DEPARTMENT OF HEALTH & HUMAN SERVICES

ADMINISTRATION FOR CHILDREN AND FAMILIES
Administration on Children, Youth and Families
330 C Street, S.W.
Washington, D.C. 20201

September 8, 2020

Brenda Donald
Director
District of Columbia Child and Family Services Agency
200 I Street, Southeast
Washington, District of Columbia 20003

Dear Ms. Donald:

Thank you for submitting the District of Columbia's (DC) amendment to the agency's approved title IV-E prevention program five-year plan for fiscal years (FYs) 2020-2024.

Plan Amendment Approval

DC submitted an amendment to the agency's approved title IV-E prevention program five-year plan to the Children's Bureau (CB) Regional Office on March 2, 2020. The amendment added Motivational Interviewing (MI). DC also submitted a request to waive the evaluation requirements for MI**.** The Children's Bureau completed a review of this submission and identified areas requiring further documentation to support compliance with the title IV-E prevention program five-year plan requirements. On August 3, 2020, DC provided a revised plan amendment that addressed the identified provisions.

We are pleased to notify you that we reviewed DC's title IV-E prevention program five-year plan amendment submitted August 3, 2020, and find it to be in compliance with applicable federal statutory and regulatory requirements. DC's title IV-E prevention program five-year plan amendment to the approved plan for FYs 2020-2024 is approved as outlined below.

The effective dates for new programs and services included as part of DC's plan amendment is: January 1, 2020. Please maintain this approval letter as a part of the final, approved plan.

Title IV-E prevention program federal financial participation claims must be for allowable costs on behalf of eligible program participants and may be submitted for applicable periods beginning no earlier than the above listed plan effective date. Additionally, all program costs other than payments for provision of prevention services directly to program recipients must be identified in an approved cost allocation plan as per federal regulations at 45 CFR §1356.60(c). This cost allocation plan may have an effective date that is the same or later than the title IV-E prevention program five-year plan, depending on when submitted and the approval granted. For state title IV-E agencies, a public assistance cost allocation plan (PACAP) amendment must be submitted addressing title IV-E prevention program administrative and training costs in accordance with applicable regulations at §95.509(a)(3). We encourage the state to review its previously

submitted/approved PACAP to determine if updates are required as a result of this amendment to the IV-E Prevention plan.

Approval of Services under the Title IV-E Prevention Program
Pursuant to Sections 471(e)(1) and 471(e)(5)(B)(iii) of the Act, only services and programs provided in accordance with promising, supported, or well-supported practices as rated by the Title IV-E Prevention Services Clearinghouse or a state's designation based on an independent systematic review approved for transitional payments as part of the title IV-E prevention program five-year plan by the U.S. Department of Health and Human Services (HHS) are permitted. In addition, section 471(e)(5)(B)(iii)(II) of the Act requires the state to describe how each program and service will be evaluated through a well-designed and rigorous evaluation strategy (unless waived for a well-supported practice rated by the Title IV-E Prevention Services Clearinghouse). The title IV-E agency must also provide information as to how each program or service will be continuously monitored to ensure fidelity to the practice model, to determine outcomes achieved, and that the state will use information gleaned from the continuous monitoring efforts to refine and improve practices. Based on this amendment, CB has approved the following additional allowable programs and services under this program:

Motivational Interviewing

Approval of Request for Waiver of Evaluation Requirements
Pursuant to section 471(e)(5)(C)(ii) of the Act, the requirement for a well-designed and rigorous evaluation of any well-supported practice rated by the Title IV-E Prevention Services Clearinghouse may be waived if the evidence of effectiveness of the practice is deemed compelling and the continuous monitoring requirements of Section 471(e)(5)(B)(iii)(II) are met. CB approves DC's request for a waiver of the evaluation requirement for the following approved services:

Motivational Interviewing

Payer of Last Resort
In approving the title IV-E prevention program five-year plan, we remind states that section 471(e)(10)(C) of the Act requires that title IV-E is the payer of last resort for services allowable under the title IV-E prevention program. This means that if public or private program providers (such as private health insurance or Medicaid) would pay for a service allowable under the title IV-E prevention program, those providers have the responsibility to pay for these services before the title IV-E agency is required to pay.

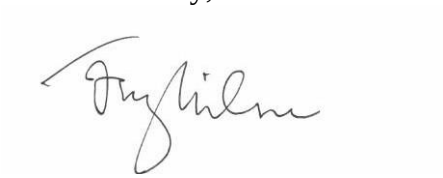
The title IV-E prevention program is part of the Children's Bureau's broader vision of advancing national efforts that strengthen the capacity of families to nurture and provide for the well-being of their children. We look forward to working together with you to implement the title IV-E prevention program as part of the broader vision, and to meet our shared goal of keeping families healthy, together and strong.

For any question or concerns you may have, please contact Shari Brown, Child Welfare Regional Program Manager in Region 3, at (215) 861-4030 or by e-mail at shari.brown@acf.hhs.gov. You

also may contact Christine Craig, Children and Families Program Specialist, at (215) 861-4065 or by e-mail at christine.craig@acf.hhs.gov.

We wish to thank you and your staff for your work and wish you all the best in implementing your important plan.

Sincerely,



Jerry Milner
Associate Commissioner
Children's Bureau

Enclosures

cc: Shari Brown, Child Welfare Regional Program Manager, CB, Region 3, Philadelphia, PA
Christine Craig, Children and Families Program Specialist, CB, Region 3, Philadelphia, PA
Janice Davis Caldwell, Director, Family Protection & Resilience Portfolio, ACF Office of Grants Management, Dallas, TX
Janice Realeza, Family Protection & Resilience Portfolio, ACF Office of Grants Management, Eastern Region

Child and Family Services Agency

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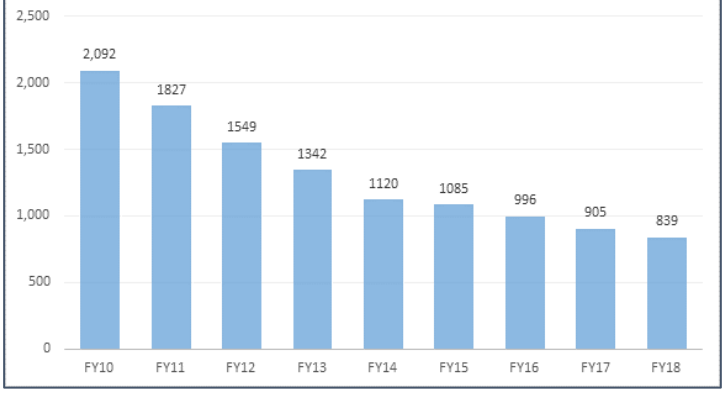
Introduction

For the past decade, The District of Columbia's (DC) Child and Family Services Agency (CFSA) has been on a journey of transformation, moving purposefully away from a system primarily focused on foster care to one that supports and strengthens families. CFSA's investments in community-based prevention and our partnerships with sister health and human services agencies have resulted in a 60% reduction in the number of children and youth in foster care (see Figure 1), from a high of 2,092 in FY10 to fewer than 900 today, even as the city's population has increased by 100,000 residents.

Figure 1 Children in District Out-of-Home Care
Point in time: Last day of Fiscal Year



The median family receiving prevention services has three children and almost half (45%) of all caregivers are between the ages of 31-40, followed closely by 21-30 year old caregivers (30%). Additionally, CFSA's FY20 Needs Assessment recently identified that families receiving prevention services often are at risk of homelessness, are served by DC's Department of Disability Services (DDS) or were former pregnant or parenting youth in foster care.[1] CFSA's deep understanding of the needs of the populations we serve has facilitated our ability to effectively tailor services and identified areas for additional resources needed to prevent child abuse and neglect.

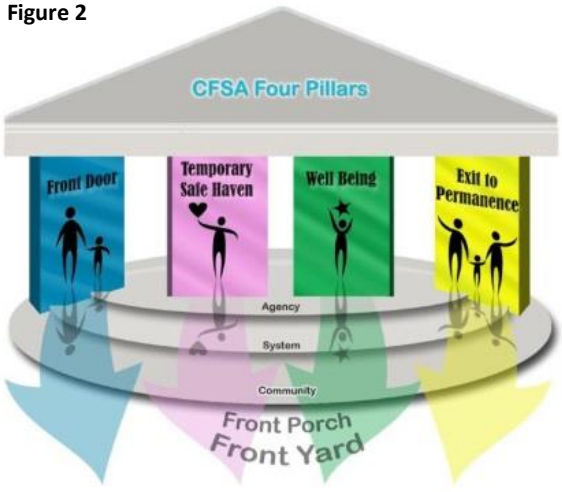
Enactment of the Family First Prevention Services Act (Family First) provided an opportunity to bridge the end of CFSA's IV-E Waiver demonstration project (Waiver) with an on-ramp to a holistic prevention strategy for DC – but only if coupled with a broader primary prevention plan. When CFSA launched its Family First Prevention Work Group in June 2018 with a cross-sector of government and community members, the charge was clear: develop a citywide strategy to strengthen and stabilize families. The plan was not to be *driven* by Family First, but rather to *leverage* new opportunities provided by Family First as part of a comprehensive approach to family and child well-being.

This proposal to the Children's Bureau represents CFSA's five year prevention plan in accordance with Family First, but it also describes it in the broader context of the District's new citywide Families First DC initiative. CFSA's prevention plan builds on the substantial progress made over the past decade to reform DC's child welfare system and bolster prevention efforts to reduce child abuse and neglect. The plan reinforces the successes garnered through the implementation of CFSA's Waiver and capitalizes on the critical lessons learned to refine programs and services to better meet the needs of DC's children, youth, and families.

[1] CFSA FY20 Needs Assessment and Resource Development Plan (October 2018): pg. 15

CFSA's plan, outlined herein, remains in close alignment with the Children's Bureau's vision to keep families healthy, together, and strong[2] and continues to build upon the primary prevention work outlined most recently by the Children's Bureau in August of 2018[3]. CFSA has remained resolute in focusing on our strategic framework developed in 2012, the Four Pillars[4] (see Figure 2). The Four Pillars represent a strategic framework to improve outcomes for children, youth, and families at every step in their involvement with the District's child welfare agency. Each pillar sits on a values-based foundation, a set of evidence-based strategies, and a series of specific outcome targets.

Figure 2



The Four Pillars are:

- **Front Door:** The goal is to narrow the Front Door. Children deserve to grow up with their families and should be removed only as the last resort. When we must remove a child for safety, we seek to place with relatives first.

- **Temporary Safe Haven**: Foster care is a good interim place for children to live while we work to get them back to a permanent home as quickly as possible. Planning for a safe exit begins as soon as a child enters the system.

- **Well Being**: Every child has a right to a nurturing environment that supports healthy growth and development, good physical and mental health, and academic achievement. Children should leave foster care better than when they entered.

- **Exit to Permanence**: Every child and youth exits foster care as quickly as possible for a safe, well-supported family environment or life-long connection. Older youth have the skills they need to succeed as adults.

As noted in Figure 2, CFSA's Four Pillars framework includes the Front Door, Front Porch, and Front Yard as a continuum of service interventions designed to meet families' needs and prevent child abuse and neglect across the child welfare system.

- Families in CFSA's **Front Yard** are not involved with CFSA but may demonstrate potential risk factors for involvement. Primary prevention efforts are designed to ensure children and families in the CFSA's Front Yard are supported in their communities.

- Families at CFSA's **Front Porch** may have engaged with CFSA, but have been able to safely remain, or reunify with their families, and receive community-based prevention services offered by our partnership with DC's Healthy Families/Thriving Communities Collaboratives

[2] Children's Bureau Strategies to Strengthen Families: https://www.acf.hhs.gov/sites/default/files/cb/cb_vision_infographic.pdf
[3] ACYF-CB-IM-1805: Reshaping child welfare in the United States to focus on strengthening families through primary prevention of child maltreatment and unnecessary parent-child separation: https://www.acf.hhs.gov/sites/default/files/cb/im1805.pdf
[4] CFSA's Four Pillars: CFSA Strategic Agenda Supports Good Outcomes for Kids: https://cfsa.dc.gov/page/four-pillars

partners (Collaboratives).[5]

- Families engaged at CFSA's **Front Door** have an open case with CFSA. Whenever possible, CFSA prioritizes keeping families together and working with parents and children in their communities.

DC's long-standing and continued commitment to primary prevention[6], family stabilization, and values-based practices are reflected throughout this plan and highlight CFSA's progressive focus on building a 21st century child welfare system.

The Shift from Waiver to Family First

CFSA's Waiver, implemented over the past five years, was designed to be responsive to the changing needs of children and families as DC experienced a decline in the number of foster-care placements and an increase in the number of children able to remain safely and stably at-home in their communities. At the time of implementation, CFSA theorized that by enhancing services and supports to children and families at various levels of involvement with the child welfare system, more children and youth would remain safely and stably in their homes, and for those children who were removed for safety concerns, a greater number of children would be able to achieve timely permanence. Progress to date has been incremental and trends towards consistently positive outcomes for families.[7] Using continuous quality improvement cycles, CFSA was able to make decisions regarding Waiver programs informed by evidence and data. Evaluation reports showed that outcomes were better for families involved in Waiver programs; however, this was for a small set of families and programs consistently failed to reach their target enrollment numbers. Through the evaluation findings and our experience in the Waiver, CFSA has gained an understanding of the kind of programs that families will use and see to completion. With the no-cost extension of the Waiver until September 30th, 2019[8], CFSA has continued to implement the evidence-based service interventions that are working well for DC's community to strengthen families and address the well-being of both children and their parents.

As CFSA moves from the implementation of the Waiver to Family First, IV-E funding will be available for a subset of the families (Family First candidates and pregnant or parenting youth in foster care, collectively referred to as Family First prevention-eligible children) previously served under the Waiver. For these children, CFSA is working to deepen partnerships with service providers and sister agency partners to leverage existing capacity where current services are working well for families. CFSA is also creating new investments in service interventions needed to meet the specific needs of DC's Family First prevention-eligible children. Family First prevention plan services will be targeted to Family First prevention-eligible children known to CFSA's "Front Door" and Front Porch", providing

[5] For over 20 years, the Healthy Families/Thriving Communities Collaboratives have been key partners to CFSA, serving as community-based prevention service providers. The Collaboratives provide an array of essential core services, including case management, information resource, referral, and linkage, as well as specialized services such as parent education and support programming to meet the needs of both CFSA-involved and all District Families.

[6] ACYF-CB-IM-1805: Reshaping child welfare in the United States to focus on strengthening families through primary prevention of child maltreatment and unnecessary parent-child separation: https://www.acf.hhs.gov/sites/default/files/cb/im1805.pdf

[7] CFSA Semi-Annual Progress Report (SAPR) Spring 2018: https://cfsa.dc.gov/publication/cfsa-safe-and-stable-families-semi-annual-progress-report-spring-2018

[8] CFSA received a No-Cost Extension (NCE) from the Children's Bureau in August of 2018 to continue funding prevention services through Title IV-E Waiver funding until September 30, 2019.

