the effectiveness of this model.

State Level CQI Activities

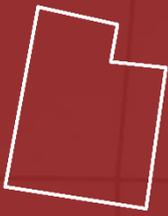
To complement the rigorous CQI methodology used to assess the PAT program, the District will conduct CQI to examine the implementation and effectiveness of its prevention approach broadly.

As discussed previously, CFSA has taken steps to partner closely with the Collaboratives as well as the District's Health and Human Services cluster agencies on the planning for core aspects of Family First through the Family First Prevention Work Group. Prior to implementation of services, this group will shift roles to become the citywide Family First Prevention Implementation Team and will oversee ongoing CQI activities for across the city's prevention services array and in alignment with FY20 State level CQI activities. A CQI Sub-group will be formed and meet more frequently, comprising representatives from each sister agency, a selection of Collaboratives, and key operational areas of CFSA. The sub-group will be charged with guiding development of metrics for the process evaluation, monitoring and data collection activities, root cause analysis, and development of proposed solutions to identified issues or problems. The sub-groups activities will be guided by Districts approved prevention plan.

This sub-group's primary charge will be to conduct CQI for all programs across the city's prevention services array. . In addition, the group will use CQI to monitor and assess the overall implementation and outcomes of all Family First services and services included in the District's prevention services array—for example, addressing questions such as Do we have the right service array to meet the needs of DC children and families? And To what extent have preventive services reduced child maltreatment in the District? To answer these questions about prevention services overall, the group will draw data collected from existing evaluation and CQI activities. The CQI Subgroup will be chaired and overseen by CFSA's Evaluation Team and will report to the city-wide Family First Prevention Implementation Team.

Consultation and Coordination

As the Work Group shifts from a function of planning to implementation and State level CQI, the group will naturally emerge as a forum for consultation and coordination on delivery and administration of services among CFSA, sister agencies, Collaboratives, and other partners. The venue will provide all participants with a role in monitoring, overseeing, and managing the ongoing operations and outcomes of the prevention services. As CQI and evaluation results point to the need for changes in programs or operations, the Work Group will identify solutions and improvements with the benefit of the entire Health and Human Service cluster, Collaboratives, and other partners represented at the table, thus advancing better intra-city coordination on citywide prevention services, including integration with Families First DC, going forward.



Utah

Status: Approved

Section VI: Evaluation Strategy and Waiver Request

Evaluation Strategy and Waiver Request

Essential to an investment in evidence-based services under the Family First Prevention Services Act by the Utah Department of Human Services (DHS) is a commitment to continuous quality improvement and well-designed and rigorous evaluation activities. Continuous quality improvement activities will be performed under the direction of the Office of Quality and Design (OQD), within DHS. Evaluation activities will be under the oversight of the OQD Management Information Center and conducted by contract through the University of Utah, Social Research Institute (SRI). SRI is a long-time partner of DHS, having recently completed the evaluation of Utah's Title IV-E Waiver Child Welfare Demonstration Project, HomeWorks. Evaluation activities may also extend to other university research partners in the future as additional services are incorporated into the five-year plan. CQI and evaluation activities will work in tandem to assess fidelity to program models, to evaluate program effectiveness, to assess outcomes for children and families, and to inform overall program and system improvements.

Evaluation Strategy

The Utah Department of Human Services is not implementing any allowable promising or supported EBPs rated by the Title IV-E Prevention Services Clearinghouse with this submission. DHS expects to submit plan amendments in the future to incorporate additional evidence based services approved by the Clearinghouse or approved through independent systematic review in accordance with the transitional payment review process issued by the Children's Bureau on July 18, 2019.¹ Full evaluation designs will be included with future plan amendments for any promising or supported services approved by Clearinghouse or for any promising, supported, or well-supported services for which the level of evidence was determined through independent systematic review. For well-supported services approved by the Clearinghouse, which includes FFT, PCIT, and PAT with this submission, a request to waive evaluation requirements may be submitted with documentation of compelling evidence of the program's effectiveness and verification that continuous quality improvement requirements will be met.

A well-designed, rigorous evaluation plan will be developed for each program or service approved in Utah's Title IV-E Prevention Plan for which no evaluation waiver has been granted. The Title IV-E Prevention Services Clearinghouse Handbook of Standards and Procedures² and the Evaluation Plan Development Tip Sheet³ provided by the Children's Bureau will be utilized to guide development of each evaluation plan.

The following evaluation approach will guide development of a detailed evaluation design for programs or services requiring evaluations that are submitted under a future plan amendment.

The evaluation of each program or service that is being newly implemented will consist of two studies: a process evaluation and an outcomes evaluation. The evaluation of programs or services that are well established and have a history of operating with fidelity may consist only of an outcome evaluation. Examples of research questions for process evaluations include:

- (1) Was the program implemented as the model intended?
- (2) To what extent did each program reach the intended target population?
- (3) Was implementation supported in a way that optimized fidelity to the model, effective operations, and successful outcomes?

Examples of research questions for outcome evaluations include:

- (1) To what extent did the evidence-based program or service programs meet anticipated outcomes?
- (2) Was there a significant difference of outcomes for the intervention group compared to a similar group from a preintervention time frame?

The scope of each evaluation plan will take into account existing evaluation activities or measures being completed by service or program developers and may result in a request to the Secretary for approval for participation in an ongoing, cross-site evaluation.

In accordance with the Evaluation Plan Development Tip Sheet, the key components listed below will be considered in developing well-designed, rigorous evaluation plans for specific evidence-based programs or services.

Program or Service Background

Provides context of the current situation to better understand the need for the intervention and its objective

- Describe the treatment or intervention, the target population, and the goal or desired outcome.
- Articulate the theory of change. Define the key issues/problems the intervention seeks to address; and theoretical or causal links between intervention activities and expected changes.
- State the key questions the research or study will address.

Evaluation Design

- Communicates the framework or process to be followed
- Determine the type of evaluation (process, outcome, or cost).
- List relevant performance targets and associated indicators/measures.
- Define the sources and methodologies for measures.
- Describe the research design (RCT, QED/propensity scoring, etc.), if applicable, and/or provide the evaluation criteria and procedures for review.
- Map the process using a logic model and specify short- and long-term outcomes.

Data Collection

- Provides the raw material needed to calculate results and to assess program effectiveness
- Confirm that all indicators are noted on the logic model.
- Ensure indicators are discrete and quantifiable.

- List and explain tools, instruments, and/or other methods of data collection.
- Determine frequency intervals for extraction.
- Develop a sampling plan, if appropriate.

Data Analysis

Cleanses, transforms, and models data to confirm whether the intervention fulfills its purpose

For quantitative data, describe specific statistical methods to be used to analyze data.

- Identify statistical software applications and packages, and strategies to address anomalies (outliers, missing data, etc.).
- Describe how results will be presented to mitigate bias and to ensure objectivity.

For qualitative data, describe analysis methods to be used to analyze qualitative data. Indicate strategies to minimize personal bias of observers/data collectors.

- Describe how results are validated using multiple data sources to corroborate accuracy.
- List potential confounding factors and efforts to manage effects.
- Articulate potential weaknesses or limitations in the selected research design and explain how these will be addressed or minimized.

Distribution of Reports and Use of Findings

Promote transparency and make information about programs and services available to the public

- Identify appropriate reports and level of detail for different audiences.
- Indicate the frequency and format of methods for communicating evaluation findings.
- Describe plans for disseminating evaluation findings.
- Explain whether and how findings that emerge during the evaluation will inform intervention activities and program/organizational improvements (e.g., continuous quality improvement plan).

Logistics

Coordinate staffing, timelines, budgets, and other infrastructures needed to perform program and service evaluations

Staffing

Determine the level of staffing resources needed. Describe the evaluation roles and responsibilities of staff and others. List their relevant knowledge, skills, and experience. Identify entities/organizations outside the core evaluation team that will be involved in the evaluation and specify their roles and responsibilities. Utah is still exploring whether some evaluation functions will use external consultants.

- **Timeliness.** Provide a timeline that specifies the estimated start and end dates of all major evaluation activities, including initial planning and startup, staff recruitment and training, IRB approval, instrument development, data collection, data analysis, submission of reports, and other dissemination activities.
- **Budget.** Estimate costs for staff salaries, administrative overhead, external consultants, data collection, statistical software, printing, supplies, equipment, or other expenses.

- Data security, informed consent procedures, and institutional review board (IRB) approval. Describe protocols for maintaining the security and confidentiality of electronic and hardcopy data sources. Determine procedures for obtaining informed consent, as needed. Identify the IRB that will review and approve the evaluation and associated research activities including the process for obtaining IRB approval.

B. Waiver Request

On April 12, 2018, the Children’s Bureau issued the following information regarding evaluation strategies for services reimbursable through Family First:

The state must have a well-designed and rigorous evaluation strategy for any promising, supported, or well-supported practice. HHS may waive this requirement if HHS deems the evidence of the effectiveness of the practice to be compelling and the state meets the continuous quality improvement requirements with regard to the practice.

DHS is submitting Attachment II, Request for Waiver of Evaluation Requirement for a WellSupported Practice, for the following well-supported services for which the evidence of the effectiveness of the practice is compelling: (1) Functional Family Therapy, (2) Parent Child Interaction Therapy, and (3) Parents as Teachers. Documentation of compelling evidence for each program or service is described below.

Compelling Evidence of Effectiveness of the Practice

Functional Family Therapy (FFT)

The effectiveness of Functional Family Therapy (FFT) has been demonstrated through multiple studies and inclusion as evidence-based in multiple clearinghouses, which, when considered together, led DHS to conclude that the program’s effectiveness is compelling for Utah’s child welfare and juvenile justice populations. For example, this conclusion is supported by the Title IV-E Prevention Services Clearinghouse’s Summary of Findings, which reflects findings from nine evaluations that were eligible to review. It is also supported by the California Evidence-Based Clearinghouse for Child Welfare Office, by the Office of Juvenile Justice and Delinquency Prevention, and by the Pew’s Results First Clearinghouse.

The review by the Title IV-E Prevention Services Clearinghouse shows that FFT had favorable⁶ effects on child behavioral and emotional functioning, child substance use, child delinquent behavior, and family functioning, which are desired outcomes for the DHS prevention service array. Unfavorable effects were minimal. These findings are summarized in the table below.

Functional Family Therapy Summary of Findings Title IV-E Prevention Services Clearinghouse

Outcome	Effective Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child well-being: Behavioral and emotional functioning	0.16 6	4 (26)	390	Favorable: 2 No Effect: 23 Unfavorable: 1
Child well-being: Substance use	0.49 18	1 (18)	52	Favorable: 9 No Effect: 9 Unfavorable: 0
Child well-being: Delinquent behavior	0.05 1	5 (20)	8636	Favorable: 4 No Effect: 16 Unfavorable: 0
Adult well-being: Positive parenting practices	0.02 0	2 (9)	163	Favorable: 0 No Effect: 9 Unfavorable: 0
Adult well-being: Family functioning	0.30 11	1 (15)	52	Favorable: 1 No Effect: 14 Unfavorable: 0

Note: For the effect sizes and implied percentile effects reported in the table, a positive number favors the intervention group and a negative number favors the comparison group. Effect sizes for some outcomes were not able to be calculated by the Prevention Services Clearinghouse.

The California Evidence-Based Clearinghouse for Child Welfare rated FFT as having supported research evidence with medium relevance for child welfare in the categories of alternatives to long-term care programs, behavioral management programs for adolescents in child welfare, disruptive behavior treatment (child and adolescent), and for substance use treatment for adolescents.

In addition, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) within the U.S. Department of Justice, which works to prevent juvenile delinquency, improve the juvenile justice system, and protect children, identified FFT as a Model Program with an effective rating. OJJDP stated, "This is a family-based prevention and intervention program for dysfunctional youth, ages 11 to 18, who are justice-involved or at risk for delinquency, violence, substance use, or other behavioral problems. The program is rated Effective. Program participants showed a statistically significant reduction in general recidivism and risky behavior, compared with control group participants. However, there were no differences between groups on felony recidivism or caregiver strengths and needs.

Finally, the Pew Foundation Results First Clearinghouse¹⁰, which is an online resource that brings together information on the effectiveness of social policy programs from nine national clearinghouses, also reported a rating of effective at the highest level for FFT, citing the CrimesSolution.gov clearinghouse as the source of information. This source indicated that outcome areas for FFT include recidivism, life domain, child behavior emotional needs, child risk behaviors, child strengths, acculturation, caregiver strengths, and caregiver needs.

Parent Child Interaction Therapy (PCIT)

Parent Child Interaction Therapy (PCIT) has been demonstrated as effective through numerous studies and inclusion as evidence-based in multiple clearinghouses and reports, which, when considered together, led DHS to conclude that the program’s effectiveness is compelling for Utah’s child welfare and juvenile justice populations. For example, this conclusion is supported by the Title IV-E Prevention Services Clearinghouse’s Summary of Findings, which reflects findings from 21 studies that were eligible to review. PCIT is also supported by the California Evidence-Based Clearinghouse for Child Welfare, and the Office of Juvenile Justice and Delinquency Prevention.

The review by the Title IV-E Prevention Services Clearinghouse shows that PCIT had favorable¹¹ and statistically significant impacts on child behavioral and emotional functioning, positive parenting practices, and parent/caregiver mental or emotional health, which are key outcomes for the DHS prevention service array. There were no unfavorable effects. These findings are summarized in the table below.

Functional Family Therapy Summary of Findings Title IV-E Prevention Services Clearinghouse

Outcome	Effective Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child well-being: Behavioral and emotional functioning	0.92 * 32	11 (46)	524	Favorable: 18 No Effect: 28 Unfavorable: 0
Child well-being: Social functioning	0.52 19	1 (2)	19	Favorable: 0 No Effect: 2 Unfavorable: 0
Adult well-being: Positive parenting practices	1.46 * 42	8 (25)	422	Favorable: 4 No Effect: 16 Unfavorable: 0
Adult well-being: Parent/caregiver	0.58 * 21	3 (6)	252	Favorable: 4 No Effect: 2 Unfavorable: 0

mental or emotional health				
Adult well-being: Family functioning	0.29 11	5 (10)	177	Favorable: 0 No Effect: 10 Unfavorable: 0

*Statistically significant Note: For the effect sizes and implied percentile effects reported in the table, a positive number favors the intervention group and a negative number favors the comparison group. Effect sizes for some outcomes were not able to be calculated by the Prevention Services Clearinghouse.

The California Evidence-Based Clearinghouse for Child Welfare rated PCIT as having well-supported research evidence with medium relevance for child welfare in the categories of disruptive behavior treatment (child and adolescent), and parent training programs that address behavior problems in child and adolescents. 13 Also, the Pew Foundation Results First Clearinghouse¹⁴, which is an online resource that brings together information on the effectiveness of social policy programs from nine national clearinghouses, also reported a rating of effective at the highest level for PCIT, citing the California-Evidence Based Clearinghouse as the source for the information.

In addition, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) within the U.S. Department of Justice, which works to prevent juvenile delinquency, improve the juvenile justice system, and protect children, identified PCIT as a Model Program with an effective rating. OJJDP stated, “The program teaches parents new interaction and discipline skills to reduce child problem behaviors and child abuse by improving relationships and responses to difficult behavior. The program is rated Effective. Program children were more compliant with less behavior problems than the wait list group. The treatment group parents gave more praise and fewer criticisms and improved negative aspects of their parenting. There were fewer rereports of physical abuse.

Parents as Teachers (PAT)

The effectiveness of Parents as Teachers has been demonstrated through multiple studies and reports, which, when considered together, led DHS to conclude that the program’s effectiveness is compelling for Utah’s child welfare population and for youth in foster care or involved with juvenile justice who are pregnant or parenting. This conclusion is supported by the Title IV-E Prevention Services Clearinghouse’s Summary of Findings, which reflects findings from six studies that were eligible for review, from studies cited by PAT, and also from a comprehensive literature review contained in the Home Visiting Evidence of Effectiveness (HomVEE) review, reported by the Office of Planning, Research and Evaluation in September 2019.

A review of PAT research by the Title IV-E Prevention Services Clearinghouse shows that PAT had favorable¹⁶ impacts on child safety as well as child social and cognitive functions, which are key outcomes DHS is seeking to attain through its prevention service array, and also corresponds to needs of parents with young children identified through the Utah Child and Family Engagement Tool. Also of importance, according to the Title IV-E Prevention Services Clearinghouse review, PAT has produced very limited unfavorable impacts on outcomes. A summary of this review’s findings can be found in the table below.

Parents as Teachers Summary of Findings Title IV-E Prevention Services Clearinghouse

Outcome	Effective Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child safety	0.11 4	2 (6)	4825	Favorable: 2 No Effect: 3 Unfavorable: 0
Child permanency	0.16 6	1 (1)	4560	Favorable: 0 No Effect: 1 Unfavorable: 0
Child well-being: Social functioning	0.12 4	1 (6)	375	Favorable: 3 No Effect: 2 Unfavorable: 1
Child well-being: Cognitive functions and abilities	0.13 5	2 (12)	575	Favorable: 2 No Effect: 10 Unfavorable: 0
Child well-being: Physical development and health	0.08 3	1 (3)	375	Favorable: 0 No Effect: 3 Unfavorable: 0
Adult well-being: Positive parenting practices	0.27 10	1 (1)	203	Favorable: 0 No Effect: 1 Unfavorable: 0
Adult well-being: Family functioning	-0.07 -2	2 (11)	640	Favorable: 0 No Effect: 10 Unfavorable: 1
Adult well-being: Economic and housing stability	-0.09 -3	1 (10)	366	Favorable: 0 No Effect: 9 Unfavorable: 1

Note: For the effect sizes and implied percentile effects reported in the table, a positive number favors the intervention group and a negative number favors the comparison group.

In addition, current studies of PAT show a significant impact on a number of outcomes vital to the child welfare system. In March of 2019, Parents As Teachers published a Fact Sheet, Prevention of Child Abuse and Neglect, reporting the following impacts of PAT on child abuse and neglect:

- In one of the largest research studies in the U.S. conducted to investigate the impact of home visiting on child maltreatment, researchers found a 22 percent decreased likelihood of substantiated cases of child maltreatment (as reported by Child Protective Services) for Parents as Teachers families compared to the non-PAT families.
- In a randomized-controlled trial of Parents as Teachers for CPS-involved families, the program was associated with a significantly lower likelihood of CPS for non-depressed mothers.
- Parents as Teachers participation was related to 50 percent fewer cases of suspected abuse and/or neglect. Parents as Teachers in Maine, focusing on families with involvement with Child Protective Services, found that once entered into a Parents as Teachers program 95 percent of families had no further substantiated reports or allegations of child abuse

Complementing the Title IV-E Prevention Services Clearinghouse's findings showing PAT's effectiveness, results from The Home Visiting Evidence of Effectiveness (HomVEE) review recently published in September 2019, which reviewed the evidence of effectiveness of 21 home visiting programs, reported that most home visiting models, including PAT, had favorable impacts on primary measures of child development and school readiness and positive parenting practices. The study also showed that PAT participants sustained favorable impacts for at least one year after beginning the program. In addition, the HomVEE report provides evidence that minimum standards for fidelity have been met in the areas of supervision, frequency of visits, pre-service training, use of fidelity tools, and an established system for fidelity monitoring.

As DHS implements evidence-based prevention programs, our goal is to have programs with sustained and favorable outcomes, and to have programs that are successfully implemented at the local level. Prevent Child Abuse Utah's Parents as Teachers program became a PAT affiliate in 2011. In the PAT model, affiliates are given several years to build training, services, and model fidelity through internal systems changes, continuous quality improvement, and feedback through the regional and national support systems to develop and prepare to meet the standards of a Blue Ribbon affiliate. The Quality Endorsement and Improvement Review Process takes 18 months to complete and allows a national committee, independent of the local PAT agency, to analyze policies, procedures and services at all levels -- fiduciary, supervisory, employment policy, professional development, services to families, and documentation -- to determine if the model is being provided with fidelity. In October 2018, Prevent Child Abuse Utah's Parents as Teachers was recognized as a Blue Ribbon affiliate. This award signifies that PCAU is a high fidelity model, meeting the Parents as Teachers essential requirements and excelling in the additional 100 PAT standards. PCAU received notification in November 2019 that this level of quality was achieved again, furthering DHS confidence in the effectiveness of this model.

C. Continuous Quality Improvement (CQI) Overall Strategy

The Utah Department of Human Services (DHS) is committed to ensuring that evidence-based programs and services provided to children, youth, and families are delivered to fidelity, and most importantly, that they are effective. In support of this, DHS has developed a multi-layered approach to continuous quality

improvement of evidence-based programs and services, which meets the continuous quality improvement requirements in subparagraph 471(e)(5)(B)(iii)(II).

DHS has embedded its fidelity monitoring, outcome measurement, and evaluation activities for evidence-based programs into its broader continuous quality improvement efforts within the DHS Office of Quality and Design (OQD). OQD is responsible for the design and development of the service array for individuals and families served by the Department and its divisions. It also has responsibility for coordinating the provider network; for quality management, data, and evaluation relative to services; and for internal quality assurance including quality case reviews. OQD has designated a clinical quality and design specialist with subject matter expertise as the lead for the CQI process for each evidence-based program. These quality and design specialists work with developers, providers, evaluation, data, and quality management staff to coordinate implementation of the evidence-based program. They also ensure that each evidence-based program is deployed and implemented effectively, and ensure that quality management, outcome measurement, evaluation, and technical assistance efforts are coordinated in a manner to produce continuous quality improvement.

In collaboration with program developers, subject matter experts, and the University of Utah Social Research Institute (SRI), OQD establishes an on-going fidelity monitoring and outcome measurement process for each evidence-based program deployed. Where a developer provides a fidelity monitoring process or fidelity monitoring tools and an outcome measurement process or outcome measurement tools, these tools are utilized as part of ongoing fidelity monitoring. If these tools are not provided by a developer, DHS works with the developer or other subject matter experts, as well as SRI, to identify the core elements of the program that are critical to the integrity of the program to be used for fidelity monitoring as well as outcome measurement procedures.

Providers are critical partners in the CQI process. As services are delivered, providers implement fidelity monitoring procedures as delineated for the program. Quality and design specialists work closely with providers, developers, trainers, and quality management staff to ensure providers receive regular technical assistance in implementation of the evidence-based program as needed.

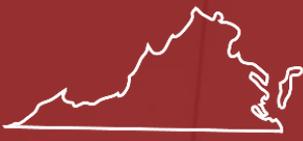
Outcomes are measured both by the provider and at the DHS level. At the provider level outcomes are measured specific to the targets of the intervention. These outcomes will be reported regularly to DHS as part of the CQI process. Outcomes measured at the DHS level include items such as safety (protective services findings), permanency (including entry into foster care), family well-being (through UFACET, Utah's version of the CANS) and risk reduction (particularly for juvenile justice involved youth).

On approximately a quarterly basis, quality management staff will review fidelity and outcome data to identify strengths and needs in implementation within and across providers. Trends and other observations in these reviews will be shared with providers in support of quality improvement. Quality and design specialists will regularly facilitate convenings with providers in conjunction with these reviews in order to discuss findings, provide technical assistance, and support peer learning. In support of quality improvement, DHS is establishing technical assistance agreements with developers and other subject matter experts to provide support in program implementation and technical assistance to DHS and providers. When needed, these convenings may also include technical assistance with developers and

other subject matter experts. When more individualized assistance is identified as needed, quality management staff will provide technical assistance directly with providers, and will engage developers or other experts as needed to provide support.

In addition to this on-going support, quality management staff will conduct implementation reviews that involve verification of fidelity and outcome measurement processes at the provider level and review of outcome measurement and evaluation trends. During these reviews, providers and quality management staff identify areas of strength and needs, and establish a collaborative quality improvement plan for providers. These reviews occur on an annual or more frequent basis according to need.

DHS will monitor fidelity and outcomes utilizing the CQI overall strategy for each evidencebased program and service. Program or service specific fidelity processes and tools that will be utilized as part of the CQI process are described for each specific service in Section 1.B.



Virginia

Status: Submitted

Section VI: Evaluation Strategy and Waiver Request

Evaluation Strategy

VDSS intends to utilize Title IV-E administrative funds to hire an evaluation team to administer the evaluation plan. The evaluation team may include staff hired by VDSS, including evaluation specialists, researchers, fidelity monitoring specialists, and data visualization specialists who will work closely with VDSS' CQI team or a contract with University Partners to provide evaluation support (Prevention Strategy 4). The evaluation team will evaluate Trauma-Focused Cognitive Behavioral Therapy by including items listed below.

Child Safety

Measures of child safety will come from OASIS records and SDM tools. Measures include substantiated and unsubstantiated reports and referral recidivism during the two-year reporting time-frame. The SDM safety tool includes items regarding a number of aspects of safety consistent with the Federal Clearinghouse Handbook description of measures that assess neglectful, aggressive, or abusive parenting behavior, as well as global determinations of safe, provisionally safe, and unsafe.

Child Safety Measure	Data Source	Time Frame	Feasibility/Supports Needed to Report
Substantiated Reports	OASIS record	Every 12 months	Flag in OASIS regarding FF eligibility
Unsubstantiated Reports	OASIS record	Every 6 months	
Referral Recidivism	OASIS record	Every 6 months	
Caretaker caused serious physical harm or plausible threat to cause harm	Safety assessment-safety factors	Baseline (initial), 6 months, 12 months, 24 months	
Caretaker fails to protect child from serious physical harm or threatened harm by others	Safety assessment-safety factors	Baseline (initial), 6 months, 12 months, 24 months	
Caretaker's explanation for the injury is questionable or inconsistent with	Safety assessment-safety factors	Baseline (initial), 6 months, 12 months, 24 months	

the type of injury and the nature of the injury suggests safety might be of concern			
Family is refusing access to the child	Safety assessment-safety factors	Baseline (initial), 6 months, 12 months, 24 months	
Child is fearful of caretaker, other family members, or others in the home	Safety assessment-safety factors	Baseline (initial), 6 months, 12 months, 24 months	
Caretaker fails to provide supervision necessary to protect child from potentially serious harm	Safety assessment-safety factors	Baseline (initial), 6 months, 12 months, 24 months	
Caretaker fails to meet the child's immediate needs for food, clothing, shelter, or medical/mental health care	Safety assessment-safety factors	Baseline (initial), 6 months, 12 months, 24 months	
Physical living conditions are hazardous and immediately threatening	Safety assessment-safety factors	Baseline (initial), 6 months, 12 months, 24 months	
Caretaker's substance use is currently and seriously affecting their ability to supervise, protect, or care for child	Safety assessment-safety factors	Baseline (initial), 6 months, 12 months, 24 months	
Caretaker's behavior towards the child is violent or out of control	Safety assessment-safety factors	Baseline (initial), 6 months, 12 months, 24 months	
Caretaker describes or acts towards the child in predominately negative terms or has unrealistic expectations	Safety assessment-safety factors	Baseline (initial), 6 months, 12 months, 24 months	

Child sexual abuse is suspected and child safety is an immediate concern	Safety assessment-safety factors	Baseline (initial), 6 months, 12 months, 24 months	
Caretaker's physical, intellectual, or mental health seriously affects their ability to supervise, protect, or care for child	Safety assessment-safety factors	Baseline (initial), 6 months, 12 months, 24 months	

Child Permanency

Measures of child permanency will come from OASIS records. Measures include length of placement if child is placed out of the home, placement disruption (number of moves within period of evaluation), stability of placement, reunification, and whether the child was placed with family (for children who enter foster care).

Child permanency measure	Data Source	Time Frame	Feasibility/Supports Needed to Report
Y/N child placed outside of home	OASIS record	Every 12 months	Flag in OASIS regarding FF eligibility
Length of placements (if any)	OASIS record	Every 12 months	
Placement disruption & stability of placement	OASIS record	Every 12 months	
Reunification	OASIS record	Every 12 months	
Kinship placement	OASIS record	Every 12 months	

Child Well-Being

Child well-being will be assessed in two ways. First, general measures of child well-being will be gathered from SDM measures, which are reliably reported by family-services specialists. Second, specific measures of child well-being will be reported by providers (contractual obligation).

General child well-being can be reliably reported by case workers. The table below outlines aspects of general child well-being that will be analyzed and reported utilizing the Family Strengths and Needs Assessment. The domains assessed are consistent with the domains in the Federal Clearinghouse Handbook regarding behavioral and emotional functioning, social functioning, cognitive functions and abilities, educational achievement and attainment, physical development and health, substance use, and delinquent behavior.

Child Well-Being measure	Data Source	Time Frame	Feasibility/Supports Needed to Report
Life Functioning	CANS	Baseline, 6 months, 12 months, 24 months	Ensure item-level information can be exported, ensure training is provided regarding time frame of reporting, ensure child-level information can be exported reliably
Child Strengths/Resiliency	CANS	Baseline, 6 months, 12 months, 24 months	
Child Behavioral/Emotional Needs	CANS	Baseline, 6 months, 12 months, 24 months	
Child Risk Factors	CANS	Baseline, 6 months, 12 months, 24 months	

To balance these evaluation needs with confidentiality rights of clients, as well as differences between reliable and valid measures of child well-being across the developmental span and across evidence-based services, providers will be contractually obligated to report on where clients fall among the validated ranges of clinical measures. This will vary by service. For example, for youth receiving TF-CBT, an appropriate outcome would be whether they fell into the clinical, subclinical, or normal range on the UCLA-PTSD Index. For PCIT, an appropriate measure would be the BASC-2 (externalizing subscale). The contractual obligation will require that providers report whether the client falls in the clinical, subclinical, or normal range of functioning, using the validated language of the specific tool. Providers will report at the beginning of treatment and every six months or when treatment concludes, whichever comes first.

As VDSS works to implement Family First and evidence-based services, we will need to address the feasibility/supports needed to report on the EBP outcome-specific measures. Although it is incredibly important to understand the outcomes of not only the EBP, but also of overall child wellbeing, the commonwealth currently does not support a centralized reporting data system across agencies that would allow for the collection of this type of data with ease.

Adult Well-Being

Adult well-being will be assessed similar to child well-being, and in two ways. First, general measures of adult well-being will be gathered from SDM measures, which are reliably reported by family services

specialists. Second, specific measures of adult well-being will be reported by providers (contractual obligation).

General adult well-being can be reliably reported by family services specialists. The table below outlines aspects of general adult well-being that will be analyzed and reported utilizing the Family Strengths and Needs Assessment. The domains assessed are consistent with the domains in the Federal Clearinghouse Handbook regarding parenting, parent/caregiver mental or emotional health, parental substance use, criminal behavior, family functioning, physical health, and economic stability.

Adult Well-Being measure	Data Source	Time Frame	Feasibility/Supports Needed to Report
Parent/Guardian Strengths/Needs	CANS	Baseline, 6 months, 12 months, 24 months	Ensure item-level information can be exported, ensure training is provided regarding time frame of reporting, consider processes to identify primary/secondary caregiver by identity (e.g., parent, kinship caregiver)

To balance these evaluation needs with the confidentiality rights of clients, as well as differences between reliable and valid measures of adult well-being across evidence-based services, providers will be contractually obligated to report on where clients fall among the validated ranges of clinical measures. This will vary by service. For example, urine drug screens will be expected for substance use treatment. Validated parenting measures will be expected for parenting interventions. And measures of mental health symptoms or functional impairment will be expected for behavioral health interventions. The contractual obligation will require that providers report whether the client falls in the clinical, subclinical, or normal range of functioning, using the validated language of the specific tool, for example, positive or negative urine drug screen. Providers will report at the beginning of treatment and every six months or when treatment concludes, whichever comes first.

As VDSS works to implement Family First and evidence-based services, we will need to address the feasibility/supports needed to report on the EBP outcome-specific measures. Although it is incredibly important to understand the outcomes of not only the EBP, but also of overall child well-being, the commonwealth currently does not support a centralized reporting data system across agencies that would allow for the collection of this type of data with ease.

Demographics

VDSS plans to investigate the demographics of individuals served under Family First. This will include information collected in the OASIS system on clients within a Family First case to include parents,

caregivers, and children. We plan to report on age, race/ethnicity of child, gender, and relationship to the child.

Comparison to Treatment Prior to Family First

In addition to collecting baseline data for each family served under Family First, VDSS will also conduct an investigation to gather a general snapshot of all families served prior to Family First. In other words, by understanding the general rates of these domains, using the agreed-upon definitions in this evaluation plan, we will be able to compare our Family First population and answer questions about how Family First may be increasing child well-being, permanency, reunification, and safety. This will utilize data from 2018.

Understanding the Family First Population and EBP Selection

The ongoing results of this evaluation plan will inform us about the Family First service population in Virginia. As we bolster and expand prevention efforts, it is expected that the Family First service population will draw from youth currently in foster care, as well as families who are at risk but are not currently identified. Thus, utilizing this data to better understand the families who comprise this population will inform future work. For example, what proportion of services are ultimately responding to a caregiver's individual need (e.g., substance use), a family system need (e.g., parenting intervention), or a child need (e.g., child behavior problem)? By understanding the profiles of the Family First population across the areas of child well-being, safety, and permanency, we will be able to inform future initiatives (e.g., the selection of appropriate EBPs based on fit and need).

Increase and Better Understand Kinship Care in Virginia

The ongoing results of this evaluation plan will inform Virginia's broader effort to increase kinship care. By evaluating kinship caregivers' well-being, services can be further targeted to support kinship caregivers as well as improve our Kinship Navigator programs.

Improving Fidelity and EBP Usage

Based on the measures we receive from providers, we will consider whether VDSS support is needed regarding measurement. For example, are clinicians reliably accessing the appropriate measures, or are there barriers to accessing these measures, even when oversight by EBP staff is provided? Is there variation across different EBPs? A regional view will be utilized for program improvement. Outside evaluators providing reporting on fidelity will be asked to also take this regional view in the reporting of their results.

Inform Implementation Procedures

For each EBP, model of implementation will be tracked (e.g., trainings/consultation calls, site visits, and community-based learning collaboratives). This will allow us to compare usage and outcomes across services, then consider implementation procedures that work and don't work in Virginia. This information will be provided to VDSS as part of the contractual process and will be monitored according to our standard sub-recipient monitoring plan.

Improve Evaluation Efforts

During the course of this evaluation, we will engage in ongoing discussions with stakeholders regarding improvements to the evaluation process. Key issues include ensuring that data capture systems are improved in a manner consistent with Family First: in other words, more flexible data capture approaches that can gather and collate well-being measures for multiple caregivers (e.g., parents, kinship caregivers, foster parents).

Improve Cross-System Coordination

Family First provides an opportunity to continue to improve cross-system coordination, particularly as services span child, family, and adult interventions across parenting, substance use, and mental health domains. As other statewide initiatives are concurrently in development (e.g., substance use treatment, behavioral health redesign), we will utilize the results and process of this evaluation to consider efficiencies in evaluation and coordination across sectors through the Three Branch team.

EVALUATION WAIVER REQUEST

VDSS intends to request evaluation waivers for all programs in the federal clearinghouse that are well supported. VDSS is requesting evaluation waivers for the following programs (See Attachment II for the State Request for Waiver of Evaluation Requirement for a Well-Supported Practice).

Program	Rating
Functional Family Therapy	Well-Supported
Healthy Families America	Well-Supported
Multisystemic Therapy	Well-Supported
Parent-Child Interaction Therapy	Well-Supported
Nurse-Family Partnership	Well-Supported
Parents as Teachers	Well-Supported

“Virginia recognizes that a robust CQI system is vital to improve services and supports for children and families, ensure effective use of resources, and achieve targets and desired outcomes. An effective system integrates the quantitative and qualitative measures toward an integrated system that thoroughly captures data processes to properly inform policy and service provision at all levels. This is inclusive of building out a comprehensive data plan allowing examination of the many data sources, while also identifying opportunities to incorporate the different qualitative and quantitative aspects of the case review system. Our approach is both data-driven and practice-informed.”

VDSS plans to utilize similar methodology of CQI models currently used in other child welfare programming and monitoring (VDSS CFSP Items 20, 21 and 25 Case Review and QAA System). VDSS intends to utilize Title IV-E administrative funds to hire an evaluation team as referenced in the Evaluation Strategy Section. The evaluation team will work closely with VDSS’ CQI team to ensure a comprehensive CQI system for the provision of Title IV-E Prevention Services.

VDSS will conduct an annual review of each contracted service provider to review their practice, guidelines and training. VDSS will conduct the review by utilizing data reported monthly by each contracted service provider and examining and analyzing our outcomes to see if there is a reduction in children entering the foster care system. If outcomes are not being met (by the program and/or VDSS' outcomes), VDSS will meet with the service provider to conduct a root cause analysis to determine why outcomes are not being met. VDSS will develop a program improvement plan in consultation with the service provider to improve outcomes. If the outcomes are not met through the program improvement plan, the service provider contract will be dissolved.

ASSURANCE ON PREVENTION PROGRAM REPORTING

VDSS will report to the secretary such information and data as the secretary requires with respect to the Title IV-E prevention program, including information and data necessary to determine the performance measures (See Attachment I).



West Virginia

Status: Approved

Section VI: Evaluation Strategy and Waiver Request

Fidelity and Outcome Measures-Evaluation Waiver Justification

West Virginia is submitting evaluation waiver requests for Parents as Teachers® and Healthy Families America® as part of this plan submission (see attachments A-F). The model fidelity outcomes used in West Virginia were developed by PAT® and HFA®.

The PAT® model currently available in West Virginia, which is being utilized for expansion through this Title IV-E opportunity, is the evidence-based model developed and owned by Parents as Teachers®. Each of West Virginia's PAT® providers is an affiliate of PAT® and must be accredited by the proprietor. Examples of accreditation documents are provided as part of Attachment B.

When a provider agency becomes an affiliate, they must develop an Affiliate Plan that outlines their specific roadmap to implementation. Once certified as an affiliate, home visitors are sent for five days of initial training in Foundational and Model Implementation and then an additional two days in Foundational Two training before they can become a model certified home visitor. Home visitors also have mandatory online modules (approximately 32 hours provided by PAT® national). An additional three-day training is required on-site by OMCFH's State PAT® on MIECHV required outcomes and activities. Approximately four weeks of shadowing with an experienced home visitor are also required. West Virginia has a certified in-state PAT® trainer and is in the process of having a second trainer certified through PAT®. In addition, the in-state trainer is in the process of being certified in the newly approved virtual PAT® trainings.

All PAT® sites are required to maintain accreditation and have a site visit for renewal every five years. Each of West Virginia's PAT® sites are in various years of their accreditation. National peer reviews are completed electronically with occasional on-site peer reviews. In addition, peer reviewers conduct interviews with families who have received PAT® services, community partners and the State PAT® office. They must meet at least 85% of the practice standards to be accredited. Essential requirements are attached along with the accreditation process.

The most comprehensive and thorough feedback from PAT® national occurs following a site visit. However, PAT® requires their affiliates to provide yearly fidelity monitoring reports called Affiliate Performance Reports (APR) in order to continue affiliation. During the fourth and fifth years of affiliation, each provider agency is expected to participate in the affiliate quality endorsement and improvement process. The State PAT® office completes site visits to all PAT® programs annually to monitor progress and ensure standards are met. If an essential requirement is not met, the site must complete a Success Plan. Also, the Director of OMCFH and a PAT® national technical assistance specialist check in monthly via telephone at all sites, and as needed.

If an affiliate's performance is below standards, the corrective action will depend on the deficiency. If it is below standards based on internal quality assurance activities, the program manager or direct supervisor will work with the staff person in question (if a specific person) or use problem solving/Continuous Quality Improvement (CQI)-type methods to improve, if an overarching problem. If performance on the standards is below 85% based on a site visit, the affiliate must submit a Performance Improvement Plan and be re-reviewed again within 3-6 months, at which time improvement must be demonstrated or risk of loss of accreditation. Any site receiving federal funding must maintain fidelity to the model, or they could lose funding. West Virginia employs two contracted CQI specialists who work with each site on CQI as needed based upon their data reports and identified needs. Each site must submit a monthly CQI report showing progress related to the CQI project. Attachment A outlines the measures used by PAT® national to monitor fidelity and model compliance.

The HFA® model currently available in West Virginia, known as Mountain State Healthy Families, which is being utilized for expansion through this Title IV-E opportunity, is the evidence-based Signature HFA® model developed and owned by Healthy Families America®. West Virginia's Mountain State Healthy Families provider is an affiliate of HFA® and must be accredited by the proprietor. The accreditation document for Mountain State Healthy Families is provided as part of Attachment E.

When a provider agency becomes an affiliate, they have access to in-person training from an HFA® certified trainer for all positions, including supervisors. HFA® also provides affiliates with technical assistance, which is offered in multiple communication venues, including webinar. There is also technical assistance that can be provided to affiliates who may be new to working with families involved with the child welfare system. West Virginia requires providers utilizing the HFA® program be accredited by HFA® and utilize the best practices standards and participate in fidelity monitoring activities. Staff are sent for two separate weeks of core training by an HFA® certified trainer. Staff also have mandatory online modules (approximately 24 hours provided by HFA® national), additional training on-site by program coordinator and/or their direct supervisor, and approximately six weeks of mentoring with a veteran home visitor. They also are required to complete one week of Growing Great Kids® (GGK) curriculum training by a GGK certified trainer. With the current COVID-19 situation, both HFA® national and GGK® national are piloting virtual trainings. Therefore, in the future, staff will not have to attend mandatory training out of state, but they will still be delivered by a nationally certified trainer. An additional three-day training is required on-site by OMCFH's state team on MIECHV required outcomes and activities.

HFA® requires applicants for affiliation to provide, along with an implementation plan, a detailed description of how HFA® will be implemented within the communities the organization wishes to serve. Accreditation happens after a two-year process that includes core training, application for accreditation and a site visit by HFA®. Site visits for accreditation renewal occur every four years. The current sole provider of this model is accredited through June 2021. National peer reviewers come on-site to review files as well as interview staff, families, and community partners. The affiliate must meet at least 85% of the 400+ best practice standards to be accredited (including certain "safety standards" and "sentinel standards" that must be met to be accredited regardless of the 85%). Site visits are completed by peer reviewers who have completed HFA® Implementation and Peer Reviewer training by an HFA® certified trainer. Program Managers are also required to complete this training, meaning they are certified to be Peer Reviewers whether they actually conduct site visits for other programs or not. There are quarterly

Peer Reviewer Community of Practice calls to stay informed. Fidelity to the HFA® Signature model is done through reporting. An annual site report is submitted to HFA® virtually.

The most comprehensive and thorough feedback from HFA® national occurs following a site visit. However, since HFA® Program Managers are required to complete Implementation/Peer Reviewer training, there is an expectation that each HFA® affiliate also self-monitor. HFA® provides formulated spreadsheets for all of the best practice standards that are related to daily activity, so at any given time, it can be monitored by the affiliate's program managers to check trends in meeting those standards. Each affiliate must also develop and implement an annual Quality Assurance Plan that includes file reviews, supervision observation, home visit observation, monitoring of those spreadsheets and other activities. Each affiliate has an assigned HFA® national technical assistance representative that checks in periodically, or as needed.

If an affiliate's performance is below standards, the corrective action will depend on the deficiency. If it is below standards based on internal quality assurance activities, the program manager or direct supervisor will work with the staff person in question (if a specific person) or use problem solving/CQI-type methods to improve, if an overarching problem. If performance on the standards is below 85% based on a site visit, the affiliate must submit a Performance Improvement Plan and be re-reviewed again within 3-6 months, at which time improvement must be demonstrated or risk of loss of accreditation. Any site receiving federal funding must maintain fidelity to the model or they could lose funding. West Virginia employs two contracted CQI specialists who work with each site on CQI as needed based upon their data reports and identified needs. Each site must submit a monthly CQI report showing progress related to the CQI project. Attachment D outlines the measures used to monitor fidelity and model compliance by HFA® national.

