



Kansas Prevention Plan

Five Year Plan: 2020-2024

Submitted To:

U.S. Department of Health and Human Services

September 30, 2019

(Resubmitted December 18, 2019; March 13, 2020)

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Introduction

The Family First Prevention Services Act (Family First or FFPSA) was signed into federal law on February 9, 2018. This bi-partisan landmark legislation (H.R. 1892) offers exciting possibilities for states to be responsive, attentive, and support meeting the integral needs of the complete family unit.

Dr. Jerry Milner, Commissioner of the Administration for Children and Families, testified to committees of the United States House of Representatives, saying: “We must re-envision child welfare in the United States as a system that strengthens families and breaks harmful cycles of trauma and family disruption, rather than waiting until children are hurt to respond.”¹ Kansas is excited to pursue this state-federal partnership to pursue prevention efforts and improve the lives of families.

Family First Prevention Services Act creates reimbursement pathways for federal funds for specified prevention services provided to families to prevent placement out of home. These services must be trauma-informed, evidence-based treatments/programs offered by qualified clinicians in the categories of mental health, substance use disorder treatment, kinship navigator, and parent skill-based programs. In accordance with Family First, states are required to spend 50% of these funds for evidence-based treatments in the well-supported category and meet the same level of spending for foster care prevention as fiscal year 2014. In FFY 2014, Kansas did not fund prevention programs which met the same criteria as detailed in Family First Prevention Services Act, and therefore, spending did not qualify for this stipulation (Reference [Appendix 1](#): Kansas Annual Maintenance of Effort).

This federal opportunity intends to prevent children entering foster care by offering more prevention services to parents and kinship providers, both formal and informal, while the child is in the home to avoid out of home placement. Funding is available for prevention services to a family for a limited time of 12 months. In addition, funding is available for services to a pregnant/parenting youth in foster care. A determination of candidate for care must be made. However, there are no income restrictions when determining eligibility. Family First funding is available from October 1, 2019, through September 30th, 2026.

Overview of Kansas Child Welfare System

The Kansas Department for Children and Families (DCF) serves children and families by providing social services throughout the state. The agency mission is to protect children, promote healthy families and encourage personal responsibility. Kansas DCF is comprised of Economic and Employment Services (EES), Prevention and Protection Services (PPS), Rehabilitation Services (RS), Child Support Services (CSS), and Foster Care and Residential Facility Licensing. Services are provided directly by the agency or through contracted providers and community partnerships. Work encompasses services to children, families with children,

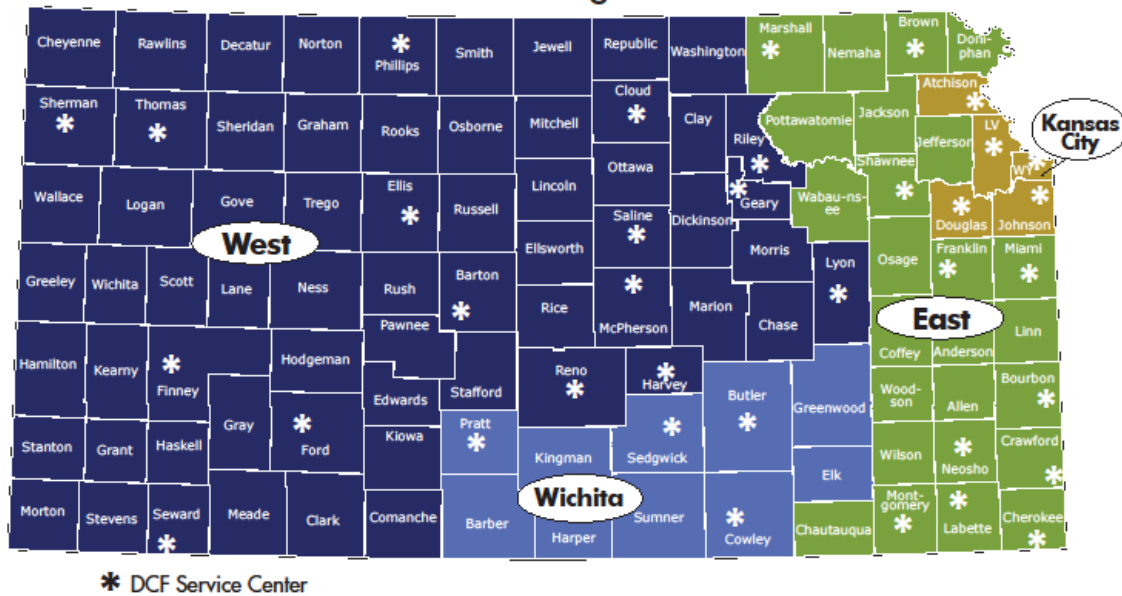
¹<https://www.acf.hhs.gov/olab/resource/testimony-of-jerry-milner-on-family-first-prevention-services-act>

vulnerable adults, adults who have special needs, and pregnant women using substances. The overarching emphasis is to secure a safe and stable environment for the individuals and families who are clients of the agency.

Services from DCF are managed statewide from the Office of the Secretary of DCF located in the capital city of Topeka. DCF is divided into four regions, Kansas City, East, Wichita and West, each led by a regional director, an assistant director for programs and an administrator for each program area.

Kansas Regional Map

DCF Regions



The state administers child welfare services through the Kansas Protection Report Center, regional offices, and contracts. Kansas Protection Report Center staff receive and assess alleged maltreatment reports to determine if they meet criteria for assignment for further investigation. PPS practitioners (also known as DCF Child Protective Specialists) complete child abuse and/or neglect investigations, family in need of assessment situations, and may refer to family preservation, foster care, adoption, and now Family First Prevention Services. Between 1996 and 1997, adoption, foster care, and family preservation services were privatized in Kansas.

Prevention in Kansas: An area of focus and growth

On January 31, 2019, in the state of Kansas, there were 7,351 children in foster care out of home placement with a monthly average of 328 children and youth entering care. From July 1, 2018 – June 2019, there were 2,689 new referrals made in the state of Kansas for family preservation. With the growing number of children in care, it is evident there is a need for partnerships alongside families in communities with local organizations, private providers, and other stakeholders working together. The goal is to generate innovations to reduce entry into foster

care and increase the array of evidence-based services available to serve the needs of Kansas families.

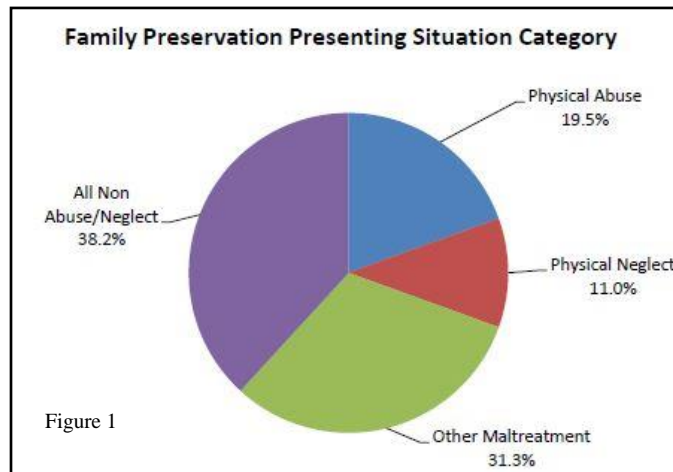
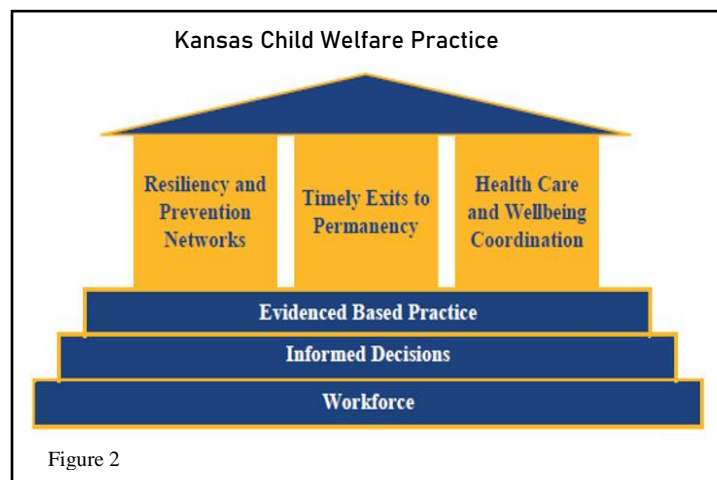


Figure 1 represents situations for family preservation referrals in SFY 2018 (July 2017-June 2018)². These primary reasons for referrals often have secondary underlying causes, such as mental health issues, substance use disorder, the need for improved parenting skills, or kinship relationship barriers. Family First will also deliver foster care prevention services, thus increasing locations, providers, and evidence-based services available to families.

When foster care is needed, Family First Prevention Services Act will allow for reimbursement for family-based settings and certain qualified residential treatment programs (QRTPs) for children with demonstrated clinical needs.

Foster Care prevention approaches are family-centered, safety-focused and provide a voice to and for a child and family’s safety network. As noted on the Child Welfare Information Gateway³, family-centered practice is characterized by mutual trust, respect, honesty, and open communication between parents and service providers. Families are active participants in the discussion of program improvement, service referrals, and evaluation. They are active decision-makers in selecting services for themselves and their children. Family and child assessments are strength-based and solution-focused while services are community-based and build upon formal and informal supports and resources.