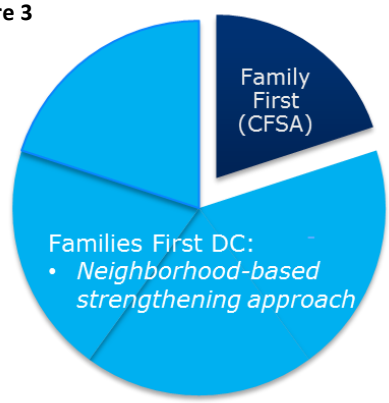
secondary and tertiary services to meet the needs of families that have had contact with CFSA (see Section 1 for description of CFSA's target populations and candidate definition).

Families First DC: Primary Prevention Strategy

DC has embraced a family strengthening vision that is broader and bolder than Family First, and Mayor Muriel Bowser has reinforced that vision with a companion initiative: Families First DC. In her FY20 budget, the Mayor has proposed $4.75 million to fund ten Family Success Centers in targeted neighborhoods east of the Anacostia River, where approximately three-quarters of the children and families served by CFSA live.[9]

While CFSA's prevention plan, detailed in the following pages, focuses on the array of secondary and tertiary prevention services that will be available to support Family First prevention-eligible children and caregivers, the District is also building family-strengthening supports upstream. The goal is to create a network of primary prevention services and neighborhood-driven resources to round-out DC's robust city-wide prevention strategy (see Figure 3). Families First DC is a direct outgrowth of the planning conducted to be ready for implementation of the Family First Prevention Services Act.

Figure 3



> *Families First DC is a neighborhood-based, whole family approach for vulnerable families who live in DC. Families First DC is designed to disrupt the way services are delivered in ten neighborhoods where barriers to well-being, economic opportunity, and achievement are most acute.*[10]

Families First DC has the following goals:

- **Empower communities** – through a place-based approach, neighborhoods and families will envision and create Family Success Centers that will meet their specific needs. Community Advisory Committees will be established, neighborhood action planning will be employed, and strategically tailored community-based grants will be provided to fill services gaps to meet their communities' needs.

- **Integrate Services –** the Family Success Centers will be uniquely designed by each community to facilitate access to existing government resources and new initiatives tailored to meet families' needs.

- **Focus Upstream –** The Family Success Centers will focus on increasing protective factors[11] and mitigating trauma to build on community and family strengths. Services will be designed

[9] All ten neighborhoods are located in Wards 7 and 8. Data analysis was conducted to select these neighborhoods based on social determinants of health, violence prevention priority areas, and substantiated reports of child abuse and neglect.
[10] Families First DC is a new primary prevention initiative of DC Mayor Muriel Bowser.
[11] Center for the Study of Social Policy's (CSSP) Strengthening Families Framework: https://cssp.org/wp-content/uploads/2018/11/About-Strengthening-Families.pdf

to prevent crises through early engagement, offer assistance to meet families' basic needs, respond flexibly to the needs of families and the communities, and provide services outside of a traditional office setting.

As Families First DC unfolds its tapestry of community-grounded primary prevention supports, CFSA proposes the following Family First prevention plan as a complement to this larger effort by serving the most vulnerable and at-risk populations of children and families through evidence-based services to prevent foster care entry. The two initiatives align and intersect without overlapping, providing a comprehensive approach to preventing child maltreatment in the nation's capital.

Section 1: Target population (Child and Family Eligibility for Title IV-E Prevention Program)

Pre-print Section 9

Overview of Target Population

CFSA's target population for prevention services under Family First comprises sub-populations of children at risk of entry into foster care and their caregivers. **These sub-populations were selected by CFSA's Family First Prevention Work Group (Work Group) as the target population for Family First prevention services in light of each group's (1) high rates of foster care entry or re-entry in the past calendar year and (2) high assessed levels of risk according to CFSA's Structured Decision Making (SDM) tool, CFSA's validated risk assessment tool, in the past calendar year.** Where available, additional research evidence and data were examined to form a deeper understanding of each sub-population's risk of foster care entry. Careful application of these criteria has ensured that the children most at risk of imminent foster care entry will be targeted.

It is important to know that Family First prevention-eligible children may or may not be substantiated as maltreated, but all instances where findings are "unfounded" or "inconclusive" will be assessed as either high or intensive risk for maltreatment according to the SDM to be considered at imminent risk of entering foster care. In instances where maltreatment has been substantiated, children and their caregivers will be considered eligible for prevention services, regardless of the level of risk. To follow is a table (Table 1) displaying the target sub-populations who will be eligible in for Family First preventive services, as determined through development of a child-specific Prevention Plan, as outlined in the Family First legislation.

Table 1 Target sub-population groups of Family First Prevention-Eligible Children [12]

Front Porch
(1) Children served through the Healthy Families/Thriving Communities Collaboratives (the Collaboratives) following a CPS investigation or closed CFSA case.
(2) Children who have exited foster care through reunification, guardianship, or adoptions and may be at risk of re-entry.[13]
(3) Children born to mothers with a positive toxicology screening.
Front Door
(4) Children served through CFSA's In-Home Services program, which offers intensive case management and service referrals to families.
(5) Pregnant or parenting youth in/recently exited foster care with eligibility for services ending at age 21.

[12] Each sub-population is categorized within the intervention group they belong to at the start of their candidacy. Note that individuals within each subgroup could move in to different intervention groups during the course of their candidacy.

[13] Children in this subgroup can be determined eligible for services via a Prevention Plan at various times relative to their child welfare involvement, e.g., immediately upon permanency or later when the family returns to CFSA's attention.

(6) Children of pregnant or parenting youth in/recently exited foster care (non-ward children) with eligibility for services ending five years after exiting foster care.
(7) Siblings of children in foster care who reside at home and have assessed safety concerns.

As discussed in Section 1, a substantial body of data show that approximately three-quarters of children served by CFSA reside within DC's Wards 7 and 8, east of the Anacostia River. Services for candidates will echo and integrate with the larger Families First DC initiative with its focus on this area of the city where need is the greatest.

How CFSA will assess children and their parents or kin caregivers to determine eligibility for Family First prevention services

As outlined in the Family First legislation, **a Family First Eligibility Screen and Prevention Plan (Prevention Plan) will be completed by CFSA staff for each Family First prevention-eligible child if appropriate** to establish that they are eligible to receive prevention services, and to articulate an associated foster care prevention strategy. Only CFSA staff will determine child-specific eligibility for prevention services. To ensure that CFSA workers correctly identify children who are Family First prevention-eligible, there will be an eligibility screen designed to confirm the child's (1) membership in one of the above-noted subgroups, (2) risk level per the SDM, and (3) imminent risk of entering foster care. The technical interface will guide the appropriate CFSA worker through development of a foster care prevention strategy and selection of associated EBP interventions.

Process for Establishing Candidacy Date and Inclusion in a Prevention Plan

CFSA staff responsible for determining eligibility will select from a series of fields that include questions and answers to select in FACES, CFSA's system of record, to document child-specific eligibility for prevention services. The selection of these fields in FACES will validate eligibility and provide a child-specific candidacy timestamp also known as "candidacy determination date" for the candidate child or youth, and their family. This timestamp will be used to determine the 12 month time limit and will be monitored and tracked electronically in FACES and the CFSA's Community Portal, a web-based interface CFSA's Collaborative partners will use to accept all referrals/cases transferred from CFSA to the Collaboratives for ongoing case management and prevention plan management throughout 12 month period. Collaborative staff will not be responsible for determining eligibility for prevention services but will be responsible for managing prevention plans for prevention-eligible children and their families when candidacy has been established by CFSA. CFSA is currently building the technical solution in FACES and the Community Portal to meet this stated business process.

Eligibility for Prevention Services Determination Process

The Prevention Plan interface will allow workers to view risk and comprehensive assessment results while developing the plan, thus enabling CFSA workers to refer to and draw on assessment results when determining eligibility, developing the foster care prevention strategy, and selecting appropriate services. CFSA workers responsible for completing a child's Prevention Plan will be trained in understanding assessment results to inform an eligibility determination and service selection. The same methodology will be used for redetermination of eligibility should there be a need for services beyond twelve (12) months or if there has been a change in risk level. CFSA will use management reports as well as the support of staff within CFSA's prevention unit to ensure claiming ceases when a child is determined to no longer be a candidate prior to the 12 month time limit.

Prevention Plan Completion and Storage

The Prevention Plan template will be linked to within the existing in-home services case plans, foster care case plans, intervention plans, and sustainability plans in CFSA's child welfare information system, FACES. Integration within existing technology solutions will allow CFSA to streamline case documentation and ensure that the Prevention Plan aligns with larger case and service planning efforts. If the need for a foster care prevention strategy and associated services becomes necessary in the life of any case that falls within the Family First prevention-eligible population, or when a youth in foster care who is pregnant or parenting is identified, a Prevention Plan will be created to confirm the child's eligibility.

The Prevention Plan will always be completed and (if needed) edited by CFSA staff or CFSA's community-based contracted Collaborative partners. In situations where a child eligible for Family First prevention services has a CFSA in-home or foster care caseworker, that caseworker will complete the Prevention Plan as part of the case planning process. For families referred directly from investigations to the Collaboratives, who don't have CFSA caseworkers, CFSA's Collaborative partners will complete the Prevention Plan.

Collaborative Case Transfer Process

When a referral (if following a closed investigation) or case (following an open In-Home or Out-of-Home case) is ready to be transferred to a Collaborative for case management services and ongoing prevention plan management, the FACES technology will allow a CFSA staff person to initiate CFSA's electronic "Case Transfer Process". The Case Transfer Process allows CFSA staff to transition the referral or case, including the prevention plan, to the appropriate Collaborative based on geography and service needs of the prevention-eligible children and their family. All relevant information related to the prevention-eligible child and their family will be transferred electronically to the specified Collaborative. The candidacy determination date and "eligibility clock" will be visible through the CFSA Community Portal (Community Portal). The Community Portal is the technical interface the Collaboratives will use to

accept all referrals/cases transferred from CFSA to the Collaboratives for ongoing case management and prevention plan management. The Collaboratives will be able to view the candidacy determination date and "eligibility clock" when reviewing or updating a prevention plan.

Prevention Plan Maintenance by the Collaboratives

CFSA developed a web-based Community Portal (technical solution) which allows CFSA staff to transfer a prevention plan to the appropriate Collaborative as part of the Case Transfer Process. After the case is successfully transferred, the Collaborative is able to view relevant assessment data about the prevention-eligible child and their family, as well as view and update the prevention plan as needed to reflect current service needs. The Collaborative is not able to edit the original candidacy determination (eligibility timestamp) but can re-assess risk based on changes to the child/family's situation and needs. The Collaboratives report to CFSA in real-time if the child/family is no longer participating in services. CFSA staff have full access to the Community Portal to review cases.

Oversight

Oversight is provided as part of FY20 Contract management performed by CFSA Community Partnerships Administration program staff and CFSA Contract Monitoring Divisions' contract monitors. CFSA uses real-time management reports, monthly and quarterly data analyses, and quarterly case-record reviews performed by the Contract Monitors to oversee the Collaboratives performance and ensure quality service delivery to children and families. The Collaboratives 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. In addition to regular contract oversight, in FY20, CFSA monitors CQI activities as part of CFSA's evaluation design. The requirements of the prevention plan and all aspects of the prevention plan management and ongoing risk assessment are being written into the Collaboratives' FY20 contracts.

Section 2: Title IV-E Prevention Services (Service Description and Oversight)

Pre-print Sections 1 and 4

The Backdrop: Lessons Learned through CFSA's Waiver

Through the implementation of the Waiver, CFSA learned important lessons that have strongly influenced the development of this five-year plan, and specifically, the selection of evidence-based program (EBP) services included herein. Namely, CFSA learned that:

- Narrow inclusionary/exclusionary requirements of nationally recognized EBP models led to low rates of referral acceptance in DC's local implementation. Moreover, different EBPs work well for different families, as family preferences vary regarding program intensity, format, and focus. Consequently, **it is essential to maintain an array of EBPs that is as diverse as the families served** to ensure that each family can be matched to EBPs that align with their needs and circumstances.
- Families often struggle to take up and sustain participation in EBPs due to a variety of barriers. **Families are more likely to initiate EBP participation if actively supported by a skilled and engaged caseworker** in order to overcome psychological, logistical, and other barriers.
- **Successful EBP implementation and program sustainability require diligent attention to business processes and continuous quality improvements.** These processes must be planned carefully and monitored through CQI and evaluation, as will be discussed in Section 4 below.

To select the EBPs outlined in this five year plan, CFSA staff and stakeholders closely assessed not only each program's level of research evidence, but also the target populations, eligibility criteria, and time-intensity of each intervention to ensure the available service array includes the best-fit services for greatest number of families within the identified target populations.

Rationale for Service Selection

CFSA drew on diverse evidence as well as a robust stakeholder engagement process to drive data-driven and locally-informed decisions around the most appropriate evidence-based services to support the District's Family First prevention-eligible children and their caregivers to reduce risk factors and increase protective factors for child abuse and neglect. Services were explored and selected by the District of Columbia Family First Prevention Work Group (Work Group), which met for over six months and comprised diverse CFSA staff and external stakeholders from key community organizations and sister agencies (see Stakeholder Engagement in Target Population and EBP Service Selection below for additional details). The Work Group prioritized **three broad criteria in selecting each service: (1) Identifying a service array that aligns with the characteristics and service needs of target families,** thus ensuring that each family will be able to secure a service that meets their specific needs and circumstances, **(2) Ensuring each service identified has a high level of evidence of**

effectiveness—not only from national evaluations, but also drawing on data and experiences with these very programs as implemented in DC, and **(3) Prioritizing selecting services that currently are in place and successful within DC, building on existing capacity, model familiarity, and effectiveness.** To follow is an overview of how data and evidence were used to inform selection in accordance with each of these criteria.

(1) Identifying a service array that aligns with the characteristics and service needs of targeted families. Building upon the lessons learned from the Waiver described above, CFSA selected an array of EBPs in the domains of in-home parent skill-based programs, mental health, and substance abuse prevention and treatment services selected specifically to meet the needs of Family First prevention-eligible children and their caregivers. To gain an understanding of the needs of these children and families, **CFSA conducted extensive analyses, including taking into account the following data and evidence to inform a deep understanding of the range and nature of service needs of Family First prevention-eligible children and their caregivers**.

- ***Child and family demographic data derived from FACES,*** including but not limited to child age, parent age, and family size, which are among the top eligibility criteria for each EBP under consideration.
- ***Case characteristic data derived from FACES,*** including removal reasons and maltreatment indices, which illustrate patterns family risks and needs.
- ***Child and family assessment data***, including aggregate results from CFSA's comprehensive assessments: the Child and Adolescent Functional Assessment Scale (CAFAS), Preschool and Early Childhood Functional Assessment Scale (PECFAS), and the Caregiver Strengths and Barriers Assessment (CSBA). These results paint a rich picture of child and family strengths and needs.
- ***Input from subject matter experts and stakeholders*** who work directly with or administer programs for the target population, to answer questions not addressed by data sources listed above and to make recommendations based on first-hand experience regarding necessary components of the preventive services array.
- ***Sister agency data analyses*** describing the service needs of the families they serve who also have CFSA involvement.
- ***Two focus groups with families*** who have both engaged or disengaged in evidence-based services across the District. The conversations yielded an understanding not only of family service needs broadly but also the characteristics of services that tend to work best, barriers to services, and characteristics of case managers that can support and promote service participation.
- ***A focus group with service providers*** provided insights about barriers to services and perceptions as to which EBPs have worked best for families locally.
- ***DC's Title IV-E Waiver preliminary evaluation***, providing insights and lessons-learned about the implementation and effectiveness of Waiver-funded EBPs.
- ***Evaluation of CFSA's Initiative to Improve Access to Needs-Driven, Evidence-Based/Informed Mental and Behavioral Health Services in Child Welfare trauma grant,*** including information about CFSA's experiences completing extensive workforce training on trauma, implementing

trauma-sensitive assessment tools, and engaging in data-driven case planning and monitoring.