In addition to the fidelity monitoring through PAT® national, each affiliate of these in-home visitation services must also be scored on MIEHCV program outcomes, which are monitored through OMCFH annual site visits using the West Virginia Maternal, Infant & Early Childhood Home Visiting Quality Assurance/Improvement Annual Site Visit Review tools, which are included in Attachment G.

Attachment G, pages 1-3, outlines the outcomes, or benchmarks, that will be used to monitor PAT® in West Virginia. Specifically, the six outcomes are:

1. Improved maternal and newborn health
2. Child Injuries, child abuse/neglect/maltreatment and reduction in emergency room visits
3. Improvements in School Readiness and achievement
4. Crime and domestic Violence
5. Family economic stability
6. Coordination and referrals for other community resources and support

The PAT® program was implemented in West Virginia using the established federal MIEHCV review tool criteria as a guide for ensuring West Virginia implemented the programs with measurable outcomes and evidence to show efficacy.

In addition to the fidelity monitoring through HFA® national, each affiliate of these in-home visitation services must also be scored on MIEHCV program outcomes, which are monitored through OMCFH annual site visits using the West Virginia Maternal, Infant & Early Childhood Home Visiting Quality Assurance/Improvement Annual Site Visit Review tools, which are included in Attachment G.

Attachment G, pages 1-3, outlines the outcomes, or benchmarks, that will be used to monitor HFA® in West Virginia. Specifically, the six outcomes are:

1. Improved maternal and newborn health
2. Child Injuries, child abuse/neglect/maltreatment and reduction in emergency room visits
3. Improvements in School Readiness and achievement
4. Crime and domestic Violence
5. Family economic stability
6. Coordination and referrals for other community resources and support

The HFA® program was implemented in West Virginia using the established federal MIEHCV review tool criteria as a guide for ensuring West Virginia implemented the programs with measurable outcomes and evidence to show efficacy.

While the population of recipients under IV-E will not be funded using MIECHV dollars, the programs will still be part of the established structure of oversight for these evidence-based programs. New providers of PAT® and HFA® will be required to become affiliates of the proprietors and become accredited. The IV-E funded recipients will be tracked independently from the recipients utilizing MIECHV funds in order to allow reporting of outcomes to ACF.

Literature Review

The evidence detailing the use of Parents as Teachers® as a tool to help reduce the number of children under five from coming into foster care is compelling and sufficiently warrants a waiver of the evaluation requirements. This request for a waiver is based on the following:

The evidence shows that the service is effective in lowering the occurrences of child abuse and neglect;

The evidence indicates that PAT® can be implemented in West Virginia with no modifications to the model as it appears on the Title IV-E Clearinghouse.

An example in the literature has shown Parents as Teachers® to be more effective than usual parenting education services at reducing the occurrence of abuse and neglect. There was a significantly lower occurrence of any substantiated child maltreatment in the home-visiting group than in the comparison group (7.8% vs. 9.9%). Home visiting was also associated with lower rates of substantiated neglect (7.5% vs. 9.7%). Results showed that substantiated reports of maltreatment among families receiving home-visiting services occurred later in the child's life than families in the comparison group (Chaiyachati, B.H 2018). West Virginia has seen an increase of children under age five coming into foster care due to abuse and neglect, with nearly half, or 44%, of all children in foster care aged five or younger.

A review of the literature outlined on the Title IV-E Clearinghouse, as well as independent research of other publicly available data sources, revealed no reason for West Virginia to believe its families are substantively different than the families who found success and favorable outcomes as a result of their intervention with PAT®.

The evidence detailing the use of Healthy Families America® as a tool to help reduce the number of children under five from coming into foster care is compelling and sufficiently warrants a waiver of the evaluation requirements. This request for a waiver is based on the following:

The service has shown to be effective in ensuring child safety;

The evidence shows HFA® to increase positive parenting practices;

The evidence indicates that HFA® can be implemented in West Virginia with no modifications to the model as it appears on the Title IV-E Clearinghouse.

An example in the literature has shown HFA® to be more effective than usual parenting education services at increasing child safety. Mothers in New York who received the service were found to use serious physical abuse less frequently (.03 versus .15 $p < .01$) than mothers in the control group and used non-violent strategies more often (49.27 versus 45.27 $p < .05$) (Dumont 2010). West Virginia, during FY19, [reported](#) that half of child fatalities and near fatalities were children aged four or younger with slightly fewer than half of the perpetrators being the child's mother.

As stated previously, West Virginia found young motherhood to be a significant risk factor for children entering foster care, revealing the potential lack of positive parenting practices. One study shows that HFA® increases positive parenting practices. In Arkansas, the mothers who participated in this program had greater parenting self-efficacy (35.1 vs. 34.6 based on the Teti Self-Efficacy Scale, $p < .05$).

Services that can help mitigate the risk of removal due to substance use disorders are key to decreasing the rate West Virginia removes children. With over 80% of families encountering the child welfare system due to substance use issues, it is vital that services be available to help struggling parents. A study involving mothers in Hawaii showed a significant reduction in one measure of poor mental health ... a significant reduction in maternal problem alcohol use and repeated incidents of physical partner violence (Duggan, 2004).

A review of the literature outlined on the Title IV-E Clearinghouse, as well as independent research of other publicly available data sources, revealed no reason for West Virginia to believe its families are substantively different than the families who found success and favorable outcomes as a result of their intervention with HFA®.

Furthermore, West Virginia currently contracts with an administrative services organization (ASO) to conduct retrospective case reviews for providers of socially necessary services. However, as discussed in the Bureau for Children and Families' Right-Sizing Out-of-Home Care for West Virginia's Children: A Five-Year Plan for Family First in West Virginia, the socially necessary services program will be transferred

to a managed care organization (MCO). The MCO intends to utilize the same process for socially necessary services that the ASO uses, which will create a more seamless transition. The outcomes for PAT® and HFA® will be incorporated into the retrospective review process. These reviews are described in more detail below in the section Quality Matters - Continuous Quality Improvement.

Fidelity and Outcome Measures – Well-Supported Services Evaluation Waiver

West Virginia is submitting an evaluation waiver request for FFT® since it is rated as a well-supported service on the Title IV-E Prevention Services Clearinghouse. Participation in FFT® requires that program fidelity be paramount to the process. Functional Family Therapy®, LLC, has embedded quality into its services.

Functional Family Therapy®, LLC's web-based Client Services System (CSS) is the primary tool used to monitor program fidelity. Clinicians are required to document cases using the CSS, which is designed to ensure that goals and interventions at each session are consistent with the family's phase of treatment and the FFT® model. Supervisors and consultants review documentation in the CSS as one way to monitor therapists' adherence to the FFT® model. Therapist alliance with family members, which is emphasized from the start of treatment and is critical to the model, is monitored by the Family Self Report (FSR) and Therapist Self Report (TSR), rating scales completed by the therapist and every family member after the first and second sessions. FSR and TSR scores help therapists identify when an alliance is not developing as it should. FSR and TSR data are gathered during the first 2 sessions of each phase of treatment (Engagement/Motivation, Behavior Change and Generalization).

In addition, specific adherence measures are collected in the CSS and monitored by the site supervisor and Functional Family Therapy®, LLC, the consultant assigned to West Virginia. The supervisor or consultant rates each therapist weekly on several factors based on cases he/she discussed during supervision. At least three times per year, these ratings are used to derive a Global Therapist Rating for each therapist, gauging therapists' adherence to and competence in the model. The Global Therapist Rating includes two scales: 1) Dissemination Adherence, which is the degree to which the therapist adheres to FFT® protocols such as timeliness of documentation, appropriate spacing of sessions, flexible scheduling, responsiveness to community partners, etc.; and 2) Fidelity, which considers both therapist competence (e.g., sophistication of interventions, tailoring treatment to the family) and adherence (e.g., applying the model as intended and doing the "right thing at the right time").

The provider also manages outcomes through use of the following assessment tools administered at pre- and post-treatment, as well as following booster sessions:

Outcome Questionnaire (OQ) - for all caregivers and adults over 18 to score on themselves;

Youth Outcome Questionnaire (YOQ) - for all caregivers to score on the identified youth;

Youth Outcome Questionnaire - Self-Report (YOQ-SR) - for the identified youth to score on him or herself.

At the culmination of treatment, the FFT® therapist administers the following:

- Client Outcome Measure (COM-A) - completed with the identified youth;
- Client Outcome Measure (COM-P) - completed on the caregivers;
- Therapist Outcome Measure (TOM) - completed by the therapist. This tool explores the changes the therapist and family report over the treatment process.

Therapists also document presence of and/or change in risk and protective factors over the course of treatment.

Outcomes are further monitored through data gathered including the following: length of time between referral and first contact (no more than 48 hours), length of time between referral and first session (no more than 7 days), and number of sessions required in each phase of treatment (goal is first three sessions in 10 days).

Longitudinal data is gathered at six months post-discharge, measuring youth who still have continued involvement in the juvenile justice system.

Functional Family Therapy®, LLC, also has their own internal measures for determining program fidelity, which is the Tri-Yearly Performance Evaluation (TYPE Report). The TYPE report is pulled by FFT® three times per year. They send it to the provider and review with them. The provider then has to provide a corrective action plan on how they will fix the areas that are below threshold. This helps ensure fidelity to the model the timeframes and expectations of the program. See Attachment H for a sample report.

Weekly Supervision Checklist: Following every clinical staffing, the clinical supervisor completes a fidelity rating for the case that was reviewed for each therapist. This fidelity rating reflects the degree of adherence and competence for that therapist's work in that case in a specific session. Thus, the weekly supervision ratings are not global, but specific to a single case presentation. Over the course of the year, a therapist may receive up to 50 ratings, which provide the supervisor with critical information about the therapist's progress in implementing FFT®.

Global Therapist Rating (GTR) is another tool to measure therapist competence and adherence to the model. Three times a year the clinical supervisor rates each therapist's overall adherence and competence in FFT®. The GTR allows for the supervisor to provide feedback to the therapist on their overall knowledge and performance of each phase and general FFT® counseling skills. The GTR specifically targets time period measures with the hope of displaying therapist growth. With respect to the GTR, DHHR encourages supervisors to utilize the comments box under each phase to target specific strengths and specific phase areas of growth.

Cut-off scores indicate whether the therapist demonstrates satisfactory dissemination adherence and model fidelity, and each therapist has a Learning and Growth Plan to facilitate adherence and competence (Alexander, et. al., 2013).

Functional Family Therapy®, LLC, requires the use of its Client Services System (CSS) by licensed FFT® providers to document the application of treatment and clients' subsequent progress. Functional Family Therapy®, LLC, monitors its licensed providers through this system ensuring compliance with key service delivery factors. Providers who struggle with fidelity are contacted by Functional Family Therapy®, LLC, and provided technical assistance to remedy the identified issues. Providers who are unable to maintain fidelity to the model, after technical assistance is provided, may lose their license.

Unique to West Virginia, the partnership with Functional Family Therapy®, LLC, began as a state funded initiative, therefore, West Virginia also maintains monitoring access through the CSS system and is notified by Functional Family Therapy®, LLC, when providers are struggling to come into compliance with fidelity standards. Upon notification that a provider is struggling with fidelity, the state immediately reaches out to the provider to discuss key issues affecting service delivery and possible solutions.

If the state recognizes poor outcomes through its quarterly reporting requirements, it will initiate contact with the provider prior to Functional Family Therapy®, LLC, involvement. This system has proven effective. It has also helped to identify external factors affecting fidelity, such as referrals for service. These issues are quickly addressed on a systems level with ongoing outreach and education to potential referents.

The FFT® outcome data process is provided with this plan with Attachment H.

West Virginia currently contracts with an administrative services organization (ASO) to conduct retrospective case reviews for providers of socially necessary services. However, as discussed in the Bureau for Children and *Families' Right-Sizing Out-of-Home Care for West Virginia's Children: A Five-Year Plan for Family First in West Virginia*, the socially necessary services program will be transferred to a managed care organization (MCO). The MCO intends to utilize the same process for socially necessary services that the ASO uses, which will create a more seamless transition. The outcomes for FFT® will be incorporated into the retrospective review process. These reviews are described in more detail below in Quality Matters: Continuous Quality Improvement.

Literature Review

The evidence detailing the use of FFT® as a tool to help reduce the number of children aged 11-18 from coming into foster care is compelling and sufficiently warrants a waiver of the evaluation requirements. This request for a waiver is based on the following:

- The evidence shows that the service is effective in reducing problem behaviors;
- The evidence indicates that FFT® can be implemented in West Virginia with no modifications to the model as it appears on the Title IV-E Clearinghouse.

There are multiple examples in the literature that verify FFT® to be effective at reducing juvenile delinquency, improving behavioral and emotional functioning. A study in Washington State showed that when FFT® was delivered with fidelity by competent therapists, it reduced felony and violent felony recidivism in a cost-effective manner (Baronski, 2004).

When FFT® was delivered to an at-risk group of adolescents in New Jersey as a preventive service, “FFT participants, relative to those in the comparison group, improved more on the Life Domain Scale ($F = 5.571, p < 0.05$), the Child Behavioral/Emotional Needs Scale ($F = 8.137, p < 0.01$), and the Child Risk Behaviors Scale ($F = 12.459, p < 0.001$)” (Celinsa, 2013). Researchers in the United Kingdom found significant reductions in all measures of reoffending and anti-social behaviors at six-month and 18-month follow-up for youth receiving FFT® (Hunayun, 2017).

The reductions in behaviors outlined is compelling for West Virginia since approximately 40% of foster children between the ages of 11 and 18 are coming into contact with the juvenile justice and child welfare systems due to their unsafe behaviors and mal-adaptive functioning issues that manifest in delinquency.

A review of the literature outlined on the Title IV-E Clearinghouse, as well as independent research of other publicly available data sources, revealed no reason for West Virginia to believe its families are substantively different than the families who found success and favorable outcomes as a result of their intervention with FFT®.

Quality Matters – Continuous Quality Improvement

West Virginia has partnered with an administrative services organization since 2004 to provide continuous quality monitoring and improvement strategies for West Virginia’s socially necessary services program. Effective January 1, 2020, West Virginia’s new MCO became contractually required to perform administration services organization management services not only for all medical and dental services but also for all socially necessary services for foster children, post-adoptive children and foster care candidates. The Title IV-E prevention services that West Virginia will be providing will be embedded into the current utilization management structure as all other socially necessary services. Contracts outlining performance requirements for providers of socially necessary services were implemented in July 2018, which require providers to achieve a score of 80% or higher during retrospective quality assurance reviews.

The “80% Rule,” which has been in effect since 2015, requires that socially necessary services providers score at least 80% during their retrospective on-site review. The retrospective review is conducted by the ASO, as part of their contractual relationship with the MCO, at least every 12 months. If the provider scores less than 80% on any service they provide, the provider receives written notice that a six-month probationary period is in effect. Training and technical assistance is offered during the probationary period. After the six-month probationary period ends, the administrative services organization conducts another on-site review on the service(s) scoring less than 80%. If the service still scores less than 80%, that service will be removed from the provider’s service offerings, and they will no longer be able to receive referrals to provide that service.

If, during the retrospective review process, a provider scores zero on any safety-related service, that service will be automatically closed from the provider's array of services. There will not be a six-month probationary period when a safety service scores zero.

The retrospective review tool that is used by the ASO, as part of their contractual relationship with the MCO, will be revised to meet the needs of capturing outcomes and fidelity measures to the models for the Title IV-E prevention services through a public-private partnership that will include providers of each prevention service.

The Bureau for Children and Families currently determines qualitative data and customer satisfaction for socially necessary services through client focus groups. These focus groups are conducted with recipients of all services offered through the socially necessary services program. The results from the focus groups are shared with Bureau for Children and Families managers, the service array workgroup and the socially necessary services providers for improvements to be made to programs. These focus groups will continue with the new MCO, as part of their continuous quality improvement processes.

The Division of Program and Quality Improvement, housed within BCF, will utilize its CFSR-style reviews to collect data for CQI monitoring of outcomes, unmet needs and service availability. This will ensure that West Virginia is capturing specific service-related patterns as they develop. There will be reference to unmet needs within each CQI review that will be compiled for the CFSR service array workgroup, the entity responsible for ensuring availability of adequate services for families who are served by West Virginia's child welfare agency. The program manager for the service array is the key player in using the focus group results and DPQI unmet needs data to inform the community collaboratives about service development work and system improvements.

Additional Outcomes Monitoring

An important provision of the MCO contract will be the enhanced outcomes monitoring of socially necessary services for all foster care candidates. DHHR will use the established outcome measures that have been demonstrated by research and have been embedded into each evidence-based service. The outcomes developed for West Virginia with Functional Family Therapy®, LLC, will continue to be used as outlined in Attachment H.

DHHR's Bureau for Children and Families will partner with DHHR's OMCFH to utilize the established state and federal outcome measures for the two in-home visitation programs through MIECHV, as mentioned above and outlined in Attachment G.



Alaska

Status: Submitted

Section VI: Evaluation Strategy and Waiver Request

Evaluation Strategy

Alaska's strategy for evaluation of Family First Prevention Services implementation will be facilitated by a Continuous Quality Improvement (CQI) framework involving internal state agency processes in addition to collaboration with Tribes active in management of prevention services cases. Funding through Family First will only be sought for well-supported programs described in the waiver request, no rigorous evaluation of the programs is necessary; however, a robust CQI evaluation design will be utilized to analyze implementation.

Evaluation will be comprised of quantitative and qualitative measures generally described in following paragraphs targeted for process and outcome evaluation. The key to the evaluation strategy for Alaska is designing an evaluative method that will be consistent regardless if the prevention services case is managed through the state agency or Tribe. This will require collaboration in CQI processes and reporting mechanisms to fully inform implementation with respect to the target population and anticipated outcomes identified in the Theory of Change.

Alaska is comprised of five state regions and numerous Tribes have articulated interest and commitment to serving prevention services cases. As Alaska is a large and vast state, there is awareness and understanding that service availability and access will have disparity in regard to where the prevention services case is located. The OCS will be selective in the assignment of prevention services cases to regions that have workforce capacity to implement the proposed case management expectations with fidelity. With this stated, it will be important to have collaborative stakeholder involvement in addition to State Office oversight in the CQI process. The OCS is committed to using the analysis of information and evidence collected to inform refinements needed to criteria set for candidates for care to maximize positive outcomes for families, service array and case management practice improvements.

Theory of Change

Alaska has long recognized the need for earlier service delivery to families in attempt to prevent entry into foster care. Historical case reviews, analysis of current practice, previous in home service models, and data reports inform the trajectory of Alaska families who ultimately enter the foster care system. Ongoing problem analysis and previous efforts in conjunction with the current internal workgroup analysis has been central in the development of the Theory of Change. Alaskan families involved with the foster care system are overrepresented with substance abuse and historical trauma precipitating violence and chronic addiction behaviors. As family conditions deteriorate and risk to child safety escalates there have not been solid methods to provide early intervention services successfully. This has been attributed to incorrect identification of family characteristics that would be most successful, adherence to a consistent statewide model, and the importance of authentic engagement, specifically cultural engagement. Problem analysis contributed to the formation of the criteria set for defining candidates for foster care, which theorizes which families may successfully benefit from prevention services.

The inputs in the Theory of Change to redirect the family trajectory center around the Strengthening Families framework and target enhancing the protective factors in caregivers. This includes the services described throughout the plan, evidence based programs well supported to impact outcomes in addition to culturally relevant services. Utilizing the Strengthening Families framework is maximizing a foundation already laid in Alaska, where many communities have been trained and have incorporated programs and services aimed at the five protective factors. A critical component in Theory of Change is authentic engagement of the families to the extent possible to assess readiness for change, facilitate motivation and behavioral change.

The anticipated outcome is families will enhance protective factors where they are diminished, to mitigate the risk or safety indicators present in the family that have brought them to the agency's attention. Risk factors may always be present; however, with sustainable enhanced protective factors maltreatment of children and entry into the foster care system could be deterred.

In summary, the Theory of Change hypothesizes family characteristics and conditions that may benefit optimally from prevention services through a culturally relevant and evidence based service delivery model focusing on engagement to enhance protective factors diminishing entry into foster care and minimizing repeat maltreatment.

Evaluation Design

The driver of the evaluation design is the established CQI framework adopted in the OCS. The OCS utilizes a PDSA (Plan, Do, Study, Act) cycle for implementation and fully incorporates the Theory of Change and evaluation of the selected intervention in relation to desired outcomes. The PDSA structure will be utilized for process and outcome evaluation. In adherence to the PDSA cycle, the first two years of the plan will focus on the implementation and evaluation of the selected interventions to inform needed changes or potential to scaling out to more prevention services cases.

An internal state structure has been established in which a workgroup team is tasked with the activities in the PDSA with a reporting requirement to the Change Management Leadership Team (CMLT). The internal workgroup will incorporate the data collection and analysis activities described in the following sections in conjunction with the state Evaluation and Research Units.

For Tribe administered prevention services cases, Tribes will be provided technical assistance in learning and understanding the CQI PDSA framework as needed or requested. This will facilitate consistency in evaluation and reporting for all prevention services cases with the added benefit of input through the lens of the party managing the case. The same evaluation tools and reporting format will be required for all prevention services cases.

As previously indicated, the first two years will focus on process evaluation and short term outcome evaluation. The process evaluation will gather evidence particular to questions surrounding the case management method, referral and accessibility of services, timeframes associated with case opening and closure and to what extent the target population was engaged. The short term outcome evaluation will provide information on enhancement of protective factors in caregivers and families. Distal outcome evaluation will incorporate indicators of reoccurrence of maltreatment, entry or re-entry into foster care.

Data Collection

Data collection will include qualitative and quantitative methods. Prevention services case information and management activities will be documented and stored in the state SACWIS system. At each opening and before closure of a prevention services case, a protective factors survey will be administered. The Protective Factors Survey is a research informed, peer reviewed and valid instrument that assesses multiple protective factors to prevent child abuse and neglect. In addition, stakeholder focus groups and surveys will be incorporated to provide feedback and qualitative information. Stakeholders for focus groups will include Tribes, state agency staff, and service providers who are in receipt of referrals and providing services. Case reviews through the Evaluation Unit will be completed on prevention services cases for information related to the safety and well-being of children in addition to case management processes, this review may include interviews with parents, caregivers, staff and children.

It is anticipated that on initial implementation, prevention service caseloads will be small. Robust data collection could be sought on every prevention service case and re-determined to move to a sample collection criteria and timeframe as caseload size warrants. Periodic submission and aggregation of required data collection will be determined once the state and Tribe case size is fully realized.

Data Analysis

Data analysis will occur twofold, with the primary analysis occurring in the established internal CQI structure and oversight and additional analysis occurring through OCS state office Evaluation and Research Units. Analysis occurring at the implementation level and through the scope of State Office will provide secondary reviews to eliminate any potential for bias and provide a more comprehensive analysis to scale out prevention services cases.

The Evaluation Unit will be responsible to aggregate qualitative case review and protective factors survey data with statistical analysis. The Research Unit will be responsible for developing report generation and analysis from documentation entered into the SACWIS system and outcome indicators.

Distribution of Reports and use of Findings

Regular report and finding updates will occur from the internal CQI workgroup to the Change Management Leadership Team (CMLT). The internal CQI workgroup will determine at what junctures enough data collection and analysis has occurred to report progress, successes and barriers to CMLT. CMLT meets monthly offering regular reporting and feedback structure. Dependent on case data collection size and geographic sample, reporting structures will be developed to provide data analysis and opportunity for feedback for stakeholders either directly or indirectly involved in the implementation of Family First Prevention cases.

Waiver Request

Attachment II, Request for Waiver of Evaluation Requirement for a Well-Supported Practice is submitted for the following well-supported services on the Title IV-E Prevention Services Clearinghouse: Parent Child Interaction Therapy, Multisystemic Therapy, Functional Family Therapy, Motivational Interviewing, Nurse Family Partnerships and Parents as Teachers.

Parent Child Interaction Therapy

Parent Child Interaction Therapy (PCIT) has been thoroughly studied and reviewed with a conclusion as a well-supported service on the Title IV-E Prevention Services Clearinghouse. Review of evidentiary support showed PCIT had favorable and significant impacts on child behavioral and emotional functioning, positive parenting practices, and parent/caregiver mental or emotional health which is a key factor in promoting protective factors in families aimed at children ages two to seven years old. Parents or caregivers receive immediate feedback and coaching to enhance parenting competencies. Studies show PCIT has been found effective for decreasing the risk for child physical abuse and enhancing positive parent and child relationships.

Several groups have identified PCIT as a model treatment program after systemic reviews including the California Evidence-Based Clearinghouse for Child Welfare, The National Child Traumatic Stress Network, and National Crime Victims Research and Treatment Center, Office for Victims of Crime at the U.S. Dept. of Justice.

Following is a summary of findings from the Title IV-E Prevention Services Clearinghouse:

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child well-being: Behavioral and emotional functioning	0.92 32	11 (46)	524	Favorable: 18 No Effect: 28 Unfavorable: 0
Child well-being: Social functioning	0.52 19	1 (2)	19	Favorable: 0 No Effect: 2 Unfavorable: 0
Adult well-being: Positive parenting practices	1.46 42	8 (25)	422	Favorable: 20 No Effect: 5 Unfavorable: 0
Adult well-being: Parent/caregiver mental or emotional health	0.58 21	3 (6)	252	Favorable: 4 No Effect: 2 Unfavorable: 0
Adult well-being: Family functioning	0.29 11	5 (10)	177	Favorable: 0 No Effect: 10 Unfavorable: 0

MultiSystemic Therapy

MutiSystemic Therapy (MST) is designed as an intensive treatment for youth to promote pro-social behavior and reduce criminal activity, out of home placements and illicit substance use in 12 to 17 year old youths. The service is available to access 24/7 to allow for crisis management and interventions. This service aligns with the issues Alaskans families face with the exposure to ACES and historical trauma and

aimed at enhancing resiliency and protective factors. Multiple studies were reviewed and concluded to be a well-supported service on the Title IV-E Prevention Services Clearinghouse. In addition, the California Evidence-Based Clearinghouse has concluded a scientific rating of well supported and has a medium relevance to child welfare, meaning the program is commonly used to service youth who are similar to child welfare populations. Notable was the favorable effect on child behavioral and emotional functioning as highlighted on the summary of findings table located on the Title IV-E Prevention Services Clearinghouse and has been identified as a treatment model by the U.S. Surgeon General in reducing rates of recidivism of juvenile offenders.

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child permanency	0.12 4	2 (4)	1395	Favorable: 2 No Effect: 2 Unfavorable: 0
Child well-being: Behavioral and emotional functioning	0.22 8	6 (89)	1455	Favorable: 21 No Effect: 67 Unfavorable: 1
Child well-being: Social functioning	0.02 0	3 (12)	946	Favorable: 0 No Effect: 12 Unfavorable: 0
Child well-being: Cognitive functions and abilities	0.13 5	1 (3)	486	Favorable: 0 No Effect: 3 Unfavorable: 0
Child well-being: Substance use	-0.04 -1	2 (7)	703	Favorable: 1 No Effect: 5 Unfavorable: 1
Child well-being: Delinquent behavior	0.13 5	7 (48)	2200	Favorable: 11 No Effect: 34 Unfavorable: 3
Child well-being: Educational Achievement and Attainment	-0.13 -5	1 (1)	153	Favorable: 0 No Effect: 1 Unfavorable: 0

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Adult well-being: Positive parenting practices	0.12 4	3 (49)	969	Favorable: 12 No Effect: 37 Unfavorable: 0
Adult well-being: Parent/caregiver mental or emotional health	0.29 11	4 (7)	979	Favorable: 4 No Effect: 3 Unfavorable: 0

Functional Family Therapy

This is a short term prevention program for at risk youth and their families, Functional Family Therapy, or FTT, targets risk and protective factors that impact development of 11 to 18 year old youth. This service aligns with maximizing the Strengthening Families protective factors to impact high risk families and prevention of ongoing behaviors of teens that intersect with juvenile justice, schools, child welfare systems and mental health. FFT is promoted by the U.S. Department of Justice, Office of Justice Programs citing reviews of studies to conclude the service as being a prevention and intervention program for adolescent behavior problems. This service is chosen by Alaska as it aims to curb the cycle of generational trauma and evidentiary study reviews showing favorable effect to teen substance use. Summary of findings table on the Title IV-E Prevention Services Clearinghouse.

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child well-being: Behavioral and emotional functioning	0.16 6	4 (26)	390	Favorable: 2 No Effect: 23 Unfavorable: 1
Child well-being: Substance use	0.49 18	1 (18)	52	Favorable: 9 No Effect: 9 Unfavorable: 0

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child well-being: Delinquent behavior	0.05 1	5 (20)	8636	Favorable: 4 No Effect: 16 Unfavorable: 0
Adult well-being: Positive parenting practices	0.02 0	2 (9)	163	Favorable: 0 No Effect: 9 Unfavorable: 0
Adult well-being: Family functioning	0.30 11	1 (15)	52	Favorable: 1 No Effect: 14 Unfavorable: 0

Motivational Interviewing

Numerous studies and evidence supports the conclusion of Motivational Interviewing (MI) as a well-supported evidence based service. On the Title IV-E Prevention Services Clearinghouse, seventy five studies were reviewed demonstrating a favorable impact to parental or caregiver substance use. The strategies are designed to promote behavioral change through the five stages of change. Increasing motivation reinforces behavioral change is possible with the setting of behaviorally based goals and is a widely used counseling approach. The summary of findings reflect the extensive studies conducted on MI:

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child well-being: Substance use	0.02 0	5 (33)	1634	Favorable: 0 No Effect: 33 Unfavorable: 0
Adult well-being: Parent/caregiver	0.00 0	3 (5)	1464	Favorable: 0 No Effect: 5 Unfavorable: 0

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
mental or emotional health				
Adult well-being: Parent/caregiver substance use	0.08 3	15 (109)	6066	Favorable: 16 No Effect: 91 Unfavorable: 2
Adult well-being: Parent/caregiver criminal behavior	-0.01 0	2 (7)	1610	Favorable: 0 No Effect: 7 Unfavorable: 0
Adult well-being: Family functioning	0.10 4	1 (1)	777	Favorable: 0 No Effect: 1 Unfavorable: 0
Adult well-being: Parent/caregiver physical health	0.02 0	4 (10)	2158	Favorable: 0 No Effect: 10 Unfavorable: 0
Adult well-being: Economic and housing stability	-0.02 0	1 (1)	777	Favorable: 0 No Effect: 1 Unfavorable: 0

Nurse Family Partnership

Alaska has experienced success with current Nurse Family Partnership (NFP) Programs and is encouraged to continue supporting services through Family First Prevention Services. Alaska’s Native Medical Center started NFP in 1993. Services are provided by nurses targeted to young, first time and low income mothers through home visiting. These services may continue until the child is two providing support, goal making and enhancing parental competencies. These services impact child safety in Alaska as an example, through education of Safe Sleep practices, and enhancement of caregiver protective factors. NFP has been researched and provided detailed findings through three randomized controlled trials which has had extensive research finding published. A summary of findings through the Title IV-E Clearinghouse is listed in the following the table:

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child safety	-0.10 -3	4 (14)	197308	Favorable: 1 No Effect: 7 Unfavorable: 6
Child well-being: Behavioral and emotional functioning	0.18 7	1 (7)	417	Favorable: 0 No Effect: 7 Unfavorable: 0
Child well-being: Cognitive functions and abilities	0.21 8	2 (13)	1353	Favorable: 1 No Effect: 12 Unfavorable: 0
Child well-being: Physical development and health	0.02 0	3 (16)	111412	Favorable: 5 No Effect: 11 Unfavorable: 0
Child well-being: Educational Achievement and Attainment	-0.09 -3	1 (5)	396	Favorable: 0 No Effect: 4 Unfavorable: 1
Adult well-being: Positive parenting practices	0.18 7	1 (1)	407	Favorable: 0 No Effect: 1 Unfavorable: 0
Adult well-being: Parent/caregiver mental or emotional health	0.06 2	1 (8)	1121	Favorable: 0 No Effect: 8 Unfavorable: 0

Adult well-being: Parent/caregiver substance use	0.00 0	2 (3)	1733	Favorable: 0 No Effect: 3 Unfavorable: 0
Adult well-being: Family functioning	0.03 1	2 (2)	1470	Favorable: 0 No Effect: 2 Unfavorable: 0
Adult well-being: Parent/caregiver physical health	-0.01 0	2 (9)	2668	Favorable: 0 No Effect: 9 Unfavorable: 0
Adult well-being: Economic and housing stability	0.06 2	2 (13)	1577	Favorable: 1 No Effect: 12 Unfavorable: 0

Parents as Teachers

New and expectant parent's skills are enhanced through Parents as Teachers (PAT) home visiting program. The goal of services is to prevent maltreatment and enhance the physical and mental development of children through caregiver education and enhancement of capacities. The model includes four core functions of personal home visits, supportive groups, health and developmental screenings and community resource networks. Evidence of studies reviewed show positive impact to child safety and the overall health and wellbeing of children enhanced. In Alaska, PAT is used in Head Start programs and is diverse in its reach among urban and rural communities. A summary of findings table is as follows supporting the conclusion on the Prevention Services Clearinghouse as a well-supported program.

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child safety	0.11 4	2 (6)	4825	Favorable: 2 No Effect: 3 Unfavorable: 0

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child permanency	0.16 6	1 (1)	4560	Favorable: 0 No Effect: 1 Unfavorable: 0
Child well-being: Social functioning	0.12 4	1 (6)	375	Favorable: 3 No Effect: 2 Unfavorable: 1
Child well-being: Cognitive functions and abilities	0.13 5	2 (12)	575	Favorable: 2 No Effect: 10 Unfavorable: 0
Child well-being: Physical development and health	0.08 3	1 (3)	375	Favorable: 0 No Effect: 3 Unfavorable: 0
Adult well-being: Positive parenting practices	0.27 10	1 (1)	203	Favorable: 0 No Effect: 1 Unfavorable: 0
Adult well-being: Family functioning	-0.07 -2	2 (11)	640	Favorable: 0 No Effect: 10 Unfavorable: 1
Adult well-being: Economic and housing stability	-0.09 -3	1 (10)	366	Favorable: 0 No Effect: 9 Unfavorable: 1



Kansas

Status: Approved

Section VI: Evaluation Strategy and Waiver Request

Evaluation strategy and waiver request (Section 2 Pre-print)

Kansas has contracted with an independent evaluator to conduct a well-designed and rigorous evaluation. The University of Kansas (KU) School of Social Welfare and KU Center for Public Partnerships and Research will conduct evaluations for all Kansas Family First Prevention Service providers and service interventions.

The evaluation plan is guided by a utilization-focused approach that includes two major components: (1) a process evaluation, and (2) an outcomes evaluation. See Attachment 3 for the detailed Evaluation Plan for Family First Prevention Services.

During first year of implementation, DCF will collaborate with the evaluation team and other states, to review all service models for foster care prevention programs. Kansas may submit these programs at a future date for review of eligibility for transitional payments.

Waiver Request

Kansas is not requesting evaluation waivers for well-supported services. As indicated above, Kansas has contracted with an independent evaluator to conduct a well-designed and rigorous evaluation of all services.



Kentucky

Status: Approved

Section VI: Evaluation Strategy and Waiver Request

Evaluation Strategy and Waiver Requests

Kentucky's evaluation strategy for Family First implementation will apply an evaluation model that includes process, outcome, and impact measures. While DCBS is contemplating an overarching evaluation strategy for Family First implementation as a whole within the State, the agency will be working with Cabinet for Health and Family Services (CHFS) evaluators and an internal CQI team to administer a discrete, well-designed and rigorous evaluation or CQI strategy for each EBP proposed within this Title IV-E Prevention Plan.

An evaluation/CQI team of CHFS Family First research/evaluation staff, program leadership, front line staff, community stakeholders, and client stakeholders has been developed for this effort. The evaluation team will be led by Matthew Walton, PhD, MSSW and Dana Quesinberry, JD, DrPH from the Division of Analytics in the Office of Health Data and Analytics at the Cabinet for Health and Family Services. Dr. Walton's research interests involve the intersection of behavioral health and child welfare; he was on the team that conducted the evaluation of the START program under Kentucky's Title IV-E Waiver Demonstration project (included in the promising strategies to be implemented under this plan). Additionally, Dr. Walton has direct social work practice experience in psychiatric and general hospital settings. Dr. Quesinberry practiced law for 15 years with a focus in child abuse and neglect cases. Under multiple federal grants, Dr. Quesinberry has conducted evaluations of existing public health prevention programs, the implementation of new programs, and health policy.

While DCBS is proposing that a formal evaluation will apply to some EBPs and CQI strategies will apply to others, this evaluation/CQI team will work in partnership to ensure a shared conceptual framework, promote collaboration and information sharing, and create a sound foundation for DCBS' broader Family First implementation.

Evaluation waiver for well-supported interventions

Pursuant to Section 471(e)(5)(C)(ii), states may submit a request to waive the evaluation requirement for allowable programs or services that have been deemed well-supported by the Title IV-E Prevention Services Clearinghouse. Specifically, this section reads:

"(ii) WAIVER OF LIMITATION.—The Secretary may waive the requirement for a well-designed and rigorous evaluation of any well-supported practice if the Secretary deems the evidence of the effectiveness of the practice to be compelling and the State meets the continuous quality improvement requirements included in subparagraph (B)(iii)(II) with regard to the practice."

Kentucky will be seeking a waiver request for the evidence-based practices included in this plan that are rated as well supported by the Title IV-E Prevention Services Clearinghouse. Those EBPs include parent child interaction therapy (PCIT), motivational interviewing (MI), multisystemic therapy (MST), and functional family therapy (FFT). See Appendix J for the signed waiver requests.

Request for Waiver of Family First Evaluation Requirement:

Compelling Evidence Review for Parent-Child Interaction Therapy

The evidence in favor of the use of Parent Child Interaction Therapy (PCIT) as a means of promoting positive family dynamics and reducing the risk of foster care placements in Kentucky is compelling. Moreover, the weight of the evidence is sufficiently compelling to warrant a waiver to the Kentucky Department of Community Based Services for the Family First evaluation requirements for PCIT. This request for a waiver of the evaluation requirement for Parent Child Interaction Therapy is based on the following:

- (1) It has been shown to be efficacious in a wide variety of locations and has universal application,
- (2) It has demonstrated flexibility and favorable outcomes with children of various cultural backgrounds and underlying problems and
- (3) It can be adapted for Kentucky's target population without materially altering the EBP as reviewed by the Title IV-E Prevention Services Clearinghouse; moreover, PCIT has been successfully tailored for use with Appalachian children and families

Efficacious in Variety of Locations and Broad Contextual Applications

There are several well-designed studies identified by the Title IV-E Prevention Services Clearinghouse literature review of PCIT that demonstrate its ability to reduce child maltreatment and disruptive behavior across a wide variety of contexts and populations (e.g., Thomas & Zimmer-Gembeck, 2011; Bjørseth & Wichstrøm, 2016). Among the six highest-rated studies in the review, half were performed internationally (two in Hong Kong, one in Norway). PCIT's consistent success with diverse racial and ethnic groups in multiple cultural contexts suggests the intervention would be successful with Kentucky children and families as well (McCabe, Yeh, Lau, & Argote, 2012). The body of evidence describes that the core components of PCIT have a degree of universal application, and therefore PCIT will have the same desired effects in Kentucky that have been demonstrated elsewhere.

Favorable Outcomes and Flexibility Across Cultural Backgrounds and Underlying Problems

Not only has PCIT demonstrated favorable outcomes in multiple locations with various ethnicities (and languages), but it has also demonstrated flexibility in terms of the particular diagnostic presentations of children. For example, a randomized controlled trial conducted by Leung, Tsang, Ng, and Choi (2017) found that PCIT promoted positive outcomes for children with ADHD diagnoses. A similar investigation by Solomon, Ono, Timmer, and Goodlin-Jones (2008) found comparable favorable results for children on the autism spectrum. Finally, yet a third study authored by Bagner, Sheinkopf, Vohr, and Lester, (2010) found PCIT to be effective in children who were born premature. ADHD, Autism, and prematurity are common

problems in the child welfare population broadly, but are particularly present in Kentucky's CPS caseloads. According to the March of Dimes 2018 Premature Birth Report Card, Kentucky received a grade of "D", with an 11.1% rate of all live births being born preterm. This is likely related to epidemic levels of drug use in the state affecting prenatal circumstances for pregnant women. Studies authored by the Medical Director of Kentucky's Department for Community Based Services suggests that each of these diagnostic presentations will be common in the eligible pool of Kentucky foster care candidates that will receive PCIT (Lohr et al., 2018; Lohr et al., 2018). Therefore, the literature suggests that PCIT is capable of flexibility in terms of the particular national/cultural background where it is provided and the particular medical or behavioral problems experienced by the children who benefit from it.

Adaptability without Altering PCIT, and Prior Success in Appalachian Context

Most compellingly, the evidence suggests that PCIT can be successfully adapted to the particular context where it is being delivered without materially altering the practice or diminishing its efficacy. Indeed, evidence of successful adaptation of PCIT to rural Appalachian contexts has been described in Taubenheim and Tiano (2012), which found several meaningful strategies to tailor the intervention in ways that will be instructive for DCBS in Kentucky. These include:

- Granting Appalachian families the opportunity to talk about other concerns beyond parent training and child behavior problems appears to increase the likelihood of retention in treatment.
- Much of Kentucky is either sparsely populated, mountainous, or both. This is especially true in most of Eastern Kentucky, where poverty, underdeveloped infrastructure, and distance to treatment facilities make transportation a particular hardship for families. Taubenheim and Tiano (2012) recommend finding innovative ways to provide transportation as a means of promoting retention in PCIT.
- There is often a distrust of government authority figures and professionals in Appalachian culture. This may be a barrier to engaging in treatment. Enlisting the assistance of trusted local leaders, such as religious figures, is likely to increase retention.
- Taking a strengths-based approach to local culture is likely to help build rapport. "Strengths of Appalachians include persevering through hard times, making do with limited resources, having pride, being close-knit and protective, and caring about friends and families" (p. 22).

Just as PCIT has been successfully adapted for Spanish-speaking Mexican-Americans in California or high-risk families in Australia (e.g., Thomas & Zimmer-Gembeck, 2011); DCBS believes that it can be adapted for Appalachian residents of Eastern Kentucky or urban families in Louisville without altering its beneficial effects on parent-child relationships, as described in

Taubenheim and Tiano (2012). This particular dimension of EBP adaptation and implementation is mentioned in the Title IV-E Prevention Services Clearinghouse Handbook of Standards and Procedures (2019, p. 15):

Exhibit 4.1. Examples of Program and Service Adaptations within a Study for the Purpose of Study Review

Eligible Adaptations	Adaptations that Result in Different Program or Service
<ul style="list-style-type: none"> • Modestly changing session frequency or duration • Delivering the intervention in the home compared to office-based delivery • Making small changes to increase the cultural relevancy of the intervention (e.g., changing examples to match the cultural background of subjects; providing the intervention in a different language) without changing program components • Delivering the program by slightly different types of professionals than described in the manual or original research on the program or service (e.g., using social workers instead of counselors to deliver the program) 	<ul style="list-style-type: none"> • Changing from individual to group therapy • Adding any new modules or session content • Subtracting any modules or session content that was part of the original intervention • Radically changing content for different cultural groups, such as to reflect particular issues experienced by those groups • Delivery of the program by substantially different providers than described in the manual (e.g., using para-professionals instead of nurses to deliver the program)

Evaluation Waiver Request – Parent Child Interaction Therapy

The evidence described above is sufficiently compelling that an evaluation of PCIT, a well-supported evidence-based practice, is not necessary for Kentucky’s 5-year prevention plan. The evidence-base is already strong for this practice, the resources that Kentucky has available for evaluation would be most prudently applied to another prevention service that has an evidence-base that is less robust (i.e., a promising or supported EBP). Based on previous studies and evaluation reports that were identified by the Title IV-E Prevention Services Clearinghouse from similar contexts, DCBS feels that CQI measures will suffice in this case.