FFPSA provides a unique opportunity to position Kansas as a leader in child welfare prevention, as the state will add a significant amount of new prevention programs available to families. Family First requires laying a foundation of evidence-based treatments and trauma-informed decisions, which will bolster the state’s strong child welfare workforce. The strategy for Kansas, illustrated in Figure 2, is to build on this



groundwork and strengthen prevention networks, placement stability, health care coordination, and reduce delays to legal permanency. Ultimately, Kansas will re-invest in prevention, place

² http://www.dcf.ks.gov/services/PPS/Documents/FY2018DataReports/InHome-FamilyPres/Pressituation_FamilyPresFY18.pdf

³ Child Welfare Information Gateway website: <https://www.childwelfare.gov/>

emphasis on family-based placements, and pursue systematic partnerships throughout the communities, counties, and state.

A primary goal for Kansas is to safely reduce the need for foster care and the number of children in out of home care by supporting more children safely in their homes. Kansas will focus on safely reducing the need for children to be removed from home (removal rate), increasing timely permanency, and improving services to prevent re-entry. Increased access to prevention services is crucial for addressing the most common risk factors for abuse and neglect and ensuring children can remain safely in their homes. With additional prevention services, it is anticipated the number of children able to remain safely in their homes will increase.

Practice culture will be transforming over the next five years with the resurgence of the prevention practice approach, see [Appendix 2](#) for the State's Child Welfare Practice Model and timeline. Prevention encompasses both preventing child maltreatment and preventing entry into foster care when safely possible. Family prevention services are time-consuming and take connection and commitment to families. Kansas will be recruiting new staff during this time to improve the practice skills of both new and future staff. New staff will be trained during this revival period of prevention practices, and current staff will be supported with tools to enhance their skillset. The goal is to provide child welfare workforce with a fulfilling career and ultimately shift the culture.

Since FFPSA was signed into law, Kansas has been taking steps to educate and prepare the state partners and workforce. Kansas is prepared to implement Family First October 1, 2019. Refer to [Appendix 3](#) for the full timeline for the state.

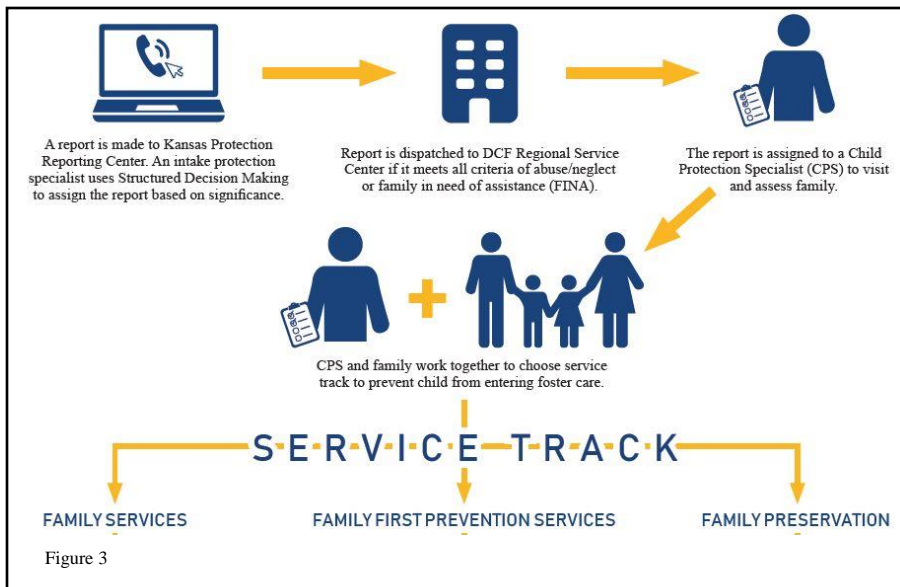
The Department of Children and Families is supported by the state administration to focus on front-end prevention of child welfare. Governor Laura Kelly set aside 6.5 million dollars in state funds for the federal match, accounting for the 13.9 million dollars for the Family First program. In 2018, 42 new qualified child protection positions were created. In addition, 3 new administrative staff were added to conduct fingerprinting and criminal record checks for any adult working in a childcare institution and 2 additional staff positions were funded for program and grant managing.

Prevention Service Track: Choosing the right path for families

When families are assessed by a PPS practitioner, there are multiple paths they will review with the family before making a final determination. Starting October 1, 2019, staff will have three main service tracks to access for foster care prevention, which include Family Services, Family First Prevention Services, and Family Preservation Services. Figure 3 illustrates this service track. Please refer to the full diagram in [Appendix 4](#).

DCF believes all services are based on family-centered practice. Referrals to ongoing services will be based on the PPS practitioner family assessments and family choice.

Family Services may be offered in non-crisis situations to families in need. Family Services may include concrete goods, services, and case management to alleviate a specific situation the family is facing. PPS practitioners can offer these through referrals to community agencies. Services can



be provided without regard to income and may be voluntary or court ordered. Family Services may help families locate and use additional assistance through community support systems, counseling and treatment services, housing, childcare, job training, and other basic support systems.

Family First Prevention

Services adds new programs in the areas of mental health, substance use disorder and treatment services, kinship navigator, and parent skill-based programs. Family First Prevention Services may be provided to families when at least one child in the home is at imminent risk for out of home placement. Providers were selected to suit the unique needs of each community. Staff and families can together craft a personalized Prevention Plan after reviewing the service menu to select programs to fit their individual needs. Services are unique to counties, regions, or catchment areas.

Family Preservation Services has been the state’s highly accessed prevention program for families and will remain an option for home-based, intensive, therapeutic and/or case management service offered to families in crisis when children are at high risk of out-of-home placement. Like Family First, the decision to refer a family to the provided services may be made at any point during DCF’s assessment and prevention process. A unique aspect to the Family Preservation program is services are accessible in all 105 counties in Kansas and case management crisis services are available 24 hours a day and 7 days a week. Family Preservation may also assist the family with concrete goods and services including exterminator services, head lice treatment supplies, clothes, rent and deposits, bus passes, car repairs and refrigerators.

Family Preservation in Kansas began new contracts on January 1, 2020 (refer to Figure 4 for the map of these contracts). In the request for proposal, child welfare agencies were asked to submit plans for evidence-based Family Preservation models. Kansas will also begin offering two tiers of services; Tier 1, Intensive in-Home Family Preservation and Tier 2, Short Term Case Management. Tier 1 offers Intensive In-Home Family Preservation Services, provided by a master’s level practitioner for an intensive and time-limited service period with the intent to mitigate immediate child safety concerns, stabilize family crisis, and assess family’s needs. Tier 2 offers Family Preservation Services Case Management, provided by a worker dyad consisting

of an assigned Case Manager and a Family Support Worker, assessing for existing risk and emergent safety issues and when identified, initiating services to stabilize and support the family. Please see [Appendix 5](#).

The new Family Preservation contracts have a caseload limit of a maximum of 4 families for Tier 1 and 10 to 12 families for Tier 2 **Cornerstones of Care** of will manage the Family Preservation contract in the East region. Cornerstones of Care provides intensive in-home services in several Missouri counties including the Kansas City area. Cornerstones of Care will use the Solution Based Casework™ model.

DCF awarded **TFI Family Services** the contract for the West region. TFI previously provided family preservation services in Kansas from 2005 to 2009. The agency also has provided recruitment, training, retention and support of foster families across Kansas since 1996. TFI Family Services will use Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Alternatives for Families as their evidence-based models.

DCF awarded **DCCCA** the contracts in the Kansas City and Wichita Regions. DCCCA has 12 years of experience providing family preservation services in Kansas. The agency also has more than 30 years as a prevention services provider and more than 43 years as substance use disorder and addiction-provider. DCCCA Tier 1 referrals will use the Family Centered Treatment (FCT) evidence-based practice. For Tier 2, DCCCA will use the Sobriety Treatment and Recovery Teams (S.T.A.R.T) model for families with at least one child under 6 years of age who have a parent whose substance use is determined to be a primary child safety risk factor.

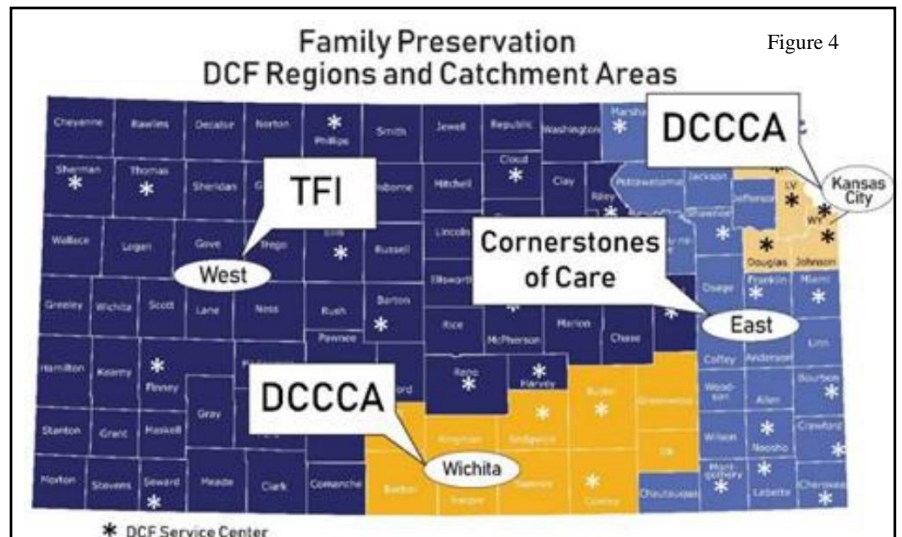


Figure 4

Section 1: Child and Family Eligibility *(Pre-print Section 9)*

Under the Family First Prevention Services Act, the target population is described as children who are at imminent risk of entering foster care and who can remain safely at home with services. This population fits the statewide developed definition of candidacy of care staff are familiar with and currently use to determine if a family is eligible for services. Neither Family First nor Family Preservation is bound to income restrictions for families.