Taken together these data clearly illustrate the characteristics and service needs of Family First prevention-eligible children and their caregivers. Following synthesis, meaning-making, and discussion within the Work Group, these data directly informed the specific array of preventive services proposed herein. This process produced a broad proposed array of services, none of which are duplicative. Each EBP serves a different target population, operates with different format or intensity, and/or is designed to produce different outcomes, thus aligning with the diverse identified needs and characteristics of the children and families in the target population.

(2) Ensuring each service identified has a high level of evidence of effectiveness. As the Work Group explored and defined the service needs of families in DC, it became apparent that **the 12 programs under initial review on the Title IV-E Prevention Services Clearinghouse were not sufficient alone to meet the needs of the families CFSA serves**. Therefore, **CFSA developed a proposed service array that demonstrates a high level of evidence according to the ratings of the California Evidence-Based Clearinghouse for Child Welfare (CEBC)[14] and estimated ratings based on the criteria defined in the legislation that will be used by the Title IV-E Prevention Services Clearinghouse**. Ratings likely to be produced by the Title IV-E Prevention Services Clearinghouse were estimated based on a close review of research evidence associated with each program within the District's proposed service array relative to criteria for ratings clearly described in PI 18-09, Attachment C.[15] Using these methods, CFSA has closely considered the evidence associated with each program and determined that the proposed service array reflects a mix of programs likely to be rated as promising, supported, and well-supported in accordance with the requirements of the legislation, including projections indicating that over 50% of claiming will be for well-supported programs.

(3) Prioritizing selecting services that currently are in place and effective within the District, building on existing capacity, model familiarity, and effectiveness. DC maintains an unusually broad array of social services available to residents through the Department of Behavioral Health (DBH), Department of Human Services (DHS), DC Health, and numerous other agency and community-based providers. The Work Group and CFSA obtained extensive information about existing services in order to assess the supply of existing services relative to the estimated demand from Family First prevention-eligible children and their caregivers, including the following:

- A **prevention services survey** completed by all Work Group stakeholder organizations to capture information on existing mental health, substance abuse, and in-home parenting EBPs, as well as key information about each. The survey was designed to help CFSA and stakeholders gain a holistic understanding of the breadth of existing service array and the depth of capacity already within the District.
- **Collaborative and sister agency presentations** to the Prevention Work Group, including key

[14] California Evidence-Based Clearinghouse for Child Welfare (CEBC) – designed to advance the effective implementation of evidence-based practices for children and families involved with the child welfare system. http://www.cebc4cw.org

[15] ACYF-CB-PI-18-09: HHS Initial Practice Criteria and First List of Services and Programs Selected for Review as part of the Title IV-E Prevention Services Clearinghouse: https://www.acf.hhs.gov/sites/default/files/cb/pi1809.pdf

health and human services agency stakeholders and DC's Department of Employment Services to gather additional information about EBPs and other prevention activities already in place in the District.

- **In-depth information and data gathering** about existing EBP models, current capacity and utilization, staffing, effectiveness, and cost.

Evidence collected indicated that an impressive array of in-home parenting, mental health, and substance abuse treatment EBPs exists in DC. All selected services have existing capacity within DC. The Work Group determined leveraging existing capacity, where programs are currently meeting the needs of families within the community, will allow CFSA to realize proximal outcomes (see Theory of Change in Section 4) for families while continuing to assess program efficacy and refine the best set of programs to meet the candidate populations' needs over time. By selecting existing service interventions currently offered within the community, CFSA is ensuring the ability to effectuate this plan while minimizing time and energy to start-up new services.

Implementation Approach

As described in the sections above, CFSA has developed strong partnerships with our health and human services sister agencies and community-based service providers to offer an array of parenting, mental health, and substance use treatment services to families currently involved with CFSA and more broadly to vulnerable populations across the District. CFSA's comprehensive approach to preventing child maltreatment and strengthening families is embedded deeply in the fabric of the Agency and threaded throughout the child welfare system. The efforts undertaken to identify a comprehensive service array for prevention-eligible children and their families has produced a roadmap for possible services to be claimed under Family First as part of CFSA's five year Prevention Plan. As CFSA's Family First implementation begins in year one, CFSA has leveraged existing partnerships and evidence-based program capacity to serve candidate children and their families. Of the services currently deemed allowable by the Title IV-E Prevention Services Clearinghouse, the six outlined below in CFSA's proposed service array have existing capacity in the District and are funded through other federal sources (Medicaid and the Maternal, Infant, and Early Childhood Home Visiting Program; MIECHV). Due to the existing federal funding mechanisms in place to support the existing service capacity, at the time of this submission, CFSA will be using local dollars to support adding capacity to one of the allowable evidence-based programs, the Parents As Teachers (PAT) model, outlined in the proposed service array below.

CFSA is using year one of our five year Prevention Plan to conduct State-level CQI activities to assess capacity needs across our existing prevention service array to determine if additional capacity is needed and additional slots of existing services, or new interventions, should be added to our Prevention Plan to be claimed under Family First in subsequent years. As additional services are rated by the Title IV-E Prevention Services Clearinghouse, Independent Systematic Reviews are conducted and approved[16], or

[16] Required independent systematic review of services as part of the process to claim transitional payments as specified in ACYF-CB-PI-19-06: Transitional Payments for the Title IV-E Prevention and Family Services and Programs: https://www.cwla.org/wp-content/uploads/2019/07/ACYF-CB-PI-18-09-Attachment-A.pdf.

if additional capacity is needed to support prevention-eligible children and their families, and is not already funded by Medicaid or MIECHV, CFSA may amend our Prevention Plan to expand our service array and specify additional services to be claimed under Family First. At this time, CFSA does not plan to submit an Independent Systematic Review (ISR) of services currently not yet rated by the Title IV-E Prevention Services Clearinghouse.

Proposed Service Array

Tables 2 and 3 below provides an overview of the selected prevention services, including the service type, target population, their rating on the CEBC and Title IV-E Prevention Services Clearinghouse, whether each intervention is currently under review by the Title IV-E Prevention Services Clearinghouse, and the estimated rating that is likely to be produced by the Title IV-E Prevention Services Clearinghouse. These tables clearly show the high level of research evidence associated with the service array, as well as **the distinct target populations and desired outcomes across programs, demonstrating that the District has selected a continuum of services that is as diverse as the needs and characteristics as the families we serve**. This builds on the waiver lesson learned that a diverse array of EBPs is necessary to ensure that each family can be matched to an EBP that aligns with their needs and circumstances. The service array is well-calibrated to effectively and comprehensively meet the needs of Family First prevention-eligible children and their caregivers and will effectively utilize the opportunity created by Family First to claim Title IV-E dollars for allowable EBP service capacity not already supported by other federal sources. Table 2 highlights the specific evidence-based prevention services, Parents As Teachers (PAT) and Motivational Interviewing (MI), that the District seeks approval to claim for under Family First as part of the District's comprehensive evidence-based prevention service array, fully outlined in Table 3.

Table 2. Family First Prevention Service (Claimable)

	EBP Interventions	Target Population (in years)	Selected Proximal Outcomes[17]	Average Length of Service	Currently Rated on Clearinghouse "Allowable"[18]	Title IV-E Clearinghouse Rating	Funding Source (Family First, Other Federal, or Local)
In-home Parenting	Parents as Teachers (PAT)	Parents of children 0-5	Inreased knowledge of child development, improved parenting practices, detection of developmental delays, school readiness	60 months	✓ Allowable	Well Supported	Family First MIECHV
Cross-Cutting	Motivational Interviewing (MI)	Parents (all ages)	Enhance internal motivation to change, reinforce that motivation, develop a plan to achieve change.	2 or more sessions, as needed throughout a case	✓ Allowable	Well Supported	Family First

[17] Proximal outcomes obtained from individual program profiles on the California Evidence-Based Clearinghouse for Child Welfare: https://www.cebc4cw.org/

[18] Rated in first round of review by the Title IV-E Prevention Services Clearinghouse (Attachment C): ACYF-CB-PI-18-09: HHS Initial Practice Criteria and First List of Services and Programs Selected for Review as part of the Title IV-E Prevention Services Clearinghouse: https://www.acf.hhs.gov/sites/default/files/cb/pi1809.pdf
https://www.acf.hhs.gov/sites/default/files/cb/pi1809.pdf

Table 3 Comprehensive Overview of Selected Evidence-Based Prevention Services

	EBP Interventions	Target Population (in years)	Selected Proximal Outcomes[19]	Average Length of Service	Currently Rated on Clearinghouse "Allowable"[20]	Title IV-E Clearinghouse Rating	Estimated Title IV-E Clearinghouse Rating[21]	Funding Source (Family First, Other Federal, or Local)
In-home Parenting	Parents as Teachers (PAT)	Parents of children 0-5	Inreased knowledge of child development, improved parenting practices, detection of developmental delays, school readiness	60 months	✓ Allowable	Well Supported	N/A	Family First MIECHV
	Healthy Families America (HFA)	Parents of children 0-5	Increased nurturing parent-child relationships, healthy child development, enhanced family functioning, increased protective factors, reduced risk	60 months	✓ Allowable	Well Supported	N/A	Family First MIECHV
	Chicago Parenting Program (CPP)	Parents of children 2-5	Improved parent-child relationships, reduced reliance on harsh discipline methods, increased parent confidence & competence, reduced child behavior problems	4 months	✗	Not Yet Rated	Well Supported	Local
	Effective Black Parenting Program (EBPP)	Parents of children 0-17	Reduce parental stress, promote cultural pride, improve child school performance & behavior, strengthen family cohesion, increased coping with racism and prejudice	15 weeks	✗	Not Yet Rated	Promising	Local
	ACT: Raising Safe Kids	Pregnant Mothers/Partners or Parents of children 0-10	Increased knowledge and skills that change or improve parenting practices. Increases parental knowledge of child development, discipline methods, and media literacy, as well as addresses parents' anger management, social problem-solving skills and their ability to teach/model these skills to children. Reduces/addresses children's aggression and behavior problems.	9 weeks	✗	Not Yet Rated	Promising	Local
	YVLifeset	Pregnant or Parenting Youth 17-22	Increased engagement in education and vocational pursuits, improved interpersonal and social skills, decreased interference from substance abuse and mental health issues, increased independent living.	7-9 months	✗	Not Yet Rated	Promising[22]	Local

[19] Proximal outcomes obtained from individual program profiles on the California Evidence-Based Clearinghouse for Child Welfare: https://www.cebc4cw.org/

[20] Rated in first round of review by the Title IV-E Prevention Services Clearinghouse (Attachment C): ACYF-CB-PI-18-09: HHS Initial Practice Criteria and First List of Services and Programs Selected for Review as part of the Title IV-E Prevention Services Clearinghouse: https://www.acf.hhs.gov/sites/default/files/cb/pi1809.pdf https://www.acf.hhs.gov/sites/default/files/cb/pi1809.pdf

[21] Estimated ratings complete through a combination of individual program evidence reviews by the authors of this plan and review of *Interventions with Special Relevance for the Family First Prevention Services Act (FAMILY FIRST) (Second Edition)*: https://caseyfamilypro-wpengine.netdna-ssl.com/media/Executive-Summary_Interventions_Family-First-Prevention-Services.pdf.

[22] Following recent completion of a study with a comparison group showing favorable outcomes, YVLifeset's rating on the CEBC should be updated to "promising."

	EBP Interventions	Target Population (in years)	Selected Proximal Outcomes[19]	Average Length of Service	Currently Rated on Clearinghouse "Allowable"[20]	Title IV-E Clearinghouse Rating	Estimated Title IV-E Clearinghouse Rating[21]	Funding Source (Family First, Other Federal, or Local)
	Transition to Independence (TIP)	Pregnant or Parenting Youth 14-29	Increased engagement in education and vocational pursuits, improved interpersonal and social skills, decreased interference from substance abuse and mental health issues, increased independent living.	18 months	✗	Not Yet Rated	Promising	Local
	Project Connect	Parents of children 0-17	Decreased problematic substance use, improved parenting skills, linkages to community resources	16 months	✗	Not Yet Rated	Promising	Local
Substance Abuse	Recovery Coaches[23] - Connecticut Center for Addiction and Recovery (CCAR) certification	Caregivers (all ages)	Caregiver: Support with addiction and recovery: improved relationships with providers and social supports, increased satisfaction with the treatment experience overall, reduced rates of relapse, and increased retention in treatment.	Specific to program	✗	Not Yet Rated	Promising	Local
	Adolescent Community Reinforcement Approach (A-CRA)	Children 12-25	Child: Abstinence, increased positive social activity, improved family and peer relationships. Caregiver: Support for child abstinence, increased parenting knowledge and skills.	3-6 months	✗	Not Yet Rated	Well Supported	Medicaid
	Multi-Systemic Therapy (MST)	Children 11-17	Youth: Reduce behavior problems. Caregiver: increased ability to address parenting difficulties and empower youth.	4-6 months	✓ Allowable	Well Supported	N/A	Medicaid
Mental Health	Trauma-Focused Cognitive Behavioral Therapy	Children 3-18 and their caregivers	Improved PTSD, depression, anxiety symptoms, reduced behavior problems, improved adaptive functioning improved parent skills, reduced parent distress.	3-6 months	✓ Allowable	Promising	N/A	Medicaid
	Functional Family Therapy	Children 11-18	Youth: Eliminate behavior problems, delinquency, and substance abuse; improve prosocial behavior. Family: Improve functioning and skills.	7 months	✓ Allowable	Well Supported	N/A	Medicaid
	Parent Child Interaction Therapy (PCIT)	Children 2-6	Child: Increased parent-child closeness, decreased anger and frustration, increased self-esteem. Parent: Increased ability to comfort child, improved behavior management and communication with child.	6 months	✓ Allowable	Well Supported	N/A	Medicaid
	Parents	All families	Caregiver: Develop strengths-based personal goals, learn to	12 – 18	✗	Not Yet Rated	Promising	Local

[23] DBH currently offers nationally recognized training in Connecticut Community for Addiction Recovery (CCAR): https://ccar.us/

	EBP Interventions	Target Population (in years)	Selected Proximal Outcomes[19]	Average Length of Service	Currently Rated on Clearinghouse "Allowable"[20]	Title IV-E Clearinghouse Rating	Estimated Title IV-E Clearinghouse Rating[21]	Funding Source (Family First, Other Federal, or Local)
	Anonymous[24]		monitor personal progress and advocate for effective services, learn modeled effective coping techniques and self-help strategies, help with resolving issues, help navigating the behavioral health system, build community supports	months				
	Motivational Interviewing (MI)	Parents (all ages)	Enhance internal motivation to change, reinforce that motivation, develop a plan to achieve change.	2 or more sessions, as needed through-out a case	✓ Allowable	Well Supported	Well Supported	Family First
Cross-Cutting								

In addition to the comprehensive prevention service array outlined above in Table 3, CFSA and sister agency partners have seen promising results in other locally implemented programs (outlined below in Table 4). While these services may not have the same level of rigor, or meet the specific criteria outlined in the Family First legislation, these programs have shown promise of effectiveness and support target populations outside of Family First prevention-eligible children and their caregivers to round-out a comprehensive city-wide prevention strategy. CFSA believes family-stabilizing services, post-permanency supports, peer-based programs for families receiving a range of mental health, substance use treatment services, or disability services, and programs to help teen parents successfully transition from care are powerful tools as part of CFSA's comprehensive suite of interventions to meet the specific needs of children and their caregivers. Further, while these programs may incorporate one or more evidence-based models at the center of their design, CFSA recognizes the strength of coupling interventions (which many of these services do) to provide a suite of supportive services within one program.