Request for Waiver of Family First Evaluation Requirement: Compelling Evidence Review for Motivational Interviewing

The evidence in favor of the use of Motivational Interviewing (MI) as a means of promoting positive family dynamics and reducing the risk of foster care placements in Kentucky is compelling. Moreover, the weight of the evidence is sufficiently compelling to warrant a waiver to the Kentucky Department of Community Based Services of the Family First evaluation requirements for MI. This request for a waiver of the evaluation requirement is based on the following:

- (1) It has been shown to be efficacious in a wide variety of locations and settings,
- (2) It has demonstrated flexibility and favorable outcomes with youths and families of various cultural backgrounds and underlying problems and
- (3) Because MI is designed to peak a client’s motivation for behavioral change, it has been shown to be an especially effective intervention to pair with other child welfare programs to reduce risk of maltreatment and placement into out of home care

Efficacious in Variety of Locations and Broad Scope of Application

There are several well-designed studies that have demonstrated MI's benefit to people who receive it. The usefulness of MI has been demonstrated in outpatient clinic settings, correctional institutions, hospitals, schools, and several other environments where child welfare-involved families receive services. Because MI is used to help people identify their core values and assist them to understand how their behavior is inconsistent with those values, it is a versatile intervention. Broadly speaking, child welfare authorities operate under the assumption that parents love their children and want them to grow and develop in healthy ways. Indeed, this is among the most powerful values that a parent can have, and does not significantly vary based on culture, language, ethnicity, or religious affiliation. With this in mind, practitioners of MI in Kentucky will be able to use it to connect their work with clients to this underlying set of values about the well-being of their children.

Favorable Outcomes and Flexibility Across Cultural Backgrounds and Underlying Problems

MI has demonstrated favorable outcomes in multiple locations with people of various ethnicities, but it has also demonstrated flexibility in terms of the particular diagnostic presentations that it can help treat. Though it was initially developed as a means of helping patients engage in addiction treatment, MI has been found to be useful in a host of behavioral health settings where people may be reluctant to participate. Specifically, it appears to be most applicable to Family's First's emphasis on treating addiction and severe mental illness. As described in a literature review by Shah and colleagues (2019), there is an emerging body of evidence that MI is also specifically useful for child welfare professionals in a range of settings and for certain targeted family outcomes.

MI Appears to be Especially Valuable as an Adjunctive Intervention

Motivational interviewing is unique from other identified prevention services for a few meaningful reasons. Chief amongst these reasons is that MI can be provided as a stand alone intervention, but is commonly provided as a means of addressing hesitancy or resistance to behavior change in advance of some other intervention. Notably, there is evidence that MI is particularly beneficial when it is offered as an adjunct to two other prevention services listed on this prevention plan: (1) PCIT (Chaffin et al., 2009; Chaffin, Funderburk, Bard, & Valle, 2011), and (2) CBT (Randall & McNeil, 2017). Using random assignment, Dr. Chaffin's research group in Oklahoma noted that a combination of MI and PCIT improved parents retention in PCIT treatment, which then in turn improved child welfare outcomes after a period of 2.5 years. Similarly, in a review of the clinical literature, Randall and McNeil (2017) noted:

"Limitations and the preliminary nature of the work in this area notwithstanding, it appears that it is feasible to supplement or integrate CBT with MI and that doing so has the potential to improve treatment initiation and engagement, as well as clinical outcomes." (p. 1)

Evaluation Waiver Request – Motivational Interviewing

The evidence described above is sufficiently compelling that an evaluation of MI, a well-supported evidence-based practice, is not necessary for Kentucky's 5-year prevention plan. The evidence-base is already strong for this practice, and the resources that Kentucky has available for evaluation would be

most prudently applied to other prevention services that have an evidence-base that is less robust (i.e., a promising or supported EBP). Based on previous studies and evaluation reports that were identified by the systematic review attached to this document, DCBS feels that CQI measures will suffice in this case.

Request for Waiver of Family First Evaluation Requirement:

Compelling Evidence Review for Multisystemic Therapy

The evidence in favor of the use of Multisystemic Therapy (MST) as a means of promoting positive youth behavior change and reducing the risk of foster care placements in Kentucky is compelling. Moreover, DCBS believes the weight of the evidence is sufficiently compelling to warrant a waiver of the evaluation requirements for MST. This request for a waiver of the evaluation requirement for Multisystemic Therapy is based on the following:

(1) It has been shown to be effective in a wide variety of locations, in a variety of client populations, and with multiple target outcomes

(2) There is evidence that MST can be adapted for the Kentucky's population at a statewide scale without materially altering the EBP as reviewed by the Title IV-E Prevention Services Clearinghouse

Efficacious in Variety of Locations and Broad Scope of Application

There are numerous examples in the literature where MST has been shown to be more effective than usual services at reducing out of home care placements and conduct problems in children and adolescents (e.g., Vidal, Steeger, Caron, Lasher, & Connell, 2017; Butler, Baruch, Hickey, & Fonagy, 2011). The MST intervention has now been implemented and evaluated over several decades and in multiple locations around the world; and many families have demonstrably benefited from receiving it.

A program of research on MST led by Dr. Scott Henggeler at the Medical University of South Carolina has demonstrated its capacity to positively affect a number of outcomes for youths and their families in South Carolina (e.g., Henggeler et al., 2003). Among these outcomes are: reduced out of home care placements, reduced suicide attempts in emotionally disturbed youths, and improvements in measures of family cohesion. A set of similar favorable outcomes were also observed in Rhode Island, when the intervention was taken to scale across the state, by a team of researchers from Westat, the University of Washington, and Yale University (Vidal et al., 2017). While Kentucky, South Carolina, and Rhode Island are undoubtedly different from one another in meaningful ways, DCBS believes that South Carolina and Rhode Island are suitable comparison states to conclude that MST will have similar beneficial effects when scaled up in Kentucky. For example, according to the National Institute on Drug Abuse (NIDA), Kentucky and Rhode Island appear to be facing a similar burden from the opioid crisis. In Rhode Island, there were 26.9 overdose deaths per 100,000 residents in 2017; for that year in Kentucky, that number was 27.9. Additionally, according to data reported in Radel, Baldwin, Crouse, Ghertner, and Waters, (2018), Rhode Island and Kentucky appear to be struggling with comparable proportions of counties reporting rates of

drug overdose deaths and foster care entries that are both simultaneously above their respective national medians.

Important conclusions were drawn in Vidal and colleagues (2017):

“Consistent with findings from efficacy and effectiveness studies, our findings support the promise of taking MST to scale.” (p. 861)

“Taken together, our findings underscore the potential benefits of taking evidence-based programs such as MST to scale to improve the well-being and functioning of high-risk and high-need youth.” (p. 863)

MST is a Scalable Intervention

These findings came from studies with diverse samples of several hundred youths. The Vidal and colleagues (2017) study reported on a statewide scale-up of MST in Rhode Island that describes an implementation process that is comparable to Kentucky’s FFPSA prevention plan in several important ways. There now exists several precedents and resources that can be used to guide Kentucky’s large scale implementation of the MST and adaptation of the practice to suit Kentucky’s unique needs. Importantly, because MST has been implemented around the United States (as well as Chile and the United Kingdom), a method of transfer, implementation, and continuous quality improvement has been established for agencies that elect to provide the practice to their population. This method is outlined in Henggeler (2011), which states:

“The effectiveness trials with serious juvenile offenders have demonstrated the capacity of MST to achieve key ultimate outcomes in real-world clinical settings, and the hybrid efficacy-effectiveness studies have supported the promise of several MST adaptations and shown that second- and third-generation MST experts can provide a level of quality assurance needed to achieve key outcomes.” (p. 366)

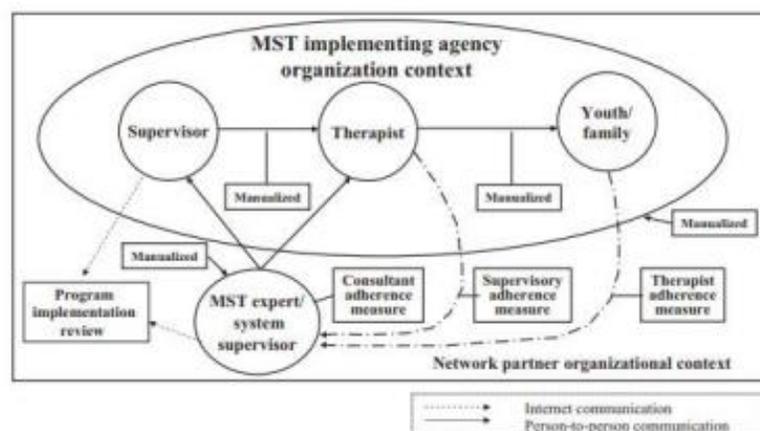


Figure 3
 Multisystemic therapy (MST) quality improvement system. Note that linkage between therapist adherence, as reported by caregivers, and child outcomes has been empirically supported in clinical trials. Additionally, the linkages between supervisor adherence and therapist adherence as well as consultant adherence and therapist adherence have been empirically demonstrated in research studies of MST. Current research efforts are directed at evaluating this model and identifying possible barriers to successful implementation of MST.

*Henggeler (2011, p. 370)

Evaluation Waiver Request – Multisystemic Therapy

The evidence described above is sufficiently compelling that an evaluation of MST is not necessary for Kentucky's 5-year prevention plan. The systematic review performed by the Title IV-E Prevention Services Clearinghouse suggests that Kentucky would be best served by allocating its evaluation resources to other prevention services with a less well-developed evidence base. DCBS must use its available resources to strike a balance between monitoring the quality of existing well-supported practices and providing well-designed, rigorous evaluations for the remaining practices. It is DCBS' position that the marginal added value of a full evaluation of MST in this case simply does not warrant the projected cost. Therefore, DCBS feels that CQI measures will suffice as Kentucky implements Family First.

Request for Waiver of Family First Evaluation Requirement:

Compelling Evidence Review for Functional Family Therapy

The evidence in favor of the use of Functional Family Therapy (FFT) as a means of reducing the risk of foster care placements in Kentucky is compelling. Moreover, DCBS believes the weight of the evidence is sufficiently compelling to warrant a waiver of the evaluation requirements for FFT. This request for a waiver of the evaluation requirement for Functional Family Therapy is based on the following:

(1) It has been shown to be effective in a wide variety of locations, in a variety of client populations, and with multiple target outcomes

(2) There is evidence that FFT can be adapted for Kentucky's target population without materially altering the EBP as reviewed by the Title IV-E Prevention Services Clearinghouse

Efficacious in Variety of Locations and Broad Scope of Application

There are numerous examples in the literature where FFT has been shown to be more effective than usual services at reducing conduct problems in older children and adolescents across a wide range of sites and contexts, suggesting universal applicability. These results are described for young people in (among other locations) Washington State, the United Kingdom, and New York City. Specifically, the highly rated studies by the Title IV-E Prevention Services Clearinghouse most commonly describe the capability of FFT to reduce youth substance abuse and criminal behavior (e.g., Humayun et al., 2017). This is particularly relevant to Kentucky, a state that ranked 7th highest in the nation for drug overdose deaths among 12-25 year olds and 35th lowest in the nation for overall child wellbeing (Cole, Logan, & Scrivner, 2017). Early versions of FFT were found to be effective at promoting favorable child welfare outcomes (see Barton, Alexander, Waldron, Turner, & Warburton, 1985). DCBS believes that the wide variety of settings, localities, and client populations that have successfully used FFT to address disruptive behavior in families is evidence of its ability to be successfully implemented in Kentucky. Further evidence of this can be found in the endorsement of the practice by the U.S. Centers for Disease Control and Prevention, which identifies FFT as a effective means of addressing youth violence (see David-Ferdon et al., 2016). A review of the literature identified by the Title IV-E Prevention Services Clearinghouse as well as additional publicly available material leaves DCBS to conclude that there exists no reason to believe that the population of Kentucky is materially distinct from the populations who have documented accounts of responding

favorably to FFT. Therefore DCBS feels confident that similar benefits will be realized in the child welfare-involved families in Kentucky.

Evaluation Waiver Request – Functional Family Therapy

The evidence described above is sufficiently compelling that an evaluation of FFT is not necessary for Kentucky's 5-year prevention plan. The systematic review performed by the Title IV-E Prevention Services Clearinghouse suggests that, rather than conducting a rigorous evaluation of FFT as a component of Kentucky's Family First implementation, its evaluation-related resources are best allocated to other prevention services that do not have the same evidence base. Therefore, DCBS feels that CQI measures will suffice in this case.

CQI strategy for Well-Supported Interventions

A consistent, statewide CQI strategy will be utilized to monitor fidelity to the interventions and achievement of intended outcomes by those well supported EBPs. CQI processes may also measure additional performance outcomes to the extent possible, like families' experiences and/or satisfaction with the programs or treatment models included in the candidates' childspecific prevention plan. Kentucky is building CQI capacity and integrating CQI activities into existing practice in several ways. In addition to including CQI processes within Standards of Practice (SOP), DCBS is also hiring a Family First program specialist within the Prevention Branch of the Division of Protection and Permanency (DPP) to support statewide CQI activities and provide additional contributions and oversight to regional Family First liaisons as well as gatekeepers. The continuous monitoring processes and systems described in this section will also extend to be tailored to all interventions, in addition to well-supported interventions.

CQI processes will include quality periodic case reviews conducted with providers to ensure alignment with the practice models. Data will be collected and stored in model specific databases, the state CCWIS system, as well as an in-home provider database. Data will also be collected utilizing a screening tool to ensure data are collected consistently and accurately. Quality Control Analysts within the Information and Quality Improvement Unit will assist with regard to any data issues encountered. The sample size reviewed will be large enough to make statistical inferences and reviewed with regard to geographical location and population. Specific caseload data will be screened to provide context and address agency performance. Quarterly CQI meetings will be held with a variety of providers reviewing administrative reports consisting of key data points, assessing challenges to successful implementation and planning for solutions to eliminate the barriers identified by stakeholders. Data collected during the case review process will also be shared with providers during quarterly meetings. This will allow for providers to inform analysis and to increase collaborative efforts. Furthermore, focus groups with families and providers will be conducted annually.

Intervention fidelity will be monitored at several levels to determine outcomes achieved:

1. Provider level-adherence to intervention model purveyor fidelity activities;
2. DCBS Central Office administered case reviews to ensure intervention specific fidelity; and

3. State level interagency collaboration to refine and improve processes.

Executing all necessary protocols to monitor and promote fidelity, and collaborating with DCBS, for well-supported interventions, in the implementation of case reviews, quarterly meetings, and focus group participation, will be added to provider contacts during this state fiscal year (SFY) or at the latest, SFY 21. Providers are expected to complete intervention specific fidelity monitoring, as prescribed by each individual implementation manual. All Kentucky providers participate in a workgroup formed to develop Kentucky's CQI process for well-supported interventions. Providers are engaged in the developing of case review screening tools and collection methods. This provides additional awareness of state monitoring and fidelity expectations, such as utilizing intervention model specific databases, collaborating with model purveyors to examine client outcomes or ongoing trainings. A Family First Specialist in DCBS Central Office will complete administration of the case review. Case reviews will be administered yearly, by region and intervention specific. Case reviews will assess if interventions are completed per model implementation manual, familial outcomes, if clinician training or certification is appropriate, if consultation occurs as prescribed, etc. Regional focus groups will also occur at the time of regional case review completion, with program recipients as participants. This will allow for the collection of additional performance measures to assess for program and intervention satisfaction, and familial experience. Focus groups will be facilitated by the Family First Specialist in DCBS Central Office to ensure objectivity, in that recipients answer without fear for repercussion or influence to answer favorably towards the agency.

Data collected through model specific databases, Kentucky's CCWIS system, the in-home provider database, case reviews, and focus groups, will be used to determine intervention-specific outcomes by region and provider, as well as statewide aggregate findings on key outcomes, such as rates of entry foster care and sustained reunification. This data will also be shared with each private provider regionally, following the completion of their regional/agency case reviews and focus groups. Areas in need of improvement identified will help to identify systematic issues requiring refinement, along with improving practices where growth is indicated for intervention implementation. Both areas of need and areas of success will be share with at quarterly statewide provide meetings. This feedback will assist in achieving fidelity statewide and identifying areas of growth for agencies, prior to them becoming problematic. Kentucky's development of processes and systems for CQI strategy for well-supported interventions largely compliments the revitalization of the department wide CQI process, with similar opportunities for regional meetings, stakeholder engagement, and a feedback loop. This also includes a forthcoming partnership with the Center for States and Chapin Hall. Three separate but closely aligned and integrated components will be included in the overall approach to the statewide CQI, Family First CQI, and Family First evaluation processes. These processes will work in tandem, by the engagement of service providers, along with the feedback loop of any necessary communication to field staff.

Evaluation Strategy for Promising and Supported Programs

Pursuant to Section 471(e)(5)(B)(iii)(V), the Family First Prevention Services Act of 2018 requires states to conduct a well-designed and rigorous evaluation of allowable programs or services. Specifically states are required to outline:

"(V) how each service or program provided will be evaluated through a well-designed and rigorous process, which may consist of an ongoing, cross-site evaluation approved by the Secretary."

Kentucky's Family First Well-Designed and Rigorous Evaluation Efforts

Kentucky's evaluation strategy for Family First implementation will apply an evaluation model that includes process, outcome, and impact measures. Given their evidence ratings from the Title IV-E Clearinghouse (or to be determined rating), this evaluation plan will apply to: (1) START, (2) TF-CBT, (3) CBT, and (4) Homebuilders. While DCBS has developed an over-arching evaluation strategy for Family First implementation as a whole within the State, the agency will be working with Cabinet for Health and Family Services evaluators and an internal CQI team to ensure that there is a discrete evaluation or CQI strategy for each EBP proposed within this Title IV-E Prevention Plan.

This section will present the roles and responsibilities of the evaluation team, the unique features of each evaluation strategy, some particularities around data collection and sampling, and perceived limitations and they will be addressed.

Evaluation Roles and Responsibilities

An evaluation/CQI team of CHFS Family First research/evaluation staff, program leadership, front line staff, community stakeholders, and client stakeholders is being developed. As mentioned earlier, the evaluation team will be led by Matthew Walton, PhD, MSSW and Dana Quesinberry, JD, DrPH. They are each staff members of the Division of Analytics in the Office of Health Data and Analytics (OHDA) at the Cabinet for Health and Family Services – where they work alongside a team of analysts.

In addition to the leadership of Dr. Walton and Dr. Quesinberry, the Family First evaluation will be supported by the technical professionals of the Office of Health Data and Analytics (OHDA). OHDA operates within a close partnership with the Kentucky Department of Medicaid Services, and serves as one of CHFS' primary resources for data analytics, data privacy and confidentiality concerns, and statistical analysis. It is staffed by biostatisticians, data architects, and analysts with expertise in health and social services data. The research support provided by OHDA will enable the evaluation team to have access to multiple technical experts to aid their efforts.

Dr. Walton and Dr. Quesinberry will also coordinate with the lead evaluator of the former Title IV-E Waiver Demonstration programs; Dr. Martin Hall, PhD, MSSW at the University of Louisville – Kent School of Social Work. Dr. Hall is the lead evaluator for the START program in Kentucky. Dr. Hall is a tenured professor of social work, and has several years of experience as a program evaluator. He has built the research infrastructure to sustain the ongoing program evaluation of START. Therefore, rather than serving as primary evaluation team for START, OHDA plans to serve as a coordinator and source of support for Dr. Hall and the START evaluation during its implementation under Family First.

More specifically, the evaluation strategy outlined in this plan is largely an extension of the methodologies employed by the START evaluation – meaning that DCBS has the full confidence that the continuation of the START evaluation will adhere to the historical satisfactory degree of rigor and strength of design. Additionally, Dr. Walton and Dr. Hall have been in consultation during the development of this evaluation to coordinate their efforts, methodological approaches, and knowledge of the available data in the TWIST system. For further information about the historical approach to the design elements of the START evaluation, please see Huebner et al. (2012), Huebner, Posze, Willauer & Hall (2015), and Hall et al. (2015).

While DCBS is proposing that a formal, well-designed, rigorous evaluation will apply to some EBPs and CQI strategies will apply to others, this evaluation/CQI team will work in partnership to ensure a shared conceptual framework, promote collaboration and information sharing, and create a sound foundation for DCBS' broader Family First implementation. Again, in light of Kentucky's waiver request for well supported interventions, DCBS still intends to use data and a critical appraisal of evidence to inform decision making about child safety and program outcomes.

A Note on Evaluation Strategies

Because Kentucky has a comprehensive, state-wide data collection tool (i.e., the TWIST system) and a data-sharing agreement between OHDA and DCBS, each of the four individual well designed and rigorous evaluations of prevention services will share a set of underlying methodological similarities. Specifically, secondary child welfare administrative data will be stored and accessed in the same way for each evaluation, and utilizes the same structure (i.e., variable names, conceptual/theoretical definitions, assessment tools). Furthermore, there are foreseeable instances where DCBS clients will receive two or more prevention services during the same case plan (START + TF-CBT being particularly common in Kentucky). Drawing from a common source of data will allow the evaluation team to estimate whether synergistic treatment effects are realized by these clients who receive multiple interventions for the same case. This being the case, this section will provide an outline of each program's individual evaluation strategy, and then proceed to describe how the evaluation team understands those common underlying elements that will inform the evaluation as a whole.

Evaluation Outline – Trauma-Focused Cognitive Behavioral Therapy

As described earlier, Trauma-Focused Cognitive Behavioral Therapy is a psychiatric intervention intended to address disorders specifically related to psychological/emotional trauma. TF-CBT is one of the most widely offered of the EBP's listed on this plan. It will be provided by a network of community mental health centers, clinics, and other centers that treat the psychological needs of children and families. The thesis behind offering TF-CBT as a means of preventing out of home care Table 5 provides an outline of the approach that will be taken to perform the evaluation of TF-CBT as part of Kentucky's implementation of Family First.

Inclusion Criteria & Sampling

TF-CBT will be offered to children and their parents or caregivers who exhibit signs and symptoms of psychological distress that is consistent with trauma. The treatment manual dictates that the intervention is intended to benefit children aged 3 years to 18 years of age – and is most commonly provided for anxiety and mood disorders. The intervention (i.e., "experimental") group will be sampled through purposive sampling; in other words all eligible clients who are deemed appropriate to participate after the referral and assessment processes will be followed for the evaluation study. In terms of the comparison groups, 1:1 nearest neighbor PSM matching will be used; without replacement and with a caliper size of .20 of the standard deviation of the propensity score. The matching variables will be as follows:

Variable	Description	Justification for Inclusion
DCBS Service Region	Service region where the index CPS case originated	Sampling from the same geographic and administrative state region helps reduce selection bias in non-experimental studies
Child's Age	Families will be matched based on the features of the youngest named child on the CPS report	It is known that younger children are at highest risk of the most extreme consequences of maltreatment
Child's Race	Will be coded as White, Black, or Other Race	There is an extensive body of literature that details how racial disproportionality is manifested in child welfare practice
Child's Biological Sex	Will be coded as Male or Female	Boys and girls differ in their degree of risk for certain types of maltreatment (e.g., girls are more often sexually abused)
Investigation Finding	"Substantiated" or "Services Needed"	The case designations required to be named a FFPSA foster care candidate
Index Year of Contact with CPS	The year a case was opened	Time is a meaningful covariate in statistical analyses (e.g., fixed vs random-effects linear models)

Past Substantiated CPS Case	Whether a family has been served by CPS in the past	Past substantiated reports of child maltreatment are predictors of future risk
Parental Mental Illness	Whether mental illness is an identified risk factor	Parental mental illness significantly effects the outcomes of child welfare work
Domestic Violence	Whether domestic violence in the home is an identified risk factor	Domestic violence is an important risk factor for certain child welfare outcomes
Poverty	Whether an investigation has identified the presence of material deprivation as a risk factor	Poverty and material hardship are significantly related to the risk for child maltreatment reports
Parental Criminal History	Whether an investigation identified criminal history as a risk factor	A parent's criminal history may be suggestive of risks to child safety or permanency
Risk Due to Substance Use	Whether parental substance use was identified as a risk for future maltreatment	Parental substance use is recognized by FFPSA as a meaningful predictor of risk to children's safety and well-being

Data Collection

Data Collection

The DCBS TWIST system will be used to collect data on child welfare outcomes for families that receive TF-CBT. DCBS case workers and psychiatric treatment providers will enter data continuously throughout the case as clients participate in the intervention; key outcome measures will be whether children are subjected to subsequent maltreatment, are removed from the home, and which placement types are utilized (e.g., kinship care, fictive kin, QRTF, etc.).

Outcome Measures

This evaluation will make treatment effect estimates for whether TF-CBT: (1) reduces the likelihood of a subsequent, substantiated maltreatment report, (2) reduces the likelihood of a child being removed from the home, and (3) whether TF-CBT decreases the average length of time children spend in out of home care. Please see Table 5 for the proposed analytic approaches for these outcomes.

Orienting Question	Is effectively addressing psychological trauma (and its associated anxiety and depression) associated with favorable child welfare outcomes?
Target Population	<ul style="list-style-type: none"> o Children and adolescents that have been exposed to traumatic experiences (i.e., child candidates for foster care) <ul style="list-style-type: none"> - Diagnosed with anxiety and/or mood disorder (e.g., Depression) - Often children exhibiting signs & symptoms of PTSD - Not for very young, pre-verbal children (typically ages 3 – 18 years old) or children with severe communication disorders o The parents & caregivers of traumatized children and adolescents
Data Collection & Management	<ul style="list-style-type: none"> o The DCBS TWIST child welfare case management software system; and affiliated data systems with the Cabinet for Health and Family Services. Example data stored in the TWIST system includes:

	<ul style="list-style-type: none"> - Data will be collected by DCBS workers as they go about their casework with families (which will then be made available to evaluators) - Case milestone dates (investigation, case opening, removal dates, etc.) - Flag variable for which children have been identified as FFPSA candidates - Flag variables to identify children that have been placed in foster care - Results of assessments and screenings
Measurement Instruments, Assessment Tools, etc.	<ul style="list-style-type: none"> o The DCBS Assessment and Documentation Tool (ADT) <ul style="list-style-type: none"> - Primary source of secondary administrative child welfare data - Used for investigatory phase, assessing family risk and protective factors o The Structured Decision Making Tool (SDM)* o The North Carolina Family Assessment Scale
Sampling	<ul style="list-style-type: none"> o Treatment group – Purposive, non-probability sampling: <ul style="list-style-type: none"> - i.e., clients who are: a) determined to be families w/ a FFPSA child candidate; b) screened for clinical appropriateness to receive services; c) receive at least 6 sessions of TF-CBT o Comparison group – propensity score matched sample <ul style="list-style-type: none"> - i.e., clients who reside within the same DCBS service region, and match along a set of demographic and risk-factor based variables
Outcomes of interest	<ul style="list-style-type: none"> o Recurrence of any type of substantiated child maltreatment within 1 year after discharge from services o Removal of a child candidate from the home within: a) 6 months of case opening; b) 1 year of case opening; c) 2 years of case opening o Improvements in NCFAS measures of: a) overall child well-being; b) overall family health; c) overall family safety o Differences in days spent in out of home care between treated vs. untreated children that have been removed from the home
Analysis Plan	<ul style="list-style-type: none"> o For assessing between-group equivalence at baseline: <ul style="list-style-type: none"> - Categorical variables – Chi-square tests (χ^2) - Continuous variables – t-tests o For non-parametric, categorical outcome variables: <ul style="list-style-type: none"> - Chi square tests of significance (χ^2) - Logistic regression o For time-oriented outcome variables: <ul style="list-style-type: none"> - Event-history analysis (i.e., Kaplan-Meier estimation) o For non-parametric, continuous outcome variables: <ul style="list-style-type: none"> - Generalized linear modeling techniques - (Will consider natural log data transformations if appropriate and indicated) o For non-parametric, count-based outcome variables:

	<ul style="list-style-type: none"> - Poisson regression modeling w/ corrections for zero-inflated and/or over-dispersed distributions
Limitations	<ul style="list-style-type: none"> o PSM cannot control for unobserved co-variates o The TWIST system cannot provide information on several relevant features of cases, such as: <ul style="list-style-type: none"> - Parental motivation/capacity for change - Therapist/counselor experience, skill level, and therapeutic rapport o Measures of parent and child well-being o Variance in case features not related to intervention <ul style="list-style-type: none"> - Judicial decision-making - Availability of extra services & supports (e.g., housing/utilities support, child support payments, school-based services)
<p>*The SDM is not currently in use in the field by DCBS staff. It is in process of being acquired and implemented, but data produced by the tool will be an asset to future evaluation efforts and analyses.</p>	

Evaluation Outline – Homebuilders

As described earlier, Homebuilders is a child welfare intervention designed to prevent foster care placement among children at imminent risk of removal from the home. It will be offered to DCBS clients by specially contracted service providers around the state of Kentucky. The thesis behind offering Homebuilders as a means of preventing out of home care placement operates on the premise that assisting families to develop healthier means of conflict resolution and life skills will serve as a protective factor against future instances of child maltreatment. Table 6 provides an outline of the approach that will be taken to perform the evaluation of Homebuilders as part of Kentucky’s implementation of Family First.

Inclusion Criteria & Sampling

Homebuilders will be offered to family units who exhibit maladaptive parenting strategies and/or conflict resolution practices. The treatment manual dictates that the intervention is intended to benefit children of all ages – and is most commonly provided for environmental risk factors in the home. The intervention (i.e., “experimental”) group will be sampled through purposive sampling; in other words all eligible clients who are deemed appropriate to participate after the referral and assessment processes will be followed for the evaluation study. In terms of the comparison groups, 1:1 nearest-neighbor PSM matching will be used; without replacement and with a caliper size of .20 of the standard deviation of the propensity score. The matching variables will be as follows:

Variable	Description	Justification for Inclusion
DCBS Service Region	Service region where the index CPS case originated	Sampling from the same geographic and administrative state region helps reduce selection bias in non-experimental studies
Child's Age	Families will be matched based on the features of the youngest named child on the CPS report	It is known that younger children are at highest risk of the most extreme consequences of maltreatment
Child's Race	Will be coded as White, Black, or Other Race	There is an extensive body of literature that details how racial disproportionality is manifested in child welfare practice
Child's Biological Sex	Will be coded as Male or Female	Boys and girls differ in their degree of risk for certain types of maltreatment (e.g., girls are more often sexually abused)
Investigation Finding	"Substantiated" or "Services Needed"	The case designations required to be named a FFPSA foster care candidate
Index Year of Contact with CPS	The year a case was opened	Time is a meaningful covariate in statistical analyses (e.g., fixed vs random-effects linear models)
Past Substantiated CPS Case	Whether a family has been served by CPS in the past	Past substantiated reports of child maltreatment are predictors of future risk
Parental Mental Illness	Whether mental illness is an identified risk factor	Parental mental illness significantly effects the outcomes of child welfare work
Domestic Violence	Whether domestic violence in the home is an identified risk factor	Domestic violence is an important risk factor for certain child welfare outcomes
Poverty	Whether an investigation has identified the presence of material deprivation as a risk factor	Poverty and material hardship are significantly related to the risk for child maltreatment reports
Parental Criminal History	Whether an investigation identified criminal history as a risk factor	A parent's criminal history may be suggestive of risks to child safety or permanency
Risk Due to Substance Use	Whether parental substance use was identified as a risk for future maltreatment	Parental substance use is recognized by FFPSA as a meaningful predictor of risk to children's safety and well-being

Data Collection

The DCBS TWIST system will be used to collect data on child welfare outcomes for families that receive Homebuilders. DCBS case workers and home-based treatment providers will enter data continuously throughout the case as clients participate in the intervention; key outcome measures will be whether children are subjected to subsequent maltreatment, or are removed from the home.

Outcome Measures

This evaluation will make treatment effect estimates for whether Homebuilders: (1) reduces the likelihood of a subsequent, substantiated maltreatment report. (2) Reduces the likelihood of a child being removed from the home (at any point during the case, or up to one year after discharge). (3) Whether TF-CBT decreases the average length of time children spend in out of home care. Please see Table 5 for the proposed analytic approaches for these outcomes.

Table 6 <i>Evaluation Strategy – Homebuilders</i>	
Orienting Question	Is effectively addressing a set of household risk factors associated with favorable child welfare outcomes?
Target Population	<ul style="list-style-type: none"> o Families with children and adolescents that are at imminent risk for placement into out of home care <ul style="list-style-type: none"> - Substantiated or services needed case determination - Family home determined to be safe enough for child to remain at home during the course of the intervention
Data Collection & Management	<ul style="list-style-type: none"> o The DCBS TWIST child welfare case management software system; and affiliated data systems with the Cabinet for Health and Family Services. Example data stored in the TWIST system includes: <ul style="list-style-type: none"> - Data will be collected by DCBS workers as they go about their casework with families (which will then be made available to evaluators) - Case milestone dates (investigation, case opening, removal dates, etc.) - Flag variable for which children have been identified as FFPSA candidates - Flag variables to identify children that have been placed in foster care - Results of assessments and screenings
Measurement Instruments, Assessment Tools, etc.	<ul style="list-style-type: none"> o The DCBS Assessment and Documentation Tool (ADT) <ul style="list-style-type: none"> - Primary source of secondary administrative child welfare data - Used for investigatory phase, assessing family risk and protective factors o The Structured Decision Making Tool (SDM)* o The North Carolina Family Assessment Scale
Sampling	<ul style="list-style-type: none"> o Treatment group – Purposive, non-probability sampling: <ul style="list-style-type: none"> - i.e., clients who are: a) determined to be families w/ a FFPSA child candidate; b) screened for clinical appropriateness to receive services; c) engage in services o Comparison group – propensity score matched sample <ul style="list-style-type: none"> - i.e., clients who reside within the same DCBS service region, and match along a set of demographic and risk-factor based variables
Outcomes of interest	<ul style="list-style-type: none"> o Recurrence of any type of substantiated child maltreatment within 1 year after discharge from services o Removal of a child candidate from the home within: a) 6 months of case opening; b) 1 year of case opening; c) 2 years of case opening o Improvements in NCFAS measures of: a) overall child well-being; b) overall family health; c) overall family safety o Differences in days spent in out of home care between treated vs. untreated children that have been removed from the home
Analysis Plan	<ul style="list-style-type: none"> o For assessing between-group equivalence at baseline: <ul style="list-style-type: none"> - Categorical variables – Chi-square tests (χ^2)

	<ul style="list-style-type: none"> - Continuous variables – t-tests
	<ul style="list-style-type: none"> o For non-parametric, categorical outcome variables: <ul style="list-style-type: none"> - Chi square tests of significance (χ^2) - Logistic regression
	<ul style="list-style-type: none"> o For time-oriented outcome variables: <ul style="list-style-type: none"> - Event-history analysis (i.e., Kaplan-Meier estimation)
	<ul style="list-style-type: none"> o For non-parametric, continuous outcome variables: <ul style="list-style-type: none"> - Generalized linear modeling techniques - (Will consider natural log data transformations if appropriate and indicated)
	<ul style="list-style-type: none"> o For non-parametric, count-based outcome variables: <ul style="list-style-type: none"> - Poisson regression modeling w/ corrections for zero-inflated and/or over-dispersed distributions
Limitations	<ul style="list-style-type: none"> o PSM cannot control for unobserved co-variates o The TWIST system cannot provide information on several relevant features of cases, such as: <ul style="list-style-type: none"> - Parental motivation/capacity for change - Therapist/counselor experience, skill level, and therapeutic rapport o Measures of parent and child well-being
<p>*The SDM is not currently in use in the field by DCBS staff. It is in process of being acquired and implemented, but data produced by the tool will be an asset to future evaluation efforts and analyses.</p>	

Evaluation Outline – Cognitive Behavioral Therapy

As described earlier, Cognitive Behavioral Therapy is a psychiatric intervention primarily intended to treat anxiety and mood disorders. CBT is a widely offered EBP of those listed on this plan. It will be provided by a network of community mental health centers, clinics, and other centers that treat the psychological needs of children and families. The thesis of offering CBT as a means of preventing out of home care placement operates from the premise that helping a parent resolve their anxiety or mood disorder will serve as a sufficient protective factor against future child maltreatment. Table 7 provides an outline of the approach that will be taken to perform the evaluation of CBT as part of Kentucky’s implementation of Family First.

Inclusion Criteria & Sampling

CBT will be offered to family units (either youths or their parent) who exhibit signs and symptoms of general anxiety or mood disorders. The treatment manual dictates that the intervention is intended to benefit children and adults – and is most commonly provided for the many manifestations of anxiety and depression. The intervention (i.e., “experimental”) group will be sampled through purposive sampling; in other words all eligible clients who are deemed appropriate to participate after the referral and assessment processes will be followed for the evaluation study. In terms of the comparison groups, 1:1 nearest-neighbor PSM matching will be used; without replacement and with a caliper size of .20 of the standard deviation of the propensity score. The matching variables will be as follows:

Variable	Description	Justification for Inclusion
DCBS Service Region	Service region where the index CPS case originated	Sampling from the same geographic and administrative state region helps reduce selection bias in non-experimental studies
Child's Age	Families will be matched based on the features of the youngest named child on the CPS report	It is known that younger children are at highest risk of the most extreme consequences of maltreatment
Child's Race	Will be coded as White, Black, or Other Race	There is an extensive body of literature that details how racial disproportionality is manifested in child welfare practice
Child's Biological Sex	Will be coded as Male or Female	Boys and girls differ in their degree of risk for certain types of maltreatment (e.g., girls are more often sexually abused)
Investigation Finding	"Substantiated" or "Services Needed"	The case designations required to be named a FFPSA foster care candidate
Index Year of Contact with CPS	The year a case was opened	Time is a meaningful covariate in statistical analyses (e.g., fixed vs random-effects linear models)
Past Substantiated CPS Case	Whether a family has been served by CPS in the past	Past substantiated reports of child maltreatment are predictors of future risk
Parental Mental Illness	Whether mental illness is an identified risk factor	Parental mental illness significantly effects the outcomes of child welfare work
Domestic Violence	Whether domestic violence in the home is an identified risk factor	Domestic violence is an important risk factor for certain child welfare outcomes
Poverty	Whether an investigation has identified the presence of material deprivation as a risk factor	Poverty and material hardship are significantly related to the risk for child maltreatment reports
Parental Criminal History	Whether an investigation identified criminal history as a risk factor	A parent's criminal history may be suggestive of risks to child safety or permanency
Risk Due to Substance Use	Whether parental substance use was identified as a risk for future maltreatment	Parental substance use is recognized by FFPSA as a meaningful predictor of risk to children's safety and well-being

Data Collection

The DCBS TWIST system will be used to collect data on child welfare outcomes for families that receive CBT. DCBS case workers and home-based treatment providers will enter data continuously throughout the case as clients participate in the intervention; key outcome measures will be whether children are subjected to subsequent maltreatment, are removed from the home, and other measures of safety and well-being.

Outcome Measures

This evaluation will make treatment effect estimates for whether CBT: (1) reduces the likelihood of a subsequent, substantiated maltreatment report. (2) Reduces the likelihood of a child being removed from the home (at any point during the case, or up to one year after discharge). (3) Whether TF-CBT decreases the average length of time children spend in out of home care. Please see Table 5 for the proposed analytic approaches for these outcomes.

Table 7 <i>Evaluation Strategy – Cognitive Behavioral Therapy</i>	
Orienting Question	Is effectively addressing anxiety and mood disorders associated with favorable child welfare outcomes?
Target Population	<ul style="list-style-type: none"> o Families with a child and/or caregiver that have been diagnosed with an anxiety or mood disorder and: <ul style="list-style-type: none"> - Substantiated or services needed CPS case determination - Child determined to be a candidate for foster care - Family home determined to be safe enough for child to remain at home during the course of the intervention
Data Collection & Management	<ul style="list-style-type: none"> o The DCBS TWIST child welfare case management software system; and affiliated data systems with the Cabinet for Health and Family Services. Example data stored in the TWIST system includes: <ul style="list-style-type: none"> - Data will be collected by DCBS workers as they go about their casework with families (which will then be made available to evaluators) - Case milestone dates (investigation, case opening, removal dates, etc.) - Flag variable for which children have been identified as FFPSA candidates - Flag variables to identify children that have been placed in foster care - Results of assessments and screenings
Measurement Instruments, Assessment Tools, etc.	<ul style="list-style-type: none"> o The DCBS Assessment and Documentation Tool (ADT) <ul style="list-style-type: none"> - Primary source of secondary administrative child welfare data - Used for investigatory phase, assessing family risk and protective factors o The Structured Decision Making Tool (SDM)* o The North Carolina Family Assessment Scale
Sampling	<ul style="list-style-type: none"> o Treatment group – Purposive, non-probability sampling: <ul style="list-style-type: none"> - i.e., clients who are: a) determined to be families w/ a FFPSA child candidate; b) screened for clinical appropriateness to receive services; c) receive at least 6 sessions of CBT o Comparison group – propensity score matched sample <ul style="list-style-type: none"> - i.e., clients who reside within the same DCBS service region, and match along a set of demographic and risk-factor based variables
Outcomes of interest	<ul style="list-style-type: none"> o Recurrence of any type of substantiated child maltreatment within 1 year after discharge from services o Removal of a child candidate from the home within: a) 6 months of case opening; b) 1 year of case opening; c) 2 years of case opening o Improvements in NCFAS measures of: a) overall child well-being; b) overall family health; c) overall family safety o Differences in days spent in out of home care between treated vs. untreated children that have been removed from the home
Analysis Plan	<ul style="list-style-type: none"> o For assessing between-group equivalence at baseline:

	<ul style="list-style-type: none"> - Categorical variables – Chi-square tests (χ^2) - Continuous variables – t-tests
	<ul style="list-style-type: none"> o For non-parametric, categorical outcome variables: <ul style="list-style-type: none"> - Chi square tests of significance (χ^2) - Logistic regression
	<ul style="list-style-type: none"> o For time-oriented outcome variables: <ul style="list-style-type: none"> - Event-history analysis (i.e., Kaplan-Meier estimation)
	<ul style="list-style-type: none"> o For non-parametric, continuous outcome variables: <ul style="list-style-type: none"> - Generalized linear modeling techniques - (Will consider natural log data transformations if appropriate and indicated)
	<ul style="list-style-type: none"> o For non-parametric, count-based outcome variables: <ul style="list-style-type: none"> - Poisson regression modeling w/ corrections for zero-inflated and/or over-dispersed distributions
Limitations	<ul style="list-style-type: none"> o PSM cannot control for unobserved co-variables o The TWIST system cannot provide information on several relevant features of cases, such as: <ul style="list-style-type: none"> - Parental motivation/capacity for change - Therapist/counselor experience, skill level, and therapeutic rapport - Measures of parent and child well-being
<p>*The SDM is not currently in use in the field by DCBS staff. It is in process of being acquired and implemented, but data produced by the tool will be an asset to future evaluation efforts and analyses.</p>	

Evaluation Outline – Sobriety Treatment and Recovery Teams

A Proposed Sub-study of the START Program

A rigorous evaluation was undertaken as part of the IV-E Waiver (2014-2019) awarded to Kentucky's Department of Community Based Services. This evaluation consisted of 526 children in families randomized to START or usual child welfare services in Jefferson County, Kentucky. Additionally, the IV-E Waiver evaluation included 336 children in families receiving START or usual services who were part of a propensity score matched (PSM) outcome evaluation in Boyd, Fayette, and Kenton Counties (the PSM process was similar to the one outlined for START elsewhere in this document). The evaluation assessed subsequent maltreatment and out of home placement within 12-months of the event that initiated START or usual child welfare services. Due to the duration of START (14 months on average) and the time constraints of the Waiver, outcomes beyond that could not be assessed as part of this specific evaluation effort.