Candidacy of Care for Family First is defined as:

- A child(ren) or youth placed with a parent who PPS determines is at imminent risk of foster care and out of home placement but can be safe at home with prevention services.
- A child(ren) or youth who exited foster care to adoption or permanent custodianship or guardianship, or who was reunified with parents is at risk of entering foster care and out of home placement.
- A child(ren) or youth in placement with relative caregivers.
- A child(ren) or youth living with parents but needs to be with a relative caregiver as a guardian with prevention services
- Pregnant and parenting youth in foster care and out of home placement.
- Siblings of youth already in foster care.

As Figure 3 illustrates, initial reports are made to the Kansas Protection Reporting Center (KPRC). An intake specialist completes an assessment of the report using Structured Decision Making (SDM). If the report meets criteria of Abuse and/or Neglect or Family in Need of Assessment, it will be assigned to the regional DCF Service Center. An assigned PPS practitioner within the region will then locate and assess the family.

The PPS practitioner completes an initial assessment of the family, using the research-based Family-Based Assessment tool, to determine if they meet criteria for services. If answers to questions 1-3 below are “yes”; and questions 4-7 are either “yes” or “NA,” they are deemed eligible for services.

1. The family is at risk of having a child(ren) removed; and
2. A parent/caregiver is available to protect the child; and
3. A parent/caregiver is willing and able to participate in services.
4. A family with chronic problems has experienced a significant change which makes them able to progress.
5. A parent/caregiver with mental/emotional health issues has been stabilized.
6. A parent/caregiver with limitations demonstrates an ability to care for self and children.
7. A parent/caregiver with substance abuse issues functions adequately to care for children.

In addition to the questions above, the regional PPS practitioner will utilize risk and safety assessment decisions to help guide the decision for candidacy for care and service referral. Families with the following risk level and safety decisions are deemed eligible for service:

1. Risk Level = High to Intense (SDM in pilot counties = High to Very High)
2. Safety Decision = Conditionally Safe (SDM in pilot counties = Safe with immediate safety plan)

The PPS practitioner and the family will decide on which program(s) best meets the family’s needs. The PPS practitioner will upload the required documentation into Kansas Initiatives Decision Support (KIDS). KIDS is a web-based system to record, maintain, and report assigned abuse/neglect and non-abuse neglect intakes. Key milestones and the family’s services are also

tracked in the Family and Child Tracking System (FACTS), the DCF-PPS system for maintaining data and reporting to legislature, federal government, internal management, department budget, and the general public.

Section 2: Service Description and Oversight *(Section 1 Pre-print)*

The title IV-E Prevention Clearinghouse (section 476(d)(2) of the Act) ratings will be defined as such:

Promising Practice

- At least 1, independently verified, “well-designed and well-executed” study
- Used some form of control measures outcome

Supported Practice

- Same as above + used “rigorous random-controlled trial or quasi-experimental research design”
- Carried out in usual care or practice setting
- Showed sustained effect after 6 months

Well-Supported

- At least 2, independently verified, “well-designed and well-executed” studies
- Used “rigorous random-controlled trial or quasi-experimental research design”
- Carried out in usual care or practice setting
- Showed sustained effect after 12 months

Evidence-Based Table of Services

The following array of selected evidence-based programs (Figure 5, page 12) includes the service name, target age, and the Title IV-E Clearinghouse rating, the California Evidence-Based Clearinghouse (CEBC) rating and program funding sources. Kansas awarded grants for these selected services for October 1, 2019 through June 30, 2020, with intent to expand services and prevention partners in the future. Some chosen services have not been reviewed by the Title IV-E Clearinghouse, making them ineligible for Family First funds. Kansas selected these targeted services to fill a specified gap and is hopeful many will be rated or approved soon. Figure 6, located on page 13, demonstrates the distribution and availability of selected services statewide.

See [Appendix 6](#) for DCF’s signed assurance all services provided under this Prevention Plan will be administered within a trauma-informed organizational structure and treatment framework.

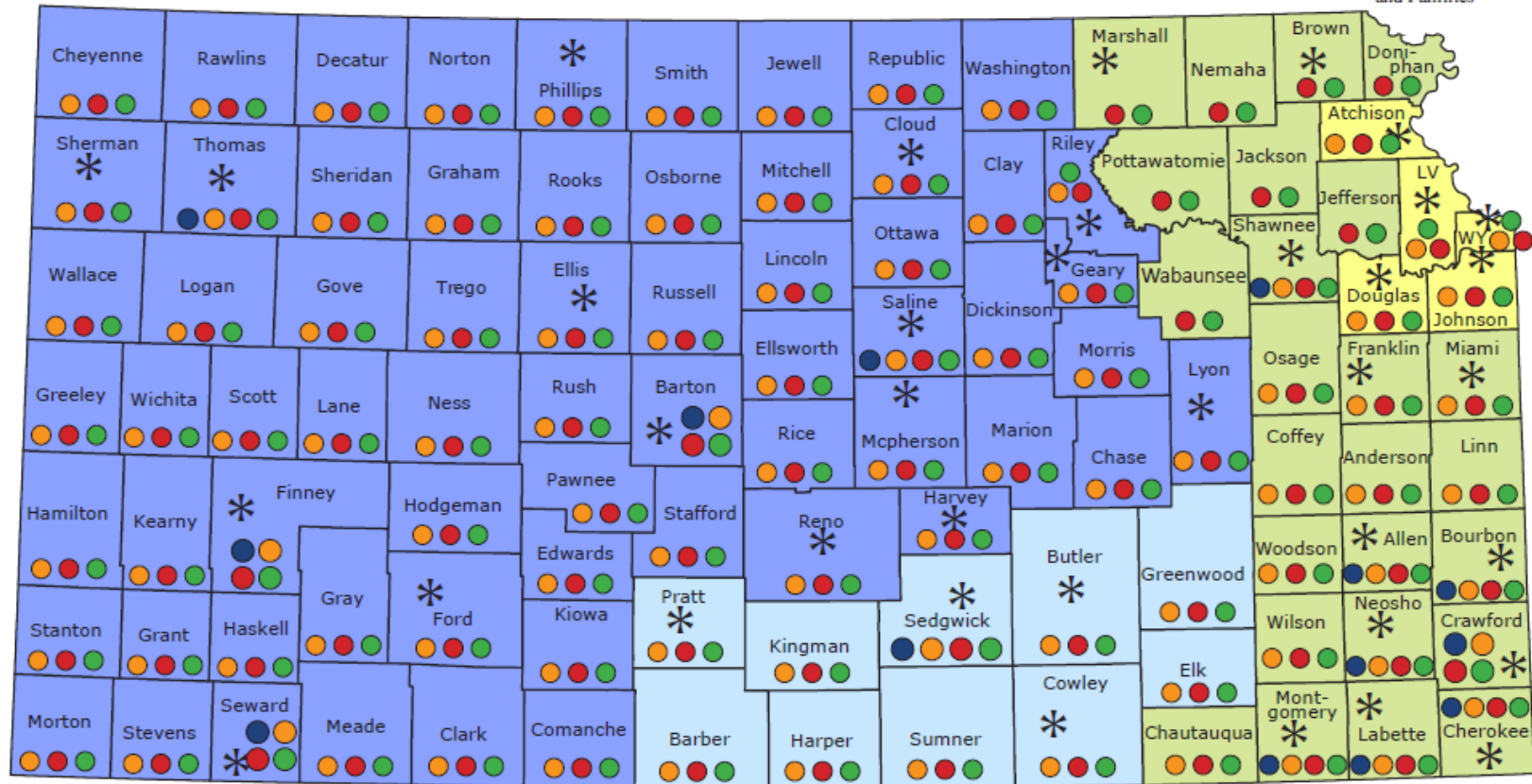
Kansas' Family First Evidence-Based Services

Figure 5

| Evidence Based Service | Target Age | Title IV-E Clearinghouse Rating (X = not rated in IV-E Clearinghouse) | CEBC Clearinghouse Rating | Funding Source |
|--|----------------------|---|---------------------------|----------------|
| Substance Use Disorder Services | | | | |
| Adolescent Community Reinforcement Approach (A-CRA) | 12 to 18 years | X | Supported | State |
| Parent Child Assistance Program (PCAP) | Prenatal to 1 year | X | Promising | State |
| Seeking Safety (SS) | 0 to 3 years.; teens | Does not meet criteria | Supported | State |
| Mental Health Services | | | | |
| Family Centered Treatment (FCT) | 0 to 17 years | Well-Supported (Approved Independent Review) | Promising | Family First |
| Functional Family Therapy (FFT) | 11 to 18 years | Well-Supported | Well-Supported | Family First |
| Parent Child Interaction Therapy (PCIT) | 2 to 7 years | Well-Supported | Well-Supported | Family First |
| Multi-Systemic Therapy (MST) | 12 to 17 years | Well-Supported | Well-Supported | Family First |
| Kinship Navigator Services | | | | |
| Kinship Interdisciplinary Navigation Technologically Advanced Model (KIN-TECH) | 0 to 18 years | Does not meet criteria | Supported | State |
| Parent Skill Building Services | | | | |
| Attachment and Biobehavioral Catch-Up (ABC) | 6 months to 4 years | X | Well-Supported | State |
| Family Mentoring Program (NPP) | 0-17 years | Does not meet criteria | X | State |
| Fostering Prevention (NPP) | 6-16 years | Does not meet criteria | X | State |
| Healthy Families America (HFA)– Signature Model | Prenatal to 3 years | Well-Supported | Well-Supported | Family First |
| Healthy Families America – Child Welfare Adaptation | Prenatal to 5 | X | X | State |
| Parents as Teachers (PAT) | Prenatal to 3 years | Well-Supported | Well-Supported | Family First |
| Service Enhancement | | | | |
| Motivation Interviewing (MI) | Parents & caregivers | Well-Supported | Well-Supported | Family First |

Figure 6

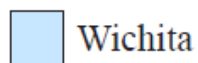
Family First Prevention Services Act Programs



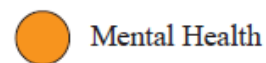
* DCF Service Center



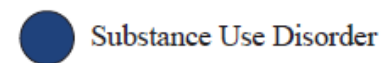
West



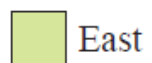
Wichita



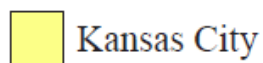
Mental Health



Substance Use Disorder



East



Kansas City



Parent Skill Building



Kinship Navigator

Substance Use Disorder and Treatment Services

Approximately 161 at risk children and families may receive these new evidence-based services.