[24] Parents Anonymous (PA) is currently used as a primary prevention service intervention across the District.

Table 4 Overview of Other District Prevention Service Interventions – CFSA's Additional Suite of Prevention Services and Partnerships

	Service Interventions	Target Population (in years)	Selected Proximal Outcomes[25]	Average Length of Service	Estimated Title IV-E Clearinghouse Rating[26]
Family Stabilization Services	Mobile Stabilization Services (MSS)	Children and youth in foster care	De-escalate family crises, stabilize children in the home.	<1 month	Insufficient evidence
Mental Health and Substance Abuse Treatment Services	Certified Peer Specialists	Caregivers (all ages)	Caregiver: Develop strengths-based personal goals, learn to monitor personal progress and advocate for effective services, learn modeled effective coping techniques and self-help strategies, help with resolving issues, help navigating the behavioral health system, build community supports	Specific to program	Unknown
	Family Peer Coaches - Strengthening Family Coping Resources (SFCR)[27]	Caregivers (all ages)	Child: Reduce symptoms of traumatic stress and other trauma-related disorders in any family member Family: Increase coping resources in children, caregivers, and in the family system to help families a) boost their sense of safety, b) function with stability, c) regulate their stress reactions, emotions, and behaviors, d) and make use of supports	2-4 months	Unknown
Post-Permanency Supports/ Mental Health	C.A.S.E. - Center for Adoption Support and Education	Caregivers and youth (all ages)	Program designed to support CFSA staff with technical assistance including intervention planning and matching. CASE provides support to families through individual and family therapy before and after guardianship or adoptions have taken place.	9 -12 months	Unknown
	Adoptions Together	Caregivers and youth (all ages)	Program designed to provide support for grief and loss, attachment and bonding through 6-week support groups, as well as provide children/youth and caregivers with individual/family therapy to address adoption/guardianship issues and mitigate disruption or adoption dissolution.[28]	6-9 months	Unknown

[25] Proximal outcomes obtained from individual program profiles on the California Evidence-Based Clearinghouse for Child Welfare: https://www.cebc4cw.org/

[26] Estimated ratings complete through a combination of individual program evidence reviews by the authors of this plan and review of *Interventions with Special Relevance for the Family First Prevention Services Act (FAMILY FIRST) (Second Edition)*: https://caseyfamilypro-wpengine.netdna-ssl.com/media/Executive-Summary_Interventions_Family-First-Prevention-Services.pdf

[27] Family Peer Coaches Program (Certified Family Peer Specialists) group classes use the Strengthening Family Coping Resources (SFCR) Model. Staff are Certified Peer Specialists trained by DC Department of Behavioral Health.

[28] Adoptions Together and C.A.S.E. clinicians use and array of treatment modalities including TF-CBT.

	Service Interventions	Target Population (in years)	Selected Proximal Outcomes[25]	Average Length of Service	Estimated Title IV-E Clearinghouse Rating[26]
In Home Parenting/ Support for specific populations	The Association for Successful Parenting (TASP): Successful Parenting DC[29]	Parents with intellecutal and other learning disabilites	Increase the safety and well-being of children living with parents who have an intellectual disability and to provide appropriate supports to families to ensure all are safe. Decrease the rate of children entering the foster care system by increasing protective factors and parents' abilities to care for their children.	6 months	Unknown
	Nurturing Parent Program (NPP)	Parents of children 5-12	Increased self-worth for parents and children, increased parental empathy, use on non-violent discipline strategies, increased nurturing parenting knowledge and skills	4.5 months	Insufficient evidence

[29] The Association for Successful Parenting (TASP): http://achancetoparent.net/dc-project/: Successful Parenting DC program purpose: (1) develop a curriculum used to teach parenting skills to DC parents with ID who are receiving services from CFSA and DDA, by building on the parents' strengths; (2) hire, train and provide on-going supervision and training to 5 grass-roots Parent Educators/Peer Navigators (individuals with lived experience with a disability or the parent/care giver of an individual with a disability) for family-support purposes and lastly; (3) conduct quarterly trainings for CFSA and DDA professionals who work with DC parents

Consultation and Coordination: Federal Funding for EBPs

In-home parenting and skill-based programs:

DC Health currently receives federal Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV)[30] funds to implement the Parents As Teachers' (PAT) home-visiting program model. In addition to the existing capacity supported by DC Health's grant, DC Health also funds local program slots. CFSA will work with DC Health to determine how best to leverage existing funds and support/expand locally funded slots as needed using Family First funding. In year one, CFSA has determined to support additional slots of PAT (see Table 2) to meet the needs of the target populations identified in this plan (see Table 1). In addition to intra-district government partnerships, CFSA may also compete funds for award to private agencies to provide in-home parent skill-building evidence-based curricula. CFSA selected in-home parent skill-building programs in part due to their existing capacity, perceived effectiveness within DC, as well as the substantial number of city-wide providers with implementation expertise.

Medicaid funding and Mental Health and Substance Abuse prevention and treatment services:

DBH directly contracts with mental health and substance abuse prevention and treatment providers across DC. When selecting EBP services, DBH presented the services sub-group with an array of behavioral health services and treatment modalities that have been rigorously evaluated and implemented in DC for several years, and in alignment with this evidence, have been both rated by the CEBC as well-supported practices and have been approved in DC as Medicaid allowable services. Under the *payer of last resort* requirement, therefore Medicaid is the primary payer for these well-supported services.

CFSA's recommends the Children's Bureau clarify the provided program guidance in PI 18-09 Section C [31] such that the requirement around prevention spending on well-supported EBPs be 50% of *all spending* (inclusive of spending that is reimbursed through other programs or payers, such as MIECHV and Medicaid). Programs included in this five year prevention plan that could be reimbursable through another public or private source should be included in the calculation. As the guidance is currently written, DC and other Medicaid expansion states/states that receive other federal funds are penalized for having identified and developed other federal funding sources for existing well-supported services and cannot maximize claiming under Family First. Please see Appendix B for full analysis of the impact of Medicaid expansion and Family First requirements.

While CFSA notes the tension in the requirements related to prevention program financing and federal reimbursement, EBP recommendations were made by the services sub-group with the particular focus

[30] DC Health currently receives MIECHV grant funding: https://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting-overview

[31] ACYF-CB-PI-18-09: https://www.acf.hhs.gov/sites/default/files/cb/pi1809.pdf

on selecting the program models that would be the best fit to serve DC's Family First prevention-eligible children and their caregivers while ensuring optimal levels of evidence. CFSA will work with DBH to determine how best to leverage existing programs and support/expand locally funded slots as needed using Family First funding. As noted above, CFSA may also compete funds for award to private agencies to provide additional mental health and substance abuse treatments services where appropriate to meet the needs of children and families.

Case Management: A Fundamental Service

To provide Family First prevention-eligible children and their caregivers with access to this array of EBPs, CFSA recognizes the critical importance of robust case management and ongoing engagement with families. CFSA's existing practice model[32] employs a trauma-informed service delivery framework that threads theory to practice through casework with families (see Section 6 for more about CFSA's trauma-informed service delivery). **Building on the lessons learned from the Waiver implementation around the challenges of service utilization and ongoing engagement in EBPs, CFSA is investing in training focused specifically on building the skills of case managers to directly provide an evidence-based service, Motivational Interviewing, so they in turn are better prepared to encourage and motivate meaningful connections-to and engagement-in additional EBP services provided external to CFSA, and to enhance engagement with and achievement of the child specific prevention plan.**

Motivational Interviewing within Case Management

Under Family First, CFSA will train all agency social workers and supervisors and contracted prevention services case management providers (Collaboratives) in Motivational Interviewing (MI), which is integrated as a core component of the practice model[33]. As a central aspect of the practice model, MI will equip CFSA and Collaborative caseworkers with a proven service to enhance partnering with families to set goals within the child specific prevention plan, crafts strategies and goals, make a plan to reach those goals, and boost motivation and internal resolve to follow-through. It will be used seamlessly throughout the life of the family's prevention case to promote uptake of services, ensure completion of services and reduce premature drop-off, and to increase the successful attainment of the child specific prevention plan including individualized case goals related to improved parenting skills and mental health and reductions in substance abuse.

MI will be carried out with fidelity as an integral component of the practice model and case management for all families served through Family First. In the MI handbook on the Title IV-E Clearinghouse, model developers William Miller and Stephen Rollnick describe MI as a "collaborative, goal-oriented style of communication with particular attention to the language of change," which is designed to facilitate a personal change process from start to finish, and will be used accordingly by

[32] DC CFSA 2019 Annual Progress and Services Report, June 30, 2018: https://cfsa.dc.gov/sites/default/files/dc/sites/cfsa/publication/attachments/DC_CFSA_APSR_2019_63018_FINAL.PDF
[33] CEBC: https://www.cebc4cw.org/program/motivational-interviewing

CFSA and Collaborative case managers throughout the life of the family's prevention case.[34] The handbook also describes MI as four overlapping processes: Engaging, Focusing, Evoking, and Planning—which align with and will enrich the stages in CFSA's practice model. MI will be carried out by case managers both as:

(1) *Stand Alone Evidence-Based Service*: To advance case goals identified in the child specific prevention plan in partnership with families, regardless of whether the family participates in any additional EBP services throughout the life of the family's prevention case.
(2) *Adjunctive Evidence-Based Service*: When participation in an additional EBP is appropriate, to improve appropriate selection of the additional EBP for both children and caregivers, ensure that each family has the dedicated support and motivation to sustain engagement in often intensive service interventions—thereby bolstering outcomes of additional EBPs.

The empirical evidence available in the psychological literature has strengthened CFSA's commitment to designing and implementing MI not only as a stand-alone service integrated within case management, but also as a service adjunctive to a broader range of preventive EBPs.

Research shows that pairing MI with PCIT and other EBPs should lead to better outcomes for children and their families. Studies have found the combination of Parent-Child Interaction Therapy (PCIT) and Motivational Interviewing to be effective in treating children with behavioral problems and their families. In a randomized trial involving 110 physically abusive parents, Chaffin and colleagues compared PCIT to a standard community-based parenting program. Only 19% of parents who participated in the combined PCIT and MI program were reinvestigated for child physical abuse, compared to 49% of parents who participated in the community-based program.[35] A similar field implementation trial of 192 parents showed that families who participated in a six-session group program based on Miller and Rollnick's MI principles prior to PCIT also had the lowest rates of recidivism and longer periods of time before another child maltreatment report was filed compared to other treatment options, including PCIT without MI.[36] A more recent study found greater reductions in externalizing and internalizing child behavior problems and parental stress among families who received a combination of motivational interviewing and PCIT, compared with waitlisted families.[37] By providing an evidence-based service at the heart of case management to improve service engagement, CFSA is also leveraging lessons learned garnered from the Waiver implementation to be responsive to the existing service-delivery challenges.

[34] Motivational Interviewing: A Primer for Child Welfare Professionals, Child Welfare Information Gateway (2017): https://www.childwelfare.gov/pubPDFs/motivational_interviewing.pdf, page 2.
[35] Chaffin, M., Silovsky, J. F., Funderburk, B., Valle, L. A., Brestan, E. V., Balachova, T., Jackson, S., Lensgraf, J. & Bonner, B. L. (2004). Parent-child interaction therapy with physically abusive parents: efficacy for reducing future abuse reports. *Journal of consulting and clinical psychology*, *72*(3), 500.
[36] Chaffin, M., Funderburk, B., Bard, D., Valle, L. A., & Gurwitch, R. (2011). A combined motivation and parent–child interaction therapy package reduces child welfare recidivism in a randomized dismantling field trial. *Journal of consulting and clinical psychology*, *79*(1), 84.
[37] Webb, H. J., Thomas, R., McGregor, L., Avdagic, E., & Zimmer-Gembeck, M. J. (2017). An evaluation of parent–child interaction therapy with and without motivational enhancement to reduce attrition. *Journal of Clinical Child & Adolescent Psychology*, *46*(4), 537-550.

Moreover, implementation of MI within case management is responsive to case management enhancements requested by families in focus groups conducted during CFSA's Family First planning process.

Research also clearly demonstrates MI's effectiveness in bringing about a wide range of behavior changes when used absent another EBP, including multiple studies suggesting its effectiveness in a child welfare context. Evidence of MI's effectiveness is discussed further in section 4 of this plan.

While its roots are grounded in substance abuse treatment, MI has emerged as a prominent case management tool in the field of child welfare beyond substance abuse. [38]

> *"Much like clients in the substance use field, child welfare clients may be ambivalent to change, which makes them good candidates for the use of motivational interviewing. Child welfare practice also tends to embrace some of the same tenets present in motivational interviewing, such as engaging clients in decisions and focusing on their strengths. Additionally, motivational interviewing incorporates self-determination, which is one of the tenets of trauma-informed care. Research has shown that motivational interviewing is also effective when paired with other treatment strategies, such as cognitive behavioral therapy (Substance Abuse and Mental Health Services Administration, 2017)."[39] (Child welfare Information Gateway, 2017)*

Research and evaluation to date has already highlighted MI as an effective service delivery strategy with both adult and youth populations, making it an ideal fit for CFSA's foster care candidates and their families as well as pregnant or parenting youth in care.[40] By providing an evidence-based service at the center of case management, CFSA will equip its public and private agency case managers with the tools necessary to engage youth and families to make meaningful change, improve family well-being and independence, and prevent entries into foster care.

EBP Procurement

CFSA will select the best procurement vehicles to ensure timely delivery of the five year prevention plan services to DC residents. Upon approval of this plan, CFSA will established Memorandums of Understanding (MOUs) with sister agency partners: DC Health, the Department of Behavioral Health (DBH), and other sister agencies as relevant, to expand or leverage their respective capacity/slots for in-home parenting, mental health, and substance use disorder services to meet the needs of CFSA's candidate populations. By capitalizing on DC's existing providers and service infrastructure, CFSA can ensure timely start-up with minimal costs associated with standing up new providers. In using a combination of agency partnerships and competitive procurements, CFSA's array of evidence-based interventions will afford CFSA and partner organizations the ability to create a robust prevention

[38] Motivational Interviewing: A Primer for Child Welfare Professionals, Child Welfare Information Gateway (2017): https://www.childwelfare.gov/pubPDFs/motivational_interviewing.pdf Page 1
[39] Motivational Interviewing: A Primer for Child Welfare Professionals, Child Welfare Information Gateway (2017): https://www.childwelfare.gov/pubPDFs/motivational_interviewing.pdf Page 2
[40] Motivational Interviewing: A Primer for Child Welfare Professionals, Child Welfare Information Gateway (2017): https://www.childwelfare.gov/pubPDFs/motivational_interviewing.pdf Page 2

services continuum across District agencies and private non-profit partners.