However, this creates an interesting opportunity for longer-term follow-up study with this sample. Such a study would stand to make an important contribution as it would provide estimates of START's effects 6 and 12-months after case closure. If START were found to demonstrate favorable effects in this follow-up period, it could potentially elevate START's status from a promising to well-supported practice. Given that this study sample resulted from randomization and a rigorous propensity score matching process, it presents an opportunity to build on the existing evidence base of START. This would be valuable for Kentucky's DCBS and other jurisdictions that either offer START currently or plan to in the future.

Specifically, in the third year of this plan, TWIST data will be used to evaluate recurrent maltreatment and out of home placements 6 and 12-months after case closure for children included in the IV-E Waiver sample. Waiting until the third year of the plan to execute this substudy will ensure that all IV-E Waiver families have at least 12 months of case closure.

As described earlier, Sobriety Treatment and Recovery Teams is a child welfare intervention oriented around partnerships between special CPS units and addiction treatment providers. This intervention is designed to intervene in families with very young children where a parent or caregiver struggles with substance use. It is currently administered in seven counties around Kentucky. Its primary approach to reducing the risk of out of home care placement is based on the thesis that helping a parent establish long-term addiction recovery will serve as a sufficient protective factor against future maltreatment. Table 8 provides an outline of the approach that will be taken to perform the evaluation of START as part of Kentucky's implementation of Family First.

Inclusion Criteria & Sampling

START will be offered to families of children aged birth – 5 years old. START is designed to build rapport with, and then support parents and caregivers who exhibit high-risk substance use and consent to participating with intensive psychosocial services in order to maintain custody of their child. The START treatment manual dictates that the intervention is intended to be administered over an approximately one-year period of time (adherence to ASFA permanency timelines is especially emphasized). The intervention (i.e., "experimental") group will be sampled through purposive sampling; in other words all eligible clients who are deemed appropriate to participate after the referral and assessment processes will be followed for the evaluation study. In terms of the comparison groups, 1:1 nearest-neighbor PSM matching will be used; without replacement and with a caliper size of .20 of the standard deviation of the propensity score. The matching variables will be as follows:

Variable	Description	Justification for Inclusion
DCBS Service Region	Service region where the index CPS case originated	Sampling from the same geographic and administrative state region helps reduce selection bias in non-experimental studies
Child's Age	Families will be matched based on the features of the youngest named child on the CPS report	It is known that younger children are at highest risk of the most extreme consequences of maltreatment
Child's Race	Will be coded as White, Black, or Other Race	There is an extensive body of literature that details how racial disproportionality is manifested in child welfare practice
Child's Biological Sex	Will be coded as Male or Female	Boys and girls differ in their degree of risk for certain types of maltreatment (e.g., girls are more often sexually abused)
Investigation Finding	"Substantiated" or "Services Needed"	The case designations required to be named a FFPSA foster care candidate
Index Year of Contact with CPS	The year a case was opened	Time is a meaningful covariate in statistical analyses (e.g., fixed vs random-effects linear models)
Past Substantiated CPS Case	Whether a family has been served by CPS in the past	Past substantiated reports of child maltreatment are predictors of future risk
Parental Mental Illness	Whether mental illness is an identified risk factor	Parental mental illness significantly effects the outcomes of child welfare work
Domestic Violence	Whether domestic violence in the home is an identified risk factor	Domestic violence is an important risk factor for certain child welfare outcomes
Poverty	Whether an investigation has identified the presence of material deprivation as a risk factor	Poverty and material hardship are significantly related to the risk for child maltreatment reports
Parental Criminal History	Whether an investigation identified criminal history as a risk factor	A parent's criminal history may be suggestive of risks to child safety or permanency
Risk Due to Substance Use	Whether parental substance use was identified as a risk for future maltreatment	Parental substance use is recognized by FFPSA as a meaningful predictor of risk to children's safety and well-being

Data Collection

The DCBS TWIST system will be used to collect data on child welfare outcomes for families that receive START. DCBS case workers and psychiatric treatment providers will enter data continuously throughout the case as clients participate in the intervention; key outcome measures will be whether children are subjected to subsequent maltreatment, are removed from the home, and which placement types are utilized (e.g., kinship care, fictive kin, QRTF, etc.).

Outcome Measures

This evaluation will make treatment effect estimates for whether START: (1) reduces the likelihood of a subsequent, substantiated maltreatment report, (2) reduces the likelihood of a child being removed from the home, and (3) whether START decreases the average length of time children spend in out of home care. Please see Table 5 for the proposed analytic approaches for these outcomes.

Table 8	
<i>Evaluation Strategy – Sobriety Treatment and Recovery Teams</i>	
Orienting Question	Is effectively addressing parental substance use disorders associated with favorable child welfare outcomes?
Target Population	<ul style="list-style-type: none"> o Families with a young child and a parent/caregiver that has been determined to engage in high-risk substance use; and: <ul style="list-style-type: none"> - Substantiated or services needed CPS case determination - Child determined to be a candidate for foster care - Family home determined to be safe enough for child to remain at home during the course of the intervention
Data Collection & Management	<ul style="list-style-type: none"> o The DCBS TWIST child welfare case management software system; and affiliated data systems with the Cabinet for Health and Family Services. Example data stored in the TWIST system includes: <ul style="list-style-type: none"> - Administrative data will be collected by DCBS workers as they go about their casework with families (which will then be made available to evaluators) - Case milestone dates (investigation, case opening, removal dates, etc.) - Flag variable for which children have been identified as FFPSA candidates - Flag variables to identify children that have been placed in foster care - Results of assessments and screenings
Measurement Instruments, Assessment Tools, etc.	<ul style="list-style-type: none"> o The DCBS Assessment and Documentation Tool (ADT) <ul style="list-style-type: none"> - Primary source of secondary administrative child welfare data - Used for investigatory phase, assessing family risk and protective factors o The Structured Decision Making Tool (SDM)* o The North Carolina Family Assessment Scale
Sampling	<ul style="list-style-type: none"> o Treatment group – Purposive, non-probability sampling: <ul style="list-style-type: none"> - i.e., clients who are: a) determined to be families w/ a FFPSA child candidate; b) screened for clinical appropriateness to receive services o Comparison group – propensity score matched sample <ul style="list-style-type: none"> - i.e., clients who reside within the same DCBS service region, and match along a set of demographic and risk-factor based variables
Outcomes of interest	<ul style="list-style-type: none"> o Recurrence of any type of substantiated child maltreatment within 1 year after discharge from services o Removal of a child candidate from the home within: a) 6 months of case opening; b) 1 year of case opening; c) 2 years of case opening o Improvements in NCFAS measures of: a) overall child well-being; b) overall family health; c) overall family safety o Differences in days spent in out of home care between treated vs. untreated children that have been removed from the home
Analysis Plan	<ul style="list-style-type: none"> o Propensity score matching to construct comparison group

	<ul style="list-style-type: none"> ○ For assessing between-group equivalence at baseline: <ul style="list-style-type: none"> - Categorical variables – Chi-square tests (χ^2) - Continuous variables – t-tests
	<ul style="list-style-type: none"> ○ For non-parametric, categorical outcome variables: <ul style="list-style-type: none"> - Chi square tests of significance (χ^2) - Logistic regression
	<ul style="list-style-type: none"> ○ For time-oriented outcome variables: <ul style="list-style-type: none"> - Event-history analysis (i.e., Kaplan-Meier estimation)
	<ul style="list-style-type: none"> ○ For non-parametric, continuous outcome variables: <ul style="list-style-type: none"> - Generalized linear modeling techniques - (Will consider natural log data transformations if appropriate and indicated)
	<ul style="list-style-type: none"> ○ For non-parametric, count-based outcome variables: <ul style="list-style-type: none"> - Poisson regression modeling w/ corrections for zero-inflated and/or over-dispersed distributions
Limitations	<ul style="list-style-type: none"> ○ PSM cannot control for unobserved co-variates ○ The TWIST system cannot provide information on several relevant features of cases, such as: <ul style="list-style-type: none"> - Parental motivation/capacity for change - Therapist/counselor experience, skill level, and therapeutic rapport - Measures of parent and child well-being
<p>*The SDM is not currently in use in the field by DCBS staff. It is in process of being acquired and implemented, but data produced by the tool will be an asset to future evaluation efforts and analyses.</p>	

Common Evaluation Elements - Data Collection, Storage, and Security

Data will be collected and stored in both the state CCWIS system (known as “TWIST”; The Worker Information System), as well as an in-home provider database. Every single family who makes contact with Kentucky’s CPS agency has information generated and stored in the TWIST system; even if their allegation is not investigated or substantiated. The TWIST system is the case management software platform used by DCBS child protection workers. In other words, the primary source of data for the evaluation of Family First evidence based programs will be secondary administrative data and case records that have been documented by workers in the field. This data system has been used for program evaluations of child welfare interventions in Kentucky for over ten years; most recently by Title IV-E Waiver Demonstration evaluation teams. Please refer to Hall and colleagues (2015); Hall, Wilfong, Huebner, Posze, and Willauer (2016); and Huebner, Willauer, and Posze (2012) for examples of this use of TWIST data in published articles.

The TWIST system allows for DCBS to collect and store data at the level of an individual child, the named adult on their CPS case, and the family unit. This data is collected and entered into the centralized system each time a DCBS case worker makes contact with a client family, meaning the evaluation team will have access to a rich set of variables on each family. Moreover, each individual is assigned a system-generated identification number, a family case number, and a unique incident number. This allows analysts to observe outcomes across time and space when a child enters services more than one time or moves to

another Kentucky county. TWIST data is ideal for use in the Family First evaluation for three reasons: (1) because the TWIST system is already in use as DCBS' case management software platform, it is the least burdensome means for staff to report client data. (2) TWIST is a rich source of data, with very large sample sizes. (3) TWIST data allows the evaluation team to describe results as they occur in the field, under all of the real-world circumstances that families and DCBS workers face as they carry out their casework. DCBS and OHDA have negotiated and signed a memorandum of understanding that allows for the sharing of child welfare data from the data systems operated by DCBS to the evaluation team at OHDA. With this memorandum comes an established protocol for keeping the data secure, including encryption measures for storage and access and training for all staff that will work with it. Please see appendix S.

Information Housed in the TWIST System and Example Variables

The TWIST system in Kentucky is a very comprehensive case management and data storage platform to assist caseworkers in the field as they work with clients. While it is beyond the scope of this plan to outline the full capacity of the TWIST system, this section will describe some of the specific variables that are of particular relevance to the evaluation effort. There are several notable features of the system that make it particularly useful for tracking outcomes and creating suitable comparison groups within the child welfare-involved population in Kentucky.

First, the TWIST system collects data on each CPS case that is received by a Kentucky child abuse hotline. Each family then receives a case ID number that remains constant during each additional contact with the state child welfare system. In other words, whether a family contacts CPS one time or one hundred times, an evaluator will always be able to identify that family from a single database by their unique TWIST case ID. Moreover, the TWIST system also assigns individual ID numbers to each person named on a case. Therefore, each child and each adult involved with the act of maltreatment has an ID that can be tracked by evaluators. This TWIST ID follows clients as they receive services from contracted providers of health and social services; allowing analysts to coordinate data systems. This is a particularly useful feature given the reality that families often enter, exit, then reenter DCBS services.

Second, the TWIST system collects rich data about DCBS case milestones. For example, the date that a call is received with a child maltreatment allegation, the date that a case is opened, and the date that prevention services are discontinued are all stored in the TWIST system in a manner that is accessible to the evaluation team. The TWIST system also stores the results of investigations and assessments, which allow evaluators to match along baseline risk factors and stratify or cohort families based on important demographics. This level of precision allows analysts to understand several important features of an individual case and make inferences about outcomes of interest.

Third, the TWIST system collects data that can be used to investigate child welfare outcomes. Among these are: (1) whether recurrent maltreatment occurs, (2) whether a child is removed from the home, (3) the type of placement utilized by DCBS for each child (and how many placements occur within the removal), (4) whether a children that has been removed is ultimately reunified with their family of origin.

Table 9 outlines some of the most relevant information stored in the TWIST system. Several members of the evaluation team have experience using ADT data to create comparison groups and test measures of

baseline equivalence when estimating treatment effects of child welfare interventions. Principally, the DCBS investigations teams collect ADT data that describes granular levels of detail about child-level and adult-level risk and protective factors. There is a significant degree of overlap in terms of the detail that is collected by the ADT and the variables of interest that Family First targets (e.g., parental mental illness and substance use as risk factors for child placement in out of home care). Importantly, the ADT collects information related to social determinants of health and wellness, such as child nutrition, housing stability, and educational matters. The evaluation team views this data as an important source to inform future recommendations for ways to address the needs of DCBS families.

Table 9
Sample Variables Contained in the DCBS Assessment & Documentation Tool

Child Physical and Mental Health

Risk Factors

- Hearing or vision impaired
- History of seizures
- Medical diagnosis requiring life sustaining care
- Medical issues (asthma, broken arm, allergies, etc.)
- Mental health diagnosis requiring ongoing medications
- Physical disability
- Requires psychotropic medication to function
- No risk factors

Protective Factors

- No physical/mental health issues
- Received care for identified mental health issues
- Receives care for identified medical issues
- Up to date on immunizations

Risk of General Harm

- Caretaker has a prior Termination of Parental Rights order on another child
- Caretaker self-reports inability to cope [with parental duties]
- Caretaker self-reports they may harm child
- Child allowed to use drugs and/or alcohol

- Child born exposed to drugs and/or alcohol
- Child or family member threaten with a weapon
- DV related incidents are more severe/frequent
- Parent's cannot meet own needs
- Per court order, caretaker does not have custody of child
- Sibling of a child fatality/near fatality victim
- Violation of Emergency Protective Order/Domestic Violence Order puts child in danger
- No issues

CPS/APS/Criminal History

Risk Factors

- Adult is registered sex offender
- Parental rights on a child involuntarily terminated
- Prior convictions involving drugs/alcohol
- Variety of types of criminal convictions
- Prior felony convictions involving weapon/violence
- Prior reports of domestic violence
- Prior revocation of parole/probation
- Prior substantiated reports
- Prior substantiation death/near death of another child
- Action or lack of action contributed to death/serious harm of a child
- Multiple prior reports not accepted for investigation
- Prior unsubstantiated reports
- No risk factors

Protective Factors

- Acknowledges responsibility for prior charges
- Acknowledges responsibility for child welfare allegations
- No criminal charges
- No felony convictions
- No prior CPS/APS history
- Non-violent/traffic offenses
- Other rehabilitative services
- Received treatment/rehabilitative services related to prior sexual abuse

Maltreatment Risk Factors (Degree of Connection to Incident that Precipitated Case)

- Mental Health | – Directly Contributed – Indirectly Contributed – Was a Risk Factor – Not Applicable
- Family Violence | – Directly Contributed – Indirectly Contributed – Was a Risk Factor – Not Applicable
- Substance Abuse | – Directly Contributed – Indirectly Contributed – Was a Risk Factor – Not Applicable

In preparation for the implementation of Family First, DCBS has adapted the TWIST software to allow CPS workers to identify children as Family First foster care candidates. This will allow the evaluation team to easily isolate study samples from the broader child welfare population in TWIST reporting. In the language of propensity score matching, this designation of candidacy for foster care variable (in addition to the other observed covariates) will also allow the evaluation team to estimate propensity scores for non-treated children's predicted propensity to receive treatment. Additionally, The TWIST system collects data on several fields that are important for analysis and reporting outcomes – among these are:

- (1) Recurrence of substantiated maltreatment reports;
- (2) Removal and placement into out of home care;
- (3) Time spent in out of home care (in days);
- (4) Type of placement (kinship care, residential treatment, etc.);
- (5) Which services families were referred to

The in-home provider database was built by Eastern Kentucky University (EKU), and will be maintained by EKU throughout the implementation of Family First in Kentucky. It was built specifically for use by DCBS' specialized services for particularly at-risk families, and is therefore well suited for the purposes of the Family First evaluation. Because the providers that use this system are engaging in special services, this database also stores information on families collected through the administration of the North Carolina Family Assessment Scale (NCFAS; Reed-Ashcraft, Kirk, & Fraser (2001). Additionally, the in-home provider database has been in operation for several years, and has generated rich data for use by the Title IV-E Waiver projects in Kentucky in the past (i.e., START; K-STEP). There are several examples of published studies in peer-reviewed journals that used TWIST data for their analyses (see Huebner et al. 2012; Hall, Wilfong, Huebner, Posze, & Willauer, 2016; Hall et al., 2015). As these studies illustrate, the TWIST system contains sufficient administrative data to create valid comparison groups for analysis (i.e., untreated families that received usual CPS services). In many ways, the Family First evaluation team intends to replicate and enhance the approach used by the existing evaluation efforts of Title IV-E Waiver Demonstration programs.

Data will also be collected utilizing a screening tool to ensure data are collected consistently and accurately. Quality Control Analysts within the Information and Quality Improvement Unit of DCBS will assist with regard to any data issues encountered. The sample size reviewed will be large enough to make statistical inferences and reviewed with regard to geographical location and population. Because TWIST stores data on every single contact that DCBS makes with a family in KY (including hotline calls that are not even investigated), past evaluation efforts have had data on thousands of families. In the case of Family First, sample size will be dictated more by referral volume and provider capacity than by limitations related to data collection. Specific caseload data will be screened to provide context and address agency performance. Quarterly CQI meetings will be held with a variety of providers reviewing administrative

reports consisting of key data points, assessing challenges to successful implementation and planning for solutions to eliminate the barriers identified by stakeholders. Data collected during the case review process will also be shared with providers during quarterly meetings. This will allow for providers to inform analysis and to increase collaborative efforts. Furthermore, focus groups with families and providers will be conducted annually.

In addition to client-level data collected by DCBS' case management software applications, DCBS has commissioned the adaptation of its invoicing system to be able to record data on payments to providers for prevention services. This process has involved consultants and CHFS software developers to allow invoices to store information on which family was provided a given service, which EBP was provided, which agency provided it, and how much DCBS paid for it. This data will also be made available to the evaluation team to enable cost analyses.

The evaluation team will also plan for the inclusion of provider and client surveys in the evaluation plan. A dissemination plan for evaluation findings - both interim, periodic, and final - will be developed and will include a report to the Clearinghouse of evidence that supports the inclusion or identification of these interventions as well-supported.

Common Evaluation Elements - Notes on Methodology & Design

This will be a utilization-focused evaluation, with its chief objective being to be of use to DCBS in assessing the quality of programming that it offers to its clients. As a secondary objective, this evaluation will seek to further develop the knowledge base around what practices are effective at promoting favorable family outcomes in Kentucky. Keeping in mind that the evaluation is beholden to individual providers' programmatic and administrative particularities, the realities of a data management system that is adapting to the needs of Family First, and the practical features of the DCBS standard operating procedure, the evaluation team feels that a tailored approach should be taken as appropriate for each prevention service. This is especially true for conceptualizing appropriate comparison groups. The evaluation team foresees instances where alternative comparison strategies can be used to enhance the propensity score approaches described earlier. Therefore, to estimate the treatment effects on maltreatment recurrence and the prevention of out of home care placement, there will be multiple means available to compare families who receive promising or supported prevention services. These include:

- Propensity Score Matching: Given the reality of the evaluation's data sources, propensity score matching will be the primary methodology to construct suitable comparison groups. A fortunate byproduct of the thorough assessments that are warehoused by the TWIST system is a rich set of baseline measures of family functioning prior to the referral to services which can serve as matching variables for propensity score matching. This method has been successfully executed by Dr. Walton in the past (Walton, 2019), and is also currently being utilized in studies produced by the Title IV-E Waiver evaluation of START.
- Waitlist Control: Comparing families that engaged in and successfully completed services to those who were referred to services, but had to be waitlisted and referred back to usual CPS care whilst awaiting a treatment spot. This method of comparison balances an attempt to account for some degree of selection bias with not requiring the level of burden or perceived risk to children that randomization imposes on the DCBS workforce and administration. This information is already

collected as a component of daily child welfare practice. This method was successfully employed in a statewide evaluation study of family drug treatment courts in North Carolina (Gifford, Eldred, Vernerey, & Sloan, 2014). Admittedly, this approach cannot fully contend with possible validity threats in as robust a manner as RCT's can. Waitlisted clients may differ in some systematic way from their peers. However, the mere fact that the evaluation will only ever make comparisons between candidates who (1) receive prevention services and other candidates who also reside in the same service region, (2) share the same referring risk factors, and (3) enter CPS involvement around the same point in time will substantially reduce the risk of erroneous estimations of treatment effects. The evaluation team will have several data fields available to them to enable secondary checking and to ensure satisfactory baseline equivalence before performing further analyses or drawing conclusions.

- Randomized Controlled Trial: For special instances where a certain set of circumstances are in place (e.g., buy-in from DCBS staff, IRB interest and approval, etc.), the evaluation team will implement a randomized controlled trial of a promising or supported evidence based practice to test its effects on child welfare outcomes. The CHFS IRB has historically approved a random assignment procedure as a subcomponent of the START evaluation – this will serve as a model for the Family First evaluations of individual programs.

Every evaluation must contend with the validity threats of selection bias and the influences of unobserved covariates. Therefore, in every instance where this evaluation will make comparisons between treated and untreated clients, it will constrain those comparisons within geographic regions. Because there are meaningful regional differences in the economic, political, and sociocultural circumstances across the Commonwealth of Kentucky, this evaluation will only ever compare people within the DCBS service region where their case originated.

Common Evaluation Elements - Research Questions

The following is a list of additional research questions that will be used to guide the analysis of each prevention service in its respective evaluation plan (i.e., CBT, TF-CBT, Homebuilders, & START). Sampling, data collection, and outcome measures will be tailored to the particularities of each intervention.

Process evaluation questions:

1. Out of all the children and families served by DCBS in Kentucky, how many children are identified as Family First foster care candidates?
 - a. What are the frequencies of each presenting family problem/risk factor (mental health diagnoses, addiction, in-home skill building)?
 - b. What are the frequencies of each service provided to candidates and their caregivers?
2. What are the demographics of the identified Family First foster care candidates?
 - a. Age
 - b. Race
 - c. Sex
 - d. County of residence
 - e. Socioeconomic status
3. How long (on average) does it take for referred families to receive their first service?

- a. How long (on average) does it take for referred families to receive their first five sessions? (This is a measure of fidelity and client engagement used by the START program; see Huebner et al., 2015).
4. Are there any identifiable trends in the total number of petitions to remove children from the home after the implementation of Family First in Kentucky?
 - a. E.g., Is there a generally detectable rate of decline?
5. Are there any identifiable trends in the total number of children placed in foster care in Kentucky as a result of Family First implementation?

The evaluation will aim to collect data for the following confounding variables:

1. Social support
2. Household income; Percent Federal Poverty Level
3. DCBS staff turnover
4. Ecological risk factors

Impact evaluation questions

1. Has the implementation of Family First Prevention Services kept at-risk children from being removed from their homes at six months, one year, and two years postdischarge?
2. What is the contribution of each EBP to the reduction of removals of at-risk children?
 - a. Is there a dose-response effect for these services?
 - b. Are there better outcomes when services are provided to both caregivers and children than when provided only to the children or only to the caregivers?
 - c. Is there a synergistic effect when two or more services are provided? What are the more effective combinations?
3. Do families with Medicaid have significantly different outcomes after the provision of services than families privately insured or uninsured? (Florence, Brown, Fang, & Thompson, 2013; Fang, Brown, Florence, & Mercy, 2012; Johnson-Reid, Drake, Kohl, 2009)
4. Are there treatment effects in terms of differences in utilization of therapeutic foster care?

Program-specific impact evaluation questions

1. What percentage of the families who participate complete the program?
2. What are the costs, and who bears them, for providing this service? Is the program cost effective? (Johnson-Motoyama, Brook, Yan, & McDonald, 2013)
 - a. By family served
 - b. By reduction of removals of at-risk children
 - c. By number of days spent in out of home care

Additional outcomes that may be examined include:

- Increase in provider capacity to provide evidence-based programs.
- Fewer children placed in out of home care statewide.

Common Evaluation Elements – Institutional Review Board Approval

The evaluation plan includes engaging the CHFS Institutional Review Board (IRB) for a review and approval of the study methods. Kentucky has a fully functioning and independent IRB headquartered in the CHFS that is charged with evaluating research projects that involve state government services. This IRB is well-versed in issues concerning data security and confidentiality, and has been the historical source of IRB reviews of child welfare evaluations in Kentucky (especially the Title IV-E Waiver Demonstration projects). CHFS has a prescribed process of obtaining IRB approval that begins with sending the proposal to the office of the Ombudsman, where the IRB is headquartered. Because Family First involves the provision of services to especially vulnerable populations (children in foster care, adults with mental illness, etc.) and the use of sensitive data (psychiatric diagnoses, orders of termination of parental rights), the evaluation team imagines the proposal will require a full review, and will not be exempted. The evaluation team expects this process to take no longer than one month from initial submission to approval. Since this proposed evaluation does not involve direct risk of physical harm or discomfort to children or their adult caregivers, the primary risks outlined in this IRB proposal will involve the use of protected data. The CHFS IRB has reviewed the evaluation team's proposal, and exempted it from further review (i.e., has allowed the research to proceed). Please see Appendix T for IRB documentation related to this evaluation plan.

Evaluation Timeline

The evaluation will proceed along semi-annual, internal reporting milestones. Summary annual reports will be provided to DCBS leadership in December of each year to outline outcomes, discuss implementation, and offer data-driven recommendations. The Gantt chart provided in this section describes the projected timeline of major evaluation activities, which will progress from primarily descriptive analyses in the first year to outcome and impact-oriented analyses as more data is collected from the TWIST system.

Figure 1 – Gantt Chart of Evaluation Timeline



Common Evaluation Elements – Reporting, Disseminating, and Using Findings

The results and the insights that are drawn from them by the evaluation team and DCBS officials will be disseminated through a variety of mediums. The primary means of cataloging and reporting findings will be the preparation of semi-annual reports in the same style as those required by the Title IV-E Waiver Demonstration Projects. These will become the authoritative accounts of Family First activities and outcomes for Kentucky.

The evaluation team also intends to report the findings of its well-designed, rigorous evaluations through the broader academic child welfare community. This includes presentations at professional conferences, manuscript submissions to refereed academic journals, and other forums such as government policy briefs and community engagement events. Kentucky acknowledges that Family First provides states with a unique and special opportunity to further test the treatment effects of existing behavioral health interventions on child welfare outcomes. DCBS intends to seize this opportunity by being an active partner with the research and academic community to further develop the evidence base of the child welfare field.

Furthermore, the evaluation team intends to maintain an active partnership with DCBS officials to allow their findings to inform programmatic and organizational improvements. One of the ways in which this will be done will be to monitor if any gaps in services exist. The identification of such gaps will be relayed to the relevant DCBS committees to potentially result in the recommendation of new EBP’s to satisfy unmet needs in the population. For example, housing instability is a recognized risk factor for child maltreatment (Gubits et al., 2018). Should this surface as an underlying feature in a sufficient number of CPS cases, the

evaluation team will alert DCBS to allow them to consider how to best address the needs of Family First candidates.

Common Evaluation Elements – Limitations

The evaluation of each of these EBP's will have limitations in terms of the conclusions they will be able to draw about how families respond to services. Chief amongst these limitations will be its primary reliance on secondary administrative data. While the TWIST system is extraordinarily useful for evaluation research, it ultimately cannot match the degree of insight and precision that primary data collection can provide. What this data source can contribute in terms of its large scale comes at the cost of the exactitude that validated measurement scales offer. For example, the evaluation methods outlined herein will very capably capture the estimated treatment effects of Family First EBP's on concrete, procedural variables – such as out of home care placement – but it will be limited about what it can conclude about the more abstract indicators of child and family wellbeing. Similarly, while the TWIST system captures many of the important confounding variables that influence child welfare outcomes, there are many that it will be unable to incorporate into its analyses. The inability to capture the effects of unobserved (i.e. endogenous) covariates is the chief limitation of between-group comparison strategies that rely on propensity score matching.

Furthermore, it must be noted that DCBS-involved families typically navigate multiple systems at once. For example, the judges in Kentucky that preside over cases involving child maltreatment often differ substantially from one county to another in terms of their judicial philosophy and decision making – especially around choices involving removing children from their homes. This reality could be a source of between-group differences that are not attributable to whether a client received a given intervention. However, because Family First foster care candidates will have their cases heard in courtrooms all across Kentucky (alongside comparison group families), the evaluation team does not believe this will be a source of systematic bias in the analyses.

In a related vein, analyses that do not utilize random assignment are limited in terms of making causal inferences, and attributing any observed between-group differences to the intervention under study. This evaluation methodology is admittedly limited in this same way. However, this plan builds in several strategies to address this methodology. The most important of these is to restrict matching procedures to participants whose CPS cases originated within the same geographic DCBS service region. This measure not only addresses limitations that could arise from heteroscedasticity, but also enhances the evaluation by making comparisons to families who will receive usual CPS services in the same geographic area – where CPS practices are theoretically the most similar.

In their investigation of the performance of quasi-experimental vs. experimental methods in program evaluation of welfare to work programs, Bloom, Michalopoulos, Hill, & Lei (2002) wrote:

“So what do we conclude from these tests? With respect to the first question addressed, ‘which nonexperimental methods work best?’ we conclude that local comparison groups [as compared to interstate comparisons] are the most effective and simple differences of means or OLS regressions perform as well as more complex alternatives. Because these findings are consistent across many replications based

on large samples from combinations of six different states, we believe that they probably generalize to many other mandatory welfare and work programs. It is less clear, however, how they generalize to voluntary programs where the sources, nature, and magnitude of selection bias might be different.”

A second strategy for addressing this limitation is by using a risk factor-based matching strategy for between-group comparisons. These variables rely on data collected from trained child welfare workers who are making assessments based on direct contact with clients in their homes and communities and interviews with collateral sources. For example, the ADT assessments that DCBS workers complete include recording information related to whether: a) substance use; b) mental illness; c) domestic violence or d) proxy indicators of poverty are risk factors for child maltreatment. In other words, this evaluation plans to not make Each of these features of CPS cases have been empirically demonstrated to correlate with child welfare outcomes (especially out of home care placement). This reflects a level of precision not found in other child welfare studies that have utilized propensity score matching (e.g., Florence et al. 2013).

Table 10: Promising and Supported programs to be implemented and submitted to evaluation

Program	CEBC Rating	Title IV-E Prevention Services Clearinghouse Rating	Program Description
Cognitive Behavior Therapy for Co-occurring Disorders	Not Rated	To Be Determined	CBT is a skills-based, present-focused, and goal-oriented treatment approach that targets the thinking styles and behavioral patterns that cause and maintain depression-like behavior and mood.
Homebuilders*	Supported	To Be Determined	Homebuilders* is a home and community-based intensive family preservation services treatment program designed to avoid unnecessary placement of children and youth into foster care, group care, psychiatric hospitals, or juvenile justice facilities. The program model engages families by delivering services in their natural environment, at times when they are most receptive to learning, and by enlisting them as partners in assessment, goal setting, and treatment planning.
Sobriety Treatment & Recovery Team (START)	Promising	To Be Determined	START is a child welfare intervention designed to partner with parents whose involvement with CPS is related to drug or alcohol use. Specific features of the intervention include the presence of a peer mentor, capped caseloads, and rapid access to treatment.
Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)	Well supported	Promising	TF-CBT is a conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events.



Nebraska

Status: Approved

Section VI: Evaluation Strategy and Waiver Request

EVALUATION STRATEGY

Evaluation Intent and Approach

Evidence-based interventions that are determined to be supported, promising by the Federal Clearinghouse or provided a proposed rating via the independent systematic review process, will be evaluated by Chapin Hall. These programs in Nebraska's Plan consist of FCT and Trauma-Focused Cognitive Behavioral Therapy. Consistent with federal legislation and subsequent HHS guidance, the Department is requesting a waiver of evaluations requirements for its well-supported programs.

Ability to Conduct an Evaluation of Prevention Programming

Please refer to Attachment H to review Nebraska's rigorous evaluation strategy, as set forth by Chapin Hall.

Evaluation Waiver

CFS is requesting a waiver for the following programs rated well-supported on the Federal Clearinghouse and will follow established procedures to monitor, compile, assess and report fidelity and outcomes data as part of the ongoing effort to monitor the effectiveness of selected interventions.

- Healthy Families America
- Homebuilders
- Parents as Teachers
- Motivational Interviewing
- Parent-Child Interaction Therapy
- Multisystemic Therapy
- Functional Family Therapy
- Evidence of Effectiveness
- Healthy Families America

Evidence of Effectiveness

Healthy Families America

HomVEE14, Home Visiting Evidence of Effectiveness, a program administered by the United States DHHS ACF, reviews the effectiveness for specific home visiting models. Per this review of HFA last updated in September 2018, HFA meets the criteria set forth by US DHHS. HFA was found to have favorable results in studies rated high or moderate in the following areas: child development and school readiness, child health, family economic self-sufficiency, linkages and referrals, maternal health, positive parenting practices, reductions in child maltreatment, and reductions in juvenile delinquency, family violence, and crime.

Since its inception in 1992, the HFA model has been working with child welfare referred families and has also allowed flexibility with regard to age of child at intake in its manuals [pg. 63, HFA Best Practice Standard 3-1.B regarding families enrolled with open and active child welfare/CPS involvement].

Over the past several years, HFA has developed an optional child welfare protocol, which maintains the expected rigor and fidelity requirements providers have expected from HFA for almost 30 years. HFA sites that have received national office approval to utilize this adaptation are able to extend enrollment for families with a child up to 24 months of age referred by the child welfare system. All of the Nebraska sites implementing the HFA child welfare protocol have received national office approval.

HFA's best practice standard is to strive for serving at least 80% of families beginning prenatally or while in the newborn period because doing so optimizes the ability to achieve greater maternal and child health outcomes, but there is flexibility so this standard is not absolute [pg. 48, HFA Best Practice Standard 1-3.B regarding 80% first home visits occurring prenatally or within first three months, and pg. 6-7, HFA BPS Glossary, which indicates threshold for accreditation and demonstration of model fidelity requires adherence to 85% of all HFA Best Practice Standards].

HFA's best practice standard requires home visiting services are offered for a minimum of three years and through age five, allowing children enrolled up to 24 months of age the full length of service [pg. 80, HFA Best Practice Standard 4-3].

Studies have been conducted to prove the efficacy of HFA and its use of the child welfare protocol. Below are four studies and identified outcomes:

Study: DuMont, K., Mitchell-Herzfeld, S., Greene, R., Lee, E., Lowenfels, A., Rodriguez, M., & Dorabawila, V. (2008). Healthy Families New York (HFNY) randomized trial: Effects on early child abuse and neglect. *Child Abuse & Neglect*, 32, 295-315. doi:10.1016/j.chiabu. 2007.07.007.

This study assessed the use of Healthy Families America, by families who were considered "at risk" for child abuse and neglect, during the first two years of life for the child, with approximately 20% of the sample having already had prior involvement with Child Protective Services.

Outcome: Mothers utilizing HFA were found to have a reduction in the use of child abuse and harsh parenting. During year one, mothers participating in HFA reported having drastically fewer acts of physical abuse, physical aggression and/or psychological aggression. Within year two, HFA parents reduced their use of physical abuse by one fourth, as compared to the year prior. This suggests that by prioritizing or enhancing the HFA model to meet the needs of "hard to serve" families, the effectiveness of the model will be realized; abusive and neglectful parenting during the first two years of the child's life will be reduced.

Study: Rodriguez, M. L., Dumont, K., Mitchell-Herzfeld, S. D., Walden, N. J., & Greene, R. (2010). Effects of Healthy Families New York on the promotion of maternal parenting competencies and the prevention of harsh parenting. *Child Abuse & Neglect*, 34, 711-723. doi:10.1016/j.chiabu.2010.03.004.

This study used observational assessments of the interactions between the mother and child via a random controlled trial study. A focal point of this study was on parenting in the third year of life amongst mothers who were deemed at risk for perpetrating child abuse and/or neglect. The purpose of these assessments was to identify if the mothers who received the home visiting services (HFA) were more likely to utilize positive parenting and less negative parenting behaviors in comparison to the mothers who did not receive home visiting services.

Outcome: Positive parenting for mothers who were identified as being “at risk” for abuse and/or neglect of their child, was promoted and found to be successful. It was suggested that the use of positive parenting such as maternal responsivity and cognitive engagement, demonstrated the use of harsh parenting to decrease, therefore preventing the initiation of child abuse and neglect. Results indicated during the third year of life, that mothers who received HFA, demonstrated a higher propensity of engaging in positive parenting. These positive parenting behaviors can promote the child to regulate their emotions, demonstrate self-control and decrease the risk of the child having negative outcomes such as delinquency.

Study: Lee, E., Kirkland, K., Miranda-Julian, C., & Greene, R. (2018). Reducing maltreatment recurrence through home visitation: A promising intervention for child welfare involved families. *Child Abuse & Neglect*, 86, 55-66. doi:10.1016/j.chiabu.2018.09.004.

This study conducted a randomized controlled trial (RCT) of HFA, which included mothers who had at least one substantiated child protective services report within five years prior to enrolling into the HFA program. Through this RCT, the long term maltreatment outcomes were reviewed.

Outcome: During the time between the child’s fourth and seventh birthdays, the rates of additional CPS reports increase more slowly for the parents participating in the HFA program. Over time, the recurrence of maltreatment was found to steadily reduce for the mothers participating in the HFA program. The use of the HFA model was also found to significantly lower the rate of child welfare services related to foster care placement. This study supports the extension of the program to those families that are involved in the child welfare system.

Study in support of the Child Welfare Protocol: Easterbrooks , M. A., Kotake, C., & Fauth, R. (2019). Recurrence of maltreatment after newborn home visiting: A randomized controlled trial. *American Journal of Public Health*, 109(5), 729-735. doi:10.2105/AJPH.2019.304957.

This study evaluated if HFA for first time young mothers (ages 16-20), reduced the recurrence of child maltreatment in the first seven years of the firstborn child’s life, as evidenced by child protective services reports. This evaluation was conducted through a RCT study with 704 first time mothers assigned to the HFA group or to a control group.

Outcome: It was determined that approximately 50% of the mothers in the HFA group experienced an additional report to CPS. Mothers who received home visits were found to have reduced risk of receiving a report of recurrence of maltreatment. It was also found that if a second report of maltreatment was made, the report occurred approximately 18 months following the initial report of maltreatment. Therefore, the use of HFA was found to reduce the recurrence of maltreatment and increased the period of time between the initial CPS report and subsequent CPS report, if one was made.

HFA’s evidence of effectiveness and the flexibility of enrollment makes HFA a great prevention choice for states and child welfare agencies seeking to strengthen families and reduce the number of children placed in foster care. Almost half of all children who enter foster care in Nebraska are ages 0-5, and 14% of which are age 1 or younger.

The Healthy Families America website includes specific research on how HFA prevents child abuse and neglect. HFA released a one pager specific to FFPSA and highlights a few of the child welfare areas in which HFA was found to be effective in eight studies including: fewer substantiated child abuse/neglect reports,

less neglect and abuse, reduced child welfare involvement and preventing recurrence of child maltreatment by 1/3 among families with prior child welfare involvement.

Homebuilders

According to the Institute for Family Development, report outcomes demonstrated that reduction of risk and increase in community connections. The Washington State Office of Children's Administration Research indicated that at the start of the Homebuilders service, the majority of the families served had a caretaker risk factor. However, at time of case closure, a high percentage of those families demonstrated a reduced risk within that same category. Further, those same families had an increased connection to their communities, especially within mental health and medical services, along with the child's school. Additional resources regarding program effectiveness can be found here.

Per the CEBC, there are three relevant published, peer-reviewed research articles listed regarding Homebuilders. Of those, one was focused on the preservation of the family. This article, by Wood, S., Barton, K., & Schorder, C. (1988), demonstrated the effectiveness of Homebuilders as results indicated that 74% of the families served remained in the home, with a follow up completed 1 year post-intervention.

Motivational Interviewing

According to the official MI website, which can be found here, there is a variety of research articles posted to reflect the effectiveness of MI. Per the CEBC, eight relevant published, peer-review research articles are listed, which reviewed the use of MI in certain target populations and the outcomes of the intervention, up to four years post intervention. In review of each study, a majority reflected behavioral and motivational changes within the clients being provided with MI, in comparison with control group or in random controlled trials.

The Federal Clearinghouse reports that of prioritized studies that were considered to be high or moderate, sixteen favorable outcomes were identified. MI was found to have favorable results within adult well-being: parent/caregiver substance use.

Parents as Teachers

According to the PAT official website, which can be found here, over a dozen outcome studies have been completed on the PAT model. The overall results indicate that use of this model can assist in identifying a child's developmental delays and/or health problems early; children are ready and prepared to enter kindergarten; children achieve school success as they proceed through elementary school; parents own parenting knowledge and skills are improved; parents are more involved in their children's schooling; families are more inclined to promote children's language and literacy, and; child abuse and neglect is prevented. Additional details and information can be found on the PAT website, listed above.

The Federal Clearinghouse provides a number of studies that have been identified and reviewed for PAT. Within these studies, findings indicated a favorable outcome within child safety, child well-being: social functioning, and child well-being: cognitive functions and abilities.

Parent-Child Interaction Therapy

The CEBC rated PCIT as having well-supported research evidence with medium relevance to child welfare in the following areas: disruptive behavior treatment (child and adolescent) and parent training programs that address behavior problems in child and adolescents.

The U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention (OJJDP)¹⁷ identified PCIT as a model with an evidence rating of effective. According to their website, "Program children were more compliant with less behavior problems than the wait list group. The treatment group parents gave more praise and fewer criticisms and improved negative aspects of their parenting. There were fewer reports of physical abuse."

PCIT was also one of the programs included in the annual evaluations by the Nebraska Child Abuse Prevention Fund Board¹⁸, which was created in 1986 by the State Legislature and is administered by Nebraska DHHS. A few areas where PCIT was found to be effective was in reducing child behaviors, child conduct scores and positive parent interactions.

Multisystemic Therapy

The CEBC rated MST as having well-supported research evidence with medium relevance to child welfare in the following areas: alternatives to long-term residential care programs, behavioral management programs for adolescents in child welfare, disruptive behavior treatment (child & adolescent) and substance abuse treatment (adolescent).