Adolescent Community Reinforcement Approach (A-CRA)

Not rated on Title IV-E Clearinghouse

Supported on California Evidence-Based Clearinghouse

A-CRA will provide an outpatient treatment intervention for youth with substance use and co-occurring mental health disorders, and their families. The goals of the program are:

- Promote abstinence from alcohol, marijuana, and other drugs
- Promote positive social activity
- Promote positive peer relationships and improved relationships with family
- Motivate caregiver participation in the A-CRA treatment process
- Promote caregiver support of adolescent's abstinence from alcohol, marijuana, & other drugs
- Provide information to the caregiver about effective parenting practices
- Help the adolescent and caregiver(s) create a home and community environment conducive
- to recovery
- Teach the adolescent problem solving⁴

Service Provider: DCCCA

Motivational Interviewing (MI) will be used with A-CRA. The A-CRA model is congruent with DCCCA's historical approach grounded in the National Institute of Drug Abuse Thirteen Principles of Effective Treatment, and incorporates Cognitive Behavioral Therapy, Motivational Interviewing, Trauma Informed Care, and engagement in community-based social support efforts such as Twelve Step. Motivational Interviewing (MI) is a goal-directed, client centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. The operational assumption in MI is that ambivalent attitudes or lack of resolve is the primary obstacle to behavioral change, so that the examination and resolution of ambivalence becomes its key goal. DCCCA's use of MI is first evidenced as a strategy during the screening and assessment process by measuring stage of change – a key MI tenant – with the SOCRATES 8A/8D tool. Understanding where a youth and his or her family are on the stage of change continuum allows the DCCCA clinician to adjust his or her approach with the A-CRA components to meet the client where he or she is.

Program manual/book/information used in Implementation:

Miller, W.R. & Rollnick, S. (2012). *Motivational Interviewing, Third Edition: Helping People Change*. Guilford Press.

⁴ Source: California Evidence-Based Clearinghouse. <https://www.cebc4cw.org/program/adolescent-community-reinforcement-approach/>

Available in:

East Region: Crawford, Cherokee, Labette, Neosho, Allen, Bourbon and Montgomery Counties

Approximate Number of Families to be Served: 15**Parent-Child Assistance (P-CAP)**

Not rated on Title IV-E Clearinghouse

Promising on California Evidence-Based Clearinghouse

P-CAP will help parents maintain sobriety and learn skills to help them parent their child and provide an environment which teaches skills like self-regulation. The target population for this program is parents using substances with a child under the age of one, or pregnant women who may be referred if there is concern of substance use during pregnancy. Goals of the program are:

- Assist mothers in obtaining alcohol and drug treatment and to stay in recovery
- Link mothers and their families to community resources that will help them build and maintain healthy and independent family lives
- Help mothers prevent the births of future alcohol and drug-affected children⁵

Service Provider: Kansas Children's Service League**Available in**

East Region: Shawnee County

Approximate Number of Families to be Served: 48**Seeking Safety (SS)**

Does Not Meet Criteria on the Title IV-E Prevention Clearinghouse

Well-Supported on California Evidence-Based Clearinghouse

Seeking Safety is an integrated cognitive behavior-based model designed to concurrently address symptoms of post-traumatic stress disorder and substance use through a single trained person with flexibility to treat other high-risk behaviors. Gender-specific and gender-responsive treatment lead to the integration of family-centered treatment approaches to engage the whole family, helping members find their voice and feel valued. Services are provided in individual, group and/or family settings to support recovery.

The SS program targets families with children ages 0–3 and teens who are at-risk of being removed from the home as a direct or indirect result of the teen's or parent's substance use. Children ages 0–3 could be currently living with a relative due to a parent's substance use. Pregnant or parenting youth in foster care or out-of-home placement who are currently experiencing SUD are also eligible. Services typically last 6 months. Goals of the program are:

⁵ Source: California Evidence-Based Clearinghouse. <https://www.cebc4cw.org/program/parent-child-assistance-program/>

- Reduce trauma and/or substance abuse symptoms
- Increase safe coping in relationships
- Increase safe coping in thinking
- Increase safe coping in behavior
- Increase safe coping in emotions⁶

Service Provider: Saint Francis Ministries

Available in

West Region: Thomas, Finney, Barton, Seward, Saline

Wichita Region: Sedgwick

Approximate Number of Families to be Served: 98

Mental Health Services

Approximately 1,030 at risk children and families may receive these new evidence-based services.

Family-Centered Treatment (FCT)

*Not rated on the IV-E Prevention Clearinghouse; Approved for Transitional Payments
Promising on the California Evidence-Based Clearinghouse*

FCT provides intensive in-home treatment services for youth and families to prevent children being removed from the home, using psychotherapy designed to reduce maltreatment, improve caretaking and coping skills, enhance family resiliency, develop healthy and nurturing relationships, and increase children’s physical, mental, emotional and educational well-being through changing family value.

FCT will be offered to families with children 0-17 and crossover youth. Services last an average of 6 months. Specifically, families eligible for this service include those: impacted by trauma, conflict due to abuse and/or neglect, who have environmental stressors which have deteriorated the family’s resiliency, whose prior treatment models indicate the client’s progress is thwarted by non-involved family members, those with a family member who is hospitalized or in OOH placement, who need intervention due to crisis or the cumulative effect of a family member with chronic physical or mental illness, and those with serious behaviors of a family member which include substance abuse, domestic violence, youth running away or delinquent. Referrals for children who are actively suicidal, homicidal, or psychotic without medication stabilization are not appropriate. However, referrals for a child who is stabilizing/finishing treatment can be accepted. Goals of the program are:

⁶ Source: California Evidence-Based Clearinghouse. <https://www.cebc4cw.org/program/seeking-safety-for-adults/>

- Enable family stability via preservation of or development of a family placement
- Enable necessary changes in the critical areas of family functioning identified as the underlying causes for the risk of family dissolution
- Bring a reduction in hurtful and harmful behaviors affecting family functioning
- Develop an emotional and functioning balance in the family so the family system can cope effectively with any individual member’s intrinsic or unresolvable challenges
- Enable changes in referred client behavior to include family system involvement so changes are not dependent upon the therapist
- Enable discovery and effective use of the intrinsic strengths necessary for sustaining the changes made and enabling stability⁷

Service Provider: Saint Francis Ministries

Program manual/book/information used in Implementation:

Painter WE, Smith MM. (2004). *Wheels of Change—Family Centered Specialists Handbook and Training Manual*. Richmond, VA: Institute for Family Centered Services.

Wood TJ, (2014) *Family Centered Treatment® Design and Implementation Guide*. Revised 2018, Charlotte, NC: Family Centered Treatment Foundation Inc.

Family Centered Treatment® is taught to staff through an intensive training and orientation curriculum entitled “Wheels of Change©.” This dynamic education program includes tools and resources tailored to various learning styles and clinical backgrounds. In 2008, the Wheels of Change (WOC) training manual was digitalized as part of an interactive online learning platform. Currently, the WOC is maintained by the FCT Foundation and hosted by Mindflash⁸.

Available in

Wichita: All Counties
West: All Counties

Approximate Number of Families to be Served: 300

Functional Family Therapy (FFT)

Well-Supported on the Title IV-E Clearinghouse

Functional Family Therapy (FFT) is a short-term prevention program for at-risk youth and their families. FFT aims to address risk and protective factors impacting the adaptive development of 11 to 18-year-old youth who have been referred for behavioral or emotional problems. The

⁷ Source: California Evidence-Based Clearinghouse. <https://www.cebc4cw.org/program/family-centered-treatment/>

⁸ <http://www.familycenteredtreatment.org/continuing-education>

program is organized in five phases consisting of 1) developing a positive relationship between therapist/program and family, 2) increasing hope for change and decreasing blame/conflict, 3) identifying specific needs and characteristics of the family, 4) supporting individual skill-building of youth and family, and 5) generalizing changes to a broader context. Typically, therapists will meet with the family face-to-face for at least 90 minutes per week and for 30 minutes over the phone, over an average of three to five months.⁹ Goals of the program are:

- Eliminate youth referral problems (i.e., delinquency, oppositional behaviors, violence, substance use)
- Improve prosocial behaviors (i.e., school attendance)
- Improve family and individual skills¹⁰

Service Provider: Cornerstones of Care

Program manual/book/information used in Implementation:

Alexander, J. F., Waldron, H. B., Robbins, M. S., & Neeb, A. A. (2013). *Functional Family Therapy for Adolescent Behavioral Problems*. Washington, D.C.: American Psychological Association.