EBP Training/Referral Capacity Building

Case management and EBP provider trainings will be needed to support start-up or ramp-up for provider's new and existing staff. Please see Section 6 for CFSA's training plan and activities to ensure success of the Family First programs and services across the District. In addition to trainings needed to support the ongoing implementation of EBP models, CFSA also recognizes the opportunity to better coordinate and align referral processes from the point the social worker documents the child-specific prevention plan and service needs. As part of the Family First implementation, CFSA leveraged available technology to create a referral pipeline to available EBP services and community-based resources to quickly link parents and children with appropriate services and ensure timely connection once a referral has been made. Technology updates will also allow CFSA staff and community-based organizations to effectively track engagement in EBP service delivery and support financial claiming. CFSA's Child Welfare Training Academy (CWTA) trains staff to effectively use these system enhancements in daily practice to support children and families.

Trauma-Informed Service Delivery

In 2012, CFSA was awarded a five year grant from the U.S. Department of Health and Human Services' Administration for Children and Families (ACF) to make trauma-informed treatment the foundation of serving children and youth in the District's child welfare system. Since that time, CFSA, through its Child Welfare Training Academy (CWTA[41]) and Office of Well Being designed the Practice Guidance for Resilience, Adversity, and Trauma (PGRAT) and infused trauma-informed training components at the foundation of pre-service and in-service trainings for CFSA direct service staff, resource parents, foster care providers, and Collaborative contractors. CFSA focused the trauma grant on deepening child welfare practice through implementation of critical thinking and clinical case work practice through a trauma-informed lens. Specialized training was also developed for prevention services staff and non-direct services staff. The Trauma Systems Therapy (TST) model, an EBP shown to dramatically speed and improve healing in children who have experienced abuse or neglect without relying on medication, hospitalization, or prolonged counseling[42], was used in the initial training and development of ongoing trauma-informed practice curriculums. **Please see Appendix C - Attachment III for Assurance, for each service, that each HHS approved title IV-E prevention service provided meets trauma-informed service delivery standards, per CFSA CWTA.**

Improving Outcomes

[41] The ***Initiative to Improve Access to Needs-Driven, Evidence-Based/Informed Mental and Behavioral Health Services in Child Welfare*** was awarded to CFSA in October 2012 by the Administration for Children and Families (ACF). The grant was for $3.2 million ($640,000/year for five years). While funding was anticipated to cease in 2017, CFSA received a one year no cost extension to spend remaining funds in 2018.

[42] CFSA website: https://cfsa.dc.gov/page/trauma-informed-practice

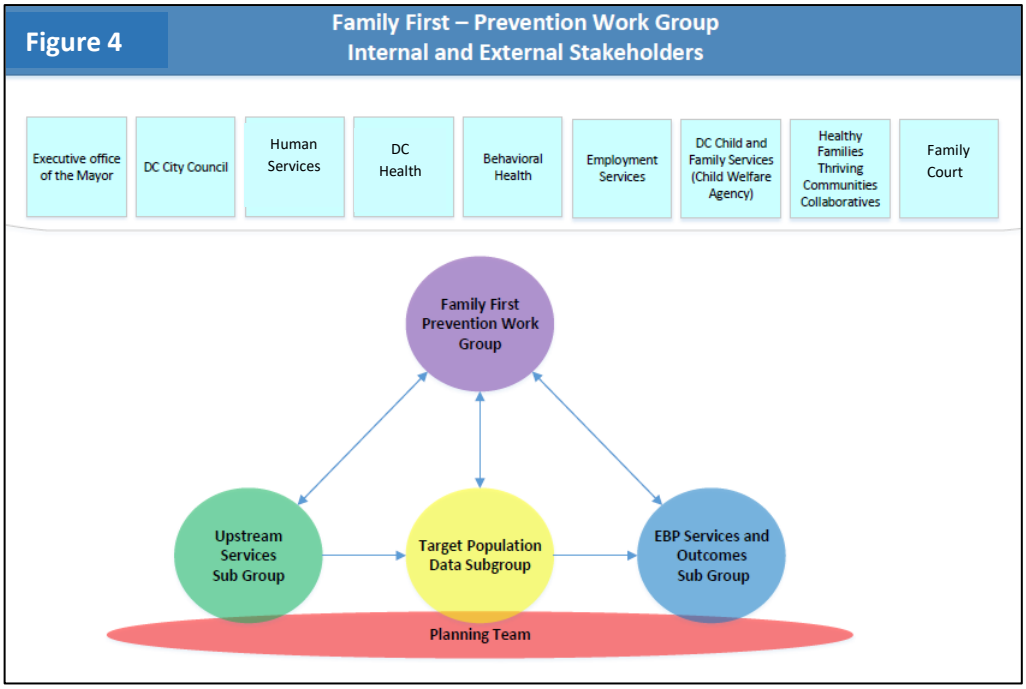
By providing children and families at risk of foster care entry with an expanded array of well-implemented evidence-based preventive services, coupled with evidence-based case management using motivational interviewing techniques to support service uptake and participation, DC posits that outcomes for families will be significantly improved in accordance with the intended outcomes of each program. For example, parents enrolled in substance abuse treatment EBPs will experience reductions in problematic patterns of use; parents and children enrolled in dyadic therapy will experience improved attachment; and a teen enrolled in an EBP focused on improving mental and behavioral health will experience increased pro-social behaviors and reduced acting out. These improvements in individual and family functioning will in turn lead to reduced child maltreatment and, ultimately, reduced demand for foster care as the preventive services expand. CFSA's Theory of Change (see the Evaluation section) depicts the sequence of causal events and mechanisms by which outcomes for children, families, and communities are expected to improve due to Family First.

Consultation and Coordination: Stakeholder Engagement in Target Population and EBP Service Selection

As a small and agile jurisdiction, DC is uniquely poised to regularly convene key staff and stakeholders across all levels of government. As noted above in Sections 1 and 2, the candidate populations (Section 1) and the evidence-based services and outcomes (Section 2) were all determined through a robust stakeholder engagement leading up to the submission of this five year plan.

Beginning in June of 2018, CFSA launched our Family First planning process through the creation of DC's Family First Prevention Work Group (Work Group). The Work Group was charged with making key recommendations for CFSA's five year prevention plan by (a) Identifying target populations for services, including upstream (primary prevention) target populations and candidates for foster care, and (b) recommending the best-fit evidence-based interventions to meet District families' specific service needs. The Work Group participants included leadership and program staff from across DC government and local community-based organizations, including DC's Health and Human Services cluster agencies, DC City Council, the Executive Office of the Mayor, Family Court, CFSA's court monitor, advocacy organization partners, and CFSA's community-based child-abuse prevention partners, the Healthy Families Thriving Communities Collaboratives (Collaboratives).

Figure 4 Family First – Prevention Work Group Internal and External Stakeholders



The Work Group met regularly from June 2018 to February 2019 to make recommendations about upstream (primary prevention) and candidate target populations and evidence-based service interventions. The Work Group served as the "committee of the whole" for the effort. CFSA leadership and staff used this forum to report-out all major updates and sub-group recommendations. To implement the work needed to complete this five year plan, the Work Group convened three sub-groups (Upstream Primary Prevention, Target Population (Data), and Services/Outcomes) responsible for meeting regularly (often weekly) to bring recommendations back to the larger Work Group. The sub-groups met sequentially, with each recommendation building upon the previous sub-group's work. See Figure 4 for a visual representation

of the Work Group and sub-group's stakeholder engagement process, including the successive sub-group work and overall reporting structure and Appendix A for the full list of the Work Group's meeting schedule and key accomplishments.

Parents and youth were engaged through the focus groups held this year to assess the value and fit of evidence-based programs to meet DC families' needs. CFSA will continue to engage youth and family stakeholders in the process of providing feedback about the quality and fit of evidence-based programs and services. CFSA uses multiple venues and methods throughout the year as part of our Continuous Quality Improvement (CQI) efforts to garner parent and youth input. For example, focus groups are convened as part of our annual Needs Assessment and Resource Development Plan, the completion of our FY2020-2024 Child and Family Services Plan and Annual Progress and Services Report, and ongoing community-engagement events hosted by our community-based Collaborative partners.

Underpinning all work of the Prevention Work Group was CFSA's Planning Team, a project management team comprised of CFSA's Director, program staff from across CFSA's Community Partnerships Administration and the Office Policy, Planning, and Program Support, and Chapin Hall, CFSA's technical assistance provider (in partnership with Casey Family Programs). The Planning Team met bi-weekly throughout the duration of this planning process to serve as the project management team for CFSA's prevention plan implementation and is responsible for the drafting and submission of this plan.

Section 3: Monitoring Child Safety and Risk

Pre-print Section 3

During the 12-month period when EBP services are being delivered to Family First prevention-eligible children and their caregivers , CFSA will ensure that each child receives a thorough and accurate assessment of risk on a regular basis through one or both of the following mechanisms: (1) informal risk assessment on an ongoing basis, for example though conversations and observations of the family dynamics and/or the home, by staff formally trained to assess risk or (2) formal risk assessment through completion of the SDM risk assessment instrument every 90 days. Protocols for both formal and informal risk assessments are outlined in longstanding CFSA in-home services policy, stating that "CFSA in-home and private agency (as applicable) staff shall continually assess for safety and risk factors throughout the family's involvement with the District's child welfare system, starting with the initial contact and ending with a safe case closure." [43] The policy clearly indicates that CFSA staff as well as staff at the Collaboratives and CFSA's foster care provider conduct routine safety and risk assessments for all cases. Furthermore, Collaborative and foster care provider staff are required to carry out periodic risk assessments through their contracts with CFSA.

In addition, since October 1, 2019, clinicians delivering EBP services to Family First prevention-eligible children and their caregivers have been required through Memoranda of Understanding (MOU) between CFSA and sister agencies to complete risk assessments as outlined above for cases where there is no CFSA, Collaborative, or contracted case manager. Through the fulfillment of this requirement, all Family First prevention-eligible children and their caregivers receiving Family First EBP services have received periodic risk assessments. Risk assessments are conducted by the family worker that is most closely engaged with the family at any point in the case, acknowledging that risk assessments are more accurate when conducted by a worker who routinely engages with the family.

Risk assessment results will be monitored alongside progress toward service goals by the responsible caseworker or clinician. **If a child's risk of entering foster care does not improve at a reasonable rate during or following the provision of services, the Prevention Plan will be re-assessed** and changed as needed. The reasonable rate at which risk of foster care entry can be expected to diminish will vary among cases due to unique family and case circumstances as well as significant variations in the length of each service, which range from three months to multiple years. Responsible caseworkers or clinicians will be trained through pre-service and in-service training to identify a "reasonable risk reduction" rate and thereby determine whether a Prevention Plan change is needed.

Table 5 below displays the caseworker who will be responsible for initial and ongoing risk and safety assessment for children receiving EBP services, and the individual internal to CFSA responsible for updating the Prevention Plan if warranted (in some cases these are the same person). Note that an

[43] CFSA Policy: Delivery of In-Home Services
https://cfsa.dc.gov/sites/default/files/dc/sites/cfsa/publication/attachments/Program%20-%20In-Home%20Services%20%28final%29%28H%29%28rev%203.19.12%29_3.pdf

update to the Prevention Plan may be required due to a lack of "reasonable risk reduction" or because family circumstances and needs have changed.

Table 5 Responsibility for Initial and Ongoing Risk Assessment and Prevention Plan Changes

Target Sub-Population	Individual Completing Risk & Safety Assessments and Monitoring "Reasonable Risk Reduction"	Individual responsible for Updating Prevention Plan if Needed
Front Porch		
(1) Children served through the Healthy Families/Thriving Communities Collaboratives (the Collaboratives) following a CPS investigation or closed CFSA case.	Child's Collaborative caseworker	Child's Collaborative caseworker
(2) Children who have exited foster care through reunification, guardianship, or adoptions and may be at risk of re-entry.	*While youth's case is open:* Child's foster care social worker	*While youth's case is open:* Child's foster care social worker
	After youth's case is closed: Clinician delivering service in Prevention Plan	*After youth's case is closed:* Collaborative caseworker for parent and children
(3) Children born to mothers with a positive toxicology screening.	*If a case is open:* Child's in-home services or foster care social worker	*If a case is open:* Child's in-home services or foster care social worker
	If no case is open/after closed: Clinician delivering service in Prevention Plan	*If no case is open/after closed:* Collaborative caseworker for parent and children
Front Door		
(4) Children served through CFSA's In-Home Services program, which offers intensive case management and service referrals to families.	Child's in-home services social worker	Child's in-home services social worker
(5) Pregnant or parenting youth in/recently exited foster care with eligibility for services ending five years after exiting foster care.	Child's foster care social worker	Child's foster care social worker
(6) Children of pregnant or parenting youth in/recently exited foster care (non-ward children) with eligibility for services ending five years after exiting foster care.	*While youth's case is open:* foster care caseworker for parent in foster care	*While youth's case is open:* foster care social worker for parent in foster care
	After youth's case is closed: Clinician delivering service in Prevention Plan	*After youth's case is closed:* Collaborative caseworker for parent and children
(7) Siblings of children in foster care who reside at home and have assessed safety concerns.	Foster care social worker for all siblings	Foster care social worker for all siblings

Collaborative staff managing cases will be trained by CFSA's Child Welfare Training Academy (CWTA) to conduct risk assessments to continually assess risk. If the Collaborative determines that risk of foster care entry remains based on these assessments, the Collaborative will communicate with CFSA staff to re-examine the prevention plan. For families who are served by sister agencies or community organizations providing prevention services, it is the expectation that these agencies assess risk through informal risk assessment. All CFSA staff, sister agency staff, and prevention services contractors will be trained to conduct informal risk assessments. If it is determined that risk remains, the sister agency or community partner will communicate the assessed risk to CFSA or Collaborative worker responsible for that family's prevention-plan management. If the Collaborative determines that risk of foster care entry remains high based on this assessment, the Collaborative will communicate with CFSA staff to re-examine the prevention plan and the child's eligibility for prevention-services.

Section 4: Evaluation Strategy and Waiver Request

Pre-print Sections 2 and 4

On April 12, 2018, the Children's Bureau[44] issued the following information regarding evaluation strategies for services reimbursable through Family First:

> *The state must have 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. The state cannot receive FAMILY FIRST for the program or service unless the evaluation strategy is included in the five year plan.*[45]

In addition to the criteria above, at least 50 percent of the expenditures reimbursed by federal funds must be for prevention services and programs that meet the requirements for supported or well-supported practices starting in FY 2022, and well-supported practices started in FY 2024. Programs that are well-supported may not require rigorous evaluation however CFSA would still be required to provide a plan for continuous quality improvement (CQI) with regard to ongoing practice.