The OJJDP identified MST as a model with an evidence rating of effective. Per their website, "The treatment group had fewer rearrests and spent fewer days incarcerated than a comparison group that received usual services. The program had a positive impact on family cohesion and social skills for the intervention group."

Functional Family Therapy

The CEBC rated FFT as having supported research evidence with medium relevance to child welfare in the following areas: alternatives to long-term residential care programs, behavioral management programs for adolescents in child welfare, disruptive behavior treatment (child & adolescent) and adolescent substance use treatment.

The OJJDP identified FFT as a model with an evidence rating of effective. According to their website, "Program participants showed a statistically significant reduction in general recidivism and risky behavior, compared with control group participants."

The effectiveness of the HFA, PCIT, MST, and FFT have been demonstrated through multiple research studies and inclusion as evidence-based programs in various clearinghouses. When considered together along with the Federal Clearinghouse's Summary of Findings , Nebraska child welfare-involved families demographics and desired outcomes, Nebraska determined these programs effectiveness is compelling for Nebraska's child welfare populations.

See Attachments Section for Attachment II: State Request for Waiver of Evaluation Requirement for a Well-Supported Practice.



Washington State

Status: Approved

Section VI: Evaluation Strategy and Waiver Request

Evaluation Strategy and Waiver Request Pre-Print Section 2

DCYF will implement the evaluation strategy described here to ensure approved services that are not granted waivers are analyzed through a rigorous, robust, and well-designed research methodology. This plan calls for evaluations to use FFPSA-approved evidence-based practices. The practices and evaluations will serve to inform internal and external stakeholders on the progress being made by DCYF in improving the lives of children, youth, and families in Washington State. Furthermore, this work will build upon previous and concurrent practice and evaluation studies being conducted by DCYF and help guide the agency toward being datadriven and outcomes-focused in its programmatic decisions. This goal supports the vision that was established for DCYF through the enactment of House Bill 1661 (2017) by the Washington State legislature and governor. FFPSA offers DCYF the opportunity to continue the developments already being made by the agency: focusing on outcomes, providing appropriate services to clients, and enhancing delivery best practices.

In addition to Washington's history of promoting the use of evidence-based practices in child-serving agencies, DCYF is implementing outcomes-oriented performance-based contracting reform for all contracted client services in an effort to analyze and improve these services, their qualities, and their outcomes. The evidence-based practices included in Table 1, with the exception of Motivational Interviewing, are already under contract with DCYF; additionally, there now exists some level of service capacity around the state. The majority of the existing contracts for these services were part of DCYF's inaugural performance-based contracting cohort, which began in 2018. While these efforts are in their early stages, all existing providers of these services have worked for more than a year to identify appropriate quality and outcome metrics that align with the agency's identified outcomes for children, youth, and families.

DCYF has established a workgroup within the Office of Innovation, Alignment, and Accountability (OIAA) to oversee the design and implementation of the evaluations. The OIAA is designated in the DCYF's founding legislation as the research unit within the agency and is comprised of researchers and analysts as well as the data warehouse and reporting units.

The OIAA also established an Evidence, Data, and Evaluation (EDE) workgroup consisting of DCYF employees:

- All Members of the PhD research team (currently six)
- Director of the OIAA
- Administrator for the OIAA Evaluation and Research Unit
- Administrator for the OIAA Performance-Based Contracting Unit

The members of this workgroup have demonstrated leadership in government systems and methodology and have implemented continuous quality improvement as well as process and outcome evaluations using qualitative, quantitative, and community-based participatory research methodologies.

The EDE workgroup will ensure that all evaluations of approved evidence-based programs will use a rigorous methodology; comply with federal requirements; and deliver timely results by determining the order of program evaluations, assigning internal evaluations, identifying and contracting with external evaluators when necessary, and monitoring and consulting with both internal and contracted evaluators. In addition to reviewing and approving evaluation design and implementation, the EDE workgroup will provide ongoing review and consultation throughout the evaluation period to ensure the appropriate methodology is utilized. In this way, OIAA intends to operationalize a community of practice among evaluators and analysts who can support and learn from one another as well as engage in multistate communities of practice for continued learning.

In order to support the significant increase in demand for program evaluations, DCYF will expand its research and analysis positions or OIAA researchers will oversee qualified external researchers who will conduct contracted evaluations. The OIAA director will assign the principal evaluator for each evaluation, and this decision will be informed by staff availability and content expertise.

Many of the practices that DCYF will evaluate, although well-supported, have not been studied or tested with a child welfare population to determine whether the results produce the primary child welfare outcome of interest in this plan—to prevent the entry of children into foster care. DCYF will evaluate the remaining practices to ensure that the overall portfolio of evidencebased practices will meet the needs of the state’s diverse population. Washington State has chosen to evaluate these programs in order to gain an understanding of what works for the children, youth, and families that DCYF serves. DCYF is committed to producing positive outcomes with these services as implemented, and to do so, the agency must be able to determine and then monitor the extent to which this implementation of prevention services is able to safely prevent entry into foster care.

Table 7 describes DCYF’s theory of change for the evidence-based practices it will implement under this Prevention Plan

Table 5: Washington State Prevention Plan Theory of Change

Target Population	Intervention	Proximal Outcomes	Outcomes
<p>Identify, assess and engage families in approved candidacy groups with children at risk of entry or re-entry into foster care.</p> <p>Child protective services (CPS) with screened-in referrals to both the Families in Family Assessment Response (FAR) and the CPS Investigation response</p> <p>Families requesting CPS Family Voluntary Services</p> <p>Children/families on trial return home following placement</p> <p>Screened out CPS referrals for pregnant women with substance use disorder.</p> <p>Adoptions experiencing challenges</p> <p>Pregnant/parenting youth in foster care and those in state JR institutions</p> <p>Youth referred for Family Reconciliation Services (FRS)</p> <p>Youth/families discharged from Juvenile Rehabilitation</p>	<p>Deliver high fidelity evidence-based practices that align with the specific needs and characteristics of each family in the target population.</p> <ul style="list-style-type: none"> • Child-Parent Psychotherapy • Homebuilders • Incredible Years • Functional Family Therapy • Motivational Interviewing • Multi-Systemic Therapy • Nurse-Family Partnership • Parents as Teachers • SafeCare • Triple P 	<p>Parent, child, and family functioning improves by achieving the desired outcomes of each intervention as demonstrated by (but not limited to)</p> <ul style="list-style-type: none"> • Engagement in agreed upon services • Improved parenting skills/behaviors to support child development • Improved parent-child interaction • Increases in family connections to community resources • Increased parental capacity to meet the needs of their children. • Increased family communication • Increased family/child/youth protective factors 	<p>Child maltreatment declines</p> <ul style="list-style-type: none"> • Reduced foster care entry • Reduced foster care re-entry • Reduced foster care census

Evaluation Strategy for Evaluation of Well-Supported and Supported EBPs

The researchers involved in the evaluation process of evidence-based practices (EBPs) are trained and possess the necessary scientific expertise in evaluation design and methodology. The primary responsibility for program evaluation will be assigned to researchers in the OIAA and qualified contracted evaluators with doctoral degrees. Fidelity monitoring reporting systems have been or will be established by DCYF programs for each practice, and management of contracts with provisions requiring fidelity monitoring and continuous quality improvement within DCYF’s approved outcomes-oriented framework for performance-based contracting will be the responsibility of program staff.

DCYF will conduct, either directly or by contract, fidelity monitoring and outcome evaluation for well-supported or supported EBPs that are approved in the Washington State FFPSA Prevention Plan. The well-supported or supported EBPs have fidelity metrics identified by developers that must be monitored to ensure the practices are being implemented as intended. Additionally, fidelity indicators are important sources of information that can be used to inform continuous quality improvement efforts and fidelity metrics are important indicators of quality. Thus, DCYF will work with implementing agencies to establish fidelity monitoring, if none exists, and will include this information in the evaluation of well-supported or supported EBPs. DCYF will continuously monitor fidelity indicators of all well-supported or supported EBPs to ensure fidelity to the practice model, to determine the role of fidelity in producing desired outcomes, and to inform a continuous quality improvement cycle that will perpetually refine and improve practices.

The OIAA team will collaborate and coordinate with relevant stakeholders of each program to develop a comprehensive plan to determine the timeline, data collection process, research questions, outcome metrics, operationalization of outcome measures from the child welfare data source system, analytical procedures,

limitations, responsibilities, and evaluation dissemination. In addition, each plan will include the methods for assessing outcomes and the appropriate statistical design control for child, family, community factors, and comparison groups. The evaluation strategy for well-supported and supported EBPs will be conducted through quantitative analysis using quasi-experimental designs with a comparison group whenever feasible. DCYF is also interested in the extent to which each EBP impacts the parent and child intermediate outcomes noted in the theory of change as indicated in Table 7 of this report. Thus, each EBP will be examined to determine whether the research supports its relationship to the intermediate outcomes, and the identified EBP-appropriate intermediate outcomes will become part of the evaluation implemented to the extent that data are available.

Motivational Interviewing

Motivational Interviewing (MI) is a client engagement approach used with youth and adults to improve client motivation for behavior change and to increase engagement rates with available services. Unlike the other EBPs included in this plan, the MI intervention will be implemented primarily with DCYF child welfare caseworkers with the possibility of moving the intervention to community-based providers following the establishment of the intervention. This service will be incorporated into the DCYF evaluation plan as indicated by Table 6. Month 1 indicates the month of implementation of the MI model using FFPSA funding.

Month	1	2	3	4	5	6	7	8	9	10	Continuous
Create Data Collection and Report Plan	X	X	X								
Create Evaluation Dissemination Plan	X	X									
Establish Fidelity Monitoring	X	X	X	X							
Plan for Performance Monitoring	X	X	X	X							
Plan for Data Analysis	X	X	X	X	X						
Conduct Data Analysis									X	X	X
Implement Key Performance Metrics Data Display										X	X
Dissemination of Evaluation											X

Research Questions

1. Did the implementation of MI by caseworkers or community-based providers lead to increases in the initiation of EBPs by the clients over time?
2. Did the implementation of MI by caseworkers or community-based providers lead to substantial increases in the dosage of EBPs received by clients over time?
3. Did the implementation of MI by caseworkers or community based providers lead to substantial increases in the completion of EBPs by clients over time?

Data Collection Method

DCYF has not implemented the MI model yet, and the researcher assigned to this EBP will collaborate with relevant stakeholders to establish a systematic approach for the data collection procedure, quality assurance process, and quality control monitoring. This process will be a pertinent aspect of MI because this will allow an assessment of the program's effectiveness while lessening the likelihood of statistical inaccuracies.

Since this intervention is expected to be delivered primarily by DCYF staff members, the evaluation will rely on administrative data. Caseworkers will enter MI delivery data, including utilization metrics, into the DCYF FamLink case management system. The researcher will work with program and IT staff to plan and implement data collection within the existing FamLink system, so that sufficient data are available to conduct the evaluation. The dataset will include information regarding DCYF services received, client characteristics, demographics, and outcomes.

Outcomes of Interest

The FFPSA Clearinghouse for EBPs has reviewed and rated MI as a well-supported practice. Research has found that MI was an effective case management tool for improving engagement with support programs and services. There are 4 levels of engagement that are of interest for this evaluation: initial referrals to identified services, initial engagement with services, level of dosage and completion with services, and family engagement in other community services and supports. The initial referrals will examine how MI impacted client service selection, initial engagement measurement will examine whether clients had at least one visit with the service provider, level of dosage or completion with services will analyze whether there was significant increase in the dosage and completion of services by clients following the MI intervention, and family engagement in other community services and supports will provide insight into the families building natural community-based support systems.

Statistical Techniques and Quasi-Experimental Methodology

Because DCYF has not implemented this intervention yet, this proposed evaluation methodology is preliminary and may change once MI is implemented and the data collection process commences. The target and study population for the evaluation will be all eligible individuals from the approved candidacy groups involved in the child welfare system. DCYF divides Washington State into six geographic regions and prior evaluations have found that geography has a significant effect on program participation rates. DCYF will use a geographically based phased-in approach for the training and application of MI at local offices because providing simultaneous statewide MI training will be an intensive process.

The researcher will implement an office-based readiness assessment tool in order to determine the phased-in process for MI. The research design will use the regional or area implementation of this EBP to create a statistical comparison for the intervention by matching regions or offices on variables like implementation readiness, case mix, and urban-rural classification. The researcher use this information to conduct match-paired stratified randomization to select initial intervention offices, with delayed implementation of MI in the comparison offices. For example, the researcher will select 10 local offices statewide and place them into 5 pairs based on similar characteristics. Once the groups have been

formulated, one office will be randomly assigned to the treatment group (MI implementation) while the other office will be the comparison group (no MI implementation).

The researcher will obtain the covariates used for the paired matching and inferential multivariate regression analyses from the child welfare source system and the MI data collection process in order to control for heterogeneous characteristics known to impact engagement and outcomes. To the extent that data are available, covariates may include family poverty level, age, parental education level, child educational experience, race, ethnicity, parental employment status, child welfare history, contractor fidelity, and community poverty level.

If the researcher determines that match-paired stratified randomization is not feasible, they may use another quasi-experimental methodology such as difference-in-differences, multivariate Cox regression, regression discontinuity design, or instrumental variable estimation.

Research Limitations

The process of training caseworkers and community-based providers with the MI technique is imperative but providing the proper match for services during the assessment phase could optimize the advantages of MI. The mismatching of clients to the appropriate services is a limitation that will lead to problematic outcomes, incorrect dosage measurements, or lack of participation in the services by the families. Therefore, the implementation process of MI will need to include assessment training to ensure that caseworkers and community-based providers have adequate service matching tools and skills.

In scientific studies, randomized controlled trials are often considered the “gold standard” because the randomization of participants into the treatment or control group eliminates selection bias and results can be attributed to the intervention being evaluated. The outlined research design, stratified matched-pairs randomization, is considered a close approximation to a randomized controlled design while also reducing the risk of sampling bias when a limited number of sites can be targeted with an intervention.⁶ However, this research method will require additional effort to implement and monitor, which will reduce the number of offices that can be included in the initial analysis.

Additionally, while the researcher will establish a robust readiness assessment and data collection procedure, there could be limitations with the collection and use of administrative data such as missing or inaccurate data, timeliness of data entry, and lack of participants leading to a small sample size. These limitations may potentially impact the evaluation of MI because they could confine the scope of the analysis, prevent the discovery of meaningful correlation, and restrict the generalizability of the study.

Functional Family Therapy and Multi-Systemic Therapy

Functional Family Therapy (FFT) and Multi-Systemic Therapy (MST) are two intervention programs aimed at addressing disruptive behaviors in adolescents, with MST generally reserved for youth with the most disruptive behaviors. Therefore, the evaluation strategy for these two services will be similar in terms of research questions, identified outcomes, and data collection methods. DCYF currently has established contracts for FFT and MST, thus service providers are already engaged with the process of data collection, reporting and performance improvement. This evaluation plan will build upon those existing relationships, referral pathways, and data collection systems in order to incorporate the requirements of FFPSA.

Functional Family Therapy

Table 7 provides the anticipated timeline of the FFT evaluation strategy. Month 1 indicates the month of implementation of the FFT using FFPSA funding.

Table 7. Functional Family Therapy (FFT) Evaluation Timeline											
Month	1	2	3	4	5	6	7	8	9	10	Continuous
Create Data Collection and Report Plan	X	X	X								
Create Evaluation Dissemination Plan	X	X									
Establish Fidelity Monitoring	X	X									
Plan for Performance Monitoring	X										
Plan for Data Analysis	X	X	X	X	X						
Conduct Data Analysis			X	X	X	X	X	X	X	X	X
Implement Key Performance Metrics Data Display										X	X
Dissemination of Evaluation											X

Research Questions

1. How did family characteristics and risk factors differ for families based on whether they received a service referral, started an EBP, and/or completed the EBP?
2. Were families who completed the EBP more likely to connect with additional community resources compared to similar families who did not receive the EBP?
3. Were families who completed the EBP less likely to experience a new period of homelessness or housing insecurity compared to similar families who did not receive the EBP?
4. Were families who received FFT less likely to have a child enter or reenter care compared to similar families who did not receive the EBP?

Data Collection Method DCYF contracted researchers at the Research and Data Analysis (RDA) unit of the Washington State Department of Social and Health Services (DSHS) will obtain child-family level data, FFT service data, and referral and treatment session dates and types from the data reports that contracted providers are required to submit to DCYF. The purpose is to have an integrated data collection approach that will provide a comprehensive and nuanced understanding of the services being provided to FFT participants. DCYF and contracted researchers currently have access to sufficient data within the existing data systems to conduct these analyses.

The researcher will extract longitudinal administrative data from the RDA Integrated Client Databases (ICDB) and the DCYF FamLink case management system to generate measures of FFT client characteristics.

The FamLink data from DCYF will contain the following information for the evaluation:

- Current and prior case openings
- Safety assessments

- Structured Decision Making (SDM) risk assessments
- Family assessments
- Removal records
- Child Health and Education Tracking (CHET)

The ICDB data from RDA will use the following information to characterize child and caregiver risk factors:

- Economic stress: receipt of State Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), Diversion Cash Assistance, Basic Food Program, or Consolidated Emergency Assistance Program identified through the Automated Client Eligibility System (ACES), which is the Washington state data system for homeless programs
- Domestic violence: any domestic violence-related charges from Washington State Patrol (WSP)
- Homelessness: any indicator for living in a battered spouse shelter, emergency housing shelter, homeless with housing, homeless without housing, or inappropriate living situation in ACES
- Caregiver criminality: any arrest, conviction, or incarceration at a state juvenile or adult facility
- Caregiver mental illness: mental health diagnosis, inpatient and outpatient services, or prescribed psychotropic medications recorded in medical claims or publicly funded mental health records
- Caregiver substance abuse: alcohol- or drug-related diagnosis, outpatient and inpatient service recorded in medical claims, publicly funded mental health records, and substance-related arrests from WSP

The data for the homelessness indicators will be ascertained from the following:

- Washington State Department of Commerce Homeless Management Information System (HMIS), which contains variables regarding youth and adults who have received any type of housing services like emergency shelter, transitional housing, or rental assistance
- Client living arrangement from the ACES
- Address information in ACES indicating whether a youth or caregiver was homeless

Outcomes of Interest

In addition to the ultimate outcomes of preventing entry and reentry into foster care, DCYF is interested in intermediate outcomes related to homelessness (because of the great concern among policymakers about youth from the public child welfare system entering homelessness) and service utilization related to receipt of other community services as an indication of building community connections. The intermediate outcomes will be measured during a 6- month follow-up period from date of service referral and include service engagement, minimal service completion, and full service completion. These measures have already been developed for the FFT service for the purposes of performance-based contracting. After consulting with model developers, trainers, and FFT service providers, DCYF measures service engagement as the case receiving at least 3 treatment sessions and completing a CANS-F Family Plan for Change; minimal service completion is defined as the case receiving at least 8 treatment sessions; and full completion of service is defined as the case receiving 10 or more treatment sessions.

The longer-term outcomes of interest for FFT will be whether there was an entry or reentry into foster care for any child on the case within 6 and 12 months of the last day of service, new connection to community resources (Basic Food Program, Medicaid enrollment, mental health treatment, and/or substance use disorder treatment) within 6 and 12 months of the last day of service, and experience with a new period of homelessness during the 12-month follow-up process. For the new connection to community resources measure, the study population will be limited to families who were not already receiving the same community services in the month that the EBP was initiated.

Statistical Techniques and Quasi-Experimental Methodology

The target and study populations for the evaluations will be all eligible individuals from the approved candidacy groups involved in the child welfare system. Researchers will compile descriptive statistics to compare family risk and case characteristics by service referral, engagement, and completion status. Chi-square analysis will be used to identify significant differences across the sub-groups. Additionally, researchers will use propensity score matching to identify an appropriate comparison population. Multivariate Cox regression models will be used to adjust for any differences in characteristics that may remain between the treatment and comparison cases after the matching procedure. The use of multivariate Cox regression will ensure a more accurate measurement on the magnitude of the treatment effects as compared to using propensity score matching alone.

The matching variables will include family risk factors including economic stress, caregiver mental illness, caregiver substance abuse, caregiver criminality, homelessness, and domestic violence; inception case status, which will indicate whether a family was having their first encounter with Child Protective Services or Child and Family Welfare Services; participant demographics such as race, ethnicity, age, and gender; administrative region; and case management and assessment variables such as intake type, response time, and type of abuse. If the researcher determines that propensity score matching and multivariate Cox regression models are not feasible or inappropriate methodologies for the evaluations due to issues discussed below such as sample size and model convergence, they may use another quasiexperimental methodology such as difference-in-differences, regression discontinuity design, or instrumental variable estimation.

Research Limitations

In scientific studies, randomized controlled trials are often considered the “gold standard” because the randomization of participants into the treatment or control group eliminates selection bias and results can be attributed to the intervention being evaluated. In the absence of experimental research designs, quasi-experimental methods are considered an appropriate scientific methodology when randomized controlled trials are not feasible. The application of randomized controlled trials to social science research may be problematic because causal effect estimations are arduous and randomized controlled trials can be expensive, unethical, or impractical. Therefore, researchers will use non-experimental research designs, like propensity score analysis, to replicate a scientific experiment when randomization is not used in the selection process.

Despite the ubiquitous use of propensity score analysis and multivariate Cox regression as nonexperimental research methodologies, there are several limitations to using these statistical techniques. These methodologies do not include the ability to randomly assign individuals to a treatment

or control group and require a large sample size for the evaluation. Propensity score analysis replicates a natural scientific experiment, but the methodology only adjusts for observed confounding covariates and neglects unmeasured variables, which could lead to biased results.

This study may require multiple years of service data in order to construct a sufficient sample size, and the potential of a low sample size or other model convergence problems will prohibit the construction of multivariate models for the EBP. The changes in service referral criteria or capacity over time will affect the pool of an appropriate comparison population. Moreover, in State Fiscal Year 2019, 20% of DCYF cases receiving contracted services received more than one EBP. This could potentially impact the analysis because the study may have to compare separately, exclude those cases that receive more than one EBP, or statistically adjust for multiple EBPs.

Additionally, while researchers will establish a robust readiness assessment and data collection procedure, there could be limitations with the collection and use of administrative data such as a dearth of rigorous quality control method, missing or inaccurate data, timeliness of data entry, and lack of participants leading to a small sample size. These limitations may potentially impact the evaluation of FFT because they could confine the scope of the analysis, prevent the discovery of meaningful correlation, and restrict the generalizability of the study.

Multi-Systemic Therapy

Table 8 provides the anticipated timeline of the MST evaluation strategy. Month 1 indicates the month of implementation of the MST using FFPSA funding.

Table 8. Multi-Systemic Therapy (MST) Evaluation Timeline											
Month	1	2	3	4	5	6	7	8	9	10	Continuous
Create Data Collection and Report Plan	X	X	X								
Create Evaluation Dissemination Plan	X	X									
Establish Fidelity Monitoring	X	X									
Plan for Performance Monitoring	X										
Plan for Data Analysis	X	X	X	X	X						
Conduct Data Analysis			X	X	X	X	X	X	X	X	X
Implement Key Performance Metrics Data Display										X	X
Dissemination of Evaluation											X

Research Questions

1. How did family characteristics and risk factors differ for families based on whether they received a service referral, started an EBP, and/or completed the EBP?
2. Were families who completed the EBP more likely to connect with additional community resources compared to similar families who did not receive the EBP?

3. Were families who completed the EBP less likely to experience a new period of homelessness or housing insecurity compared to similar families who did not receive the EBP?
4. Were families who received MST less likely to have a child enter or reenter care compared to similar families who did not receive the EBP?

Data Collection Method

DCYF contracted researchers at the Research and Data Analysis (RDA) unit of the Washington State Department of Social and Health Services (DSHS) will obtain child-family level data, MST service data, and referral and treatment session dates and types from the data reports that contracted providers are required to submit to DCYF. The purpose is to have an integrated data collection approach that will provide a comprehensive and nuanced understanding of the services being provided to MST participants. DCYF and contracted researchers currently have access to sufficient data within the existing data systems to conduct these analyses.

The researcher will extract longitudinal administrative data from the RDA Integrated Client Databases (ICDB) and the DCYF FamLink case management system to generate measures of MST client characteristics.

The FamLink data from DCYF will contain the following information for the evaluation:

- Current and prior case openings
- Safety assessments
- Structured Decision Making (SDM) risk assessments
- Family assessments
- Removal records
- Child Health and Education Tracking (CHET)

The ICDB data from RDA will use the following information to characterize child and caregiver risk factors:

- Economic stress: receipt of State Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), Diversion Cash Assistance, Basic Food Program, or Consolidated Emergency Assistance Program identified through the Automated Client Eligibility System (ACES), which is the Washington state data system for homeless programs
- Domestic violence: any domestic violence-related charges from Washington State Patrol (WSP)
- Homelessness: any indicator for living in a battered spouse shelter, emergency housing shelter, homeless with housing, homeless without housing, or inappropriate living situation in ACES
- Caregiver criminality: any arrest, conviction, or incarceration at a state juvenile or adult facility
- Caregiver mental illness: mental health diagnosis, inpatient and outpatient services, or prescribed psychotropic medications recorded in medical claims or publicly funded mental health records
- Caregiver substance abuse: alcohol- or drug-related diagnosis, outpatient and inpatient service recorded in medical claims, publicly funded mental health records, and substance-related arrests from WSP

The data for the homelessness indicators will be ascertained from the following:

- Washington State Department of Commerce Homeless Management Information System (HMIS), which contains variables regarding youth and adults who have received any type of housing services like emergency shelter, transitional housing, or rental assistance
- Client living arrangement from the ACES
- Address information in ACES indicating whether a youth or caregiver was homeless

Outcomes of Interest

In addition to the ultimate outcomes of preventing entry and reentry into foster care, DCYF is interested in intermediate outcomes related to homelessness (because of the great concern among policymakers about youth from the public child welfare system entering homelessness) and service utilization related to receipt of other community services as an indication of building community connections. The intermediate outcomes will be measured during a 6- month follow-up period from date of service referral and include service engagement, minimal service completion, and full service completion. Working in collaboration with service providers program experts, trainers, and model developers, MST program staff will determine thresholds for engagement, minimal service completion, and full completion of service during the implementation phase. The decisions previously made for FFT will be used as an informative reference, but MST engagement metrics may not be exactly the same since this is a more intensive intervention.

The longer-term outcomes of interest for MST will be whether there was an entry or reentry into foster care for any child on the case within 6 and 12 months of the last day of service, new connection to community resources (Basic Food Program, Medicaid enrollment, mental health treatment, and/or substance use disorder treatment) within 6 and 12 months of the last day of service, and experience with a new period of homelessness during the 12-month follow-up process. For the new connection to community resources measure, the study population will be limited to families who were not already receiving the same community services in the month that the EBP was initiated.

Statistical Techniques and Quasi-Experimental Methodology

The target and study populations for the evaluations will be all eligible individuals from the approved candidacy groups involved in the child welfare system. Researchers will compile descriptive statistics to compare family risk and case characteristics by service referral, engagement, and completion status. Chi-square analysis will be used to identify significant differences across the sub-groups. Additionally, researchers will use propensity score matching to identify an appropriate comparison population. Multivariate Cox regression models will be used to adjust for any differences in characteristics that may remain between the treatment and comparison cases after the matching procedure. The use of multivariate Cox regression will ensure a more accurate measurement on the magnitude of the treatment effects as compared to using propensity score matching alone.

The matching variables will include family risk factors including economic stress, caregiver mental illness, caregiver substance abuse, caregiver criminality, homelessness, and domestic violence; inception case status, which will indicate whether a family was having their first encounter with Child Protective Services

or Child and Family Welfare Services; participant demographics such as race, ethnicity, age, and gender; administrative region; and case management and assessment variables such as intake type, response time, and type of abuse.

If the researcher determines that propensity score matching and multivariate Cox regression models are not feasible or inappropriate methodologies for the evaluations due to issues discussed below such as sample size and model convergence, they may use another quasiexperimental methodology such as difference-in-differences, regression discontinuity design, or instrumental variable estimation.

Research Limitations

In scientific studies, randomized controlled trials are often considered the “gold standard” because the randomization of participants into the treatment or control group eliminates selection bias and results can be attributed to the intervention being evaluated. In the absence of experimental research designs, quasi-experimental methods are considered an appropriate scientific methodology when randomized controlled trials are not feasible. The application of randomized controlled trials to social science research may be problematic because causal effect estimations are arduous and randomized controlled trials can be expensive, unethical, or impractical. Therefore, researchers will use non-experimental research designs, like propensity score analysis, to replicate a scientific experiment when randomization is not used in the selection process.

Despite the ubiquitous use of propensity score analysis and multivariate Cox regression as nonexperimental research methodologies, there are several limitations to using these statistical techniques. These methodologies do not include the ability to randomly assign individuals to a treatment or control group and require a large sample size for the evaluation. Propensity score analysis replicates a natural scientific experiment, but the methodology only adjusts for observed confounding covariates and neglects unmeasured variables, which could lead to biased results.

This study may require multiple years of service data in order to construct a sufficient sample size, and the potential of a low sample size or other model convergence problems will prohibit the construction of multivariate models for the EBP. The changes in service referral criteria or capacity over time will affect the pool of an appropriate comparison population. Moreover, in State Fiscal Year 2019, 20% of DCYF cases receiving contracted services received more than one EBP. This could potentially impact the analysis because the study may have to compare separately, exclude those cases that receive more than one EBP, or statistically adjust for multiple EBPs.

Additionally, while researchers will establish a robust readiness assessment and data collection procedure, there could be limitations with the collection and use of administrative data such as a dearth of rigorous quality control method, missing or inaccurate data, timeliness of data entry, and lack of participants leading to a small sample size. These limitations may potentially impact the evaluation of MST because they could confine the scope of the analysis, prevent the discovery of meaningful correlation, and restrict the generalizability of the study.

Homebuilders

Homebuilders is an intensive family preservation service for children from birth to 18 years old. DCYF currently has established contracts for Homebuilders, thus service providers are already engaged with the process of data collection, reporting and performance improvement. This evaluation plan will build upon those existing relationships, referral pathways, and data collection systems in order to incorporate the requirements of FFPSA. Table 9 provides the anticipated timeline of the Homebuilders evaluation strategy. Month 1 indicates the month of implementation of the Homebuilders model using FFPSA funding.

Table 9. Homebuilders Evaluation Timeline

Month	1	2	3	4	5	6	7	8	9	10	Continuous
Create Data Collection and Report Plan	X	X	X								
Create Evaluation Dissemination Plan	X	X									

Establish Fidelity Monitoring	X	X									
Plan for Performance Monitoring	X										
Plan for Data Analysis	X	X	X	X	X						
Conduct Data Analysis			X	X	X	X	X	X	X	X	X
Implement Key Performance Metrics Data Display										X	X
Dissemination of Evaluation											X

Research Questions

1. How did family characteristics and risk factors differ for families based on whether they received a service referral, started an EBP, and/or completed the EBP?
2. Were families who completed the EBP more likely to connect with additional community resources compared to similar families who did not receive the EBP?
3. Were families who completed the EBP less likely to experience a new period of homelessness or housing insecurity compared to similar families who did not receive the EBP? 4) Were families who received Homebuilders less likely to have a child enter or reenter care compared to similar families who did not receive the EBP?

Data Collection Method

DCYF contracted researchers at the Research and Data Analysis (RDA) unit of the Washington State Department of Social and Health Services (DSHS) will obtain child-family level data, Homebuilders service data, and referral and treatment session dates and types from the data reports that contracted providers are required to submit to DCYF. The purpose is to have an integrated data collection approach that will

provide a comprehensive and nuanced understanding of the services being provided to Homebuilders participants. DCYF and contracted researchers currently have access to sufficient data within the existing data systems to conduct these analyses.

The researcher will extract longitudinal administrative data from the RDA Integrated Client Databases (ICDB) and the DCYF FamLink case management system to generate measures of Homebuilders client characteristics.

The FamLink data from DCYF will contain the following information for the evaluation:

- Current and prior case openings
- Safety assessments
- Structured Decision Making (SDM) risk assessments
- Family assessments
- Removal records
- Child Health and Education Tracking (CHET)

The ICDB data from RDA will use the following information to characterize child and caregiver risk factors:

- Economic stress: receipt of State Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), Diversion Cash Assistance, Basic Food Program, or Consolidated Emergency Assistance Program identified through the Automated Client Eligibility System (ACES), which is the Washington state data system for homeless programs
- Domestic violence: any domestic violence-related charges from Washington State Patrol (WSP)
- Homelessness: any indicator for living in a battered spouse shelter, emergency housing shelter, homeless with housing, homeless without housing, or inappropriate living situation in ACES
- Caregiver criminality: any arrest, conviction, or incarceration at a state juvenile or adult facility
- Caregiver mental illness: mental health diagnosis, inpatient and outpatient services, or prescribed psychotropic medications recorded in medical claims or publicly funded mental health records
- Caregiver substance abuse: alcohol- or drug-related diagnosis, outpatient and inpatient service recorded in medical claims, publicly funded mental health records, and substance-related arrests from WSP

The data for the homelessness indicators will be ascertained from the following:

- Washington State Department of Commerce Homeless Management Information System (HMIS), which contains variables regarding youth and adults who have received any type of housing services like emergency shelter, transitional housing, or rental assistance
- Client living arrangement from the ACES
- Address information in ACES indicating whether a youth or caregiver was homeless

Outcomes of Interest

In addition to the ultimate outcomes of preventing entry and reentry into foster care, DCYF is interested in intermediate outcomes related to homelessness and service utilization related to receipt of other community

services as an indication of building community connections. The intermediate outcomes will be measured during a 6-month follow-up period from date of service referral and include service engagement, minimal service completion, and full service completion. These measures have already been developed for the Homebuilders service for the purposes of performance-based contracting. After consulting with model developers, trainers, and Homebuilders service providers, service engagement is measured as the case receiving at least 3 treatment sessions and completing a CANS-F Family Plan for Change; minimal service completion is defined as the case receiving at least 10 or more hours of treatment sessions; and full completion of service is defined as the case receiving approximately 40 hours of treatment sessions.

The longer-term outcomes of interest for Homebuilders will be whether there was an entry or reentry into foster care for any child on the case within 6 and 12 months of the last day of service, new connection to community resources (Basic Food Program, Medicaid enrollment, mental health treatment, and/or substance use disorder treatment) within 6 and 12 months of the last day of service, and experience with a new period of homelessness during the 12-month follow-up process. For the new connection to community resources measure, the study population will be limited to families who were not already receiving the same community services in the month that the EBP was initiated.

Statistical Techniques and Quasi-Experimental Methodology

The target and study populations for the evaluations will be all eligible individuals from the approved candidacy groups involved in the child welfare system. Researchers will compile descriptive statistics to compare family risk and case characteristics by service referral, engagement, and completion status. Chi-square analysis will be used to identify significant differences across the sub-groups. Additionally, researchers will use propensity score matching to identify an appropriate comparison population. Multivariate Cox regression models will be used to adjust for any differences in characteristics that may remain between the treatment and comparison cases after the matching procedure. The use of multivariate Cox regression will ensure a more accurate measurement on the magnitude of the treatment effects as compared to using propensity score matching alone.

The matching variables will include family risk factors including economic stress, caregiver mental illness, caregiver substance abuse, caregiver criminality, homelessness, and domestic violence; inception case status, which will indicate whether a family was having their first encounter with Child Protective Services or Child and Family Welfare Services; participant demographics such as race, ethnicity, age, and gender; administrative region; and case management and assessment variables such as intake type, response time, and type of abuse.

If the researcher determines that propensity score matching and multivariate Cox regression models are not feasible or inappropriate methodologies for the evaluations due to issues discussed below such as sample size and model convergence, they may use another quasiexperimental methodology such as difference-in-differences, regression discontinuity design, or instrumental variable estimation.

Research Limitations

In scientific studies, randomized controlled trials are often considered the “gold standard” because the randomization of participants into the treatment or control group eliminates selection bias and results can be attributed to the intervention being evaluated. In the absence of experimental research designs, quasi-experimental methods are considered an appropriate scientific methodology when randomized controlled trials are not feasible. The application of randomized controlled trials to social science research may be problematic because causal effect estimations are arduous and randomized controlled trials can be expensive, unethical, or impractical. Therefore, researchers will use non-experimental research designs, like propensity score analysis, to replicate a scientific experiment when randomization is not used in the selection process.

Despite the ubiquitous use of propensity score analysis and multivariate Cox regression as nonexperimental research methodologies, there are several limitations to using these statistical techniques. These methodologies do not include the ability to randomly assign individuals to a treatment or control group and require a large sample size for the evaluation. Propensity score analysis replicates a natural scientific experiment, but the methodology only adjusts for observed confounding covariates and neglects unmeasured variables, which could lead to biased results.

This study may require multiple years of service data in order to construct a sufficient sample size, and the potential of a low sample size or other model convergence problems will prohibit the construction of multivariate models for the EBP. The changes in service referral criteria or capacity over time will affect the pool of an appropriate comparison population. Moreover, in State Fiscal Year 2019, 20% of DCYF cases receiving contracted services received more than one EBP. This could potentially impact the analysis because the study may have to compare separately, exclude those cases that receive more than one EBP, or statistically adjust for multiple EBPs.

Additionally, while researchers will establish a robust readiness assessment and data collection procedure, there could be limitations with the collection and use of administrative data such as a dearth of rigorous quality control method, missing or inaccurate data, timeliness of data entry, and lack of participants leading to a small sample size. These limitations may potentially impact the evaluation of Homebuilders because they could confine the scope of the analysis, prevent the discovery of meaningful correlation, and restrict the generalizability of the study.

SafeCare and Child–Parent Psychotherapy

SafeCare and Child–Parent Psychotherapy (CPP) are two intervention programs aimed at serving children from birth to 5 years old. Even though SafeCare is rated as a well-supported EBP and CPP is a promising EBP, the evaluation strategy for both of these services will be comparable since the programs serve similar age groups. Therefore, the evaluation strategy for these two services will be similar in terms of research questions, identified outcomes, and data collection methods. DCYF currently has established contracts for SafeCare and CPP, thus service providers are already engaged with the process of data collection, reporting and performance improvement. This evaluation plan will build upon those existing relationships, referral pathways, and data collection systems in order to incorporate the requirements of FFPSA

SafeCare Table 10 provides the anticipated timeline of the SafeCare evaluation strategy. Month 1 indicates the month of implementation of SafeCare using FFPSA funding.

Table 10. SafeCare Evaluation Timeline											
Month	1	2	3	4	5	6	7	8	9	10	Continuous
Create Data Collection and Report Plan	X	X	X								
Create Evaluation Dissemination Plan	X	X									
Establish Fidelity Monitoring	X	X									
Plan for Performance Monitoring	X										
Plan for Data Analysis	X	X	X	X	X						
Conduct Data Analysis			X	X	X	X	X	X	X	X	X
Implement Key Performance Metrics Data Display										X	X
Dissemination of Evaluation											X

Research Questions

1. How did family characteristics and risk factors differ for families based on whether they received a service referral, started an EBP, and/or completed the EBP?
2. Were families who completed the EBP more likely to connect with additional community resources compared to similar families who did not receive the EBP?
3. Were families who completed the EBP less likely to experience a new period of homelessness or housing insecurity compared to similar families who did not receive the EBP?
4. Were families who received SafeCare less likely to have a child enter or reenter care compared to similar families who did not receive the EBP?

Data Collection Method

DCYF contracted researchers at the Research and Data Analysis (RDA) unit of the Washington State Department of Social and Health Services (DSHS) will obtain child-family level data, SafeCare service data, and referral and treatment session dates and types from the data reports that contracted providers are required to submit to DCYF. The purpose is to have an integrated data collection approach that will provide a comprehensive and nuanced understanding of the services being provided to SafeCare participants. DCYF and contracted researchers currently have access to sufficient data within the existing data systems to conduct these analyses.

The researcher will extract longitudinal administrative data from the RDA Integrated Client Databases (ICDB) and the DCYF FamLink case management system to generate measures of SafeCare client characteristics.

The FamLink data from DCYF will contain the following information for the evaluation:

- Current and prior case openings
- Safety assessments
- Structured Decision Making (SDM) risk assessments
- Family assessments
- Removal records
- Child Health and Education Tracking (CHET)

The ICDB data from RDA will use the following information to characterize child and caregiver risk factors:

- Economic stress: receipt of State Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), Diversion Cash Assistance, Basic Food Program, or Consolidated Emergency Assistance Program identified through the Automated Client Eligibility System (ACES), which is the Washington state data system for homeless programs
- Domestic violence: any domestic violence-related charges from Washington State Patrol (WSP)
- Homelessness: any indicator for living in a battered spouse shelter, emergency housing shelter, homeless with housing, homeless without housing, or inappropriate living situation in ACES
- Caregiver criminality: any arrest, conviction, or incarceration at a state juvenile or adult facility
- Caregiver mental illness: mental health diagnosis, inpatient and outpatient services, or prescribed psychotropic medications recorded in medical claims or publicly funded mental health records
- Caregiver substance abuse: alcohol- or drug-related diagnosis, outpatient and inpatient service recorded in medical claims, publicly funded mental health records, and substance-related arrests from WSP

The data for the homelessness indicators will be ascertained from the following:

- Washington State Department of Commerce Homeless Management Information System (HMIS), which contains variables regarding youth and adults who have received any type of housing services like emergency shelter, transitional housing, or rental assistance
- Client living arrangement from the ACES
- Address information in ACES indicating whether a youth or caregiver was homeless

Outcomes of Interest

In addition to the ultimate outcomes of preventing entry and reentry into foster care, DCYF is interested in intermediate outcomes related to homelessness and service utilization related to receipt of other community services as an indication of building community connections. The intermediate outcomes will be measured during a 6-month follow-up period from date of service referral and include service engagement, minimal service completion, and full service completion. These measures have already been developed for the SafeCare service for the purposes of performance-based contracting. After consulting with model developers, trainers, and SafeCare service providers, service engagement is measured as the case receiving at least 3 treatment sessions and completing a CANS-F Family Plan for Change; minimal service completion is defined as the case receiving at least 12 treatment sessions (two of three modules); and full completion of service is defined as the case receiving 18 or more treatment sessions (three of three modules).

The longer-term outcomes of interest for SafeCare will be whether there was an entry or reentry into foster care for any child on the case within 6 and 12 months of the last day of service, new connection to community resources (Basic Food Program, Medicaid enrollment, mental health treatment, and/or substance use disorder treatment) within 6 and 12 months of the last day of service, and experience with a new period of homelessness during the 12-month followup process. For the new connection to community resources measure, the study population will be limited to families who were not already receiving the same community services in the month that the EBP was initiated.

Statistical Techniques and Quasi-Experimental Methodology

The target and study populations for the evaluations will be all eligible individuals from the approved candidacy groups involved in the child welfare system. Researchers will compile descriptive statistics to compare family risk and case characteristics by service referral, engagement, and completion status. Chi-square analysis will be used to identify significant differences across the sub-groups. Additionally, researchers will use propensity score matching to identify an appropriate comparison population. Multivariate Cox regression models will be used to adjust for any differences in characteristics that may remain between the treatment and comparison cases after the matching procedure. The use of multivariate Cox regression will ensure a more accurate measurement on the magnitude of the treatment effects as compared to using propensity score matching alone.