Available in:

Kansas City Region: All counties

Approximate Number of Families to be Served: 160

Parent-Child Interaction Therapy (PCIT)

Well-supported on the Title IV-E Clearinghouse

In Parent-Child Interaction Therapy (PCIT), parents are coached by a trained therapist in behavior-management and relationship skills. PCIT is a program for two to seven-year old children and their parents or caregivers designed to decrease externalizing child behavior problems, increase positive parenting behaviors, and improve quality of the parent-child relationship. During weekly sessions, therapists coach caregivers in skills such as child-centered play, communication, increasing child compliance, and problem-solving. Therapists use “bug-in-the-ear” technology to provide live coaching to parents or caregivers from behind a one-way mirror (there are some modifications in which live same-room coaching is also used). Parents or caregivers progress through treatment as they master specific competencies, thus there is no fixed length of treatment. Most families achieve mastery of program content in 12 to 20 one-hour sessions.¹¹ Goals of the program are:

⁹ Source: Title IV-E Prevention Services Clearinghouse.

<https://preventionservices.abtsites.com/programs/108/show>

¹⁰ Source: California Evidence-Based Clearinghouse. <https://www.cebc4cw.org/program/functional-family-therapy/>

¹¹ Source: Title IV-E Prevention Services Clearinghouse

<https://preventionservices.abtsites.com/programs/105/show>

- Build close relationships between parents and their children using positive attention strategies
- Help children feel safe and calm by fostering warmth and security between parents and their children
- Increase children's organizational and play skills
- Decrease children's frustration and anger
- Educate parent about ways to teach child without frustration for parent and child
- Enhance children's self-esteem
- Improve children's social skills such as sharing and cooperation
- Teach parents how to communicate with young children who have limited attention spans
- Teach parent specific discipline techniques which help children to listen to instructions and follow directions
- Decrease problematic child behaviors by teaching parents to be consistent and predictable
- Help parents develop confidence in managing their children's behaviors at home and in public¹²

Service Provider: Horizon Mental Health Center

Program manual/book/information used in Implementation:

Eyberg, S. & Funderburk, B. (2011) *Parent-Child Interaction Therapy Protocol: 2011*. PCIT International, Inc.

Available in

Wichita Region: Barber, Harper, Kingman, Pratt

West Region: Reno

Approximate Number of Families to be Served: 120

Service Provider: TFI Family Services, Inc. will provide Grow Nurturing Families utilizing PCIT

Program manual/book/information used in Implementation:

Eyberg, S. & Funderburk, B. (2011) *Parent-Child Interaction Therapy Protocol: 2011*. PCIT International, Inc.

McNeil, C. B. and Hembree-Kigin, T. L. (2011). *Parent-Child Interaction Therapy* Springer.

Niec L. N (2018). *Handbook of Parent-Child Interaction Therapy* Springer.

¹² Source: California Evidence-Based Clearinghouse. <https://www.cebc4cw.org/program/parent-child-interaction-therapy/>

Available in

East Region: Allen, Anderson, Bourbon, Chautauqua, Cherokee, Coffey, Crawford, Franklin, Labette, Linn, Miami, Montgomery, Neosho, Osage, Shawnee, Wilson and Woodson
Wichita: Elk, Greenwood, Butler
West: Finney, Riley

Approximate Number of Families to be Served: 285

Multisystemic Therapy (MST)

Well-Supported on the Title IV-E Clearinghouse

Multisystemic Therapy (MST) is an intensive treatment for troubled youth delivered in multiple settings. This program is designed to promote pro-social behavior and reduce criminal activity, mental health symptomology, out-of-home placements, and illicit substance use in 12- to 17-year-old youth. The MST program addresses the core causes of delinquent and antisocial conduct by identifying key drivers of the behaviors through an ecological assessment of the youth, his or her family, and school and community. The intervention strategies are personalized to address identified drivers. The program is delivered for an average of three to five months, and services are available 24/7. Program duration and availability enables timely crisis management and allows families to choose which times will work best for them.¹³ Goals of the program are:

- Eliminate or significantly reduce frequency and severity of the youth's referral behavior
- Empower parents with the skills and resources needed to:
 - Independently address the inevitable difficulties which arise in raising children and adolescents
 - Empower youth to cope with family, peer, school, and neighborhood problems¹⁴

Service Provider: Community Solutions, Inc.

Program manual/book/information used in Implementation:

Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). *Multisystemic Therapy for Antisocial Behavior in Children and Adolescents* (2nd ed.). New York: The Guilford Press.

Alternative manual/book/information used in Implementation:

Cunningham PB, Schoenwald SK, Rowland MD, Swenson CC, Henggeler SW, Randall J, Donohue B. Implementing contingency management for adolescent substance abuse in outpatient settings. Family Services Research Center, Medical University of South Carolina; Charleston, SC: 2004.

¹³ Source: Title IV-E Prevention Services Clearinghouse.

<https://preventionservices.abtsites.com/programs/121/show>

¹⁴ Source: California Evidence-Based Clearinghouse. <https://www.cebc4cw.org/program/multisystemic-therapy/>

Available in

Kansas City Region: Atchison, Leavenworth, Wyandotte;
East: Allen, Crawford, Labette, Montgomery, Neosho, Shawnee;
Wichita: Butler, Cowley, Sedgwick;
West: Barton, Ellsworth, Harvey, Reno, McPherson, Saline

Kinship Navigator Services

Approximately 400 at risk children and families may receive these new evidence-based services.

Kinship Interdisciplinary Navigation Technologically Advanced Model (KIN-TECH)

*Does Not Meet Criteria on the Title IV-E Prevention Clearinghouse
Not Rated on the California Evidence-Based Clearinghouse*

The target population for KIN-TECH will be children and youth at risk for out-of-home placement, and their kin caregivers. Services provided include legal advice, representation, mediation services for guardianship, adoptions family law issues and assistance with other legal issues impeding progress to permanency. Kinship caregivers who participate in KIN-TECH can access resources through multiple channels.

Service Provider: Kansas Legal Services

Available
Statewide

Approximate Number of Families to be Served: 400

Parent Skill-Building Services

Approximately 836 at risk children and families may receive these new evidence-based services.

Attachment and Biobehavioral Catch up (ABC)

*Not Rated on the Title IV-E Prevention Clearinghouse
Well-Supported on the California Evidence-Based Clearinghouse*

Attachment and Biobehavioral Catch up (ABC) targets several key issues identified as problematic among children who have experienced early maltreatment and/or disruptions in care. These young children often behave in ways which push caregivers away. The first intervention component helps caregivers to re-interpret children’s behavioral signals leading them to provide nurturance even when it is not elicited. Nurturance does not come naturally to many caregivers, but children who have experienced early adversity especially need nurturing care. Thus, the intervention helps caregivers provide nurturing care even if it does not come naturally. Second, many children who have experienced early adversity are dysregulated behaviorally and biologically. The second intervention component helps caregivers provide a responsive,

predictable, warm environment which enhances young children’s behavioral and regulatory capabilities. The intervention helps caregivers follow their children’s lead with delight. The third intervention helps caregivers decrease behaviors which could be overwhelming or frightening to a young child. Goals of the program are:

- Increase caregiver nurturance, sensitivity, and delight
- Decrease caregiver frightening behaviors
- Increase child attachment security and decrease disorganized attachment¹⁵
- Increase child behavioral and biological regulation

Service Provider: University of Kansas Medical Center Research Institute, Inc. – Project Eagle

Available in:

Kansas City Region: Wyandotte, Douglas, Leavenworth

West Region: Cheyenne, Rawlins, Sherman, Thomas, Wallace, Logan, Decatur, Norton, Sheridan, Graham, Gove, Trego, Phillips, Smith, Rooks, Osbourne, Ellis, and Russel

Approximate Number of Families to be Served: 172

Family Mentoring Program (NPP)

*Does Not Meet Criteria on the Title IV-E Prevention Clearinghouse
Not Rated on the California Evidence-Based Clearinghouse*

The Family Mentoring program utilizes the Nurturing Parenting Program (NPP) to educate parents about healthy child development through parenting skills training and comprehensive professional support. A Family Mentor provides in-home visitation, one-one-one parent training, classroom instruction, parent/child intervention and advocacy and support to the parent. Goals of the program are:

- Measurable gains in the individual self-worth of parents and children
- Measurable gains in parental empathy and meeting their own adult needs in healthy ways
- Measurable gains in parental empathy towards meeting the needs of their children
- Utilization of dignified, non-violent disciplinary strategies and practices
- Measurable gains in empowerment of the parents and their children
- Reunification of parents and their children who are in foster care
- High rate of attendance and completion of their program
- Reduction in rates of recidivism of program graduates¹⁶

Service Provider: Child Advocacy and Parenting Services (CAPS)

¹⁵ Source: California Evidence-Based Clearinghouse. <https://www.cebc4cw.org/program/attachment-and-biobehavioral-catch-up/>

¹⁶ Source: California Evidence-Based Clearinghouse. <https://www.cebc4cw.org/program/nurturing-parenting-program-for-parents-and-their-school-age-children-5-to-12-years/>

Available in

West Region: Saline and Ottawa

Approximate Number of Families to be Served: 100

Fostering Prevention (NPP)

*Does Not Meet Criteria on the Title IV-E Prevention Clearinghouse
Not Rated on the California Evidence-Based Clearinghouse*

Fostering Prevention operates on the Nurturing Parenting Program (NPP) curriculum of a 15-session group-based family-centered program. Parents and their children attend separate groups which meet concurrently. Lessons in the program are based on known parenting behaviors contributing to child maltreatment: Inappropriate parental expectations, parental lack of empathy in meeting the needs of their children, strong believe in the use of corporal punishment, reversing parent-child family roles, and oppressing children's power and independence. Program outcomes as follows:

- Parents experience an increase in family cohesion
- Parents experience an increase in nurturing and safety capabilities

Service Provider: Foster Adopt Connect, Inc.