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 and MI models 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 and MI for Family First claiming, 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

[44] In accordance with Public Law 115-123, the Family First Prevention Services Act within Division E, Title VII of the Bipartisan Budget Act of 2018, The U.S. Department of Health and Human Services Administration on Children, Youth and Families
[45] ACYF-CB-IM-18-02: https://www.acf.hhs.gov/sites/default/files/cb/im1802.pdf

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 *(Formal evaluation Waiver)*	Formal Evaluation	State Level CQI	Claimable FFPSA
Parents as Teachers (PAT)	✓		✓	✓
Nurturing Parent Program (NPP)			✓	
Healthy Families America (HFA)			✓	
Chicago Parenting Program (CPP)			✓	
Effective Black Parenting Program (EBPP)			✓	
ACT: Raising Safe Kids			✓	
Transition to Independence (TIP)			✓	
YVLifeset			✓	
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 has hired an Evaluation Team 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 sit within CFSA's Community Partnerships Administration where they are 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 receive direct support from PAQIA analysts responsible for generating CFSA's administrative data.

- **Partnership with The Lab @ DC[46]:** 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.[47] 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 and 2020. 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.

[46] The Lab @ DC: https://thelab.dc.gov/

[47] The Lab @ DC's mission is to "Conduct high-quality evaluations… to learn how well things work and how to improve," while building a scientific community of practice between City agencies and universities, thus creating a local professional community of policy evaluators in which the Senior Evaluations Leads will participate. Moreover, a specific focus of The Lab @ DC is to explore and carry out new, innovative methodologies in applied settings that push the boundaries of existing literature. This expertise will be leveraged to promote rigorous evaluation designs even where more traditional randomized or quasi-experimental methodologies cannot be used.

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, make challenging changes due to increased motivation, 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

Target Population

Identify, assess, and engage ***children at high risk of entering foster care and their caregivers,*** *including:*

1. Children served through the Healthy Families/Thriving Communities Collaboratives (the Collaboratives) following a CPS investigation or closed CFSA case.
2. Children who have exited foster care through reunification, guardianship, or adoptions and may be at risk of re-entry.
3. Children born to mothers with a positive toxicology screening.
4. Children served through CFSA's In-Home Services program, which offers intensive case management and service referrals to families.
5. Pregnant or parenting youth in/recently exited foster care with eligibility for services ending five years after exiting foster care.
6. Children of Pregnant or parenting youth in/recently exited foster care (non-ward children) with eligibility for services ending five years after exiting foster care.
7. Siblings of children in foster care who reside at home and have assessed safety concerns.

Interventions

Deliver high fidelity evidence-based programs *that are* ***aligned with the specific needs and characteristics of each family*** *in the target population.*

- Parents as Teachers
- Nurturing Parenting Program
- Healthy Families America
- Chicago Parenting Program
- Effective Black Parenting
- ACT -Raising Safe Kids
- Transition to Independence
- YVLifeset
- Project Connect
- Recovery Coaches
- Adolescent Community Reinforcement Approach
- Multi-Systemic Therapy
- Trauma-Focused Cognitive Behavioral Therapy
- Functional Family Therapy
- Parent Child Interaction Therapy
- Parents Anonymous

+

Promote increased family engagement, motivation, completion of services, and progress toward case goals *through:*

- Individualized case management
- Motivational interviewing

Proximal Outcomes

Parent, child, and family functioning improves by achieving the ***desired outcomes each service*** *at high rates, including but not limited to:*

- Parents empowered with skills and resources
- Closer relationships and stronger attachment between parents and children
- Parents learn effective discipline techniques
- Increased parenting confidence
- Increased child self-esteem and social skills
- Increased youth ability to cope to family, peer, school, and neighborhood problems
- Reduced inappropriate behavior and increased prosocial behavior
- Reduced mental health disorder symptoms
- Improved PTSD and trauma symptoms
- Reduced problematic patterns of substance use
- Build and sustain natural supports for overburdened *families*

Child maltreatment declines

- Reduced initial occurrence of maltreatment
- Reduced repeat maltreatment

Distal Outcomes

As the number of children and ***families served in the community increases****, the number of children served in* ***foster care decreases****.*

- Increased referrals for preventive and post-permanency services
- Reduced foster care entry
- Reduced foster care re-entry
- Reduced foster care census

The child welfare system rebalances *as a primarily preventive and family-strengthening system.*

- *Resources required to run the foster care system decline*
- *Resources available to invest in prevention services increase*

Infrastructure & Implementation Supports

CFSA and city agencies provide critical administrative supports to facilitate successful implementation and achievement of outcomes, including:

- Information technology tools
- Interagency collaboration
- Training & workforce supports
- Referral business process supports
- Prevention Plan development process supports

Evaluation Design

The District does not intend to claim for any allowable supported or promising practice EBPs available under Family First at the time of this submission. The District will only seek approval to leverage Family First funding for PAT and MI, all well-supported models, at the time of this submission. 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.

Parents as Teachers (PAT)

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.

PAT has been historically funded through MIECHV. As previously mentioned, in year one of implementation, the District has worked with our partner agency, DC Health to perform CQI on this well-supported model. The District will leverage Family First funding for additional capacity added to the PAT program starting immediately in year one. **It should be noted that there have been no adaptations to the original models, and both are presently being implemented in alignment with the versions reflected in the manuals on the Clearinghouse**[48]. 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*

[48] *PAT is a copyrighted model, which prohibits the District from copying and distributing the program's manual and materials. However, Mary's Center, DC's local PAT service provider, is an affiliate of the Parents As Teachers' (PAT) national office. CFSA has included a copy of Mary's Center's PAT certificate of affiliation as Attachment VI. As an affiliate, Mary's Center is implementing the PAT to the fidelity to the model with no adaptions. In addition to maintaining their certification, the program adheres to the 20 Essential Requirements, including as Attachment VII, of the PAT model to ensure high-quality service delivery.*

are the: MIECHV Program Coordinator and DC Health Public Health Analyst, who serve as the CQI Lead Team. [49]

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.

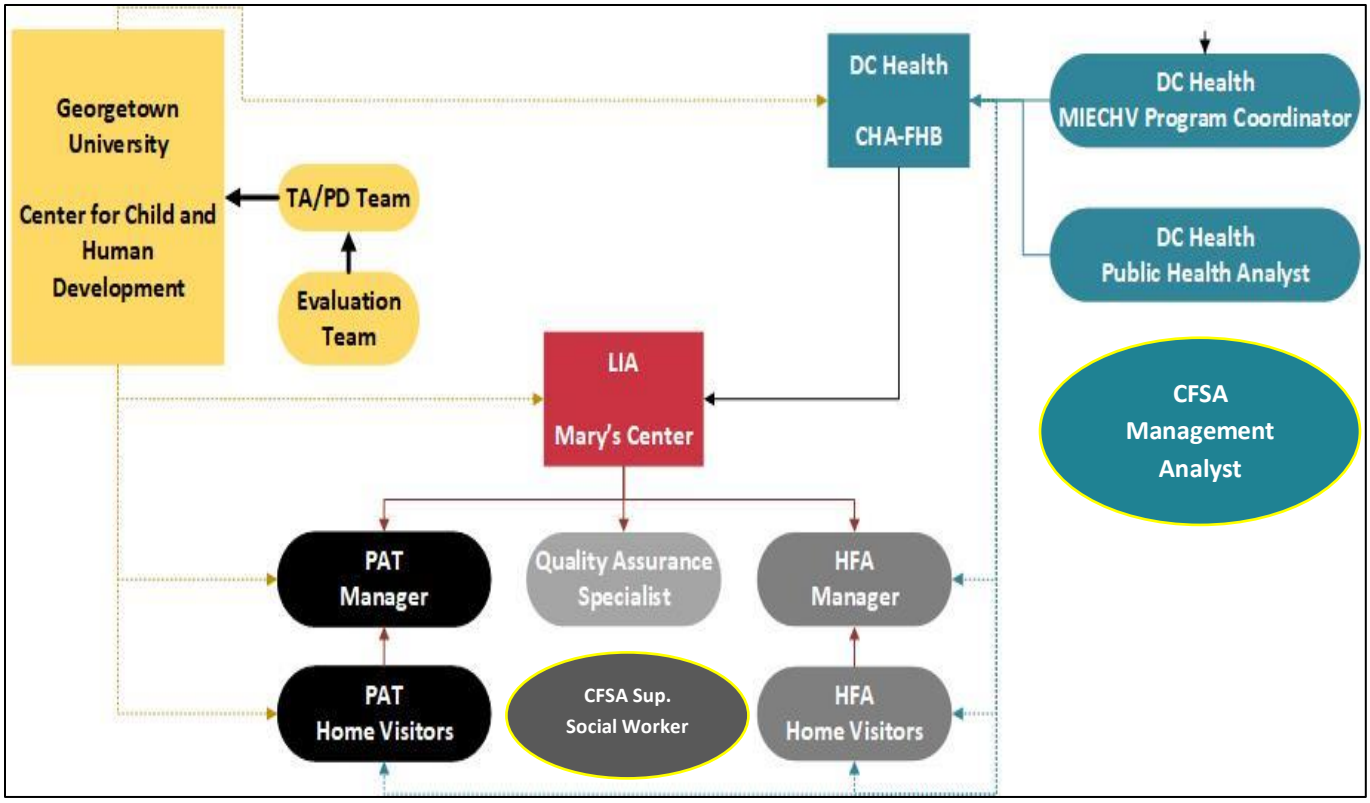
The integration of CFSA into the existing plan will require PDSA cycles related to 1) how CFSA social workers explain the referral and program to families, especially voluntary participation and 2) assurance that a family's participation status and results of PAT specific assessments will not negatively 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 April 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 (PAQIA) 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)

[49] DC Maternal, Infant, and Early Childhood Home Visiting (DC MIECHV) CQI Plan Update. September 2017-January 2020, page 3



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.*[50]

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

[50] DC Maternal, Infant, and Early Childhood Home Visiting (DC MIECHV) CQI Plan Update, December 2018, pages 3-5.

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*[51]

Additionally, a review by the Title IV-E Prevention Services Clearinghouse shows that PAT had favorable[52] 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[53]

[51] Prevention of Child Abuse and Neglect, Parents as Teachers, March 2019, page 1: https://static1.squarespace.com/static/56be46a6b6aa60dbb45e41a5/t/5c9d2c9deb39313e7359ded9/1553804446421/Fact-Sheet_ChildAbuseandNeglectPrevention.pdf

[52] According to the Title IV – E Prevention Services Handbook of Standards and Procedures, Impact estimates that are favorable (statistically significant and in the desired direction.

[53] Title IV-E Prevention Services Clearinghouse. Parents as Teachers. Summary of Findings. https://preventionservices.abtsites.com/programs/111/show

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
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, PAT was originally implemented as part of DC Health's Home Visiting program in 2010 through funding from HRSA's MIECHV grant. Since 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 both programs' effectiveness, results from The Home Visiting Evidence of Effectiveness (HomVEE)[54] 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

[54] OPRE Report #2019-93, Home Visiting Evidence Effectiveness Review: Executive Summary September 2019 https://homvee.acf.hhs.gov/sites/default/files/2019-09/HomeVEE_Executive_Summary_2019_B508.pdf

beginning the program[55]. 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[56], furthering CFSA confidence in the effectiveness of this model.

Motivational Interviewing

CQI Strategy. As previously stated, 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 MI and how CFSA plans to meet the continuous monitoring requirements, which will also be implemented as part of year one activities under Family First.

The District will leverage Family First funds to implement MI. In year one of implementation, the District will perform CQI on this well-supported model. It should be noted there are no adaptations to the original model, and it is presently being implemented in alignment with the model handbook as noted on the Title IV-E Prevention Services Clearinghouse[57].

CFSA's theory of change assumes that the use of MI by CFSA and Collaborative case managers will enhance clients' motivation to make difficult behavior changes, including reducing problematic behaviors such as substance abuse and negative parenting practices and improving mental health, as well as increasing behaviors encouraged through the case plan, such as service engagement, participation, and completion, and building on personal and family strengths. By motivating positive change as well as increased uptake and sustained participation in services, MI will strengthen child and family protective factors, improve well-being, and address risks. This improved family functioning will lead to a decrease in repeat maltreatment and entries into foster care.

Accordingly, the key outcomes of Motivational Interviewing that will be reviewed through CFSA's CQI process include:

- Increased engagement and retention in services
- Increased achievement of plan goals
- Decreased reports of maltreatment
- Decreased entries in to foster care

Through CQI, CFSA will also assess key implementation drivers and fidelity to the model.

[55] OPRE Report #2019-93, Home Visiting Evidence Effectiveness Review: Executive Summary September 2019. Page 14 Table 2. https://homvee.acf.hhs.gov/sites/default/files/2019-09/HomeVEE_Executive_Summary_2019_B508.pdf
[56] OPRE Report #2019-93, Home Visiting Evidence Effectiveness Review: Executive Summary September 2019. Page 18. Table 4 https://homvee.acf.hhs.gov/sites/default/files/2019-09/HomeVEE_Executive_Summary_2019_B508.pdf
[57] Title IV-E Clearinghouse: Motivational Interviewing. https://preventionservices.abtsites.com/programs/142/show

The Family First Implementation Team (Implementation Team), comprised of core CFSA program managers, administrators and subject matter experts, will be responsible for overseeing all CQI activities to help realize the outcomes listed above. The Implementation Team will review quantitative and qualitative data on a periodic basis to assess implementation, track fidelity to the model, and assess child and family outcomes. In these meetings, findings will be discussed with an eye to ensuring quality implementation and identifying changes to improve implementation and outcomes. Key findings from CQI reviews of MI and other Family First EBPs will also be presented and discussed on regular intervals in DC's city-wide Family First Prevention Workgroup, comprising leadership and quality assurance staff from the diverse District agencies and providers partnering with CFSA to implement Family First services. This group will serve as a forum for reflection and decision-making among the agencies jointly responsible for the City's preventive services array.

CFSA and Collaborative agency Supervisory staff will be responsible for assessing quality and fidelity of MI practice so that staff receive regular review and feedback on their MI skills and practice. Quarterly, supervisors will use the Motivational Interviewing Assessment: Supervisory Tool for Enhancing Practice (MIA:STEP)[58] to review at least one family from the caseload of each worker. Families will be chosen at random. Supervisors will accompany a case worker on a visit and document observations in real time, including the quality of the interactions between the case worker and family and use of MI techniques. Scores of the MIA:STEP assessment will be completed quarterly and maintained ongoing to assess changes in skill over time. Scores, along with additional notes by the supervisor, will be reviewed quarterly by the Family First Implementation Team to ensure fidelity to the model and to develop change activities that support the continued successful implementation of MI. It should be noted that while the MIA:STEP tool will be used in this quarterly assessment for CQI and fidelity purposes, supervisors are expected to assess worker's use of MI techniques as part of required regular case worker supervision, providing real-time feedback and discussion within the context of supervision.

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.