The matching variables will include family risk factors including economic stress, caregiver mental illness, caregiver substance abuse, caregiver criminality, homelessness, and domestic violence; inception case status, which will indicate whether a family was having their first encounter with Child Protective Services or Child and Family Welfare Services; participant demographics such as race, ethnicity, age, and gender; administrative region; and case management and assessment variables such as intake type, response time, and type of abuse.

If the researcher determines that propensity score matching and multivariate Cox regression models are not feasible or inappropriate methodologies for the evaluations due to issues discussed below such as sample size and model convergence, they may use another quasiexperimental methodology such as difference-in-differences, regression discontinuity design, or instrumental variable estimation.

Research Limitations

In scientific studies, randomized controlled trials are often considered the "gold standard" because the randomization of participants into the treatment or control group eliminates selection bias and results can be attributed to the intervention being evaluated. In the absence of experimental research designs, quasi-experimental methods are considered an appropriate scientific methodology when randomized controlled trials are not feasible. The application of randomized controlled trials to social science research may be problematic because causal effect estimations are arduous and randomized controlled trials can be expensive, unethical, or impractical. Therefore, researchers will use non-experimental research designs, like

propensity score analysis, to replicate a scientific experiment when randomization is not used in the selection process.

Despite the ubiquitous use of propensity score analysis and multivariate Cox regression as nonexperimental research methodologies, there are several limitations to using these statistical techniques. These methodologies do not include the ability to randomly assign individuals to a treatment or control group and require a large sample size for the evaluation. Propensity score analysis replicates a natural scientific experiment, but the methodology only adjusts for observed confounding covariates and neglects unmeasured variables, which could lead to biased results.

This study may require multiple years of service data in order to construct a sufficient sample size, and the potential of a low sample size or other model convergence problems will prohibit the construction of multivariate models for the EBP. The changes in service referral criteria or capacity over time will affect the pool of an appropriate comparison population. Moreover, in State Fiscal Year 2019, 20% of DCYF cases receiving contracted services received more than one EBP. This could potentially impact the analysis because the study may have to compare separately, exclude those cases that receive more than one EBP, or statistically adjust for multiple EBPs.

Additionally, while researchers will establish a robust readiness assessment and data collection procedure, there could be limitations with the collection and use of administrative data such as a dearth of rigorous quality control method, missing or inaccurate data, timeliness of data entry, and lack of participants leading to a small sample size. These limitations may potentially impact the evaluation of SafeCare because they could confine the scope of the analysis, prevent the discovery of meaningful correlation, and restrict the generalizability of the study.

Child-Parent Psychotherapy

Table 11 provides the anticipated timeline of the Child-Parent Psychotherapy (CPP) evaluation strategy. Month 1 indicates the month of implementation of CPP using FFPSA funding.

Table 11. Child-Parent Psychotherapy (CPP) Evaluation Timeline											
Month	1	2	3	4	5	6	7	8	9	10	Continuous
Create Data Collection and Report Plan	X	X	X	X	X						
Create Evaluation Dissemination Plan	X	X									
Establish Fidelity Monitoring	X	X	X	X							
Plan for Performance Monitoring	X	X									
Plan for Data Analysis	X	X	X	X	X						
Conduct Data Analysis						X	X	X	X	X	X
Implement Key Performance Metrics Data Display										X	X
Dissemination of Evaluation											X

Research Questions

- 1) How did family characteristics and risk factors differ for families based on whether they received a service referral, started an EBP, and/or completed the EBP?
- 2) Were families who completed the EBP more likely to connect with additional community resources compared to similar families who did not receive the EBP?
- 3) Were families who completed the EBP less likely to experience a new period of homelessness or housing insecurity compared to similar families who did not receive the EBP?
- 4) Were families who received CPP less likely to have a child enter or reenter care compared to similar families who did not receive the EBP?

Data Collection Method

DCYF contracted researchers at the Research and Data Analysis (RDA) unit of the Washington State Department of Social and Health Services (DSHS) will obtain child-family level data, CPP service data, and referral and treatment session dates and types from the data reports that contracted providers are required to submit to DCYF. The purpose is to have an integrated data collection approach that will provide a comprehensive and nuanced understanding of the services being provided to CPP participants. DCYF and contracted researchers currently have access to sufficient data within the existing data systems to conduct these analyses.

The researcher will extract longitudinal administrative data from the RDA Integrated Client Databases (ICDB) and the DCYF FamLink case management system to generate measures of CPP client characteristics.

The FamLink data from DCYF will contain the following information for the evaluation:

- Current and prior case openings
- Safety assessments
- Structured Decision Making (SDM) risk assessments
- Family assessments
- Removal records •
- Child Health and Education Tracking (CHET)

The ICDB data from RDA will use the following information to characterize child and caregiver risk factors:

- Economic stress: receipt of State Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), Diversion Cash Assistance, Basic Food Program, or Consolidated Emergency Assistance Program identified through the Automated Client Eligibility System (ACES), which is the Washington state data system for homeless programs
- Domestic violence: any domestic violence-related charges from Washington State Patrol (WSP)

- Homelessness: any indicator for living in a battered spouse shelter, emergency housing shelter, homeless with housing, homeless without housing, or inappropriate living situation in ACES
- Caregiver criminality: any arrest, conviction, or incarceration at a state juvenile or adult facility
- Caregiver mental illness: mental health diagnosis, inpatient and outpatient services, or prescribed psychotropic medications recorded in medical claims or publicly funded mental health records
- Caregiver substance abuse: alcohol- or drug-related diagnosis, outpatient and inpatient service recorded in medical claims, publicly funded mental health records, and substance-related arrests from WSP

The data for the homelessness indicators will be ascertained from the following:

- Washington State Department of Commerce Homeless Management Information System (HMIS), which contains variables regarding youth and adults who have received any type of housing services like emergency shelter, transitional housing, or rental assistance
- Client living arrangement from the ACES
- Address information in ACES indicating whether a youth or caregiver was homeless

Outcomes of Interest

In addition to the ultimate outcomes of preventing entry and reentry into foster care, DCYF is interested in intermediate outcomes related to homelessness and service utilization related to receipt of other community services as an indication of building community connections. The intermediate outcomes will be measured during a 6-month follow-up period from date of service referral and include service engagement, minimal service completion, and full service completion. Working in collaboration with service providers program experts, trainers, and model developers, CPP program staff will determine thresholds for engagement, minimal service completion, and full completion of service during the implementation phase.

The longer-term outcomes of interest for CPP will be whether there was an entry or reentry into foster care for any child on the case within 6 and 12 months of the last day of service, new connection to community resources (Basic Food Program, Medicaid enrollment, mental health treatment, and/or substance use disorder treatment) within 6 and 12 months of the last day of service, and experience with a new period of homelessness during the 12-month follow-up process. For the new connection to community resources measure, the study population will be limited to families who were not already receiving the same community services in the month that the EBP was initiated.

Statistical Techniques and Quasi-Experimental Methodology

The target and study populations for the evaluations will be all eligible individuals from the approved candidacy groups involved in the child welfare system. Researchers will compile descriptive statistics to compare family risk and case characteristics by service referral, engagement, and completion status. Chi-square analysis will be used to identify significant differences across the sub-groups. Additionally, researchers will use propensity score matching to identify an appropriate comparison population. Multivariate Cox regression models will be used to adjust for any differences in characteristics that may

remain between the treatment and comparison cases after the matching procedure. The use of multivariate Cox regression will ensure a more accurate measurement on the magnitude of the treatment effects as compared to using propensity score matching alone.

The matching variables will include family risk factors including economic stress, caregiver mental illness, caregiver substance abuse, caregiver criminality, homelessness, and domestic violence; inception case status, which will indicate whether a family was having their first encounter with Child Protective Services or Child and Family Welfare Services; participant demographics such as race, ethnicity, age, and gender; administrative region; and case management and assessment variables such as intake type, response time, and type of abuse.

If the researcher determines that propensity score matching and multivariate Cox regression models are not feasible or inappropriate methodologies for the evaluations due to issues discussed below such as sample size and model convergence, they may use another quasiexperimental methodology such as difference-in-differences, regression discontinuity design, or instrumental variable estimation.

Research Limitations

In scientific studies, randomized controlled trials are often considered the “gold standard” because the randomization of participants into the treatment or control group eliminates selection bias and results can be attributed to the intervention being evaluated. In the absence of experimental research designs, quasi-experimental methods are considered an appropriate scientific methodology when randomized controlled trials are not feasible. The application of randomized controlled trials to social science research may be problematic because causal effect estimations are arduous and randomized controlled trials can be expensive, unethical, or impractical. Therefore, researchers will use non-experimental research designs, like propensity score analysis, to replicate a scientific experiment when randomization is not used in the selection process.

Despite the ubiquitous use of propensity score analysis and multivariate Cox regression as nonexperimental research methodologies, there are several limitations to using these statistical techniques. These methodologies do not include the ability to randomly assign individuals to a treatment or control group and require a large sample size for the evaluation. Propensity score analysis replicates a natural scientific experiment, but the methodology only adjusts for observed confounding covariates and neglects unmeasured variables, which could lead to biased results.

This study may require multiple years of service data in order to construct a sufficient sample size, and the potential of a low sample size or other model convergence problems will prohibit the construction of multivariate models for the EBP. The changes in service referral criteria or capacity over time will affect the pool of an appropriate comparison population. Moreover, in State Fiscal Year 2019, 20% of DCYF cases receiving contracted services received more than one EBP. This could potentially impact the analysis because the study may have to compare separately, exclude those cases that receive more than one EBP, or statistically adjust for multiple EBPs.

Additionally, while researchers will establish a robust readiness assessment and data collection procedure, there could be limitations with the collection and use of administrative data such as a dearth of rigorous quality control method, missing or inaccurate data, timeliness of data entry, and lack of participants leading to a small sample size. These limitations may potentially impact the evaluation of CPP because they could confine the scope of the analysis, prevent the discovery of meaningful correlation, and restrict the generalizability of the study.

Fidelity Monitoring and Continuous Quality Improvement

DCYF is committed to maintaining continuous quality improvement and ensuring the effectiveness of approved well-supported, supported, and promising programs. The agency will align fidelity monitoring and continuous quality improvement of approved EBPs with other agency initiatives, in which outcome measurements, performance metrics, and data feedback loops are already established.

DCYF will support the continuous quality improvement related to implementation of the approved prevention services by developing and implementing program monitoring dashboards to surveil quality, fidelity, and outcomes. Researchers have identified implementation metrics in collaboration with the program teams for each contract group. Researchers rely on published literature, historical data analysis, and any evaluations that are available to help identify appropriate fidelity, quality, and outcome metrics.

Table 12 illustrates fidelity measures for each of the EBPs in Table 1. It should be noted that although many of these programs identify numerous fidelity measures in the program manuals, DCYF's implementation of fidelity monitoring and continuous quality improvement will focus on those fidelity indicators (both structural and therapeutic/interpersonal) believed to be key to producing program outcomes.

Table 12. Key Fidelity Measures

Functional Family Therapy (FFT)	<ul style="list-style-type: none">• Staff qualifications• Staff successful completion of required model training• Rate of meetings/progress notes• Family Self Report (FSR) and Therapist Self Report (TSR)• Rate of staffing and consultations with supervisors• Global Therapist Rating (GTR)• Family, client, and therapist exit survey
Motivational Interviewing (MI)	<ul style="list-style-type: none">• Staff successful completion of required model training: Initial and booster• Case documentation: frequency and consistency• Case review: thorough and adequate• Counselor competence/model adherence: collaboration, evocation, and autonomy• Counselor skill demonstration: empathy
Multi-Systemic Therapy (MST)	<ul style="list-style-type: none">• Staff qualifications• Staff successful completion of required model training• 24-hour availability• Services provided in family's home or other places convenient to the family• Services are intensive, with intervention sessions being conducted from once per week to daily• Caseload limit: maximum six families/year per therapist• Case length: three to five months
Nurse-Family Partnership (NFP)	<ul style="list-style-type: none">• Staff qualifications• Staff successful completion of required model training• Staff: supervisor ratio no more than 1:8• Caseload limit: one nurse to 25 clients

	<ul style="list-style-type: none"> • Use of reflective supervision
Parents as Teachers (PAT)	<ul style="list-style-type: none"> • Staff qualifications • Staff successful completion of required model training • Reflective supervision • Staff: supervisor ratio not more than 1:12 • Consistent use of family-centered assessment • Consistent documentation of parent goals • Consistent use of standard curriculum and visit plans • Visit completion rate • Caseload limits full-time staff to no more than 48 visits/month in first year and no more than 60 visits/month thereafter
Child-Parent Psychotherapy (CPP)	<ul style="list-style-type: none"> • Staff qualifications • Staff successful completion of required model training • Consistent therapeutic content (e.g., convey hope, develop empathetic relationship with family members, etc.) • Consistent reflective practice • Consistent use of trauma framework
Homebuilders	<ul style="list-style-type: none"> • Staff qualifications • Staff successful completion of required model training • Staff: supervisor ratio improvement • 24-hour availability • Services provided in natural environment • Caseload limit: 1 staff member to 18-22 families/year • Supervisor availability
SafeCare	<ul style="list-style-type: none"> • Staff qualifications • Staff successful completion of required model training • Consistent use of parent-infant/child interaction assessment and training • Consistent use of home safety assessment and training • Consistent use of child health assessment and training

DCYF will implement a continuous quality improvement process, as illustrated in Figure 5, to promote fidelity, accountability, and improvement. This process will be informed through collecting data, analyzing data, sharing results, and improving performance.

Figure 5. Fidelity Monitoring and Continuous Quality Improvement



The first phase of the continuous quality improvement process will involve collecting data from contractors while providing training and technical assistance to enhance data reporting quality. Contractors will also identify the data storage capacity, collection mechanism, and report process. During the second phase of the process, DCYF will analyze the collected data, conduct internal data review meetings, and provide additional training to contractors to encourage data literacy. DCYF will meet and share the results from the data analysis with contractors during the third phase of the process. Additionally, the agency will make the data analysis report available to the public through the DCYF website. The last step of the continuous quality improvement process will provide training to contractors to identify improvement strategies based on the results of the data analysis. This step will allow DCYF and providers to work collaboratively to validate model fidelity, determine if outcomes were achieved, recognize successes, and refine practices if necessary.

DCYF principles of effective continuous quality improvement include clear ownership, shared accountability, and transparent and inclusive processes for service improvement. The principle of clear ownership identifies the responsible parties for each step of the fidelity monitoring and continuous improvement process. Shared accountability actively engages multiple stakeholders in using data to improve services. Transparent and inclusive processes for service improvements involve regularly scheduled meetings to review outcome metrics data to understand performance and guide implementation action steps.

Waiver Request

DCYF is seeking an evaluation waiver for two well-supported practices: Nurse–Family Partnership (NFP) and Parents as Teachers (PAT). The evidence of effectiveness for these practices is compelling, and both were designated as “well-supported” by the FFPSA Clearinghouse in 2019. DCYF has contracts in place for NFP and PAT, with already established continuous quality improvement requirements with regard to practice for these two evidencebased practices. See Attachment II.

Compelling Evidence of Effectiveness

NFP is an evidence-based community health program that generally serves low-income women who are pregnant with their first child. Each mother is partnered with a registered nurse early in her pregnancy and receives ongoing nurse home visits. This program is designed to help families—and the communities they live in—become stronger while promoting multiple positive long-term child, maternal, and family experiences. NFP is based on rigorous evidence of effectiveness from randomized controlled trials in three locations: Elmira, New York; Memphis, Tennessee; and Denver, Colorado.

Taken together, these studies provide compelling evidence of the links between NFP services and several key outcomes including child safety, child well-being, and adult well-being. Among low-income first-time mothers, NFP has been found to significantly: (1) reduce child maltreatment, (2) improve parental capacity and knowledge about child development, (3) improve the long-term economic security of families, (4) reduce injury hospitalizations among children, (5) improve child development, and (6) reduce justice system involvement of children.

- 1) Child maltreatment. NFP has been found to reduce child maltreatment by 31% to 46.3% with reductions concentrated at ages 4–15. Based on a review of the published research on this outcome, the Washington State Institute for Public Policy estimates an average effect size reduction of 35% in child maltreatment by age 17 in realworld implementation of NFP.
- 2) Parental capacity and knowledge about child development. NFP intervention is linked to improvement in maternal parenting attitudes on non-abusive and nonneglecting behaviors.^{14,15} This was based on data on home environment and parenting skills collected when the child was 6 months, one year, and two years of age.
- 3) Economic security. Economic security is demonstrated by lower Temporary Assistance for Needy Families (TANF) payments and lower use of Supplemental Nutrition Assistance Program (SNAP). NFP reduces TANF payments by 5.6% for 9– 12 years after childbirth and reduces SNAP payments by 9.6% for at least 12 years after birth.
- 4) Injury hospitalizations. Through age 2, NFP babies have 32.6% fewer injuries that are treated in emergency departments (EDs) or through admittance to a hospital. There was a 32% reduction in ED visits for all reasons.
- 5) Child development. A study by Heckman and coauthors found significant impact of home visiting programs, particularly NFP in children’s development. The positive effects of NFP persist as children grow older. By age 6, NFP participants’ children demonstrated higher cognitive skills compared to children in the control group. Girls displayed stronger early socioemotional skills, including reduced aggression and increased empathy, while boys saw larger effect sizes on cognitive skills. At age 12, years after the intervention had ended, boys continued to demonstrate statistically significant improvements in cognition as well as math and reading achievement test scores. Heckman and coauthors noted that enhanced cognitive skill formation seen in boys resulted from healthier prenatal environments fostered by NFP, ultimately resulting in stronger long-term effects for boys than for girls.²
- 6) Justice system involvement. Children of nurse-visited mothers are 43% less likely to be arrested, and 58% less likely to be convicted, as of age 19. They also experience 57% fewer lifetime arrests and 66% fewer lifetime convictions, as of age 19.

Parents as Teachers (PAT) is an evidence-based home visiting program that helps parents develop skills to raise their children and improve their health, education, and development outcomes. PAT serves families with children between 0–5 years of age. PAT entails personal visits by parent educators along with group connections, access to resource network, and screening for children.

More than a dozen outcome studies have been conducted on the effects of PAT on development and educational outcomes of the children served. Taken together, these studies provide compelling evidence of the links between PAT services and several key outcomes including child safety and child well-being. Among families with young children, PAT has been found to significantly: (1) reduce child maltreatment and (2) improve parental capacity and knowledge about child development.

- 1) Child maltreatment. PAT participation was related to 50% fewer cases of suspected abuse and/or neglect.^{24,25} Children served by PAT had a 22% decreased likelihood of child maltreatment compared to children not in PAT.²⁶ Based on a review of the published research on this outcome, the Washington State Institute for Public Policy estimates an average effect size of 6.1% reduction in child maltreatment in real-world implementation of PAT by age 17.
- 2) Parental capacity and knowledge about child development. PAT expands parental knowledge of child development and encourages positive parent–child relationships.²⁸ Children who participated in PAT scored higher on standardized tests of intelligence and social development compared to children who did not.²⁹ The parents enrolled in PAT had better scores on Knowledge of Infant Development Inventory (KIDI) and on scales of parental attitude measurement.

Continuous Monitoring

In order to implement the Fidelity Monitoring and Continuous Quality Improvement cycle illustrated in Figure 5 for NFP and PAT, DCYF contracts with the Ounce Washington to support contracted providers to achieve model fidelity and program quality. The Ounce Washington operates the statewide Implementation Hub to support a variety of home visiting programs, including the two largest in the state—NFP and PAT. The Ounce Washington Implementation Hub houses NFP and PAT model leads, along with a team of experts in the areas of home visiting, family engagement, program implementation, and implementation science. In addition, developers share data from the model-specific datasets with Washington State monthly, which allows for near real-time analysis of program implementation. The Ounce staff support NFP and PAT using a strengths-based approach and an implementation science lens and work collaboratively with grantees to alleviate programmatic barriers.

The Ounce Implementation Hub provides support to local implementing agencies on model fidelity, training, coaching, CQI, public awareness, and community engagement. It also uses various strategies including one-on-one coaching calls, site visits, group-based community of practices, and webinars to offer training and support.



North Dakota

Status: Approved

Section VI: Evaluation Strategy and Waiver Request

SECTION 2: EVALUATION STRATEGY AND WAIVER REQUEST

North Dakota is committed to implementing prevention services that have compelling evidence of their effectiveness. This will help ensure that families are provided services that will help to keep them from moving further into the child welfare system. At the time of this submission, North Dakota will only be implementing well-supported practices and will be requesting waivers to the evaluation requirement.

The Department of Human Services (DHS) will implement a Continuous Quality Improvement process (CQI) that will include outcomes measured by both DHS and providers to monitor activities provided under the Title IV-E Prevention Plan. This CQI process will be used to ensure that participants are provided quality services that protect the safety and health of every child and family and to determine the impact of those services on child and family level outcomes and functioning. This process will involve participation from the DHS, private/community providers, children and families and other community stakeholders.

DHS (the State Title IV-E agency) will require a Memorandum of Understanding (MOU) with each provider that is approved to provide services under the Title IV-E Prevention Plan. This MOU is vital to ensure DHS oversight and will be used to ensure the collection and submission of outcomes to demonstrate that providers can meet positive outcomes for children and families. Providers will be required to follow the fidelity practices of the selected evidence-based practice interventions. As services are delivered, providers must implement fidelity monitoring procedures as delineated for the program. Providers need to submit a plan outlining their fidelity review process to include how they will facilitate fidelity reviews, work toward quality improvement, and maintain records of the continuous quality improvement procedures. Fidelity review documentation will be reviewed by DHS upon request or during audit reviews as part of the utilization review process. Providers must collect and report on outcomes including but not limited to economic stability, social and community context, neighborhood and environment, healthcare, and education. Outcomes will be collected at a minimum every three months and submitted by required deadlines as outlined in the MOU. DHS will monitor and review outcomes submitted. If outcome measures are not achieved, the provider may be required to submit an action plan that will be reviewed by DHS. DHS will facilitate utilization review, providers will be required to submit requested documentation and participate in trainings, technical assistance and other meetings as requested by DHS.

As part of the CQI process and ongoing monitoring, DHS will develop a review of programs and services to assist with determining the impact the services have on child/family outcomes and functioning to determine the effectiveness of current processes and systems. This information will be used to identify strengths and needs in implementation within and across providers in support of quality improvement. Technical assistance will be available to providers as needed to provide support in this area. Reviews will involve verification of fidelity and outcome measurement processes. Outcomes measured at the DHS level will include items such as safety, permanency (including entry into foster care) and family well-being.

Provider and state level data will be used to evaluate trends and to refine and improve practices. DHS will meet regularly to review and evaluate CQI outcomes and will communicate with stakeholders and decision makers as needed to refine and improve practices. DHS will utilize the theory of constraints model to streamline processes and efficiencies involved in administration and operations.

Continuous Quality Improvement: North Dakota believes that a fully functioning statewide Continuous Quality Improvement process will provide strategies to effectively address child welfare practice concerns and establish ongoing protocols for checks and balances within the system. North Dakota has chosen the Theory of Constraints (TOC) as the model for a statewide CQI process across all divisions within the North Dakota Department of Human Services.

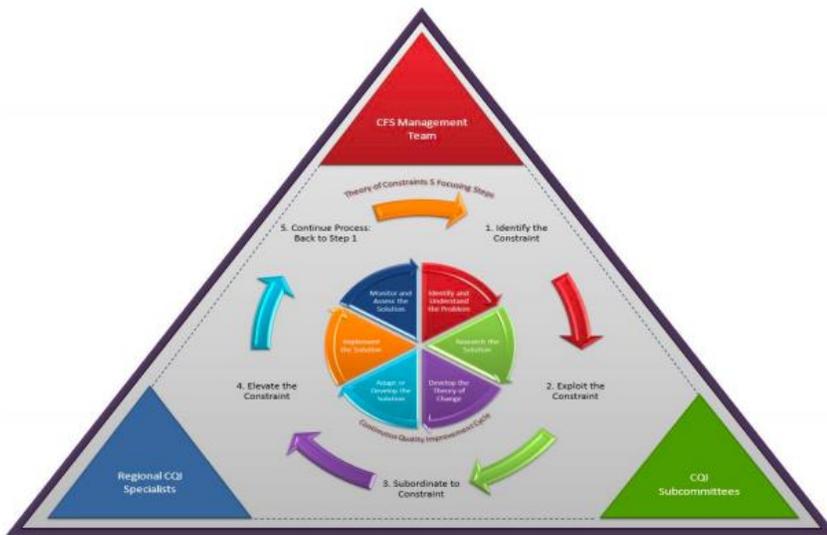
Theory of Constraints (TOC) is a methodology for identifying the most important limiting factor (i.e. constraint) that stands in the way of achieving a goal and then systematically improving that constraint until it is no longer the limiting factor. TOC focuses on how quickly results can be achieved, referred to as "throughput". On the other hand, theory of constraints focuses on the factors that hinder the speed of this "throughput", referred to as a bottleneck. The "throughput" will be increased when the "bottleneck" can be reinforced or eliminated. Generally, there are five steps that are followed when working with TOC:

1. Identify the system constraints: The weakest link in an organization is identified whereupon it must be decided whether its causes are physical, or policy related.
2. Decide how to exploit the constraint: The organization determines how this constraint can be eliminated as a result of which the "throughput" can be increased. Should these actions not lead to an increase, it is considered advisable to abandon the breakthrough of this constraint.
3. Subordinate everything else to the above decision: The organization as a whole must side with the adopted solution, as a result of which the "constraint" is solved. It is wise to make an assessment in between steps 3 and 4, to establish whether performance is still being hindered by this earlier constraint.
4. Elevate performance of the constraint: Other adjustments can be used to break through the "constraints". This could involve changes in the existing system (reorganization) or changes in the market. Such adjustments require investments and will only be deployed after all other options have been considered.
5. Continuous process: After the implementation of the opted solution and after elimination or breakthrough of the constraint, the process starts over again from Step 1. On the one hand the impact of the implemented solution is looked at and on the other hand new constraints are identified and broken through.

The following graphic shows how Theory of Constraints (outer ring of arrows) shares much of the same processes with the traditional continuous quality improvement cycle (inner grouping of arrow wedges). Both processes start with identification of the problem or constraint. The next step with TOC is Exploiting the Constraint. This corresponds with the CQI steps of Researching the Solution, Developing the Theory of Change, and Adapting or Developing the Solution. The third and fourth steps of TOC call for Subordination to the Constraint and Elevation of the Constraint, which corresponds with the CQI step of

Implementing the Solution. The last steps of both cycles involve analyzing the solution and, if needed, making further changes by going through the cycle again.

With Theory of Constraints, it is important to look at one constraint per cycle. By focusing all attention on one constraint, it can be dealt with more adequately rather than diluting focus across multiple issues. The other links in the system are regarded as non-constraints and are therefore not reinforced or broken through. Reinforcement or breakthrough of the identified constraint will automatically lead to another constraint that will have to be identified again. And like the CQI cycle, the whole TOC process starts over again. Therefore, the Theory of Constraints encourages an organization to improve its system continuously: it is a continuous quality improvement process.



As depicted in the above graphic, the CFS Management Team oversees the quality improvement activities for the public child welfare system in North Dakota. This team includes the Division Director, Assistant Division Director/CQI Administrator, QA Unit Manager, Safety Administrator, Permanency Administrator, Wellbeing Administrator, and the Early Childhood Services Administrator. Not only does this allow for ongoing and timely review of data and progress made on the system change goals, it allows for more timely adjustment to be made to programs.

Essential to a well-functioning continuous quality improvement (CQI) system is building productive CQI teams and ensuring that information generated through the system will be effectively used to make needed improvements. A productive CQI system requires a mechanism that promotes circular feedback and communication among staff, stakeholders, and teams (depicted by the dashed line in the graphic above). These feedback loops permit an ongoing, bi-directional information exchange across all levels of the agency, which in turn facilitates the change process. Equally important is sharing data with agency staff and sharing data with consumers and external stakeholders.

To help move needed system changes forward, subcommittees are established as needed (refer to the above graphic). This will include permanent regional subcommittees. The regional CQI specialist will oversee the subcommittee. Membership will include representation from public and private entities participating in the public child welfare system throughout the region including:

- Human service zones;
- Tribal social services;
- Criminal justice;
- Private agencies;
- Family members.

The subcommittees will work closely with the CFS Management Team to identify systemic issues impacting service delivery and develop processes to improve outcomes for the identified service area. They will:

- Review data from various sources including project specific data, CFSR/QA data and regional/local data reports;
- Review regional Onsite Case Review (OCR) data and discusses regional initiatives or action plans to address areas needing improvement;
- Design and implement CQI projects to improve outcomes throughout the regional service delivery system and ultimately the statewide public child welfare system;
- Provide ongoing consultation and collaboration to review and evaluate the progress of the PIP strategies and CFSP goals and recommend program adjustments to allow for successful completion of the requirements of the CFSR performance improvement plan;
- Provide for or arrange for ongoing training for individual workers on CQI principles;
- Promoting a culture that values service quality and continual efforts by the Team, its partners, and contractors to achieve strong performance, program goals, and positive results for service recipients;
- Make legislative/policy/and practice improvement recommendations to the CQI Council.

North Dakota has been using TOC as its continuous quality improvement program to improve services and outcomes. An example is the project looking at Child Protective Services. Key stakeholders came together to redesign Child Protective Services (CPS) to provide individuals and families the right service at the right time, at the right frequency and intensity. Three goals were identified as part of the CPS redesign project:

- Reduce the time it takes to complete a CPS assessment.
- Conduct a face to face meeting with the identified child within 3 days.
- Conduct complete casework 100% of the time, only passing on completed casework.

Current North Dakota statute requires that CPS assessments be completed within 62 days. Regretfully, this was only occurring 48% of the time during a 12-month assessment period. The CPS redesign Pilot Project targets are:

- 50% of CPS assessments completed at 25 days
- 75% of CPS assessments completed at 35 days
- 95% of CPS assessments completed at 62 days

Preliminary pilot project data shows progress including:

- 89% of the cases were closed with 62 days (baseline was 40.8%)
- 56% of the 499 closed cases were closed within 25 days (baseline was 7.35%)
- 89% of CPS workers met face-to-face with the identified child within three days of the report, sooner if imminent concerns were identified
- Pilot regions have, in some cases, unlocked hidden capacity, increasing access to services, and transferring staff from administrative work to direct client services.

North Dakota is in the second year of a performance improvement plan for the Round 3 CFSR. Goal One of the PIP involves strengthening its QA/CQI processes. Recently, North Dakota began receiving technical assistance from the Capacity Building Center for States. The goal of the TA is to develop and implement a CQI system that not only fulfills PIP requirements but also integrates the Theory of Constraints and includes all the functional components of an effective CQI system. Practice changes would include:

- Improved engagement of key stakeholders in the generation and meaning-making of performance data at the state, regional, and case-levels
- Improved use of data and evidence in decision-making at the state, regional, and case level
- Deeper collaboration and partnership between state and regional staff in identifying performance issues, unearthing root causes, developing and implementing improvement strategies, and monitoring their effectiveness.

North Dakota will use this CQI process to evaluate and continually improve provision of Title IV-E prevention services.

Evaluation Design: North Dakota does not intend to implement any allowable supported or promising practice evidence-based practices for consideration under FFPSA at the time of this submission. Rather, the State will only leverage FFPSA funding for well-supported models in year one of implementation (see Table 1 below). Therefore, an evaluation description is not needed at this time. As additional services are added to the Clearinghouse list of well-supported, the State may submit amendments to its plan along with appropriate waiver requests or full evaluation design (for supported or promising models).

Table 1. North Dakota Year One Implementation Programs by Evaluation Strategy

Prioritized Interventions	CQI (Formal) Evaluation Waiver	Formal Evaluation	State Level CQI	Claiming FFPSA
Brief Strategic Family Therapy	X			X
Functional Family Therapy	X			X
Healthy Families	X			X
Multisystemic Therapy	X			X
Nurse-Family Partnership	X			X
Parent Child Interaction Therapy	X			X
Parents as Teachers	X			X
Homebuilders	X			X

Waiver Request: Based on the compelling evidence for each program described above – as identified in the Extend of Evidence and Summary of Finding found within the documentation in the Title IV-E Prevention Services Clearinghouse. North Dakota is submitting Appendix B, Request for Waiver of Evaluation Requirement for each Well-Supported Practice.

Compelling Evidence

Brief Strategic Family Therapy: The request for a waiver of the evaluation requirement for Brief Strategic Family Therapy is based on compelling evidence that families in BSFT 1) had higher rates of engagement, retention and were more likely both to engage 2) adolescents of parents who used drugs at baseline had a significantly lower trajectory of substance use 3) decrease of parental alcohol usage. The following summary of research highlights the compelling evidence:

Study: Horigian, V. E., Feaster, D. J., Brincks, A., Robbins, M. S., Perez, M. A., & Szapocznik, J. (2015).

The effects of Brief Strategic Family Therapy (BSFT) on parent substance use and the association between parent and adolescent substance use. *Addictive Behaviors*, 42, 44-50. This study is a secondary analysis to determine the effects of *Brief Strategic Family Therapy (BSFT)* on parent substance use, and the relationship *between* parent substance use and adolescent substance use. This paper uses data from the BSFT effectiveness study conducted in the National Drug Abuse Treatment Clinical Trials Network. Participants were randomized to *BSFT* or treatment as usual (TAU) across eight outpatient treatment programs community treatment programs (CTPs) across the country. Adolescent substance use was assessed at baseline and at 12 monthly follow-up assessments. All additional adolescent and family assessments were completed at baseline and 4-, 8-, and 12-months postrandomization. Parent alcohol and drug use were assessed at baseline and at 12 months postrandomization. Measures utilized include the Alcohol and Drug Use items from the *Addiction Severity Index-Lite (ASI)*, the *Timeline Follow Back (TLFB)*, *C-Diagnostic Interview Schedule for Children, Substance Abuse/Dependence Module (DISC-SA)*, *Parenting Practices Questionnaire*, and the *Diagnostic Interview Schedule for Children-Predictive Scales (DISC-PS)*.

Outcome: Results found parents in BSFT significantly decreased their alcohol use as measured by the ASI composite score from baseline to 12 months. Change in family functioning mediated the relationship between treatment condition and change in parent alcohol use. Children of parents who reported drug use at baseline had three times as many days of reported substance use at baseline compared with children of parents who did not use or only used alcohol. Adolescents of parents who used drugs at

baseline in the BSFT group had a significantly lower trajectory of substance use than adolescents in the TAU group.

Study: Coatsworth, J., Santisteban, D., McBride, C., & Szapocznik, J. (2001). Brief Strategic Family Therapy versus community control: Engagement, retention, and an exploration of the moderating role of adolescent symptom severity. *Family Process, 40*(3), 313-332. This study aimed to extend the body of research investigating the effectiveness of *Brief Strategic Family Therapy (BSFT)* to engage and retain families and/or youth in treatment. The sample reported in this article was part of a large-scale, two-phase demonstration study testing the efficacy of *BSFT* with high-risk minority youth (first-phase: see above summary of Santisteban, Coatsworth, Perez-Vidal et al., 1997). 104 families were randomly assigned to *BSFT* or a community comparison (CC) condition selected to represent the common engagement and treatment practices of the community. The *Revised Behavior Problem Checklist (RBPC)*, an empirically derived measure consisting of 89 problem behaviors, was administered. A primary limitation of the study was that an intent-to-treat design was not able to be fully implemented. While the experimenters were able to complete termination assessments for 77% of the families that participated in either treatment, limited resources restricted the ability to track and assess families that did not engage into treatment. **Outcome:** Results indicated that the families assigned to *BSFT* had significantly higher rates of engagement (81% vs. 61%) and retention (71% vs. 42%) than those assigned to CC. A risk-ratio analysis revealed that families randomized into *BSFT* were 2.3 times more likely both to engage and to retain than families/participants randomized to CC condition. *BSFT* was also more effective than CC in retaining more severe cases, specifically cases with high levels of adolescent conduct disorder, and, despite the higher percentage of difficult-to-treat cases, achieved comparable treatment effects on behavior problems.

Study: Szapocznik, J., Perez-Vidal, A., Brickman, A., Foote, F. H., Santisteban, D., Hervis, O. E. & Kurtines, W. M. (1988). Engaging adolescent drug abusers and their families in treatment: A strategic structural systems approach. *Journal of Consulting and Clinical Psychology, 56*(4), 552. Using a two group experimental design, this study randomly assigned subjects to either strategic structural-systems engagement (SSSE) or engagement as usual (EAU). SSSE was developed within the conceptual framework of *Brief Strategic Family Therapy (BSFT)* (Szapocznik, Kurtines, et al., 1983, 1986), which is a structural family-systems approach. This study tested the efficacy of the strategic structural systems engagement procedure for engaging hard-to-reach cases and bringing them to therapy completion. To assess the subject's psychiatric and psychosocial functioning, the *Psychiatric Status Schedule (PSS)* was one of the measures used. Another measure used was the *Client-Oriented Data Acquisition Process (CODAP)*, which requests information on drug use by type and frequency. **Outcome:** A sustained higher level of engagement was found in the SSSE condition vs. the EAU condition. For example, over 57.7% of the families in the EAU condition failed to come to the center for intake, while only 7.1% of families in the SSSE condition were lost.

The goal of *BSFT* is to improve a youth's behavior by improving family interactions that are presumed to be directly related to the child's symptoms, thus reducing risk factors and strengthening protective factors for adolescent drug abuse and other conduct problems. *BSFT* targets children and adolescents who are displaying—or are at risk for developing—behavior problems, including substance abuse. Review of the research suggests that implementing the model in community settings in North Dakota will provide

therapists with an effective tool to increase family involvement in therapy, increase retention, reduce adolescent drug use and related risk-taking behaviors, and reconfigure family interactions to support healthy development. This will help North Dakota realize the goal of decreased out-of-home placements

Functional Family Therapy: The evidence in favor of the use of Functional Family Therapy in North Dakota to provide change in family interactions and subsequent behavior. The request for a waiver of the evaluation requirement for FFT is based on compelling evidence that 1) FFT has shown to improve family dynamics; 2) decrease delinquent behavior in youth; and 3) decrease the recidivism rate of delinquent teenagers. The following summary of research highlights the compelling evidence:

Study: Alexander J. F., & Parsons, B. V. (1973). Short-term behavioral intervention with delinquent families: Impact on family process and recidivism. *Journal of Abnormal Psychology, 81*(3), 219-225. This study examined the impact of a short-term behavioral intervention [now called Functional Family Therapy (FFT)] on the recidivism rates of delinquent teenagers and their families. Families were randomly assigned to either the short-term behavioral family intervention program or to one of three comparison groups: client-centered family groups program, psychodynamic family program (Mormon church-sponsored), or a no-treatment control group. Juvenile court records were examined following termination to assess recidivism, (i.e., referral for behavioral offense).

Outcome: Short-term family behavioral treatment had a 26% recidivism rate. No-treatment control group had a 50% recidivism rate, the client-centered family group had a 47% recidivism rate, the psychodynamic family treatment group had a 73% recidivism rate.

Study: Klein, N., Alexander, J., & Parsons, B. (1977). Impact of family systems intervention on recidivism and sibling delinquency: A model of primary prevention and program evaluation. *Journal of Consulting and Clinical Psychology, 45*(3), 469-474. Measured outcomes on three levels of evaluation: changes in the family interaction process at the termination of treatment (tertiary prevention); recidivism rates 6 to 18 months following treatment (secondary prevention); and rate of sibling contact with the court 2.5 to 3.5 years following intervention (primary prevention). Families were randomly assigned to one of four treatment conditions: the treatment program [now called Functional Family Therapy (FFT)], one of two comparison groups, or a no-treatment control group.

Outcome: The family systems approach, when compared to the other conditions, produced significant improvements in family interaction process measures and a significant reduction in recidivism. Siblings of youth receiving FFT showed lower arrest rates than siblings from alternative treatment conditions 2 ½ to 3 ½ years post-treatment.

Study: Waldron, H. B., Slesnick, N., Brody, J. L., Peterson, T. R., & Turner, C. W. (2001). Treatment outcomes for adolescent substance abuse at 4- and 7-month assessments, *Journal of Consulting and Clinical Psychology, 69*(5), 802-813. Participants were randomly assigned to one of four treatment conditions: Functional Family Therapy (FFT), individual Cognitive Behavioral Therapy (CBT), a combination of FFT and CBT (joint), or a psychoeducational group. Measures to assess substance abuse included the Timeline Follow-Back (TLFB) interview, as well as collateral reports from parents and siblings of adolescents, and urinalyses. In order to assess problem behaviors that may be associated with substance

abuse, the *Problem Oriented Screening Instrument for Teenagers (POSIT)* and *Child Behavioral Checklist (CBCL)* were used.

Outcome: Therapy conditions (FFT and joint CBT/FFT) had significant reductions in heavy marijuana use from pretreatment to the 4-month assessment, and this reduction persisted until the 7-month assessment. The initial changes in those in the CBT condition from pretreatment to 4 months, however, did not persist through the 7-month assessment.

The California Clearinghouse notes that FFT aims to address risk and protective factors that impact the adaptive development of 11 to 18-year-old youth who have been referred for behavioral or emotional problems. The program is organized in multiple phases and focuses on developing a positive relationship between therapist/program and family, increasing motivation for change, identifying specific needs of the family, supporting individual skill-building of youth and family, and generalizing changes to a broader context. Based on the research and how the model fits with the needs of the state, FFT will prove to be effective in North Dakota in decreasing the number of out of home placements by decreasing the incidence of delinquent behaviors through improved family dynamics.

Healthy Families America: The request for a waiver of the evaluation requirement for Healthy Families America is based on compelling evidence that 1) reports of fewer acts of very serious abuse, minor physical aggression, and psychological aggression 2) fostering positive parenting, such as maternal responsiveness and cognitive engagement 3) mothers were half as likely to be confirmed subjects for physical abuse or neglect 4) children of mothers in the home visiting group were less likely to receive a second report and had a longer period of time between initial and second reports. The following summary of research highlights the compelling evidence:

Study: DuMont, K., Mitchell-Herzfeld, S., Greene, R., Lee, E., Lowenfels, A., Rodriguez, M., & Dorabawila, V. (2008). Healthy Families New York (HFNY) randomized trial: Effects on early child abuse and neglect. *Child Abuse & Neglect*, 32, 295-315. doi:10.1016/j.chiabu.2007.07.007. The study evaluated the effects of Healthy Families NY [now called *Healthy Families America (HFA)*] on parenting behaviors in the first 2 years of life. There was trend toward lower levels of neglect at both times for Healthy Families NY program mothers, as well, although it did not reach significance. No group differences were found for substantiated CPS reports.

Outcome: Results indicated that at one-year follow-up, mothers in the Healthy Families NY program reported fewer acts of very serious abuse, minor physical aggression, and psychological aggression in the past year, as well as fewer acts of harsh parenting in the last week. At year 2, Healthy Families NY mothers reported significantly fewer acts of serious physical abuse.

Study: Rodriguez, M. L., Dumont, K., Mitchell-Herzfeld, S. D., Walden, N. J., & Greene, R. (2010). Effects of Healthy Families New York on the promotion of maternal parenting competencies and the prevention of harsh parenting. *Child Abuse & Neglect*, 34, 711-723. doi:10.1016/j.chiabu.2010.03.004. This study utilized participants from DuMont et al. (2008). The study evaluated the effectiveness of the Healthy Families New York [now called *Healthy Families America (HFA)*] home visiting program in promoting

parenting confidence and preventing maladaptive parenting behaviors in mothers at risk for child maltreatment.