Available in

Kansas City Region: Johnson and Wyandotte

Approximate Number of Families to be Served: 23

Healthy Families America (HFA)

*Signature Model: Well-Supported on the Title IV-E Prevention Clearinghouse
Child Welfare Adaptation: Not Rated on the Title IV-E Prevention Clearinghouse*

Healthy Families America (HFA) is a home visiting program model designed to work with families who may have histories of trauma, intimate partner violence, mental health issues, and/or substance use issues. Services are offered to families during pregnancy or at the time of birth of their child and can be provided long term.¹⁷ Goals of the program are:

- Build and sustain community partnerships to systematically engage overburdened families in home visiting services prenatally or at birth
- Cultivate and strengthen nurturing parent-child relationships
- Promote healthy childhood growth and development
- Enhance family functioning by reducing risk and building protective factors¹⁸

¹⁷ Source: Title IV-E Prevention Services Clearinghouse.

<https://preventionservices.abtsites.com/programs/116/show>

¹⁸ Source: California Evidence-Based Clearinghouse: <https://www.cebc4cw.org/program/healthy-families-america-home-visiting-for-prevention-of-child-abuse-and-neglect/>

Service Provider: Great Circle

Program manual/book/information used in Implementation:

Healthy Families utilizes a series of Best Practice Standards which define the structure of the program model. Fidelity to the program model requires adherence to the 2018-2021 HFA Best Practice Standards, see link in footnote¹⁹

Alternative manual/book/information used in Implementation:

Great Circle will utilize the signature model of Healthy Families America and the Child Welfare Adaptation. Healthy Families signature model utilizes a series of Best Practice Standards which define the structure of the program model. Fidelity to the program model requires adherence to the 2018-2021 HFA Best Practice Standards, see link in footnote.²⁰ There is not an alternative manual for the Child Welfare Adaptation, although HFA has created a guideline document outlining this model in a few pages, see link in footnote²¹

Available in

East Region: Chautauqua, Woodson, Coffey, Anderson, Linn, Franklin, Osage, Wabaunsee, Pottawatomie, Jackson, Marshall, Nemaha, Brown, and Doniphan
Kansas City Region: Atchison and Douglas

Approximate Number of Families to be Served: 232

Service Provider: Kansas Children Services League (KCSL)

Program manual/book/information used in Implementation:

Healthy Families utilizes a series of Best Practice Standards which define the structure of the program model. Fidelity to the program model requires adherence to the 2018-2021 HFA Best Practice Standards, see link in footnote²²

Alternative manual/book/information used in Implementation:

KCSL will utilize the signature model of Healthy Families America and the Child Welfare Adaptation. Healthy Families signature model utilizes a series of Best Practice Standards which define the structure of the program model. Fidelity to the program model requires adherence to the 2018-2021 HFA Best Practice Standards, see link in footnote.²³ There is not an alternative

¹⁹http://www.dhs.state.il.us/OneNetLibrary/27896/documents/GATA_2018Grants/FCS_NOFOs/2018_2021HFABes tPracticeStandardsJuly2017 .pdf

²⁰http://www.dhs.state.il.us/OneNetLibrary/27896/documents/GATA_2018Grants/FCS_NOFOs/2018_2021HFABes tPracticeStandardsJuly2017 .pdf.

²¹ <https://www.healthyfamiliesamerica.org/adaptations-child-welfare-adaptation/>

²²http://www.dhs.state.il.us/OneNetLibrary/27896/documents/GATA_2018Grants/FCS_NOFOs/2018_2021HFABes tPracticeStandardsJuly2017 .pdf

²³http://www.dhs.state.il.us/OneNetLibrary/27896/documents/GATA_2018Grants/FCS_NOFOs/2018_2021HFABes tPracticeStandardsJuly2017 .pdf.

manual for the Child Welfare Adaptation, although HFA has created a guideline document outlining this model in a few pages, see link in footnote²⁴

Available in

Wichita Region: Sedgwick

East Region: Wilson, Allen, Neosho

Approximate Number of Families to be Served: 60

Service Provider: Success by 6 Coalition of Douglas County/Lawrence Douglas County Health Department

Program manual/book/information used in Implementation:

Healthy Families utilizes a series of Best Practice Standards which define the structure of the program model. Fidelity to the program model requires adherence to the 2018-2021 HFA Best Practice Standards, see link in footnote²⁵. This grantee is providing only the Signature Model.

Available in

Kansas City Region: Douglas County

Approximate Number of Families to be Served: 20

Parents as Teachers (PAT)

Well-Supported on the Title IV-E Prevention Clearinghouse

Parents as Teachers (PAT) is an early childhood parent education, family support and well-being, and school readiness home visiting model. Parent educators work with parents to aid in assisting caregivers with strengthening protective factors and ensuring young children are healthy, safe, and ready to learn. Goals of the program are:

- Increase parent knowledge of early childhood development and improve parenting practices
- Provide early detection of developmental delays and health issues
- Prevent child abuse and neglect
- Increase children's school readiness and school success

Service Provider: Kansas Association for Parents as Teachers (KPATA) and local Parents as Teachers Affiliates

²⁴ <https://www.healthyfamiliesamerica.org/adaptations-child-welfare-adaptation/>

²⁵ http://www.dhs.state.il.us/OneNetLibrary/27896/documents/GATA_2018Grants/FCS_NOFOs/2018_2021HFABestPracticeStandardsJuly2017_.pdf.

Program manual/book/information used in Implementation: Program will serve families with children 0-3 years of age utilizing the Parent as Teacher Foundational 1 Curriculum, see link in footnote²⁶

Available in
Statewide

Approximate Number of Families to be Served: 229

Service Enhancements

Service will be provided for all families receiving Family First Prevention Services.

Motivational Interviewing (MI)

Well-Supported on the Title IV-E Prevention Clearinghouse

Motivational Interviewing (MI) is a client-centered, directive method designed to enhance client motivation for behavior change. It focuses on exploring and resolving ambivalence by increasing intrinsic motivation to change. MI can be used by itself, as well as in combination with other treatments. It has been utilized in pretreatment work to engage and motivate clients for other treatment modalities. Goals of the program are:

- Enhance internal motivation to change
- Reinforce this motivation
- Develop a plan to achieve change²⁷

Service Provider: All providers have included Motivational Interviewing as part of their services delivery. However, Kansas is only seeking approval at this time for Motivational Interviewing to be utilized with Adolescent Community Reinforcement Approach (A-CRA) Please see page 14 for additional information supporting A-CRA's use of Motivational Interviewing.

Available: Statewide all services; MI used with A-CRA available in Crawford, Cherokee, Labette, Neosho, Allen, Bourbon and Montgomery Counties

²⁶ <https://parentsasteachers.org/foundational-training-curriculum>.

²⁷ Source: California Evidence-Based Clearinghouse. <https://www.cebc4cw.org/program/motivational-interviewing/>

Oversight

In addition to the detailed evaluation plan (Attachment 3), the allowable services will be continuously monitored to ensure fidelity to the practice model by the provider and DCF. Please refer to the evaluation plan (see attachment 3) for details of how services will be monitored to ensure fidelity to the practice model. The Evaluation Team will rely on model-specific accreditation monitoring and provider-based fidelity assurance methods and administrative data to corroborate the quality and fidelity of the service delivery of each intervention. These findings will be included in the evaluation. In addition to the evaluation plan's fidelity monitoring approach, each provider of a well-supported or allowable service, has their own fidelity monitoring activities used to refine and improve practices, as outlined below.

Family Centered Treatment (FCT)

Family Centered Treatment will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved. Services are monitored through video review of specialist sessions with families, weekly staffing in team, tracking dosage and activity completion of each family based on the wheels of change. Additionally, a monthly reporting process developed by the FCT Foundation is utilized to collect data related to dosage, monitoring of progress through the treatment phases, and fidelity to the model. FCT also collects information from families at discharge through a survey process as well as following up with families after discharge. Specialists, with family input, complete the Discharge Data Collection form, and information from this form is reported to the Foundation utilizing the Discharge Tracker report.

Information learned from monitoring Family Centered Treatment will be used to refine and improve practices. Family Centered treatment offers a consultant that will assist Program Director and Clinical Supervisor on refining and improving practices through analyzing data for dosage, oversight of training and skills completion of supervisor and specialists.

Functional Family Therapy (FFT)

Functional Family Therapy will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved. This program benefits from double evaluation, feedback, and refinement processes. Cornerstones of Care, the agency contracted to provide this evidence-based service, implements outcome and efficacy monitoring processes as does the FFT Corporation. Program results are entered into a proprietary database for FFT LLC evaluation. Program staff and internal Performance Excellence Specialist regularly monitor outcome data, cultural competency measures, and other issues through the continuous quality improvement process.