A review by the Title IV-E Prevention Services Clearinghouse shows that MI had favorable and statistically significant impacts on Adult well-being: Parent/caregiver substance use. Additionally, research has demonstrated the effectiveness of MI in bringing about a range of behavior changes, such as improved oral health behaviors,[59] self-management behaviors for patients with type II diabetes,[60] diet

[58] The Motivational Interviewing Assessment: Supervisory Tool for Enhancing Practice (MIA: STEP) toolkit was developed for supervisors to use in mentoring and facilitating the development and maintenance of counselor MI skills. The toolkit is a complete package that includes a review of the clinical trials research, guidelines for conducting the MI Assessment, tools to enhance counselor skills, and instructions for assessing and rating counselor proficiency in MI. https://motivationalinterviewing.org/sites/default/files/mia-step.pdf

[59] Kay, E., Vascott, D., Hocking, A. et al. Motivational interviewing in general dental practice: A review of the evidence. Br Dent J 221, 785–791 (2016); Colvara, Beatriz & Demétrio, Daniel & Meyer, Elisabeth & Neves Hugo, Fernando & Hilgert, Juliana & Keller Celeste, Roger. (2018).

[60] Song, D., Xu, T. Z., & Sun, Q. H. (2014). Effect of motivational interviewing on self-management in patients with type 2 diabetes mellitus: a meta-analysis. International Journal of Nursing Sciences, 1(3), 291-297; Chen, S. M., Creedy, D., Lin, H. S., & Wollin, J. (2012). Effects of motivational interviewing intervention on self-management, psychological and glycemic outcomes in type 2 diabetes: a randomized controlled trial. International journal of nursing studies, 49(6), 637-644.

and exercise,[61] and cognitive and behavioral change among domestic violence offenders.[62] Furthermore, recent research supports the use of the model specifically in the child welfare field. A 2015 publication titled *Application of Motivational Interviewing Techniques in Child Welfare* authored by the Center of Advanced Studies in Child Welfare at the University of Minnesota School of Social Work highlights evaluations demonstrating that MI may be effective in child welfare-specific contexts, including engagement of families in comprehensive assessments,[63] juvenile corrections,[64] and child protection work with alcohol-abusing parents.[65] The article also clearly articulates the potential benefits of MI's use by child welfare caseworkers for promoting client engagement and improving case outcomes.[66] Moreover, a 2018 publication, *Partnering With Parents: Reviewing the Evidence for Motivational Interviewing in Child Welfare,* found that in a literature review of 16 articles studying the effectiveness of MI in child welfare, 12 suggested MI's value for improving outcomes, including parenting skills, parent/child mental health, retention in services, substance use, and child welfare recidivism.[67]

MI has been shown to be a practical intervention for precipitating diverse types of behavior change. Although MI originated in the field of substance abuse, model developers William Miller and Stephen Rollnick have encouraged the evolution of the model's use to address a wide range of behavior changes. The third and most recent edition of the MI manual, which is listed on the Title IV-E Prevention Services Clearinghouse, describes MI as a model with wide applications in diverse fields, and the authors purport to have "broadened the application of MI to behavior change more generally, no longer limited to addictive behaviors."[68] In accordance with the manual and with research on MI's effectiveness, CFSA will use MI with clients to precipitate diverse behavior changes. CFSA is confident that MI is an appropriate intervention for application to help engage families and enhance their motivation to participate in the prevention plan and services and change the range of behaviors that may contribute to child maltreatment.

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

[61] Martins, R. K., & McNeil, D. W. (2009). Review of motivational interviewing in promoting health behaviors. Clinical psychology review, 29(4), 283-293.
[62] Kistenmacher, B. R., & Weiss, R. L. (2008). Motivational interviewing as a mechanism for change in men who batter: A randomized controlled trial. Violence and victims, 23(5), 558-570.
[63] Snyder, E. H., Lawrence, C. N., Weatherholt, T. N., & Nagy, P. (2012). The benefits of motivational interviewing and coaching for improving the practice of comprehensive family assessments in child welfare. Child Welfare, 91(5), 9.
[64] Doran, Hohman, & Koutsenok, 2013
[65] Forrester, D., McCambridge, J., Waissbein, C., Emlyn-Jones, R., & Rollnick, S. (2008). Child risk and parental resistance: Can motivational interviewing improve the practice of child and family social workers in working with parental alcohol misuse?. British Journal of Social Work, 38(7), 1302-1319.
[66] Application of Motivational Interviewing Techniques in Child Welfare. Center of Advanced Studies in Child Welfare at the University of Minnesota, School of Social Work. Margaret M. Higgins, J.D. April 2015
[67] Partnering With Parents: Reviewing the Evidence for Motivational Interviewing in Child Welfare. Families in Society: The Journal of Contemporary Social Services. November 2018. https://doi.org/10.1177/1044389418803455
[68] Miller, W. R., & Rollnick, S. (2012). *Motivational interviewing: Helping people change*. Guilford press.

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** was formed and meets more frequently, comprising representatives from each sister agency, a selection of Collaboratives, and key operational areas of CFSA. The sub-group is 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 is to conduct CQI for all programs across the city's prevention services array. In addition, the group uses 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 draws data collected from existing evaluation and CQI activities. The CQI Subgroup is 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.

Section 5: Child Welfare Workforce Support

Pre-print Section 5

CFSA's Workforce Development Infrastructure

CFSA is well poised to ensure ongoing support and enhancement of a competent, skilled, and professional child welfare workforce to deliver trauma-informed and evidence-based services to children and families. **CFSA's Child Welfare Training Academy (CWTA),** a dedicated team of clinically licensed social work training and supervisory staff, is **designed to provide the District of Columbia's CFSA social workers, resource parents, and community partners with the knowledge, skills, support, and coaching** to effectively promote the safety, permanence, and well-being of children and families. CWTA trainings are provided through CFSA's pre-service (training for new hires) and in-service (ongoing staff training and continuing education (CEU)) training series designed to keep all family-serving CFSA staff, community-based organizations, and resource parents informed to effectively carry out their role as a trauma-informed child welfare professionals and caregivers. CFSA will build upon our array of existing trauma-informed workforce trainings to enhance curricula for CFSA staff and create new training modules for external EBP service provider staff (see Section 6: Child Welfare Workforce Training) to ensure all of DC's child welfare workforce is equipped with the tools they need to effectively serve children and their families under Family First.

Qualified Workforce

CFSA Staff. CFSA currently employs one of the most highly-skilled and credentialed child welfare workforces in the country with licensed Masters of Social Work comprising all CFSA caseworkers. As a result, **CFSA staff are well-positioned to effectively learn and carry out new practices associated with Family First, building on existing relevant expertise.** All CFSA Social workers must have a master's degree in social work from an accredited college and licensing certification from the DC Board of Social Work examiners.[69] In order to advance to supervisory positions, social workers must obtain a licensed clinical social worker certification from the Board and have a minimum of two years of experience in the field of child welfare. CFSA expects all employees and contracted foster care provider staff to participate in 80 hours[70] of pre-service and ongoing in-service trainings to maintain licensure and provide quality services to children and families. New CFSA social workers go through 30 full days of pre-service training. In addition to pre-service trainings, all CFSA social workers are required to complete thirty (30) hours of in-service training each year. CFSA social work supervisors are required to complete twenty-four (24) hours of in-service training each year.

[69] CFSA's requirements for entry into the child welfare profession are outlined in detail in the Agency's Annual Progress and Services Report. DC CFSA 2019 Annual Progress and Service Report; https://cfsa.dc.gov/sites/default/files/dc/sites/cfsa/publication/attachments/DC_CFSA_APSR_2019_63018_FINAL.PDF

[70] Mandated by Consent Decree (see Prevention Case Loads section for Court-monitored staff licensure and training benchmarks).

EBP Providers: Definition of "Qualified Clinician." As noted above, EBPs will be delivered by CFSA, sister agency, and Collaborative staff. All services selected as part of our five year plan have been selected due to their high level of research evidence as well as accessibility and local support within DC (see Service Selection section above). The EBPs selected each have their own unique staff qualifications and training requirements specific to the intervention's service delivery model. **CFSA expects all providers of EBPs working with CFSA families as part of this five year plan to uphold the staffing and training requirements specified by each EBP model.** CFSA will hold all EBP service providers accountable to implementing each intervention to fidelity, including requirements of staff training and fidelity monitoring (noted in our evaluation plan). All mental health and substance abuse EBPs proposed in this plan require that all or most therapists possess a master's degree or equivalent, and CFSA will ensure that providers meet requirements.

A Rich History of Trauma-Informed Practice

CFSA offers robust training in trauma-informed practice to all staff, from leadership to caseworkers, through pre-service and in-service trainings, and supports trauma-informed practice through the administration of trauma-focused assessment tools with all cases. **This strong foundation in trauma-informed practice ensures that CFSA's Family First EBPs will "be provided under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma," per the requirements of the legislation.**[71]

As noted in Section 2, CFSA's Trauma Grant was used to make trauma-informed treatment the foundation of serving children and youth in the District's child welfare system. As part of this work, in 2015, CFSA integrated a series of functional assessments and screening tools into our case management practice and system of record (FACES). These tools included the CSBA for adult caregivers and the CAFAS/PECFAS functional assessment for children and youth in foster care. The CSBA is designed to ensure each caregiver's strengths and barriers are being assessed and the CAFAS/PECFAS are designed to provide an age-appropriate assessment of each child's needs, speak to the trauma a child may be experiencing, and assess what services may need to be put in place to support each child. The CSBA was implemented agency-wide at CFSA as well as with our foster care providers, and our Collaborative community-based prevention partners. The CAFAS/PECFAS was implemented for children in foster care with CFSA as well as foster care provider staff.

This system-wide training and implementation of a trauma-informed functional assessments was coupled with a simultaneous integration of these tools into our SACWIS system (FACES). Incorporation of these tools into staff's daily work in FACES has grounded CFSA's social work practice in the trauma-informed and data driven decision making necessary to develop comprehensive case planning documents to support children and parents while engaged with CFSA, and after, when connected to community-based supports provided by the Collaboratives and other organizations. **Under Family First, CFSA will continue to use these functional assessments to craft trauma-informed child-specific**

[71] Family First Prevention Service Act: [Page 132 STAT. 234], https://www.congress.gov/bill/115th-congress/house-bill/1892/text

Prevention Plans and link to evidence-based services for candidate children and their families.

Trauma training begins the day a new hire walks through the door at CFSA to attend pre-service training and continues with in-service training throughout the year. As part our ongoing work to support and enhance our child welfare workforce, CFSA continues to implement our Practice Guidance on Resilience, Adversity & Trauma (PGRAT) series for all staff. Developed in 2016, the CWTA, in partnership with CFSA's Office of Well Being, designed PGRAT to build upon the system-wide trainings and deepen child welfare practice through the use our robust trauma-informed training curriculum for all CFSA staff and our foster care providers. The PGRAT trainings include (1) Review of scholarly materials and participation in book reviews, (2) Engagement in facilitator-led group workshops and ongoing supervisor-facilitated teaming; and, (3) Developing and enhancing trauma informed engagement, assessment, and case plan integration skills.[72]

Trauma Informed Service Delivery for EBP Providers. Many of the EBPs selected as part of this five year plan already incorporate trauma-informed service delivery in their model design[73]. As part of the procurement process, CFSA will specify the requirements needed to incorporate trauma-informed service delivery into all Family First EBP services. Where CFSA is partnering with sister agencies to deliver existing EBPs already in place, Memorandums of Understanding will be drafted to require staff receive trauma-informed service delivery training from CFSA's CWTA. All contracts CFSA negotiates for the provision of direct EBP services will include language requiring program staff receive trauma-informed service delivery training from CFSA's CWTA. CFSA will make this newly required trauma-informed service delivery training available, as one of the new **Family First EBP Provider Training Requirements** for all EBP provider staff. Consistent training across all providers will set a strong service delivery foundation for all EBPs provided under Family First.

[72] PGRAT Modules developed in 2016 to deepen Trauma Grant practice. PGRAT serves as the foundation for all trauma-informed trainings. Currently CWTA is in process of infusing PGRAT into all pre-service/in-service trainings.
[73] Developing a Trauma-Informed Child Welfare System: https://www.childwelfare.gov/pubpdfs/trauma_informed.pdf Pages 9-11

Section 6: Child Welfare Workforce Training

Pre-print Sections 4 and 6

The following section outlines the trainings that CFSA currently offers and will craft over the coming months to provide training and support to caseworkers in developing Prevention Plans, assessing risk, assessing child and family needs comprehensively, connecting families to services and coordinating with existing services, knowing how to access and deliver the needed trauma-informed and evidence-based services, and overseeing and evaluating the continuing appropriateness of services. The addition of new training modules outlined below and the need for expansion of existing training offerings across the child welfare system will likely require additional CWTA staff to ensure timely and effective training to all CFSA staff, sister agency partners, and EBP service providers outlined in this plan. Additional staffing requirements will be determined as CFSA begins implementation planning in the coming weeks.

Training to Develop Appropriate Prevention Plans. CFSA's CWTA currently provides CFSA social workers and foster care provider staff with a robust suite of pre-service and in-service trainings to utilize both safety (Danger and Safety) and risk assessment (Structured Decision Making tool) outcomes and comprehensive functional assessments (CSBA and CAFAS/PECFAS), as applicable, to develop comprehensive case and service plans. CWTA will work with CFSA Program staff and our Child Information Services Administration (CISA) to modify the existing trainings and corresponding technology (Child Welfare Workforce Training section) to incorporate the formal documentation of a Family First prevention-eligible child's Prevention Plan within FACES, CFSA's system of record (as noted in the Prevention Plan section above). The training will also be expanded to include CFSA's community-based Collaborative partners.

*Training to Conduct Risk Assessments***.** As noted in the Safety and Risk Assessment section above, CFSA currently provides CFSA Social Workers and foster care provider staff with a robust suite of pre-service and in-service trainings on CSFA's safety and risk assessments, developing comprehensive case plans and making appropriate trauma-informed service recommendations. With the implementation of the new documentation requirements outlined in the Family First legislation, CFSA will modify the existing staff trainings and will develop EBP provider-specific trainings to incorporate direct service training and overall awareness of:

- How to use safety, risk, and functional assessments to document a child-specific Prevention Plan (documentation requirements described in the Prevention Plan section above).
- How to conduct ongoing safety and risk assessment (See Safety and Risk Assessments Section for requirements).
- The process and tools required for making updates or changes to a child's Prevention Plan.

Training to monitor ongoing safety and risk will be developed by CFSA's CWTA and be required of all CFSA staff and EBP providers as part of Family First.

Assessing Safety and Risk. All CFSA social workers and foster care provider staff are trained to complete

formal and informal the safety and risk assessments, as noted in the Safety and Risk Assessment section. These initial safety and risk assessments are captured in FACES and provide a basis for safety planning activities as needed to support a child and their family.

Assessing Service Needs. As noted above, CWTA trains all CFSA social workers and foster care provider staff to complete the trauma-informed CSBA for adult caregivers, in addition to training CFSA and provider staff to complete the CAFAS/PECFAS functional assessments for children and youth in foster care. These assessments provide a comprehensive assessment of both the parent's and child's specific needs and form the foundation for recommended service interventions to meet those specific needs. As part of the PGRAT training curriculum, CWTA will train all CFSA social workers to integrate functional assessments and screening tools into current case, service planning, and prevention planning activities to support children and families with the specific interventions needed to meet their needs.