Outcome: Results indicated that Healthy Families NY was effective in fostering positive parenting, such as maternal responsivity and cognitive engagement. With respect to negative parenting, Healthy Families NY mothers in the High Prevention Opportunity subgroup were less likely than their counterparts in the control group to use harsh parenting.

Study: Lee, E., Kirkland, K., Miranda-Julian, C., & Greene, R. (2018). Reducing maltreatment recurrence through home visitation: A promising intervention for child welfare involved families. *Child Abuse & Neglect*, 86, 55-66. doi:10.1016/j.chiabu.2018.09.004. The study evaluated the effectiveness of Healthy Families New York, [now called *Healthy Families America (HFA)*] through a telephone survey. Participants were a group of mothers who had at least one substantiated CPS report who were randomly selected to assess early outcomes at their child's 1-year birthday. Participants were then randomly assigned to either HFA or a control group. Measures utilized include the *Kempe Family Stress Inventory (KFSI)*, the *Center for Epidemiologic Studies Depression Scale (CES-D)*, the *Parent-Child Relationship Inventory (PCRI)*, the *Adult Adolescent Parenting Inventory (AAPI)*, and administrative information from the New York Statewide Central Register of Child Abuse and Neglect.

Outcome: Results found that by the child's seventh birthday, mothers in the home-visited group were as half as likely as mothers in the control group to be confirmed subjects for physical abuse or neglect. The number of substantiated reports for mothers in the control group was twice as high as for those in the home-visited group. Group differences were only observed after the child's third birthday. Results indicate that home-visited mothers had fewer subsequent births that may have contributed to less parenting stress and improved life course development for mothers.

Study in support of the Child Welfare Protocol: Easterbrooks, M. A., Kotake, C., & Fauth, R. (2019). Recurrence of maltreatment after newborn home visiting: A randomized controlled trial. *American Journal of Public Health*, 109(5), 729-735. doi:10.2105/AJPH.2019.304957. The study investigated whether Healthy Families Massachusetts, [now called *Healthy Families America (HFA)*] reduced recurrence of child maltreatment in child protective (CPS) reports for primiparous (first-time) adolescent mothers. Participants were randomly assigned to either HFA or a control group. Measures utilized include administrative data from the Massachusetts CPS agency, the Department for Children and Families. The outcome variable was CPS reports available for 688 families, specifically, re-reports following an initial report (up to mean child age of 7 years). Of the studied families 33% had a child 3 months and older at the time of enrollment.

Outcome: Results found of the 52% of families who experienced initial CPS reports, 53% experienced additional CPS reports. Children of mothers in the home visiting group were less likely to receive a second report and had a longer period between initial and second reports.

The largest group of children entering foster care in North Dakota are age 0-5 and HFA serves families with children in that age range. HFA is theoretically rooted in the belief that early, nurturing relationships are the foundation for life-long, healthy development. Building upon attachment, bio-ecological systems theories, and the tenets of trauma-informed care, interactions between direct service providers and

families are relationship-based; designed to promote positive parent-child relationships and healthy attachment; services are strengths-based; family-centered; culturally sensitive; and reflective. North Dakota plans to expand Healthy Families North Dakota as well as implement the child welfare protocol which will allow families with target children up to the age of 24 months to enroll as long as the site maintains documentation to show the initial referral was received from the child welfare system. North Dakota does not want to exclude families but rather expand by using the protocol to allow families entering the child welfare system with children up to 24 months to access the service. Families engaged in the child welfare system may not have previously known about the service and even if they enroll at a later age they may see greater benefits of reducing the recurrence of child welfare involvement, increase the length of time between initial and subsequent CPS reports and strengthen the parent-child relationship. As noted above in Easterbrooks, M. A., Kotake, C., & Fauth, R. (2019.)

Healthy Families America's (HFA) best practice standard is to strive for serving at least 80% of families beginning prenatally or in the newborn period because doing so optimizes the ability to achieve greater maternal and child health outcomes, but there is flexibility so that this standard is not absolute [*pg. 48, HFA Best Practice Standard 1-3.B regarding 80% first home visits occurring prenatally or within first three months, and pg. 6-7, HFA BPS Glossary, which indicates threshold for accreditation and demonstration of model fidelity requires adherence to 85% of all HFA Best Practice Standards*]. Services delivered under the child welfare protocol are no different than the services delivered to other populations or target children in different age ranges. The only distinction under our protocol for child welfare involved families is the flexible intake window up to 24 months of age for referrals from child welfare. The HFA model has, since its inception in 1992, been working with child welfare referred families and has allowed flexibility with regard to age of child at intake in its manuals [*pg. 63, HFA Best Practice Standard 3-1.B regarding families enrolled with open and active child welfare/CPS involvement*]. These HFA target population characteristics were part of the original review, approval and well-supported rating provided by the Clearinghouse. Additionally, because the model was originally designed for families with children 0-5, model specific training covers this entire age span, meaning HFA's 3 year minimum length of service ensures children enrolled up to 24 months are served by staff trained to work with families through the age of 5. The allowance up to 24 months is intentional to remain consistent with all existing model practices.

Homebuilders: The evidence in favor of the use of Homebuilders in North Dakota to provide intensive, in-home counseling and support services for families who have a child (0-17 years old) at imminent risk of out-of-home placement or who is in placement and cannot be reunified without intensive in-home services. The request for a waiver of the evaluation requirement for Homebuilders is based on compelling evidence that 1) Homebuilders has shown to keep children in their own homes; 2) reunify children with their parents in a shorter amount of time, and 3) Homebuilders resulted in lower placement costs. The following summary of research highlights the compelling evidence:

Study: Kinney, J., & Haapala, D. (1984), First Year HOMEBUILDERS Mental Health Report. Federal Way, WA: Behavioral Sciences Institute. Study funded by the Washington State Legislature to determine the effectiveness of HOMEBUILDERS at preventing imminent placement of youth into inpatient psychiatric hospitalization. Referrals from the Washington Office of Involuntary Commitment.

Outcome: 73% of treatment group avoided hospitalization.

Study: Wood, S., Barton, K., & Schroeder, C. (1988). In-home treatment of abusive families: Cost and placement at one year. *Psychotherapy*, 25(3), 409-414. A comparison was made between families referred to the Families First home-based service program [now called Homebuilders®] and those receiving usual services. Group assignment was not random, but there was no significant difference between groups on financial aid, ethnicity, sex of referred children, or reason for referral. The groups were evaluated on cost of services and whether or not children remained at home.

Outcome: 74% treatment group remained at home and placement costs lower than comparison group.

Study: Fraser, M., Walton, E., Lewis, R., Pecora, P., Walton, W., (1996), An Experiment in Family Reunification Services: Correlates of Outcomes at One Year Follow Up. *Children and Youth Services Review*, Vol. 18, Nos. 4/5 pp. 335-361. Study by the University of Utah to determine the effectiveness of their IFPS program (using the HOMEBUILDERS model) at reunifying children with their families following out of home placement.

Outcome: 92% of the treatment group returned home.

Study: Kirk, R.S. & Griffith, D.P., (2004), Intensive family preservation services: Demonstrating placement prevention using event history analysis. *Social Work Research*, Vol. 28, No. 1, pp. 5-15. Study funded by the legislature of the State of North Carolina, examining a 7-year time frame, to determine the effectiveness of IFPS (using the HOMEBUILDERS model) at preventing imminent out of home placement.

Outcome: 81% of treatment group avoided placement

Study: Blythe, B. & Jayaratne, S., (2002), Michigan Families First Effectiveness Study. Available on the web at [www.michigan.gov/fia/o, 1607, 7-124-55458-7695-8366-21887-, oo.html](http://www.michigan.gov/fia/o,1607,7-124-55458-7695-8366-21887-,oo.html). Study to determine the effectiveness of IFPS (using the HOMEBUILDERS model) at preventing imminent out of home placement. The first study to assure accurate targeting of subjects by randomly assigning children after a foster placement decision had been approved by the court. Outcome: 93% of the treatment group avoided placement.

The California Clearinghouse notes that Homebuilders uses behavioral assessments to determine outcome-based goals and help families identify strengths and problems associated with child safety and intervention maintenance of change. It aims to support families during crises using tailored intervention strategies and a diverse range of services, such as support with basic needs, service navigation, and psychotherapy. Providers use cognitive and behavioral practices to teach family members new skills and facilitate behavior change. Based on the research and how the model fits with the needs of the state, Homebuilders will prove to be effective in North Dakota in decreasing the number of out of home placements.

Multisystemic Therapy: The request for a waiver of the evaluation requirement for Multisystemic Therapy is based on compelling evidence that MST 1) it is more effective than regular services to reduce out of

home placement and behavioral problems in youth 2) it reduces drug use, decreases days in out-of-home placement, and decreases recidivism 3) showed improved family cohesion, improved peer relations and decreased youth incarceration 4) showed improvements in the areas of home, school and community. The following summary of research highlights the compelling evidence:

Study: *Ogden, T., & Hagen, K. A. (2006). Multisystemic treatment of serious behavior problems in youth: Sustainability of effectiveness two years after intake. *Child and Adolescent Mental Health, 11*(3), 142-149. The aim of this study was to examine the effectiveness of *Multisystemic Therapy (MST)* compared to "regular services" (RS) two years after intake to treatment to investigate whether *MST* was successful at preventing placement out of home, and to examine reductions in behavior problems in multi-informant assessments. Participants were randomly assigned to *MST* or RS treatment conditions. Measures utilized include *the Child Behavior Checklist (CBCL)*, the *Youth Self-Report (YSR)*, the *Teacher's Report Form (TRF)*, and the *Self-Report Delinquency Scale (SRD)*.

Outcome: Results indicate that *MST* was more effective than RS in reducing out-of-home placement and behavioral problems.

*Study: *Henggeler, S. W., Pickrel, S. G., & Brondino, M. J. (1999).* Multisystemic treatment of substance abusing and dependent delinquents: Outcomes, treatment fidelity, and transportability. *Mental Health Services Research, 1*, 171-184. The effectiveness and transportability of *Multisystemic Therapy (MST)* were examined in a study that included 118 juvenile offenders meeting the *Diagnostic and Statistical Manual, Third Edition, Revised (DSM-III-R)* criteria for substance abuse or dependence and their families. Participants were randomly assigned to receive *MST* versus usual community services. Outcome measures assessed drug use (as measured by the *Personal Experience Inventory* and urine drug screens), criminal activity (measured by the *Self-Report Delinquency Scale* as well as Department of Juvenile Justice arrest records), and days in out-of-home placement at post treatment and at a 6-month post-treatment follow-up. Also, treatment adherence (as measured by the *MST Treatment Adherence Measure*) was examined from multiple perspectives.

Outcome: Results showed a reduction in drug use, decreased days in out-of-home placement, and decreased recidivism. Treatment adherence was linked with long-term outcomes, and analyses suggested that the modest results of *MST* were due, at least in part, to difficulty in transporting this complex treatment model from the direct control of its developers. Increased emphasis on quality assurance mechanisms to enhance treatment fidelity may help overcome barriers to transportability

Study: *Henggeler, S. W., Melton, G. B., & Smith, L. A. (1992). Family preservation using Multisystemic Therapy: An effective alternative to incarcerating serious juvenile offenders. *Journal of Consulting and Clinical Psychology, 60*, 953-961. *Multisystemic Therapy (MST)* delivered through a community health center was compared to usual services delivered by the Department of Juvenile Justice in the treatment of 84 serious juvenile offenders and their families. Offenders were assigned randomly to treatment conditions. Pretreatment and posttreatment assessment batteries evaluated family relations (as measured by the *Family Adaptability and Cohesion Evaluation Scales*), peer relations (as evaluated by the *Missouri Peer Relations Inventory*), behavioral symptomology and social competence (as measured by the *Revised*

Behavior Problem Checklist), criminal offending based on self-reports, and arrest/incarceration records through 59 weeks post-referral.

Outcome: In comparison with youth who received usual juvenile justice services (high rates of incarceration), youths who received *MST* showed improved family cohesion, improved peer relations, decreased recidivism (43%), and decreased incarceration (64%).

Study: Timmons-Mitchell, J., Bender, M. B., Kishna, M. A., & Mitchell, C. C. (2006). An independent effectiveness trial of Multisystemic Therapy with juvenile justice youth. *Journal of Clinical Child and Adolescent Psychology*, 35(2), 227-236. Families were randomly assigned to *Multisystemic Therapy (MST)* or to treatment as usual (TAU). In their introduction, the authors note that this study is unusual in that it does not involve the original MST developers and was conducted in a more naturalistic setting than some previous trials. Youth functioning was measured using the *Child and Adolescent Functional Assessment Scale (CAFAS)*, which focuses on school/work, home, community, behavior towards others, emotions, self-harming and risky behavior and thinking. Youth recidivism was also measure using family court records.

Outcome: The MST group showed a significantly lower recidivism rate. Both groups showed functional improvements, with MST showing particular improvements in the areas of home, school and community.

The California Evidence-Based Clearinghouse for Child Welfare notes that MST is designed to eliminate or significantly reduce the frequency and severity of the youth's referral behavior(s) and to empower parents with the skills and resources needed to independently address the inevitable difficulties that arise in raising children and adolescents and empower youth to cope with family, peer, school, and neighborhood problems. Based on the research and how the model fits with the needs of the state, MST will prove to be effective in North Dakota in decreasing the number of out of home placements by decreasing the incidence of delinquent behaviors through improved parent-child interactions.

Nurse Family Partnership: The request for a waiver of the evaluation requirement for Nurse Family Partnership is based on compelling evidence that 1) women visited by nurses were less likely to be perpetrators of child abuse and neglect, and had fewer arrests, convictions, and number of days jailed 2) fewer reports of child abuse and neglect, were observed to restrict and punish children less frequently, provided more appropriate play materials and had fewer emergency room visits 3) fewer child maltreatment reports involving mother as perpetrator and study child as victim. The following summary of research highlights the compelling evidence:

Study: Olds, D. L., Henderson, C. R., Chamberlin, R., & Tatelbaum, R. (1986). Preventing child abuse and neglect: A randomized trial of nurse home visitation. *Pediatrics*, 78, 65-78. Participants were determined at intake to have at least one risk factor: mother less than 19 years old, single parent status, or low socioeconomic status. Volunteers and women recruited due to a risk factor were randomly assigned to one of conditions described below: 1) Sensory and developmental screening at 12 and 24 months only (control group); 2) Free transportation to regular prenatal and perinatal visits, and sensory and developmental screening at 12 and 24 months; 3) Nurse home visitation during pregnancy only, free transportation to regular prenatal and perinatal visits, and sensory and developmental screening at 12 and 24 months; or 4) Nurse home visits until the child was 2 years old in addition to nurse home visitation during pregnancy, free transportation to regular prenatal and perinatal visits, and sensory and

developmental screening at 12 and 24 months [now called Nurse Family Partnership (NFP)]. Measures included medical examinations and developmental testing using the Bayley and Cattell Scales at 6, 12, and 24 months, and home observation using the *Caldwell and Bradley Procedure*. The list of participants was also checked against verified cases of abuse and neglect and medical records were examined.

Outcome: Among women at highest risk, those visited by a nurse had fewer reports of child abuse and neglect, were observed to restrict and punish children less frequently, provided more appropriate play materials and had fewer emergency room visits. In the second year, all nurse-visited women, regardless of risk status, had fewer emergency room visits and fewer physician visits for accidents and poisoning.

Study: Olds, D. L., Eckenrode, J., Henderson, C. R., Kitzman, H., Powers, J., Cole, R., Luckey, D. (1997). Long-term effects of home visitation on maternal life course and child abuse and neglect. Fifteen-year follow-up of a randomized trial. *Journal of the American Medical Association*, 278(8), 637-643. Participants were determined at intake to have at least one risk factor: mother less than 19 years of age, single parent status, or low socioeconomic status. This study used the same sample as Olds, et al. (1986) and Olds, et al. (1994). Volunteers and women recruited due to a risk factor were randomly assigned to one of conditions described below: 1) Sensory and developmental screening at 12 and 24 months only (control group); 2) Free transportation to regular prenatal and perinatal visits, and sensory and developmental screening at 12 and 24 months; 3) Nurse home visitation during pregnancy only, free transportation to regular prenatal and perinatal visits, and sensory and developmental screening at 12 and 24 months; or 4) Nurse home visits until the child was 2 years old in addition to nurse home visitation during pregnancy, free transportation to regular prenatal and perinatal visits, and sensory and developmental screening at 12 and 24 months [now called Nurse Family Partnership (NFP)]. Assessments at this follow-up included behavioral impairments due to drug or alcohol use, use of welfare, and reviews of Child Protective Services and New York State criminal justice records.

Outcome: Women visited by nurses were less likely to be perpetrators of child abuse and neglect, and had fewer arrests, convictions, and number of days jailed.

Study: Eckenrode, J., Ganzel, B., Henderson Jr, C. R., Smith, E., Olds, D. L., Powers, J.,...Sidora, K. (2000). Preventing child abuse and neglect with a program of nurse home visitation. *Journal of the American Medical Association*, 284(11), 1385-1391. Participants were mothers determined at intake to have at least one risk factor: mother less than 19 years of age, single parent status, or low socioeconomic status. This study used the same sample as Olds, et al. (1986, 1994, 1997, and 1998). Mothers were interviewed at 15 years, using a life history calendar designed to help them recall major life events.

Outcome: Families receiving nurse visitation during pregnancy and infancy had fewer child maltreatment reports involving mother as perpetrator and study child as victim. The treatment effect decreased as level of overall domestic violence increased. The authors conclude that the presence of domestic violence may limit the effectiveness of early visitation interventions.

The Nurse-Family Partnership (NFP) program provides home visits by registered nurses to first-time, low-income mothers, beginning during pregnancy and continuing through the child's second birthday. The program's primary goals are: to improve pregnancy outcomes by promoting health-related behaviors, to

improve child health, development and safety by promoting competent caregiving, to enhance parent lifecourse development by promoting pregnancy planning, educational achievement, and employment, to enhance families' material support by providing links with needed health and social services and to promote supportive relationships among family and friends. The largest group of children entering foster care in North Dakota is age 5 years and under. As Nurse Family Partnership focuses services primarily on pregnant women and families with children from birth to age 5, it fits well with North Dakota. The research supports the belief that this program will help the state to decrease the target population of children age 0-5 from entering foster care.

Parent Child Interaction Therapy: The request for a waiver of the evaluation requirement for Parent Child Interaction Therapy is based on compelling evidence that PCIT 1) Reductions in negative parent behavior 2) higher levels of praise and lower levels of criticism by parents in interactions with children 3) Children's compliance also increased in the observed interaction and their ECBI scores improved significantly. The following summary of research highlights the compelling evidence:

Study: Shuhman, E. M., Foote, R. C., Eyberg, S. M., Boggs, S., & Algina, J. (1998). Efficacy of Parent Child Interaction Therapy: Interim report of a randomized trial with short term maintenance. *Journal of Clinical Child Psychology, 27*(1), 34-45. Families with children referred for conduct disorder were randomly assigned either to receive *Parent-Child Interaction Therapy (PCIT)* or to a wait-list control. Observations were made of parents and children interacting at baseline using the *Dyadic Parent Child Interaction Coding System (DPICS-II)*. Parents also completed the Eyberg Child Behavior Inventory (ECBI) for the child and the *Parental Locus of Control Scale (PLOC)*, the *Beck Depression Inventory (BDI)*, *Parenting Stress Inventory (PSI)*, and the *Dyadic Adjustment Scale (DAS)*, which measures quality of adjustment between marital pairs. The authors note that this sample of families had no significant levels of marital distress or depression at baseline and were recruited from a group that actively sought treatment for their children and so results might not generalize to other populations.

Outcomes: At follow-up, the intervention group showed higher levels of praise and lower levels of criticism in interactions with children than the control group. Children's compliance also increased in the observed interaction and their *ECBI* scores improved significantly. Parental stress scores and Locus of Control scores shifted to normal levels in the *PCIT* group, while those for the control group remained at clinical levels. Although comparisons could not be made with the control group at 4-month follow-up, all gains made by *PCIT* treatment families were maintained.

Study: *Chaffin, M., Silovsky, J. F., Funderburk, B., Valle, L. A., Brestan, E. V., Balachova, T., ... Bonner, B. (2004). Parent-Child Interaction Therapy with physically abusive parents: Efficacy for reducing further abuse reports. *Journal of Consulting and Clinical Psychology, 72*(3), 500-510. Parents and children were randomly assigned to a control group receiving standard services, a *Parent-Child Interaction Therapy (PCIT)* intervention group, or to a *PCIT* enhanced group which also included extra services targeting parental depression, substance abuse, and family violence problems. Parents received the *Child Abuse Potential Inventory (CAP)*, the *Child Neglect Index (CNI)*, the *Abuse Dimensions Inventory (ADI)*, the *Dyadic Parent-Child Interaction Coding System (DPICS-II)*, the *Beck Depression Inventory (BDI)*, and the *Diagnostic*

Interview Schedule (DIS) Alcohol and Drug Modules and Antisocial Personality Disorder Module, which were modified to be administered as self-reports. The CNI and ADI were completed by consultation with the child welfare workers or reviewing written material on cases. Parents reported on their children's behavior using the *Child Behavior Checklist (CBCL)*. **Outcome:** Results showed that the *PCIT* alone group had significantly fewer re-reports of abuse over the follow-up period than did the control condition and also fewer reports than the enhanced *PCIT* condition, although this difference did not reach significance. Reductions in negative parent behavior, measured by the *DPICS-II*, were significant for both *PCIT* groups, compared to the control. Positive behaviors were high in all groups and did not differ.

Study: *Chaffin, M., Funderburk, B., Bard, D., Valle, L.A., & Gurwitch, R. (2011). A motivation-PCIT package reduces child welfare recidivism in a randomized dismantling field trial. *Journal of Consulting and Clinical Psychology*, 79(1), 84-95. This study uses the same sample as Chaffin, M. et al. (2009). Objectives were to test effectiveness in a field agency rather than in a laboratory setting, and to dismantle the SM Group vs. services as usual (SAU) orientation and *Parent-Child Interaction Therapy (PCIT)* vs. SAU parenting component effects. Assessment information was drawn from three sources—self-report questionnaires administered via audio-assisted computerized self-interview (ACASI) using touch-screen computers, observational coding of parent-child interactions, and administrative data from the state child welfare database. Measures used included *Readiness for Parenting Change Scale (REDI)*, *Child Abuse Potential Inventory (CAP)*, *Dyadic Parent-Child Interaction Coding System (DPICS-II)*, *Child and Parent Directed Interaction (CDI and PDI)*, and *P.R.I.D.E. skills*. An imputation-based approach was used to estimate recidivism survival complicated by significant treatment related differences in timing and frequency of children returned home. Methodological considerations for analyzing child welfare event history data complicated by differential risk deprivation are also emphasized

Outcome: Findings demonstrated that previous laboratory results can be replicated in a field implementation setting, and among parents with chronic and severe child welfare histories, supporting a synergistic SM+*PCIT* benefit.

Parent-Child Interaction Therapy (PCIT) is a dyadic behavioral intervention for children (ages 2 – 7 years) and their parents or caregivers that focuses on decreasing externalizing child behavior problems (e.g., defiance, aggression), increasing child social skills and cooperation, and improving the parent-child attachment relationship. It teaches parents traditional play-therapy skills to use as social reinforcers of positive child behavior and traditional behavior management skills to decrease negative child behavior. Based on the research and how the model fits with the needs of the state, PCIT will prove to be effective in North Dakota by reducing the incidence of child welfare recidivism and improved parent-child interactions.

Parents As Teachers: The request for a waiver of the evaluation requirement for Parents as Teachers is based on compelling evidence that 1) decreased likelihood of CPS substantiations 2) first substantiations of CPS also occurred later in the child's life 3) greater acceptance of child behavior among moderate income parents 4) greater tendency to read aloud or tell stories to the child among low-income parents. The following summary of research highlights the compelling evidence:

Study: Wagner, M., Spiker, D., & Linn, M. I. (2002). The effectiveness of the Parents as Teachers program with low-income parents and children. *Topics in Early Childhood Special Education, 22*(2), 67- 81. <https://doi.org/10.1177/02711214020220020101>. This study investigated the effectiveness of the *Parents as Teachers (PAT)* program with low-income families. Families were recruited through community services and agreed to be randomly assigned to receive the *PAT* program or to a comparison group. Measures utilized include the *Knowledge of Infant Development Inventory*, the *Parenting Sense of Competence Scale*, the *Child Maltreatment Precursor Scale*, the *Home Observation and Measurement of Environment (HOME) Inventory*, the *Developmental Profile II*, and the *Adaptive Social Behavior Inventory*. **Outcome:** Results indicate lower scores on parent knowledge, attitude toward parenting, and parenting behaviors were noted for lower-income families. Few measures were affected by participation in the *PAT* program. These included higher self-reported happiness when caring for the child, greater acceptance of child behavior (2nd year) among moderate-income parents, and a greater tendency to read aloud or tell stories to the child among low-income parents. There was also a moderate effect on prosocial behavior among low-income children.

Study: Chaiyachati, B. H., Gaither, J. R., Hughes, M., Foley-Schain, K., & Leventhal, J. M. (2018). Preventing child maltreatment: Examination of an established statewide home-visiting program. *Child Abuse & Neglect, 79*, 476-484. <https://doi.org/10.1016/j.chiabu.2018.02.019>. Participants were socially high-risk families involved with child welfare services. The objective of this study was to assess the impact of voluntary participation in *Parents as Teachers (PAT)* for socially high-risk families on child maltreatment as identified by Child Protective Services (CPS). Measures utilized include three CPS-related outcomes were ascertained: 1) investigated reports of maltreatment, 2) substantiated reports of maltreatment, and 3) out-of-home placements. **Outcome:** Results indicate in the unmatched sample, families who participated in home-visiting had significantly higher median risk scores. After matching families on measured confounders, the percentages of families with CPS investigations were similar between the two groups. However, there was a 22% decreased likelihood of CPS substantiations (hazard ratio [HR] 0.78, 95% confidence interval) for families receiving home visiting. First substantiations also occurred later in the child's life among home-visited families. There was a trend toward decreased out-of-home placement.

Study: Jonson-Reid, M., Drake, B., Constantino, J. N., Tandon, M., Pons, L., Kohl, P., Roesch, S., Wideman, A., & Auslander, W. (2018). A randomized trial of home visitation for CPS-involved families: The moderating impact of maternal depression and CPS history. *Child Maltreatment, 23*(3), 281-293. <https://doi.org/10.1177/1077559517751671>. The objective of this study was to assess the impact of participation in *Parents as Teachers (PAT)* in reducing recurrent maltreatment. Participants were randomized to either the *PAT* program or to usual care services from child protection. Measures utilized include the *Center for Epidemiologic Studies Depression Scale (CES-D)*, the *Parenting Stress Index*, the *Family Support Scale*, and official re-reports to child protective services (CPS) as a maltreatment measure.

Outcome: Results indicate no significant changes were found in maternal outcomes by group. Among nondepressed mothers or families without multiple CPS reports prior to study enrollment, *PAT* was associated with a significantly lower likelihood of CPS report recidivism.

Parents as Teachers is an early childhood parent education, family support and well-being, and school readiness home visiting model based on the premise that "all children will learn, grow, and develop to realize their full potential." The four goals of Parents as Teachers are: increase parent knowledge of early childhood development and improve parenting practices, provide early detection of developmental delays and health issues, prevent child abuse and neglect and increase children's school readiness and school success. As the program can focus services primarily on pregnant women and families with children from birth to age 3 or through kindergarten, it fits well with North Dakota and will help the state to decrease the target population of children aged 0-5 years from entering foster care.

Contract Monitoring: Monthly and quarterly data analyses, and quarterly case-record reviews will be performed by the Contract Manager to oversee the providers performance and ensure quality service delivery to children and families. The providers are required, as part of their contracts, to maintain fidelity with evidence-based model standards and have dedicated staff to perform internal quality assurance checks. The requirements of the prevention plan and all aspects of the prevention plan management and ongoing risk assessment are being written into the providers contracts.



Colorado

Status: Submitted

Section VI: Evaluation Strategy and Waiver Request

Evaluation Strategy & Waiver Requests

As reflected previously in this five-year prevention plan, Colorado proposes to offer a broad array of evidence-based prevention services to children, youth, and families. This initial plan includes programs that are currently being implemented and that have been rated as well-supported in the Title IV-E Prevention Services Clearinghouse. Colorado is seeking an evaluation waiver for these services and, upon approval, will assess program implementation and fidelity through a robust continuous quality improvement (CQI) process rather than through formal, independent evaluation. In addition to intervention-specific CQI, CDHS will leverage its existing performance management system to monitor outcomes of children, youth, and families at the county and state levels.

Below is Colorado's general approach to evaluation and CQI efforts as required in Family First, followed by a description of robust CQI processes specific to the prevention services being proposed in this initial plan.

Evaluation and CQI Capacity and Approach

Colorado is planning to use the following internal and external resources for completing rigorous evaluations of programs and robust CQI as part of Family First.

CDHS Family First Evaluation Team (Formal Evaluation and Evaluation Waiver): CDHS's internal Family First evaluation team will consist of the following roles and responsibilities:

- Designated leadership within CDHS to prioritize research and evaluation efforts and serve as a liaison with counties, Tribes, and providers for participation in ongoing evaluation.
- Designated leadership to serve as the agency point of contact for external partners coordinating the rigorous evaluations and providing CQI support.
- Develop a master data-sharing agreement for Family First evaluation.
- Provide timely access to administrative data for external evaluation teams. Colorado has built a standard child welfare extract that can be routinely generated by internal research and evaluation staff. Internal leadership will need to coordinate with external teams to prioritize data requests for Family First evaluations.
- Manage evaluations that are already underway with contracts established for independent research.

Partnership with the Colorado Evaluation and Action Lab (Formal Evaluation): The Colorado Evaluation and Action Lab (Colorado Lab) is a strategic research partner for Colorado government that works under the Governor's priorities to perform policy and program evaluations. CDHS will partner with the Colorado Lab to function as a coordinating hub for rigorous evaluations of promising and supported practices. The Colorado Lab will do the following:

- Build capacity within the Colorado research community to conduct rigorous evaluation studies to move promising or supported programs along the evidence continuum toward the well-supported criteria outlined in the Prevention Services Clearinghouse Standards Handbook.
- Facilitate the design of rigorous within and across-site evaluations for each promising or supported practice that does not already have a study underway. Evaluation designs will:
 - Build on the existing evidence base for a given intervention;
 - Prioritize opportunities to understand cultural relevance to Colorado communities;
 - Leverage administrative data to minimize the burden on providers and minimize costs;
 - Consider the potential for cross-system benefit; and
 - Be pre-registered to ensure transparency
- Convene research teams to conduct the program or servicespecific rigorous process and outcome studies by:
 - Leveraging the expertise of the state first (e.g., Center for Social Work Resource Center, Kempe Center, Colorado Applied Research and Action Network fellows) and national organizations second; and
 - Creating efficiencies across individual program evaluations and research teams.
- Provide secure data infrastructure to research teams.
- Coordinate with designated CDHS leadership to manage the intersection of implementation science, CQI work, and rigorous outcome evaluations.
- Develop and implement communication plans that ensure the findings are well positioned to inform policy and practice.

The Colorado Lab's staff are experts in evaluation design and methodology, and its approach is to serve as a bridge between the decision-making goals of government and the academic and scientific community. It is anticipated that the Colorado Lab will function as the umbrella for rigorous evaluations and facilitate subcontracts for specific projects and scopes of work to organizations throughout Colorado. The volume of rigorous evaluation can be scaled up or down throughout the first five years of the prevention plan.

Program or Service-Specific Rigorous Evaluation Teams (Formal Evaluation): As noted above, the Colorado Lab will convene program- or service-specific evaluation teams. These teams will be developed in response to where the program or service is currently on the evidence continuum, and the unique capacity of individuals or organizations to support movement toward a well-supported practice and/or better understand implementation in the context of unique Colorado communities.

CQI Support from Program-Specific Providers (Evaluation Waiver): For well-supported practices with an evaluation waiver, CDHS will contract for CQI support to ensure that the implementation science and fidelity monitoring is provided by individuals or organizations with expertise and capacity in the delivery of a given service (e.g., CQI for MST will be conducted by an organization with capacity to monitor Therapist Adherence Measure (TAM) scores and support providers in effectively delivering the intervention).

Evaluation Design

Following a building period, the evaluation of each supported and promising program will consist of two studies: a process evaluation and an outcomes evaluation. Descriptions of both are provided below.

Building Period: The building period will begin by setting a broad Colorado research agenda and priorities. Colorado has already begun this work by gathering data on existing evidence for programs in

our proposed service array, documenting delivery sites, and hosting a research summit to orient the academic community to opportunities for supporting Family First work in the state.

CDHS, with support from the Colorado Lab, will engage stakeholders in prioritizing process and outcome questions so that evaluation findings are tailored to Colorado's learning and decision-making goals. Close attention will be paid to the contexts and settings in which each program or service is expected to be implemented in Colorado. Furthermore, the research planning process will balance the requirement that each intervention be evaluated individually, while recognizing that these services are delivered within the broader context of the child welfare landscape.

Then, program- or service-specific rigorous evaluation teams will develop and publicly register a well thought out and rigorously designed evaluation plan for each promising or supported practice. CDHS and the Colorado Lab will ensure that there is coordination across the multitude of rigorous evaluations and CQI initiatives so that counties, Tribes, and providers are clear about expectations and requirements are reasonable.

The outcomes of the building period will be: (1) evaluation plans for each promising or supported program or service, and (2) a coordinated approach for launching those evaluations in Colorado.

Process Evaluation: For each supported and promising program, a process evaluation will be conducted.

Research Question 1: Was each program implemented as the model intended? [For all promising and supported programs/ services]

- Each program-specific research team will liaise with model developers to obtain measures, specific methodology, and tools for assessing model fidelity, and propose processes and systems for monitoring fidelity of each program on a periodic basis. • CDHS-designated leadership and the Colorado Lab will ensure that fidelity monitoring strategies are well coordinated across programs and services, and communication and expectations of counties, Tribes, and providers are clear. The goal is for providers, Tribes, and counties to have clear, consolidated information about what is required to track and report rather than having multiple messages from several research teams. • Program-specific research teams will have responsibility for implementing fidelity monitoring, and making referrals, as needed, to implementation scientists to support shoring up implementation when there is evidence.

Findings from Research Question 1 will be used to inform training and supervision to ensure that the proven benefits of the model are realized through faithful implementation, and to ensure that outcomes can accurately be attributed to the model.

While ongoing fidelity monitoring will be the foundation for our process evaluation, additional questions may be established during the building period or in response to implementation fidelity findings. Sample questions are below:

Research Question 2: To what extent did each program reach the intended target population? [For select promising and supported programs/services]

This component of the process evaluation will assess the degree to which eligible families within the target population are receiving each service (i.e., reach). Furthermore, it will elucidate barriers to reach and generate strategies to expand it. This information will be viewed in the context of the overall successes and challenges of implementation and the related competency, organization, and leadership drivers that may have influenced referrals, service uptake, and service completion for each program.

Research Question 3: What leadership, cultural, or capacitybuilding supports are needed to shore up implementation or deliver a given service outside of the Denver metro area or to a historically marginalized population? [For select promising and supported programs/services]

Colorado is a diverse state and residents have uneven access to evidence-based services. Process evaluations may generate insight into delivery methods that are feasible in rural communities or identify minor adaptations that ensure culturally responsive delivery. Colorado and CDHS are committed to culturally responsive practices.

Outcomes Evaluation: The outcomes evaluation will assess the degree to which the supported and promising programs achieve the intended outcomes for children, youth, and families associated with each individual program model, as well as distal outcomes related to reduced repeat maltreatment and reduced foster care entry and re-entry. The outcomes measured will be informed by:

- The context in which the service is being implemented in Colorado (i.e., what are the goals of serving a given target audience, with a given promising or supported practice);
- The theory or logic model underpinning the program or service, as articulated by developers in books, manuals, or writings; and
- Prior evidence and what is expected to be realized that is relevant to Family First outcomes and Colorado's overarching vision for healthy families.

The research questions and designs will be fully scoped out during the building period and address the relevant components of the Administration for Children and Families' Evaluation Plan Development Tip Sheet.

Research Question 4: To what extent did each of the evidence-based practices and other programs meet anticipated outcomes?

The evaluation design will be tailored to the evidence base for a given intervention and an assessment of what information would be needed to move along the evidence continuum. All evaluation designs will be informed by the Prevention Services Clearinghouse Standards Handbook. For example:

- Is a focus on sustained effects important to determine if a program could become a well-supported practice? Or is a rapid-cycle model more conducive to advancing Colorado's learning

goals for a given program or service? • Are the samples in prior evaluations similar to Colorado's target population or are there specific—perhaps historically marginalized—populations that are important to include in the evaluation? • Are there internal validity limitations in prior research that can be mitigated in future studies? • Are there delivery settings that may be particularly important to assess outcomes?

The evaluations will use a rigorous approach that is practical, ethical, and actionable. It is anticipated that some designs will be quasi-experimental designs and randomized controlled trials aligned fully to the Prevention Services Clearinghouse Standards. It is also anticipated that some evaluations, particularly as Colorado begins to learn what is promising when delivered in unique cultural contexts, may not have a control group or may have an alternative practice as the comparison condition. All causal studies will be pre-registered on the Open Science Framework to ensure transparency. All descriptive or inferential research designs will be made publicly available on a Colorado website or clearinghouse.

Program-Specific CQI, Evaluation Plans and Waiver Requests

As detailed below, for each well-supported program proposed in this initial five-year prevention plan, Colorado will assess program implementation and fidelity through a robust CQI process. Additionally, please see the attachment for Colorado's Request for Waiver of Evaluation Requirements for each well-supported practice.

Nurse-Family Partnership (NFP): Much of the national research demonstrating NFP's efficacy has included samples from Colorado. There is a strong partnership in place between the Nurse-Family Partnership National Service Office (NFPNSO), the University of Colorado, Invest in Kids (IIK), and CDHS to implement this program. Thus, Colorado is requesting a waiver of the rigorous evaluation requirement and proposes utilizing a well-established CQI process for ongoing monitoring.

The partnership, named the Colorado Coordination Team (CCT), has well-established processes for monitoring fidelity and engaging in continuous quality improvement in metro and rural areas. IIK is charged with ensuring all 22 NFP implementing agencies accurately input data from every home visit into a national data-collection system. Once the data are collected, IIK assists NFP teams in using the data to assess their program fidelity according to 19 model elements and to track progress toward outcome achievement. IIK employs a full-time data analyst to oversee this work. IIK also employs a program director and two nurse consultants to work with NFP teams daily on all aspects of implementation, including using the data to guide nursing practice given individual NFP site context.

Per Colorado statute, all NFP teams submit a progress report to the CCT for review annually. This review results in a feedback letter to every NFP team detailing their successes on maintaining fidelity and achieving outcomes, as well as guidance to improve areas of fidelity and progress toward outcomes that IIK will support them with throughout the following year. IIK's work to support fidelity is financed through two contracts with the University of Colorado, with the funding coming from the administrative portion of the Master Tobacco Settlement to the Nurse Home Visitor Program and a smaller portion from the administrative portion for Colorado's Maternal Infant and Early Childhood Home Visitation funding.

Parents as Teachers (PAT): PAT is administered by 26 local organizations and available in 37 counties in Colorado. The program was established in Colorado in the mid-1980s and serves approximately 2,400 children each year. PAT in Colorado relies on the close partnerships between local sites, Parent Possible, the Parents as Teachers National Center, and CDHS. Thus, Colorado is requesting a waiver of the rigorous evaluation requirement and proposes utilizing a well-established CQI process

Parent Possible, the state intermediary for PAT, has a well-established process for monitoring fidelity and ensuring sites engage in continuous quality improvement throughout the state. Parent Possible ensures that all 26 implementing agencies accurately input data from every home visit into the statewide data collection system. Once the data is collected, Parent Possible uses the data along with each site's Annual Performance Report and in-person site visits to assess program fidelity and adherence to PAT's 21 Essential Requirements. In addition to fidelity monitoring, Parent Possible has a well-established evaluation process that tracks parent growth, literacy, school readiness, and parent-child interaction. Parent Possible employs a director of research and evaluation, a data manager, and a program director to work with PAT sites on a daily basis on all aspects of implementation, data collection, and evaluation. All PAT sites set CQI goals annually and those not meeting all of the PAT Essential Requirements are required to create Success Plans that formally lay out their goals and plans for meeting the goals.

Parent Possible's work to support PAT fidelity is funded through the federal Maternal Infant Early Childhood Home Visiting program, the state Tony Gramscas Youth Services program, and private funding from foundations.

Healthy Families America (HFA): HFA is a practice that has been implemented in one rural county in Colorado since 2016 and served approximately 76 families in CY 2018. A second Colorado county is in the beginning stages of implementing HFA with the goal of serving approximately 40 families. Given the small size of the population served, it is not practical to generate actionable and timely information through a rigorous evaluation such as a quasi-experimental design or randomized controlled trial for HFA. However, the accreditation process offers a foundation for CQI. Thus, Colorado is requesting a waiver of the rigorous evaluation process.

HFA has an accreditation process through which site visitors assess adherence to the model. Colorado proposes a CQI process that is focused explicitly on the recommendations by the accreditation team and uses performance management data to track outcomes the intervention is intended to drive. For the county currently implementing HFA, the accreditation site visit took place in October 2019, and the county received the team's report in January 2020. The CQI process will include quarterly learning calls to: (1) review, strategize, and support progress toward addressing recommendations made by the site team and challenges identified by the sites, and (2) review child safety performance management data that are routinely collected and opportunities to build capacity for routinely collecting and using child and adult well-being data.

SafeCare®: Colorado State University (CSU) Social Work Research Center (SWRC) serves as the independent evaluator for SafeCare Colorado (SCC). CSU/SWRC, in collaboration with the CDHS Office of Early Childhood (OEC) SCC Program Administrators, are crafting a new evaluation design for Fiscal Year 2021 and beyond that reflects stakeholder envisioned directions for SCC research innovations as well as

the emergent requirements for ongoing rigorous evaluation in light of the Family First designation of SafeCare as a "supported" practice. The evaluation will use a quasi-experimental design (QED) measuring at least two contrasts from eligible outcome domains (namely, child well-being and adult well-being), per the Title IV-E Prevention Services Clearinghouse standards and procedures handbook. Eligible contrasts included in the QED will be prioritized for follow-up measurement at 12-months after program completion in order to examine sustained effects of SCC and build the evidence base for SafeCare as a "well supported" practice. The full evaluation plan will be provided to CDHS/OEC on 6/30/2020 and upon approval by SCC program administrators, the evaluation plan will become available for inclusion in the Colorado Title IV-E Prevention Services Plan.

Multi-Systemic Therapy (MST): MST has a well-established Therapist Adherence Measure (TAM) that has repeatedly predicted intended outcomes in clinical trials. In fact, Schoenwald and colleagues (2003) found a near linear relationship between fidelity to the MST model and treatment outcomes. Those therapists with the highest fidelity scores had dramatically better outcomes for their clients than those with the lowest fidelity scores. Specifically, two years post-treatment, criminal recidivism was 36% lower for the youth whose therapists had the highest fidelity ratings compared to those with the lowest ratings.