Assessment of adherence and competence is based on data gathered through the FFT Clinical Service System (CSS), FFT weekly consultations and FFT training activities. Staff will have access to appropriate technology including Electronic Health Record (HER), myAvatar, and the FFT CSS database, clinical resources and workspace sufficient to achieve the outcomes

proposed. In addition, a national consultant from FFT, LLC oversees the team at a frequency determined by the phase of the team (level of experience). Three times per year, the national consultant provides a TYPE report which provides multiple measures of the adherence and fidelity of the team to FFT.

Outcomes of this program will be:

1. Families will engage timely in FFT services.
2. Children are safely maintained at home with their families.
3. Families will demonstrate improved family relationships
4. 70% of families will complete therapeutic services successfully in the first nine months of service (80% thereafter).

Information learned from monitoring Functional Family Therapy will be used to refine and improve practices via a collaborative multi-agency approach with multiple levels of monitoring. FFT is a well-supported evidence-based practice with over thirty years of monitoring used to refine and improve practices. Many different tools are used to do so, including the format of the Electronic Health Record, regular case reviews by the manager and team, TYPE reports (3x per year reporting on FFT team data), and oversight by the FFT, LLC Consultant.

Cornerstones of Care also has its own means to improve and refine practices including supervision by managers, team meetings, Performance Excellence Department reviews, oversight by the FFT implementation manager and outpatient director. Collaboration with DCF staff for best outcomes will also occur on multiple levels to continue to learn and improve. Individual therapists and referring DCF staff are encouraged to communicate and collaborate. Managers and the implementation manager will be purposeful in regularly discussing problem areas and celebrating successes. Information from monitoring will be key to keep these discussions from being anecdotal and instead focusing on data-derived trends.

The advantage of using an evidence-based model is there is evidence it can be used to refine and improve practices. Collaborative work with DCF and FFT, LLC as well as internal efforts likely to gather increasingly positive results in this area.

Healthy Families America (HFA)

Healthy Families America will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved. Kansas Department for Children and Families is partnering with three agencies to provide HFA: Great Circle, Kansas Children and Service League, and Success by 6/Lawrence Douglas County Health Department.

Model fidelity is illustrated through a comprehensive accreditation process. Currently, there are over 550 affiliated HFA program sites in the United States and Internationally.

Great Circle Home Visiting will utilize important documents published by HFA as its comprehensive planning guide for expert guidance and practical tips. These documents offer guidance on model implementation and expectations related to all aspects of policy and practice. Sites implementing HFA commit to providing high quality home visiting services and

demonstrate model fidelity through the Quality Assurance and Accreditation process established through national standards. In addition, Great Circle currently offers a monthly leadership meeting to include staff from around the state whereby model fidelity and implementation, peer record results, and adherence to best practices is assured. For example, the *12-critical element Standards* are integral to the Quality Assurance and Accreditation process. They serve as the site's guide to model implementation and is structured into 3 steps: completion of a thorough program self-study, a site visit, and final determination on accreditation.

Kansas Children's Service League (KCSL) has been providing Healthy Families services in Kansas since 1996, and in 2017 became an affiliated multi-site system with Healthy Families America. As a multi-site system, KCSL goes through an additional level of accreditation for central administration functions to provide training, quality assurance, technical assistance, evaluation, and administrative functions for the Healthy Families programs within the multi-site system. KCSL contracts with HFA to bring national trainers to Kansas or arranges for staff to travel to other states when necessary to complete required trainings. The central administration staff at KCSL complete an annual site visit with each program, ensure a random selection of files are reviewed twice each year, and regularly monitor program outcomes and outputs to ensure fidelity to the model. KCSL completed five site visits for re-accreditation in 2019 and expects to receive final approval for renewed accreditation in 2020.

Lawrence Douglas County Health Department (LDCHD) has maintained programming for Healthy Families program for over six years. It was within those years the program first became accredited in 2015. Healthy Families Douglas County (HFDC) completes re-accreditation every four years from Healthy Families America. The HFDC program has annual goals and benchmarks specifically related to HFA Best Practice Standards. An annual Quality Assurance plan also comprehensively reviews components of the program as related to Best Practice Standards.

Information learned from monitoring Healthy Families America will be used to refine and improve practices. Great Circle's Performance and Quality Improvement (PQI) team completes quarterly site visits and facilitation of quarterly Peer Record Review of select cases, and monitors timeliness and completion of programmatic data entry, and adherence to Healthy Families America Best Practice Standards. Quarterly, the PQI department also assesses client and shareholder satisfaction with services. PQI provides detailed information and recommendations on how to enhance client satisfaction with services. PQI has been instrumental in assisting teams to increase consistent application of assessment tools and consistent entry of data crucial to monitoring progress and outcomes.

LDCHD utilizes data gathered from HFA National program re-accreditation, outcomes of the program's annual goals/benchmarks and the annual quality assurance plan. These are monitored by the program manager/supervisor and reviewed with staff and advisory council. The reviews result in mechanisms to address areas of improvement. These areas of improvement are incorporated into the next year's annual program goals/benchmarks and/or the annual quality assurance plan.

KCSL's administration team reviews participant files twice each year. They manage the database for all programs and assist with data entry. The administration team provides reports to the

programs twice each year to show their compliance with specific HFA standards. They complete an annual evaluation of outcomes and an annual site visit with each program to ensure fidelity to the model. Technical assistance is provided in any area the program may be struggling in. Annually, the central administration team meets to review reports and feedback from the previous year. This information assists in determining what improvements to policies, forms, procedures, and/or reports are needed. The process for improvement is ongoing as systems are continually reviewed and adjusted to improve effectiveness.

Motivational Interviewing – Service Enhancement to A-CRA

Motivational Interviewing (MI) will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved. DCCCA staff have been trained by Motivational Interviewing Network of Trainers (MINT) credentialed trainers. The focus of the training included theory, practice and skill building in the Miller/Rollnick Model of Motivational Interviewing and incorporated lecture, live demonstrations, experiential practice, and video demonstrations. The philosophy of Adolescent Community Reinforcement Approach (A-CRA), the Evidence Based substance use disorder treatment model DCCCA utilizes, coincides with that of Motivational Interviewing and uses a warm, understanding, nonjudgmental, nonconfrontational clinician approach to build strong therapeutic relationship.

A-CRA incorporates a supervision model which includes weekly supervision sessions, monitoring of certified clinicians via reviews and rating randomly selected sessions. The Clinical Coordinator utilizes this model for supervision and monitoring clinician fidelity to the A-CRA model and implementation of Motivational Interviewing practices and looks for evidence of that in in documentation as well.

Information learned from monitoring Motivational Interviewing will be used to refine and improve practices. The information obtained through supervision and monitoring of clinicians is used to provide positive and constructive feedback to improve or refine technique and skills and ensure fidelity to the ACRA model and in keeping with the spirit of Motivational Interviewing.

Multisystemic Therapy (MST)

Multisystemic Therapy (MST) will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved. Staff and stakeholders work together to ensure referred clients are a good fit with the program and problem solve challenging cases. The therapists and clinical supervisor meet monthly with referral sources and other key stakeholders for the purpose of case review. Pertinent staff are updated on each case and collaborate in the planning process. Case specific and systemic concerns are addressed using the MST analytical process.

MST teams use myEvolv, or a similar electronic case record management system, where therapists record the progress of each case. Client files are the permanent record of services provided and detail a client's progress in the program. Each therapist uploads weekly summaries into myEvolv within 72 hours of service. The clinical supervisor logs into the system and reviews the summaries. They add feedback and ultimately approve or request an addendum

to the case note. The clinical supervisor downloads all summaries from myEvolv and scans them into the System Supervisor for further review and feedback. In addition, MST programs comply with all layers of the MST QA system. As part of MST Quality Assurance Program implementation, information is gathered from caregivers, therapists, and Clinical Supervisors. Families receiving MST will be asked to answer a few questions about treatment periodically. In addition, therapists will be asked bimonthly, to rate their clinical supervisor. Finally, clinical supervisors report on organizational practices.

In all recently developed MST programs and in most of the mature programs, ratings of therapist adherence is received from caregivers two weeks after the start of treatment and monthly thereafter. The Therapist Adherence Measure Revised (TAM-R) is completed via phone interview through the MST Institute Call Center or by completion of a written TAM-R. The TAM-R is a validated 28-item tool used to evaluate a therapist's adherence to the MST model as reported by the primary caregiver of the family. The adherence measure was originally developed as part of a clinical trial on the effectiveness of MST and has proved to have significant value in measuring an MST therapist's adherence to MST. The tool is equally significant in predicting positive outcomes for families who received MST treatment.

Therapists rate their clinical supervisors by completing the Supervisor Adherence Measure (SAM) one month after their first MST supervision session. Ongoing subsequent ratings occur at two-month intervals. The SAM is a 43-item tool designed to measure and evaluate the MST Supervisor's adherence to the MST model of supervision, as reported by MST therapists. Similar to the TAM-R, data from the SAMS are entered into a database via an internet-based system. Structure for collection and the Quality Insurance process for monthly SAMS surveys includes:

1. The System Supervisor sets the dates for the collection of SAMS.
2. The MST clinical supervisor instructs therapists after supervision and consultation to complete SAMS before leaving the office.
3. System Supervisor pulls the SAM report monthly and reviews with each supervisor during their development plan meeting.

Information learned from monitoring Multisystemic Therapy will be used to refine and improve practices. Family Feedback is used to provide feedback to the MST program about how to improve adherence and program outcomes. Performance assessments of staff are primarily based on the employee's understanding of model principles, their ability to comply with the model, achievement of outcome measures, and compliance with agency policies.