Connecting to the families served, Coordinating and Accessing Trauma-Informed and Evidence-Based Services. One of the key tenets of CFSA's Family First prevention strategy is facilitating appropriate referrals to evidence-based services, which is in alignment with CFSA's existing overall approach to service delivery, as noted in our 2018 CFSA Practice Model, detailing six core practice actions.[74] Once CFSA staff identify Family First eligibility and create a child-specific Prevention Plan, facilitating successful connections and coordinating with any other child and family services to provide, often intensive services, will be critical to a family's engagement. To that end, CFSA will provide CFSA and Collaborative staff with training and informational materials on each EBP, ensuring that they are equipped to select the best possible EBP for each family. In addition, CFSA developed technology to support trauma-informed data-driven referral recommendations and trains all staff to use new EBP and community services referral recommendation and tracking tools once available. CFSA will also train all CFSA and Collaborative case managers in MI (detailed below), with the goal of increasing families' motivation to change and reach case goals, thereby increasing engagement, uptake, and completion of services.

Motivational Interviewing. CFSA's Social Workers and community-based Collaborative contractors will all be trained to provide families with Motivational Interviewing (MI) as an EBP service as an integral part of case management. MI is expected to bolster family motivation to make difficult changes and to promote increased engagement, uptake, and completion of services. Motivational interviewing does not require that staff hold a specific degree/credential to provide the service, making training on, and provision of MI a strong fit for the District's child welfare system. While CFSA's social workers are masters level social workers who are required to maintain their social work licenses in good standing, the Collaboratives' direct service staff have varied educational backgrounds.[75] CWTA will facilitate training on MI for all CFSA staff and CFSA's community-based Collaborative case managers, and CFSA's supervisors will routinely provide case managers with individualized coaching on MI practice as part of the model's ongoing fidelity monitoring processes.

Oversee and Evaluation the Continuing appropriateness of the services. Once a family is connected to EBP services in the community CFSA staff and EBP providers will be responsible for evaluating the

[74] CFSA Practice Model: 2019 APSR: Page 4
https://cfsa.dc.gov/sites/default/files/dc/sites/cfsa/publication/attachments/DC_CFSA_APSR_2019_63018_FINAL.PDF

[75] Motivational interviewing has been proven robustly effective (well-supported) without any requirement that staff hold a specific degree/credential to provide the service.

ongoing appropriateness of fit of the referral, assessing ongoing safety and risk, and determining if modification to a child's prevention plan are needed to support child and caregiver well-being. CWTA will develop Family First specific training, in partnership with CFSA program staff and CISA, that builds upon existing training curriculum and ensures community-based EBP providers are effectively assessing risk and documenting ongoing service needs. The Collaboratives will play a key role in facilitating and coordinating services for children and families that no longer have an open case with CFSA and ensuring services and programs specified in the child's Prevention Plan are coordinated with all other child and family services across the District.

Family First EBP Provider Training Requirements. As noted in the *Training to Conduct Risk Assessments* section outlined above, CFSA's will lean on the wealth of existing trainings already built into pre-service and in-service training curriculum to create, in partnership with CFSA's CWTA, CISA, and Program staff, three new trainings (see *EBP Provider Training Curriculum (Outline)* below) and offer our existing trauma-informed service delivery training to form a complete suite of EBP provider trainings to ensure appropriate trauma-informed, evidence-based services are provided to all Family First prevention-eligible children and their caregivers. Trainings will build upon and incorporate the following CWTA Training Courses (as appropriate):

- Caregivers Strengths and Barriers Assessment (existing training)
- CAFAS/PECFAS Training (existing training)
- Life of a Case (existing training)
- Family Centered Practice (existing training)
- Foundations of Child Welfare Practice (existing training)
- Foundations of Trauma-Informed Care (existing training)
- PGRAT Assessment Integration (existing training)

EBP Provider Training Curriculum (Outline)

- **Foundations of Trauma-Informed Care (Existing Training)**
    - *Training will cover the basic tenets of trauma-informed service delivery and will highlight staff's role in addressing trauma. CFSA already employs a dedicated Specialized Trauma Trainer equipped to train external partners on trauma-informed service delivery. Curriculum will be tailored to the EBP provider audience.*

- **Ongoing Assessment of Safety and Risk (New Training)**
    - *Training will cover how to conduct on-going safety and risk assessments and the process for reporting information back to the relevant CFSA social worker Collaboratives in order to refine services to address child safety and document needed updates or changes to a child's Prevention Plan.*

- **Family First Eligibility and Child-Specific Prevention Plan Development and Updates (New Training)**

- *Training will provide an overview of how CFSA staff will determine a child's eligibility for services and how to document a child-specific Prevention plan in FACES. EBP providers will be trained on how to request updates or changes to a child-specific Prevention Plan.*

- **Selecting, Facilitating, and Monitoring Appropriate EBP Services (New Training)**
  - *Training will cover the process to select appropriate EBP services, facilitating service connections and coordinating with existing services, assessing progress towards goals, and how to use existing and new technology to make these referrals, track engagement, monitor ongoing risk and appropriateness of fit. Training will cover the business process for making and accepting referrals for EBP services (including those not currently identified in a child's Prevention Plan) and reporting back to CFSA's Caseworker or Collaborative partners in order to document needed updates or changes to a child's Prevention Plan.*

As noted above, once technological enhancements have been made to new and existing tools, training will cover how to use these system enhancements to support the EBP service referral process and ongoing engagement in services.

Section 7: Prevention Caseloads

Pre-print Section 7

As described in the Section 1, all CFSA social workers within CFSA's case-carrying administrations may work with Family First prevention-eligible children and caregivers (as defined within Table 1). **For the purposes of this five year plan, all CFSA social workers and Collaboratives caseworkers are considered Prevention Caseworkers.** CFSA maintains strict case load standards for all CFSA social workers based on historic alignment with agency practice needs and legal oversight. The current caseloads ratios for all CFSA social workers are as follows:

CFSA Worker	Caseload Standard
In-home social workers	1:15 families (max 1:18)

All case load standards above apply to both CFSA and private agency staff providing these services on behalf of the agency (foster care providers). CFSA regularly oversees and monitors caseload standards through ongoing CQI practices as well as regular agency-wide performance monitoring activities using FACES reports. CFSA program managers and social work supervisors are responsible for ensuring compliance through ongoing review and monitoring of caseload size and distribution.

CFSA's community-based prevention providers also include EBP services provided by the Collaboratives. Collaborative case load size and type are determined and monitored through contract agreements based CFSA's assessed service needs with each Collaborative organization by CFSA's Four Pillar (see Introduction) case-types follows:

Collaborative Case Type	Caseload Standard
Front Yard	1:15 families
Front Porch	1:15 families
Front Door	1:30 families

As noted in Section 5, **CFSA expects all providers of all EBPs working with CFSA families as part of this five year plan to uphold the staffing and caseload requirements specified by each EBPs model.** CFSA will hold all EBP service providers accountable to implementing each intervention to fidelity, including requirements of staff caseload sizes to ensure fidelity to the model. CFSA staff will monitor and provide oversight to all partnership agreements for EBP services provided by Collaborative, sister agency, and other private non-profit partners.

Section 8: Assurance on Prevention Program Reporting

Pre-print Section 8

See Appendix C -Attachment I for assurance that CFSA will report to the Secretary such information and data as the Secretary may require with respect to the title IV-E prevention program, including information and data necessary to determine the performance measures.

APPENDIX

Appendix A: Prevention Work Group Meeting Schedule and Key Accomplishments

(Pre-print Section 2)

Prevention Work Group/Sub-group Meeting	Meeting Description/Key Accomplishments
Work Group Meeting 1: June 2018	• Overview of Family First legislation/opportunity and Prevention Plan development, discussion of City-wide prevention goals. • Defined the role and charge of the Prevention Work Group.
Work Group Meeting 2: July 2018	• Reviewed survey results and CFSA Needs Assessment data to explore target populations for primary prevention activities. • Charged sub-group with defining CBCAP funding recommendations for FY19, a down-payment on Family First.
CBCAP (Upstream Prevention) Sub-group	• Met throughout August 2018 (4 weeks). • Reviewed available data to recommended candidate target populations and services for Upstream prevention funding (CBCAP, Families First DC).
Work Group Meeting 3: September 2018	• Report-out from CBCAP/Upstream Prevention sub-group. • Reviewed updated Needs Assessment data to inform candidate Target Population "Data Sub-group" work.
Target Population Data Sub-group	• Met October 2018 -November 2018 (6 weeks) • Reviewed CFSA and external partner data to recommended candidate target populations for Family First Prevention Plan.
Work Group Meeting 4: October 2018	• Sister Agency and Partner presentations at Prevention Work Group meeting to inform possible target populations for primary prevention, bolstered environmental scan. • Agency Presenters: DC Department of Human Services (DHS) and DC Department of Behavioral Health (DBH)
Work Group Meeting 5: October 2018	• Sister Agency and Partner presentations at Prevention Work Group meeting to inform possible target populations for primary prevention, bolstered environmental scan. • Agency Presenters: DC Department of Health (DC Health), DC Department of Employment Services (DOES), and DC Health Families Thriving Communities Collaboratives (Collaboratives).
Work Group Meeting 6: November 2018	• Report-out from Target Population Data Sub-group on data-informed recommendation of candidate populations. Populations finalized in-meeting. • Report-out on Family and Provider focus group outcomes/feedback.
Services/Outcomes Sub-group	• Met December 2018 - January 2019 (8 weeks) • Recommended evidence-based service interventions for candidate populations within Five Year Prevention Plan.
Work Group Meeting 7: February 2019	• Report-out from Services/Outcomes Sub-group on data-informed evidence-based services recommendations. EBP service selections/outcomes finalized in-meeting. • Final report-out on Five Year Prevention Plan drafting process, CFSA Core Team engagement, recap all recommendations and decision points.

Appendix B: DC Child and Family Services Agency Analysis of Revenue Barriers within Family First Prevention Services Act (FFPSA, or the Act) Guidance

(Pre-print Section 2)

Introduction: During CFSA's analysis of the FFPSA regulatory implementation requirements outlined in ACYF-CB-PI-18-09, we recognized that some the requirements related to prevention program financing and federal reimbursement appear to impede the District of Columbia (as a Medicaid expansion state) from maximizing (or maybe even leveraging at all) the available title IV-E prevention services funding that has been made available through the Act. The requirements in question are those in:

- Section C [*Prevention Services* paragraph], stating that "At least 50 percent of the [IV-E] funds expended be the state for prevention services in any [fiscal year] must be for services that meet the "well-supported" practice criteria; and,
- Section I [*Payer of last resort*], stating that "if public or private program providers (such as private health insurance or Medicaid) would pay for a service allowable under the title IV-E prevention program, those provides have the responsibility to pay for these services before the title IV-e agency would be required to pay."

The District of Columbia already supports a diverse mix of promising, supported, and well-supported prevention programs, and our intention is to harness our existing capacity of Evidence-based Practices (EBPs) to target candidates for foster care and pregnant and parenting youth who are already in care, and to leverage available title IV-E funding to maximize the reach and impact of those programs on those populations. The guidance in the PI, however, seems to minimize our ability to do so.

I. Summary of the Issue

Our FFPSA implementation planning has involved working with sister agencies and community partners to complete an "environmental scan" of the prevention programs, and we were pleased that a number of the prevention programs currently deployed in the District are EBPs that are among the first services selected for systematic review for the federal Clearinghouse. Many of them have already been rigorously evaluated and are well-supported EBPs, and as a result the have been approved in the District as Medicaid allowable services. Under the *Payer of last resort* requirement, therefore, title IV-E funding is unavailable for those services.

In concert with the Section C requirement that required 50% of IV-E spending be for well-supported EBPs, the *Payer of last resort* requirement becomes problematic in DC. We anticipate that the majority of the well-supported EBPs that we plan on including in our Title IV-E State five year prevention program plan will be funded through Medicaid. Conversely, most if not all of the promising and supported programs will be funded with local dollars to be matched to title IV-E reimbursement. Removing the Medicaid funded EBPs from the overall calculation of dollars expended on prevention programming leaves us with a potentially

large local spending imbalance tilted toward promising and supported programs. Because at least 50% of our IV-E spending has to be on well-supported programs, our IV-E reimbursement for the entire continuum of prevention spending will be significantly limited with respect to what the FFPSA intended.

The table below illustrates how we believe the tension between these requirements adversely impacts Medicaid expansion states (like DC).

	a. Promising / Supported Expenditures	b. Well-Supported EBP 1	c. Well-Supported EBP 2	d. Well-Supported EBP 3	e. Well-Supported EBP 4	f. Well-Supported EBP 5	g. Well-Supported EBP 6	**h. Total Prevention Spending**	i. XIX funded (shaded b thru g)	j. Total Local $ left over for IV-E match (h – i)	k. Total Local $ on Well-Supported (unshaded b thru g)	**l. Total Local $ Available for IV-E (k x 2)**	**m. Total Local $ unavailable for IV-E (j - l)**
1. XIX Expanded State (DC)	600	100	100	100	100	100	100	**1200**	**500**	700	100	**200**	**500**
2. XIX Control State	600	100	100	100	100	100	100	**1200**	**300**	900	300	**600**	**300**
3. XIX Restricted State	600	100	100	100	100	100	100	**1200**	**100**	1100	500	**1000**	**100**

*** Shaded cells indicate that the program is Medicaid funded in that state.**

The example above depicts three figurative states with varying levels of Medicaid "coverage". Each state's overall spending across all EBPs is evenly split: 50% to a combination of promising and supported EBPs and then 50% ($600) to well-supported EBPs. The only difference among them is the extent to which well-supported programs are funded through the Medicaid program. In states with Medicaid expansion, like DC, the majority of well-supported EBPs are Medicaid-funded. Column m. above is the key area of focus; it represents the local investment that would be "left on the table" and unmatched to IV-E because it exceeds the Section C spending requirement. Medicaid restricted states would be able to optimize title IV-E funding as the FFPSA intended due to the high level of unmatched local investment across the entire continuum of EBPs. Expansion states, on the other hand, won't be able to optimize IV-E funding for the entire spectrum of prevention programs because there is not enough (per the Section C requirement) unencumbered local spending on well-supported programs; expansion states effectively get penalized for having a wider array of Medicaid covered services than their counterparts with more restrictive Medicaid coverage.

II. Potential Remedy/Solution

The most straightforward solution would be for the Children's Bureau to clarify in Section C such that the requirement around prevention spending on well-supported EBPs be 50% of *all spending* (inclusive of spending that is reimbursed through other programs or payers, such as Medicaid). Programs included in the Title IV-E State five year prevention program plan that could be reimbursable through another public or private source should be included in the calculation, such that if 50% of the state's combined spending for all prevention program were directed toward well-supported EBPs, then the state would be able to leverage title IV-E prevention dollars to support local investment in promising or well-supported programs.

Appendix C: ATTACHMENTS

Please see the following Attachments (provided in separate files) included within this plan:

ATTACHMENT I: State title IV-E prevention program reporting assurance
ATTACHMENT II: State request for waiver of evaluation requirement for a well-supported practice
ATTACHMENT III: State assurance of trauma-informed service-delivery
ATTACHMENT IV: State annual maintenance of effort (MOE) report
ATTACHMENT V: FY19 DC MIECHV CQI Plan
ATTACHMENT VI: Parents As Teachers Affiliate Certificate - Mary's Center for Maternal & Child Health/PIRC Healthy Families D.C
ATTACHMENT VII: Parents As Teachers Essential Requirements for 2018-2019