Colorado is requesting a waiver of rigorous evaluation of MST because most MST providers in Colorado are already participating in this CQI and regular fidelity monitoring through contracts with the Center for Effective Interventions at the University of Denver. Colorado proposes to engage the Center for Effective Interventions in providing CQI support to all providers for whom MST reimbursement is requested under Family First.

Fidelity to MST will be assessed by the Therapist Adherence Measure – Revised (TAM-R). The first measure is administered in the first two weeks of treatment and then monthly thereafter. The TAM-R contains 28 items that assess the primary caregiver's perception of treatment. Each item is rated on an adherence scale from 1 (not at all) to 5 (very much). The adherence score is calculated by the number of items rated as adherent (i.e., a 5) divided by the number of items that can be scored. Thus, adherence scores can range from 0 to 1, with a score of 0.61 considered the threshold for fidelity.

Under Family First, the TAM-R will be administered by an independent call center and the call center will enter all data into a database that will be used to create a feedback loop to providers and support the CQI process.

High Fidelity Wraparound: CDHS' Office of Behavioral Health, in partnership with the Office of Children, Youth and Families and other partners, has implemented a four-year initiative called COACT Colorado supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) to expand the system of care approach for children and adolescents with serious behavioral health challenges and their families. The associated outcome evaluation can be found in the attachment, which focuses on assessing outcomes related to the goals of keeping youth at home, in school, and out of trouble. There will be a final evaluation analysis and written report completed for Year 4, which will be available at the end of the calendar year.

Ongoing evaluation of High Fidelity Wraparound in Colorado will be supported and continued if OBH is awarded another 4 year grant cycle, which will be announced in the near future. The current evaluation is a pre-test/post-test design and compares outcomes at the time of admission to outcomes at discharge. Moving forward, the Colorado Client Assessment Record (CCAR) will be replaced by the Child and Youth Assessment, which incorporates the CANS (Child & Adolescent Needs and Strengths) and multisystem involvement.

Other Mental Health Services: Functional Family Therapy (FFT), Parent-Child Interaction Therapy (PCIT), and Motivational Interviewing (MI): Mental health services such as FFT, PCIT, and MI are delivered by providers throughout the state via contracts with counties. Colorado believes that investing in program implementation fidelity monitoring and CQI support is a precursor to considering further rigorous evaluations of these programs. Ensuring fidelity to the model is essential before launching RCTs or QEDs. Therefore, Colorado is requesting a rigorous evaluation waiver for these programs and may propose rigorous evaluations in the future that are targeted to learning goals (e.g., serving priority populations, delivery in rural settings).

Colorado proposes to develop a web-based platform to collect program implementation fidelity metrics for mental health services. The web-based platform will be designed for providers or supervisors to input implementation fidelity measures specific to a given program. Sampling approaches will follow best practices. Colorado will explore the need for HIPAA-compliant secure audio recording of sessions and transcription for purposes of long-distance supervision. Standard CQI reports will be developed that aggregate the data by service and provider. Dedicated staff will review these data, engage counties and providers in review of those reports, and target implementation support to support continuous improvement. Colorado will use the quality assurance processes Washington State developed for PCIT as a guide for structuring the CQI process for mental health services. Implementation support will be tailored to the root cause of gaps in program implementation fidelity and may include activating specialty supports, such as FFT LLC or PCIT International Support, for specific providers. The measures for specific interventions are described below.

FFT Fidelity Measures:

Weekly Supervision Checklist completed by a clinical supervisor after clinical staffing that reflects the degree of adherence and competence for a therapist's work on a specific case

Global Therapist Ratings that provide an overall adherence and competence in FFT (3x/year).

PCIT Fidelity Measures:

Standard PCIT protocol clinical fidelity tools.

MI Fidelity Measures:

The Motivational Interviewing Treatment Integrity (MITI) is an instrument that yields feedback that can be used to increase clinical skill in the practice of MI. The MITI measures how well or how poorly a practitioner

is using MI and can be found at: casaa.unm.edu/download/miti.pdf. Coding resources to measure fidelity can be found at: <http://casaa.unm.edu/codinginst.html>.



Maine

Status: Submitted

Section VI: Evaluation Strategy and Waiver Request

Section 6: Evaluation Strategy, Waiver Request and Quality Assurance

FFPSA Theory of Change and Logic Model

Through collaboration with stakeholders statewide and the OCFS management team, a Theory of Change and Logic Model for the implementation of the FFPSA has been developed. In Maine, the limited access and availability of prevention services for families to safely maintain their children at home has contributed to children entering into foster care in the state. Through statewide collaboration, utilization of evidenced based practices, and supporting Maine's workforce, Maine will increase prevention services available to families. This will result in families being supported to meet their needs, increased safety among families in Maine, and children being able to remain safely in their home. The FFPSA Logic Model can be located in Appendix 3.

THEORY OF CHANGE

Root Cause: Limited availability of preventative services can make it challenging for at risk families to maintain their children safely in the home leading to children entering foster care.

Goal: Increase prevention services available to families that will help address domestic violence, mental health, substance use, and parenting challenges through agency collaboration, utilization of evidenced based practice, and workforce support.

So that families can receive support and treatment to meet their needs;

So that there is enhanced safety and positive parenting;

So that children can remain safely in their home.

FFPSA Evaluation Strategy

The FFPSA requires each state to demonstrate a rigorous evaluation design and strategy of the prevention programs that are being implemented, unless they qualify as part of the waiver and are documented as well-supported in the Title IV-E Prevention Services Clearinghouse. Maine will be implementing, with Title IV-E funding, two well-supported evidenced based programs: Homebuilders Intensive Family Preservation and Reunification Program and Parents as Teachers. These programs qualify for the waiver and Maine will be utilizing the waiver to forgo the evaluation required of these evidenced based programs. Maine is committed however to ensuring the highest level of efficacy for the families in Maine, therefore, outcomes of Prevention Services will be evaluated to ensure that the programs selected to be implemented under FFPSA, are working to prevent children from entering foster care and improving the safety and well-being of families in Maine. It is critical to ensure these prevention services are effective for Maine families, that

they are being implemented with fidelity, and that programs are producing the intended outcomes, specific to the Maine population. Maine intends to conduct a competitive bidding process for these evaluation services and a Request for Proposals has been developed to secure an agency that will conduct outcome evaluation services. Evaluation services will be funded through state funds and Title IV-E funds. Evaluation services that are proposed to be procured include:

- Developing and implementing an OCFS approved 5-year evaluation plan of identified FFPSA Prevention Services, to include but not limited to:
 - The type of FFPSA Prevention Services, including Evidence-based Practices (EBPs) provided to the child/family, cost, and duration of services;
 - The outcomes of services including placement status of the child twelve (12) months after the start of the prevention plan start date; and any reentry into foster care within two (2) years from the prevention plan start date;
 - The extent that evidence-based practices meet anticipated outcomes.
 - Demographics pertinent to Maine populations being served
 - The extent in which FFPSA prevention services are being implemented with fidelity.

The implementation of this evaluation combined with OCFS' Quality Assurance and Continuous Quality Improvement Programming (QA/QI) along with program specific quality assurance strategies by program developers, will create a well-rounded evaluation strategy of Maine's implementation of the FFPSA.

Maine Quality Assurance (QA) and Continuous Quality Improvement (CQI):

In Maine, QA and CQI programming falls within the OCFS Technology and Support Team. The QA/CQI program includes Quality Assurance (QA) Specialists and Data Analysts who, combined, provide qualitative and quantitative outcome data to senior managers for consideration in decision making related to practice and services to improve outcomes for children and families in Maine. OCFS has increased the focus on quality casework practice through various measures as identified in Section 5, but also through strengthening the Quality Assurance (QA) team in recent months. Additional staff resources have been added to the QA team which will provide support to each district and central office, as well as improve coordination of the Continuous Quality Improvement (CQI) cycle with the Policy and Training Team, Child Welfare management and district staff.

OCFS' QA system currently meets the five key components of a sound QA/CQI system as laid out by the Administration for Children and Families (ACF) including: foundational administrative structure; quality data collection; case review data and process; analysis and dissemination of quality data; and feedback to stakeholders and decision makers and adjustment of program and process. Each of these are described in further detail below with these existing processes utilized to monitor prevention services cases.

Quality Data Collection:

Effective QA efforts begin with quality data collection. In conjunction with the planning and implementation of the FFPSA, a new data collection system is being built that will compliment FFPSA and other OCFS initiatives. In April of 2020, OCFS was able to finalize the procurement process for a new information technology system to support child welfare operations and quality assurance. The new system, referred to as the Comprehensive Child Welfare Information System (CCWIS), will replace OCFS' current system, Maine Automated Child Welfare Information System (MACWIS), which is over 20 years old. OCFS'

technology and support staff and child welfare staff have been collaborating as they work together with the contracted provider, Deloitte, to develop a system that reflects the unique facets of Maine's child welfare system. Child welfare staff with varying levels of experience are devoting a significant amount of time to working with technology and support staff and Deloitte's developers to create and refine the system, which includes meeting all requirements for FFPSA implementation.

Child welfare leadership has approached the development of CCWIS as an opportunity to look at current policy and practice and ensure the tools and information on which CCWIS is built represent the existing needs of the system including FFPSA. OCFS has also been able to align the policy work underway in collaboration with Muskie to ensure CCWIS is reflective of up-to-date tools, policies, procedures, and best practice guidelines when it goes live in late 2021. The goal of the CCWIS project is to modernize and improve the technological support staff have available as they work with families. There has been particular focus on minimizing the need for duplicative work within the system, allowing staff to be more engaged with the people they are working with, instead of the technology

Case Review Data and Processes:

To compliment data collection, case reviews are conducted by dedicated QA staff housed in each local district office and supervised centrally. QA staff are typically former child welfare professionals who have worked within the child welfare program, either as a direct care caseworker, and/or supervisory staff. QA staff are consistently trained in the child welfare system, policy, and specific initiatives and project needs, including FFPSA. All QA staff will be educated on the FFPSA as well as the required components of Prevention Services to assist in their review of prevention services cases. The QA team has access to the Online Monitoring System (OMS) system through the federal Child and Family Services Review (CFSR) portal and uses this system to conduct the individual case reviews. The QA team has completed the Onsite Review Instrument Item (OSRI) specific training modules to ensure they are meeting the requirements for maintaining the integrity of the tool during case review and staff have received certificates verifying this completion. As new QA staff are hired, they are trained in this process through teaming with their peers as well as reviewing the training modules on the OMS system. Maine utilizes the OSRI as a review tool which provides clear instruction and guidelines on its use. The QA Program Manager is responsible for monitoring the use of these tools. The QA process is strengthened by having a defined sampling methodology which has been approved by ACF. This includes an annual review of 130 cases, using the approved sampling methodology and OSRI. These reviews began in April 2018 and will continue throughout the Program Improvement Plan (PIP) measurement period. Prevention services cases will be included in this random sample methodology.

Analysis and Dissemination of Quality Data:

OCFS utilizes monthly management reports, Kids in Care reports, Child and Family Services Reviews (CFSRs), and has access to the Results Oriented Management System (ROMS), which all combined, allows for ongoing tracking of outcomes. OCFS has a data team of qualified staff to aggregate and analyze data that can be broken down by district office and OCFS maintains a website with current outcome data.

Feedback to Stakeholders and Decision Makers & Adjustment of Program and Process:

OCFS leadership values input from an array of stakeholders, staff being a key constituency. Historically, OCFS leadership has engaged with the Child Welfare Caseworker Advisory Team as new policies,

procedures and initiatives are being developed for their input. Recognizing the value of this advisory group, the Child Welfare Supervisor Advisory Team was created in 2019. These groups provided valuable input into the FFPSA State Plan and other policy initiatives and it is anticipated that these groups will continue to inform the OCFS Leadership Team on policy and practice. In addition, through monthly Maine Child Welfare Advisory Panel (MCWAP) meetings, co-chaired by the Associate Director of Child Welfare, there is a review of the PIP.

District staff have access to reports provided by the data and QA team. OCFS is moving towards a stronger CQI approach, and this will automatically involve the policy and training teams when outcomes are reported out that indicate a need for policy review, and/or strengthening of a training element. A Quality Circle process is implemented in every district, which allows district staff the opportunity to identify challenges to their work and create and implement strategies to overcome those barriers. QA staff continue to be available to provide more district-specific consultation through working on special reviews that could provide the district relevant information for that district in its efforts to improve outcomes.

Continuous Quality Improvement (CQI) Processes:

OCFS has numerous key CQI processes that have been implemented in its system that are an integral part of the agency's day to day operation. This includes the Quality Assurance (QA) Specialist Team as described above which incorporates quality case reviews, district specific topic reviews and statewide topic specific projects. Maine uses its case review results to set the baseline for its Program Improvement Plan (PIP) measurements. Other processes include but are not limited to:

- *Eckerd Rapid Safety Feedback (ERSF) Model:* Once a case is pulled into the ERSF process a review is completed using a standardized tool. If safety concerns are identified or if the case file does not contain sufficient information to determine if safety concerns are present, an ERSF case staffing is scheduled between the ERSF team (RSF Program Manager and the QA Specialist who reviewed the case) and the caseworker and his/her supervisor. The goals of the ERSF staffing are:
 - To mitigate safety concerns in cases with a high probability of a poor outcome;
 - For child welfare staff to utilize the feedback provided by ERSF staff to allow for case practice change in real time; and
 - For ERSF staff to provide mentoring, coaching and support to child welfare staff.
- *Statewide CQI Focused Reviews:* The QA Specialist Team has the capacity to conduct targeted focused reviews as requested by OCFS management as a move towards building a stronger CQI process with the intent being reviewing, providing outcome, allowing management and districts to develop improvement strategies and doing a follow up study later to assess the efficacy of the improvement strategy
- *District QA Engagement:* Each OCFS District has an assigned in-house QA Specialist who is available to provide more district-specific consultation through working on special reviews that could provide the District more relevant information for that district in its efforts to improve outcomes.
- *Utilization of Management Reports:* In 2007, OCFS contracted with the University of Kansas for use of the Result Oriented Management (ROM) system to provide CFSR outcome data down to a worker level through a web-based portal. In measuring and improving processes, outputs and outcomes, child welfare management is increasingly data driven. For district management, performance expectations are tied to reform targets, and data is reviewed in rating performance. A

monthly Management Report provides regular information on key activities, such as child protective response time, relative placements, and monthly caseworker contacts with foster children. ROM was designed to measure the federal outcomes and is available to management and supervisors to help in managing to the outcomes.



Oregon

Status: Approved

Section VI: Evaluation Strategy and Waiver Request

Section 6: Evaluation Strategy and Waiver Request Oregon's Overall Approach to Evaluation and Continuous Quality Improvement (CQI) of Preventive Programs

Family First requires each EBP service submitted in a state's Prevention Plan to include a well-designed and rigorous evaluation strategy. The Children's Bureau may waive this requirement for a well-supported EBP if the state provides compelling evidence of the effectiveness of the EBP and meets the CQI requirements. Oregon has reviewed each of the selected interventions for the initial phase of implementation and requests a waiver of the evaluation requirements for each of the well-supported programs: PCIT, PAT, MI and FFT. Since Oregon is not including any interventions that are not well-supported in its Prevention Plan for initial implementation, Oregon will explore whether and how to add rigorous evaluation strategies for additional interventions (e.g., FAIR or PMTO) in future amendments to the Plan. Our rationale for these evaluation waivers follows and is accompanied by waiver requests attached to this Prevention Plan.

Compelling Evidence for EBP Effectiveness and Waiver Justification

Parent Child Interaction Therapy (PCIT)

There is compelling evidence that PCIT reduces the risk of maltreatment and foster care placement by increasing the use of more effective parenting techniques, decreasing the behavior problems of children and improving the quality of the parent-child relationship.

PCIT is an evidenced-based parent training program with proven effectiveness in serving at-risk children ages 2 to 7 and their caregivers. Oregon's Prevention Plan aims to serve families that have identified stressors of child emotional behavior challenges for which PCIT is a well-aligned intervention. The Title IV-E Prevention Services Clearinghouse rated PCIT as a well-supported EBP following review of 21 eligible studies that indicated favorable effects in the target outcomes of child and adult well-being. Specifically, there were 18 favorable effect findings for child behavioral and emotional functioning, 20 for positive parenting practices and four for parent/caregiver mental or emotional health. The California Evidence-Based Clearinghouse for Child Welfare also rated PCIT as having well-supported research evidence with medium relevance for child welfare in the categories of disruptive behavior treatment (child and adolescent) and parent training programs that address behavior problems in child and adolescents. These studies provide significant demonstration of effectiveness that is applicable to the population Oregon plans to serve with its prevention services and supports a waiver of evaluation requirements for PCIT.

PCIT reduces negative child behavior. PCIT was found to have a greater reduction in behavior problems and improve parenting skills to a greater degree compared to treatments as usual (Bjørseth Å & Wichstrøm L, 2016). Similar compelling results have been found in a recent local study which validates the efficacy of PCIT for Oregon's children and families. In a population of 2,787 children and families across the state of Oregon, families who graduated from PCIT demonstrated a very large effect size in the decrease of

child problem behavior intensity ($d=1.65$) and families who terminated early but were able to attend at least four treatment sessions demonstrated significant improvements in child behavioral problems with medium-to-large effect size ($d=0.70$) (Lieneman et al, 2019).

PCIT decreases the risk of maltreatment. PCIT has also been shown to decrease the risk of child maltreatment. In a study of 110 physically abusive parents, only one-fifth (19 percent) of the parents participating in PCIT had re-reports of physically abusing their children after 850 days, compared to half (49 percent) of the parents attending a typical community parenting group (Chaffin et al., 2004). Decreases in the risk of maltreatment following PCIT treatment have also been confirmed in other studies among parents who had abused their children (e.g., Hakman et al., 2009; Chaffin et al., 2011).

PCIT is effective with diverse cultural populations: PCIT has demonstrated adaptability and positive outcomes for children of different genders and various cultural, ethnic and linguistic backgrounds (Capage, Bennett, & McNeil, 2001; Chadwick Center on Children and Families, 2004; McCabe, 2005). While PCIT was originally evaluated with white families, it has demonstrated positive effects with various populations and cultures, including African American families (Fernandez, Butler, & Eyberg, 2011), American Indian/Alaska Native families (Bigfoot & Funderburk, 2011) and Latinx and Spanish-speaking families (Borrego, Anhalt, Terao, Vargas, & Urquiza, 2006; McCabe & Yeh, 2009). These cultural applications are consistent with the approved PCIT model in the Title IV-E Prevention Services Clearinghouse.

As PCIT has been shown to be effective with populations of children and caregivers in Oregon, has demonstrated favorable outcomes for young children at risk of foster care placement and has proven application to non-white and non-English speaking populations, Oregon is requesting that the Children's Bureau waive the evaluation requirements for PCIT.

Parents as Teachers (PAT)

There is compelling evidence that PAT prevents child maltreatment by teaching new and expectant parents the skills necessary to improve healthy child social and cognitive development, including through early detection of developmental delays and health issues. PAT is also designed to be delivered to a diverse population of families with diverse needs.

PAT is an evidenced-based home-visiting parent education program with proven effectiveness in serving the needs of new and expectant parents and their young, pre-kindergarten children at risk of maltreatment. Oregon's Prevention Plan aims to serve families that have identified stressors of being new parents and/or having heavy childcare responsibility, as well as pregnant or parenting youth in foster care or transitioning to independence, for which PAT is a well-aligned intervention. PAT has a high relevance to Oregon's population of children newborn to 5 years. This age group is disproportionately overrepresented among abused and neglected children in Oregon and has experienced the majority of the state's child fatalities in FFY 2018.

The Title IV-E Prevention Services Clearinghouse has rated PAT as well-supported following review of six eligible studies that indicated favorable effects in the target outcomes of child safety and well-being. Specifically, there were two favorable effect findings for reducing child maltreatment, three for improving

child social functioning and two for improving child cognitive functions and abilities. The Home Visiting Evidence of Effectiveness (HomVEE), in a published review in September 2019, reported that PAT, along with other home visiting models, had favorable impacts on primary measures of child development, school readiness and positive parenting practices.

PAT reduces child maltreatment. PAT has demonstrated significant effects in reducing the likelihood of founded allegations of abuse. For example, in one of the largest research studies in the U.S. conducted to evaluate the impact of home visiting on child maltreatment, researchers found a 22 percent decreased likelihood of substantiated cases of child maltreatment as reported by CPS for PAT families compared to non-PAT families (Chaiyachati et al, 2018). Additionally, a 2014 Home Visiting Summary Report from the Maine Department of Health and Human Services that focused on families with CPS involvement found that, of the families that entered a PAT program, 95 percent had no further substantiated reports or allegations of child abuse.

PAT improves child social and cognitive functions. Additionally, a review by the Title IV-E Prevention Services Clearinghouse shows that PAT had favorable and statistically significant impacts on child social and cognitive functions, which are relevant outcomes for Oregon's children and families. Some studies have noted that the effects on social and cognitive functions of children may be more significant for low-income participants, teen parents and Latina mothers (Wagner, Spiker, Linn 2002; Wagner & Clayton, 1999). Oregon understands the impact of caregiver well-being on overall child well-being and thus considers the positive impact of PAT on positive parenting practices to be a significant component of the effectiveness of the program.

Given PAT's favorable outcomes for young children at risk of foster care placement due to child maltreatment and its adaptability to the needs of diverse populations, Oregon is requesting that the Children's Bureau waive the evaluation requirements for PAT.

Functional Family Therapy (FFT)

There is compelling evidence that FFT is effective in reducing substance use and delinquent behaviors as well as improving behavioral and emotional functioning of adolescent youth. FFT also improves family functioning by reducing family conflict. It has demonstrated positive outcomes for youth from diverse ethnic and cultural backgrounds.

FFT is an effective short-term prevention for adolescents and their families to address risk and protective factors that impact the adaptive development of 11 to 18-year-old youth who have been referred for behavioral or emotional problems. While this service has the capacity to serve pre-teens and their families, the evidence of effectiveness has a focus on youth ages 11- 18 years. FFT aligns well with the target populations of Oregon's Prevention Plan including children with the family stressor, child emotional behavior disability; children at risk of voluntary placement or who receive post-adoption and guardianship services; parenting youth/young adults transitioning out of foster care; and pregnant and parenting youth in foster care. Many of these youth experience disruptive behaviors with some also being jointly served by the juvenile justice system. In FFY 2018, child behavior combined with child drug and alcohol abuse was identified as a removal reason in 345 children (9.6% of total foster care entrants) and, in the same year, 314

children and young adults were served on an average daily basis in therapeutic foster care, residential care programs or psychiatric treatment facilities.

The Title IV-E Prevention Services Clearinghouse has rated FFT as well-supported following review of nine eligible studies that indicated favorable effects in the target outcomes of child and adult well-being. Specifically, there were two favorable effect findings for improving child behavioral and emotional functioning, nine for reducing child substance use, four for reducing child delinquent behavior and one for improving family function. The California Evidence-Based Clearinghouse for Child Welfare also rated FFT as having supported research evidence with medium relevance for child welfare in the categories of behavioral management programs for adolescents in child welfare, disruptive behavior treatment of children and adolescents and substance abuse treatment of adolescents.

FFT reduces adolescent substance use and delinquent behaviors and improves emotional and behavioral functioning. In a study of runaway youth with problem alcohol use and their primary caregivers, FFT was shown to be effective in significantly reducing alcohol and drug use compared with service as usual at 15-month post-baseline (Slesnick & Prestopnik, 2009). This same study, which was rated as high by the Title IV-E Prevention Services Clearinghouse, also had positive outcomes in reducing delinquent behaviors as well as family conflict. Other studies have also shown FFT's efficacy in reducing delinquent behavior (Barnoski, 2004), including reducing out of home placement (Darnell & Schuler, 2015) and improving behavioral functioning (Celinska, Furrer, & Chang, 2013).

FFT is effective with diverse cultural populations. FFT has shown positive outcomes for youth and families in different types of settings across the U.S. as well as in other countries such as in the U.K. (Humayun, S., Herlitz, L., Chesnokov, M., Doolan, M., Landau, S., & Scott, S., 2017) and in Sweden (Gustle, L., Hansson, K., Sundell, K., Lundh, L., & Löfholm, C. A., 2007). The earlier cited study of runaway youth (Slesnick & Prestopnik, 2009) consisted of predominantly nonwhite adolescents including Latinx, African American and American Indian/Alaska Native youth. Another study demonstrated the effectiveness of FFT in decreasing the re-entry of mostly Latinx and African American youth into out-of-home placements in the first two months following their release. (Darnell & Schular, 2015).

Given FFT's favorable outcomes for youth at risk of foster care placement due to behavioral reasons and its adaptability to the needs of diverse populations, Oregon is requesting that the Children's Bureau waive the evaluation requirements for FFT.

Motivation Interviewing (MI)

There is compelling evidence that MI improves treatment outcomes of parents who have substance use disorders and, as a result, will prove effective in reducing the risk of foster care placements of children whose parents are affected by substance use. In addition to addressing substance use, MI can also be applied to a range of different diagnoses and maladaptive behaviors and, when combined with other services, is effective in motivating parents to engage and participate in services. MI is also adaptable across different cultures, ethnicities and languages, and has been successfully delivered in a wide variety of locations and settings.

MI is an intervention that identifies ambivalence for change and increases motivation by helping adults or youth progress through five stages of change: pre-contemplation, contemplation, preparation, action and maintenance. Because parent/caregiver substance use has consistently been the single highest family stressor in founded allegations of abuse in Oregon, MI is very relevant to the Prevention Plan's target population of children with the identified family stressor of parent/caregiver alcohol/drug use. In FFY 2018, parent/caregiver substance use was identified as a reason for child removal in 46.7% of foster care entrants. The Title IV-E Prevention Services Clearinghouse has rated MI as well-supported following review of 75 eligible studies that indicated favorable effects in the target outcomes of adult well-being. Specifically, there were 16 favorable effect findings for reducing parents' substance use. MI has also been rated by the California Evidence-Based Clearinghouse for Child Welfare as well-supported with a medium relevance for child welfare in the categories of motivational engagement programs and substance abuse treatment of adults.

MI decreases parent/caregiver substance use. MI has demonstrated effectiveness in reducing parent/caregiver alcohol and drug use in multiple high and medium rated studies (Carey, 2006; Field, 2014; Gentilello, 1999; Marlatt, 1998; Rendall-Mkosi, 2013; Saitz, 2014; and Stein, 2011). A study focused on alcohol interventions in trauma centers found that the MI treatment group decreased their weekly alcohol consumption by 49% over the comparison group for a period of 11 months following treatment (Gentilello, 1999).

MI has a positive impact on a range of behaviors and is effectively combined with other services and interventions. MI has demonstrated efficacy in addressing an array of behaviors and underlying conditions from evoking cognitive and behavioral change among domestic violence offenders (Kristenmacher2008) to improving self-management behaviors for patients with type II diabetes (Song, 2014). Further, a 2018 literature review of MI use in child welfare found evidence in 12 studies that MI effectively improved a variety of outcomes, including parenting skills, parent/child mental health, retention in services, substance use and child welfare recidivism (Shah et al, 2018). MI can also be provided independently but is commonly provided in combination with another intervention to motivate change. Specifically, there is evidence that MI is beneficial when combined with PCIT (Chaffin et al., 2009; Chaffin, Funderburk, Bard, & Valle, 2011). A study conducted in Oklahoma reported that a combination of MI and PCIT improved parent's retention in PCIT treatment, which then in turn improved child welfare outcomes after a period of 2.5 years.

MI has demonstrated favorable outcomes in individuals from different cultural ethnic backgrounds. MI has shown positive outcomes across different ethnicities (Field, 2010), including non-white populations (Roudsari, 2009) and in multiple countries including Sweden (Palm, 2016), South Africa (Rendall-Mkosi, 2013) and Brazil (Segatto, 2011). Studies have also shown positive effects of MI with young adults of Mexican origin (Cherpitel 2016; Bernstein, 2017) and American Indian/Alaska Native adolescents (Gilder, 2017).

Given MI's favorable outcomes for parents/caregivers with substance use disorders and other maladaptive behaviors, its ability to be effectively combined with other interventions and its adaptability to diverse populations, Oregon is requesting that the Children's Bureau waive the evaluation requirements for MI.

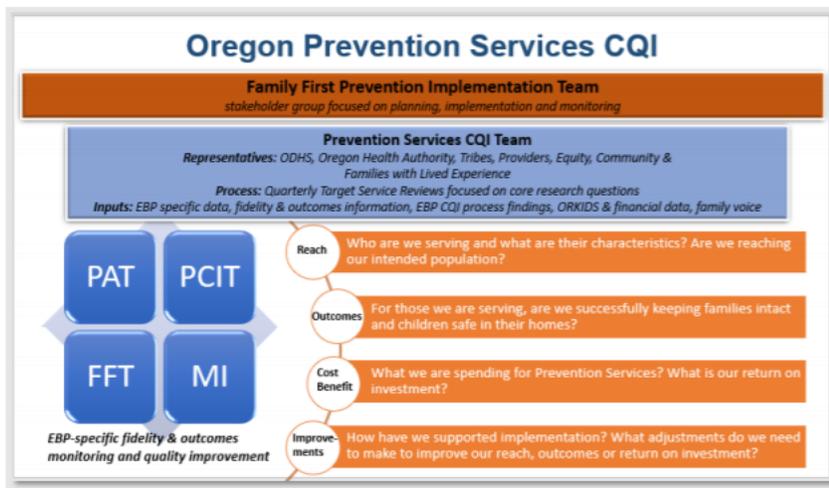
CQI Strategy

The four well-supported evidence-based programs--PCIT, PAT, FFT and MI--that are included in the initial phase of Oregon's Prevention Plan have existing fidelity and outcomes metrics by the proprietor or developer and include a robust in-state infrastructure to collect and share fidelity and outcomes information. Oregon is leveraging these existing metrics and infrastructure, in partnership with the Oregon Health Authority, Oregon's PAT and FFT certified/affiliate programs and community providers who have current Child Welfare contracts, to continue to enhance CQI strategies for these EBPs. Each service will be continuously monitored to ensure fidelity to the practice model, determine outcomes achieved and ensure that information gleaned from the continuous monitoring efforts will be used to refine and improve practices.

Prevention Plan CQI Structure and Processes

Oregon is creating new statewide CQI structure and processes for the Prevention Plan which build on existing CQI activities and will be aligned with Oregon's efforts to engage in robust CQI consistent with our Vision for Transformation. Currently, Child Welfare conducts Quarterly Targeted Reviews to measure progress towards goals in the Child Welfare Fundamentals Map (ODHS, 2020). The QTR brings programs managers from across various disciplines and areas of expertise to discuss data surrounding specific topics and incorporating diverse perspectives and recommendations for further analysis and action steps. The QTR process is a model for Quarterly Targeted Service Reviews (QTSR), which will be the main process used to understand, oversee and inform the implementation and effective service delivery of the EBPs in Oregon's Prevention Plan. The QTSR process will serve a key role in Oregon's overall Prevention Services CQI structure as the figure below details:

Figure 5. CQI structure and key research questions for Oregon's prevention services



Using core research questions to guide the CQI process, the Prevention Services CQI Team will be responsible for reviewing EBP specific data, monitoring fidelity and outcome measures and making necessary adjustments to ensure that services are effective and meet the desired outcomes for children and families. The Prevention Services CQI Team, like the Family First implementation team, will be inclusive and collaborative in conducting the QTSR. The team will be comprised of representatives from sister agencies, Tribes, service providers, community organizations and individuals with expertise regarding

equity as well as family members with lived experience, to allow varied perspectives to make meaning of the evidence and guide recommendations to service providers and the implementation team.

During the initial phase of implementation, the QTSR will primarily focus on the process and data related to the implementation of EBPs to inform how services are being implemented and the status of implementation drivers and supports. This will allow for any adjustments to be made in order to ensure implementation success. In later phases, child and family outcomes will be reviewed more closely as data become available and as implementation stabilizes sufficiently to allow for the evaluation of outcomes

To ensure information gathered during continuous monitoring efforts is used to improve EBP specific outcomes and performance, the QTSR will utilize a standardized process for monitoring, reviewing, analyzing and sharing collected data and results and obtaining feedback from service providers, Child Welfare staff and other partners. Data sources will include but not be limited to quantitative measures gathered from service provider, OR-Kids and other data system reports and qualitative measures gathered from family, service providers and Child Welfare staff. In collaboration with EBP service providers, QTSR recommendations will drive necessary adjustments or contractual changes to EBP service delivery. Based on QTSR guidance, the Prevention Services CQI Team may also utilize a time-limited program improvement plan to improve EBP specific fidelity and outcomes. Following QTSR review of progress and confirmation of practice improvements, the CQI process cycle will repeat itself.

To measure the Child and Family Outcomes and Child Welfare Agency Outcomes detailed in Oregon's Family First Prevention Services Theory of Change (Appendix A), Oregon will identify and/or develop data points within current systems that can be used to establish baseline metrics and monitor progress toward the described outcomes.

In addition to reviewing and monitoring EPB-specific fidelity and outcomes, the QTSR will:

- Understand reach of prevention services to assess the extent to which Oregon is facilitating services to the target populations identified and the characteristics of those who are receiving services
- Monitor outcomes to ensure that children remain safe while receiving services and families are preserved
- Track fiscal investments in prevention services and understand how that investment benefits Oregon families, and
- Assess our capacity building efforts and progress towards transformation.

This information will be used to inform policy and practice improvements, engage communities to inform service planning and improve partnerships and address identified system gaps. The Family First implementation team will provide the necessary leadership and guidance for the CQI process, including informing how to interpret results and determining what changes are needed for implementation based on CQI findings.

EBP-Specific CQI Processes

Specific CQI processes for each well-supported EBP in the initial phase of implementation are as follows:

Parent Child Interaction Therapy (PCIT)

The Oregon Health Authority (OHA), Child and Family Behavioral Health Program, in partnership with Child Welfare, will have lead responsibility for overseeing the CQI of PCIT programs in Oregon. This will include collecting necessary data from providers in support of fidelity and PCIT specific outcomes and working with providers to address improvements. Oregon will initially work with the existing network of PCIT providers to extend services to the eligible target populations in the Prevention Plan but will seek opportunities to expand PCIT to the remaining seven counties in Oregon that do not currently provide PCIT.

OHA collects data and monitors PCIT fidelity through regular reviews of its provider network in Oregon. PCIT providers with less than two years of experience are required to have annual fidelity reviews and PCIT providers with more than two years of experience who receive “adequate” or higher past review ratings have fidelity reviews once every biennium. Fidelity measures include ensuring that:

- PCIT providers are trained and meet all core competencies or have PCIT International certification
- PCIT providers use a fidelity checklist for each session (each session is different), specific parent handouts and the Eyberg Child Behavior Inventory (ECBI) for standard PCIT
- PCIT room equipment is in good working order, and
- PCIT providers participate in continuing education including attending the Annual Oregon PCIT Conference

Fidelity reviews are rated as “developing,” “adequate,” “excels” or “insufficient.” PCIT providers with more than five years of experience who have consistently received an “adequate” or higher fidelity review rating may be offered a virtual review. Virtual reviews still include viewing the PCIT rooms and doing chart reviews but are provided via teleconferencing software. Fidelity review meetings are strengths-based and collaborative, and most providers look forward to the reviews in order to learn how to improve their practice. Providers who receive an insufficient rating are put on a weekly or monthly workplan and are required to report on progress until they have resolved the problem(s).

QTSR will include OHA representation and will monitor PCIT fidelity measures and the following EBP specific outcomes:

- Improvement of positive parenting skills,
- Reduction of negative child behavior, and
- Improvement of parent/caregiver emotional and mental health

To enable sharing of fidelity measures and outcome data, Child Welfare will establish a partner agreement with OHA. The Prevention Services CQI Team will gather progress report data from PCIT providers and additional qualitative data may be collected from families and Child Welfare staff to determine whether the PCIT specific outcomes have been achieved, partially achieved and/or not achieved. Results of outcomes and fidelity measures will be reviewed at QTSR and, if appropriate, recommendations made to refine and improve delivery of PCIT services.

Parents as Teachers (PAT)

For the initial phase of implementation, Oregon will partner with the three PAT-affiliated providers and the national PAT organization to ensure fidelity measures and outcomes are met and to extend PAT services to

eligible target populations in Oregon's Prevention Plan. In a later phase, a request for proposal will be developed to select additional community-based providers depending on readiness and ability to meet PAT affiliation standards. Once selected, community-based providers will be required to follow the process of becoming an affiliated PAT site. Contracts will include CQI requirements for PAT fidelity and outcomes metrics and for participating in the Oregon Prevention Services CQI.

Oregon plans to partner with the PAT national organization for data collection and CQI. The PAT national organization collects data and monitors PAT fidelity through annual reviews of the affiliated PAT providers. Their CQI process covers tracking and evaluating service delivery and outcomes as well as monitoring staff requirements, including supervision, training and workload. PAT-affiliated providers are required to meet specific CQI measures referred to as Essential Requirements and Quality Standards. To meet these CQI measures, affiliates use a PDSA (Plan, Do, Study, Act) model. Together, the Essential Requirements and Quality Standards form the basis for the PAT Quality Endorsement and Improvement Process (QEIP), which is the process that affiliates go through to demonstrate their commitment to high-quality services and to potentially earn a "Blue Ribbon" designation.

The PAT national organization expects affiliates to engage in CQI of operations and service delivery on an ongoing basis and use a recognized CQI method to make improvements. PAT also provides technical assistance to its affiliates to assist with fidelity monitoring throughout the year. There is a year-end report due annually. If affiliates are not meeting certain benchmark percentages of the Quality Standards and Essential Requirements, they need to complete a "Success Plan," which outlines how they will improve in areas where they did not meet the benchmark measurements. If an affiliate requires a "Success Plan," they are labeled a "Provisional Affiliate," and will be expected to participate in rapid CQI processes using PAT worksheets and to participate in Technical Assistance (TA) work with an assigned PAT staff person. Once the minimum benchmark measures have been met, they will return to be a regular affiliate.

Oregon will partner with the PAT organization to monitor fidelity. The QTSR will monitor EBP implementation, fidelity measures and the following EBP specific outcomes:

- Improvement of child social and cognitive functioning, and
- Reduction of child maltreatment

The Prevention Services CQI Team will gather progress report data from PAT providers and additional qualitative data may be collected from families and Child Welfare staff to determine whether improvement of child social and cognitive functioning has been achieved, partially achieved and/or not achieved. Child Welfare may also establish partner agreements with Head Start/Early Intervention to share information related to child social and cognitive functioning. The reduction of child maltreatment will be monitored by collecting existing data reports in ORKids once families have completed PAT. Results of outcomes and fidelity measures will be reviewed at QTSR and, if appropriate, recommendations made to refine and improve delivery of PAT services.

Family Functional Therapy (FFT)

To implement FFT to fidelity, Oregon will develop a request for proposal to select communitybased providers depending on their readiness and ability to meet the authorized FFT service standards. Once

selected, community-based providers will be required to certify program staff in support of moving toward the FFT multi-year process to become an authorized FFT site.

Contracts will have CQI requirements for FFT fidelity and outcomes metrics and for participating in the Oregon Prevention Services CQI.

The CQI process will consist of a two-pronged approach of ensuring model fidelity and monitoring outcomes. To develop and achieve FFT authorized sites, efforts will be monitored through contract administration toward fidelity in three phases:

- Phase I: Clinical Training (Developing Expertise)
- Phase II: Supervisor Training (Creating Self Sufficiency) •
- Phase III: Ongoing Partnership (Maintenance)

FFT fidelity will utilize the following measures:

- Staff qualifications,
- Successful completion of training,
- Rating of meetings and progress notes,
- Family Self Report (FSR) and Therapist Self Report (TSR) data,
- Rating of staffing and consultations with supervisors,
- Global Therapist ratings, and
- Family exit surveys

Oregon will partner with the FFT national organization to monitor fidelity. The QTSR will monitor EBP implementation, fidelity measures and the following EBP specific outcomes:

- Reduction of adolescent substance use and delinquent behaviors,
- Improvement of child emotional and behavioral functioning,
- Improvement of family functioning, and
- Family mastery of skills 3-6 months following treatment

The Prevention Services CQI Team will gather data and metrics from providers related to FFT specific outcomes including the reduction of adolescent substance use and delinquent behaviors. Child Welfare may establish partner agreements with local juvenile justice departments, the Oregon Youth Authority and/or OHA to share information related to adolescent substance use and delinquent behaviors. FFT providers will also be expected to follow-up with families to gather and report data on family mastery of skills 3-6 months following treatment. Additional qualitative data from families and Child Welfare staff may be collected to determine whether the FFT specific outcomes have been achieved, partially achieved and/or not achieved. Results of outcomes and fidelity measures will be reviewed at QTSR and, if appropriate, recommendations made to refine and improve delivery of FFT services.

Motivation Interviewing (MI)

Although many of Oregon's community providers, including Child Welfare contracted providers, are trained to deliver MI and use it in their practice to engage families, there is no statewide CQI process in place to monitor MI fidelity or outcomes. For the initial phase of implementation, Oregon will develop training, implementation support and CQI fidelity and outcome measures for the in-home service

programs that are currently contracted through Child Welfare to include MI as a key practice for engaging and motivating parents. In a later phase, Oregon will develop similar infrastructure for Child Welfare caseworkers to deliver MI as a means of engaging parents/caregivers in order to motivate behavioral change.

Given MI's broad applicability, Oregon will expand MI beyond substance use treatment to include mental health and parent skill-based training services as well. Specifically, Oregon will implement MI to fidelity for Child Welfare's currently contracted in-home service programs, including those that provide parent training, navigator, mental health/wraparound and parent peer mentor services. Child Welfare has two primary in-home service programs: In-Home Safety and Reunification Services (ISRS) and Strengthening, Preserving and Reunifying Families (SPRF). ISRS provides services to families to prevent child removal, or when children have been placed in protective custody, to help them return home with in-home safety services. SPRF services were designed to support a comprehensive service array in local communities and are aimed at maintaining children safely in their home, reducing the lengths of stay in foster care and addressing re-abuse of children. Some of the services developed across the state include navigators, parent training specialists and parent peer mentors.

To establish fidelity standards and measures, Oregon will seek support from the Motivational Interviewing Network of Trainings (MINT) to provide MI training by credentialed trainers and will use the practice manual, "Motivational Interviewing, Third Edition: Helping People Change" by Miller, W.R., & Rollnick, S. (2012), to standardize practice. For fidelity monitoring, Oregon will use the Motivational Interviewing Treatment Integrity (MITI) instrument, which yields feedback that can be used to increase clinical skill in the practice of MI and measures how well a practitioner is using MI.

The QTSR will monitor MI implementation, fidelity measures and the following EBP specific outcomes:

- Increase of family engagement and retention in services,
- Increase of ISRS and SPRF service goals met, and
- Decrease of parent/caregiver substance use

The Prevention Services CQI Team will gather progress report data from ISRS and SPRF providers and qualitative data from families and Child Welfare staff to determine whether family engagement and retention in services following utilization of MI have been achieved, partially achieved or not achieved. Other metrics will also be considered for measuring family engagement, such as successful completion of case plan services and case closure. District contract administrators currently track the outcome of ISRS and SPRF service goals and data measuring the decrease of parent/caregiver substance use can be obtained from OR-Kids and/or other data information systems and confirmed by observations from service providers and Child Welfare staff. Results of outcomes and fidelity measures will be reviewed at QTSR and, if appropriate, recommendations made to refine and improve delivery of MI by ISRS and SPRF providers.