Supervisors complete staff supervision plans on a monthly basis. These staff plans acknowledge strengths of the clinicians during the month, along with any areas of improvements. Monthly staff plans provide data for the quarterly development plans. The development plan reviews the clinician's outcome measures for the quarter based upon model criteria. The development plan includes strengths and areas for improvements. Interventions are put in place for any outcome measures not meeting model requirements. Data from the staff plans and quarterly development plans are an integral part of the annual evaluation. Strengths and weaknesses from

the staff and development plan become a part of the annual evaluation. Any issues identified will be addressed through additional training, coaching, modeling, supervision, and/or disciplinary action when necessary. When the formal CAMs evaluation is administered, the employee is aware of their performance up to this point. All evaluations are performance based and tie directly to the job description as well as model adherence and outcomes.

Parents as Teachers (PAT)

Parents as Teachers (PAT) will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved. All Kansas State Department for Education (KSDE) Parents as Teachers Affiliates partnering with DCF through Family First Prevention Services will have completed the PAT Quality Endorsement and Improvement Process (QEIP). This process ensures the PAT program is functioning with fidelity to the model.

The degree to which an affiliate accurately implements the PAT model with an emphasis on the Essential Requirements and Quality Standards indicates fidelity to the PAT model. KSDE PAT affiliates must be designed to meet all Essential Requirements. Annually, PAT affiliates must submit data addressing the requirements to PAT National Center, KSDE, and Kansas Parents as Teachers Association.

PAT affiliates who achieve success in all 20 Essential Requirements and 75 of the 100 Quality Standards ensure fidelity is achieved through the model and high-quality services are delivered.

Information learned from monitoring Parents as Teachers will be used to refine and improve practices. Data is collected by local program affiliates, KSDE, and PAT National Center. Aggregate data capturing usage of funds, outcome compliance, and families served is collected by the Kansas Parents as Teachers Association (KPATA) in a monthly performance measure report (PMR) and in the annual performance review (APR). These reports include data related to length of visits, number of families served, and cancellations. The report informs and provides program staff targeted approaches in mitigating challenges affiliates are facing.

As a grantee with a statewide footprint, KPATA utilizes referral trend data to identify geographic areas which may benefit from expanded PAT programs in the coming years. Based on the planned funding strategy of incorporating private donors, grants, and foundations, the data provides support and justification for increased investments in communities who experience a high level of referrals.

Parent Child Interaction Therapy (PCIT)

Parent Child Interaction Therapy will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved. TFI Family Services therapists and support workers have a firm understanding of behavioral principles. They are trained in cognitive-behavior therapy, child behavior therapy, and therapy process skills. The PCIT training model requires therapists to complete forty (40) hours of intensive skills training followed by supervised service delivery with two (2) families. This must be completed prior to independent practice. Training requirements for supervisory staff remain consistent in the required 40 hours

of intensive skills training. Supervisor training differs by requiring supervised service delivery to four (4) families prior to independent practice

Clinical fidelity tools for both agencies include observation, videotaping, completing supervision, and consultation with a Master PCIT practitioner. TFI Family Services and Horizon's Mental Health Center collaborate with an established Master Training agency.

Information learned from monitoring Parent Child Interaction Therapy will be used to refine and improve practices. TFI Family Services will ensure Therapist are trained and moving toward certification. On-going supervision will occur after certification is completed. TFI will engage and collaborate with the institute related to data or information leading to needs for enhancement to the model. PCIT International is currently working on protocols for adaptations. TFI ensures they will remain aware of updates or changes to the protocols.

Horizons Mental Health Center utilizes a PDSA (Plan Do Study Act) Model for process improvement. This same structure will be applied to the monitoring and refining process for PCIT.

Rationale for Selected Services

Programs were evaluated, scored and rated by a Grant Peer Review Panel, consisting of representatives from the Kansas Department of Health and Environment (KDHE), Kansas Department of Aging and Disability Services (KDADS), the Children's Cabinet, each DCF region and DCF Administration. Team representatives had program expertise in foster care, mental health, early childhood programming, quality assurance, substance use disorder services, and prevention services. Peer reviewers evaluated applications to ensure the information presented was reasonable, understandable, measurable and achievable, as well as consistent with program and legislative requirements. Reviewers made recommendations based on many factors such as: underserved populations, strategic priorities, geographic balance, available funding, and evidence of foster care prevention.

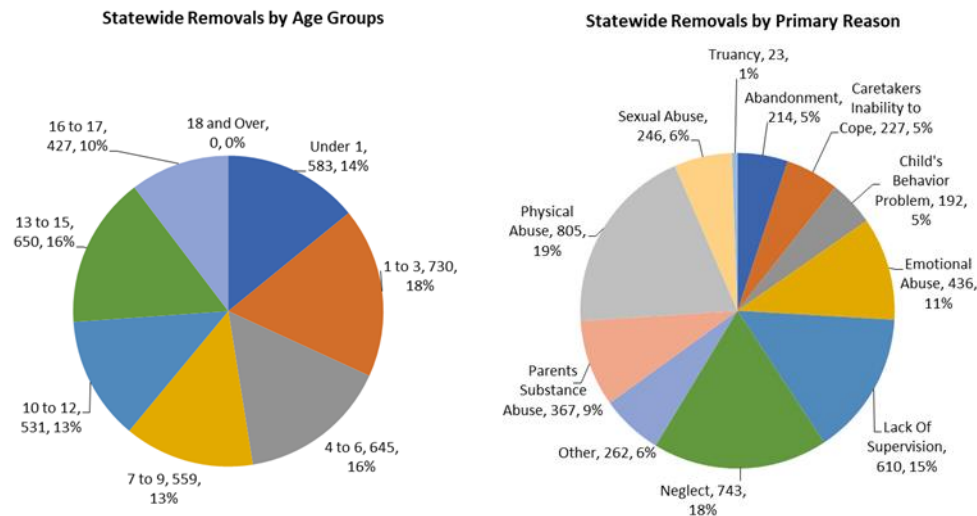
The following three factors were highly influential when selecting the chosen services:

- Kansas data showing the reasons children are placed in foster care and the ages of the children at the time of foster care referral
- Geography of services and gaps in services across Kansas
- Targeted services for crossover youth

SFY 2019 Removal Data

Of the children removed in SFY2019, 62% were age 9 or younger. When recommending removal from home, PPS practitioners indicate one primary reason for removal and may indicate up to 15 secondary reasons for removal. The most frequent abuse and/or neglect reason for removal for SFY 2019 is physical Abuse (19%) and neglect (18%). The highest non-abuse neglect removal reason is parental substance abuse (9%) (figure 7). The number of referrals with secondary reasons of parental substance abuse is drastically higher at 40%.

Figure 7



Kansas selected more than half of the evidence-based services to target children under 9 years of age. Additionally, many of the services chosen, outside of the category of substance use, have a focus on substance use disorders and will provide support and connection to services.

Geography and Service Gaps

Kansas has urban, rural, and frontier counties. Many areas in Kansas are designated medically underserved areas by the Health Resources and Services Administration.²⁸ When selecting services, the review teams considered needs based on geography and current service gaps. Page 12, Figure 5, provides a visual of the Family First Prevention Services array across the state.

Kansas has only one adolescent residential substance use disorder treatment facility, located in Johnson County, an urban area in Northeast Kansas. The Adolescent Community Reinforcement Approach (A-CRA) was proposed as an outpatient substance use disorder program in Southeast Kansas. Southeast Kansas is a more rural area where families frequently struggle finding

²⁸ <https://data.hrsa.gov/tools/shortage-area/mua-find>

transportation to services. Family First Prevention services will increase availability of substance use services to teenagers in rural Southeast Kansas.

The Kansas Department of Health and Environment has been collaborating with 32 hospitals across the state as part of the Neonatal Abstinence Syndrome opioid grant. Topeka and Wichita, both urban areas, have experienced high rates of substance-exposed birth. Two Family First Prevention services chosen will target these areas: Parent-Child Assistance Program in Topeka and Seeking Safety in Wichita.

When children in Kansas live with non-related kin, those extended families across the state often lack access to affordable legal services to prevent the children from being placed in foster care. The Kin-Tech program fulfills this service gap by assisting kinship families with family law issues such as paternity, consumer issues to relieve financial stress, housing concerns with landlord/tenant disputes or foreclosure. Services also may assist kinship families with direct legal assistance, training or education, support groups, referrals to other social, behavioral, or health services, advocacy, Guardianship clinics and maintaining a “Kansas Kin Care” web page. This program will be implemented statewide.

Access to mental health services is also a barrier for some rural and frontier counties. The review team selected Family Centered Treatment for 75 counties in the West and Wichita Regions. Family Centered Treatment provides in-home treatment services for youth and families to prevent children being removed from the home using psychotherapy designed to reduce maltreatment and enhance family resiliency.

Crossover Youth

In SFY 2019 DCF budget proviso outlined the legislative directive to convene a workgroup charged with gathering information about youth with offender behaviors entering or already in the child welfare system, referred to as “crossover youth.” This group met on June 13, 2019 to achieve three objectives: (1) defining characteristics or risk factors of crossover youth, (2) evaluating services offered to crossover youth, and (3) identifying additional services needed for crossover youth. The Crossover youth Services Working Report²⁹ and continued conversations with child welfare community stakeholders influenced Kansas’ evidence-based service selections.

In 2016, Kansas enacted Senate Bill (SB) 367, which sought to decrease the number of youth in the juvenile justice system by creating community-based alternatives to detention centers. The law was intended to focus intensive system responses on juveniles with the highest risk to re-offend, restricted the use of out-of-home placement in detention and Kansas Department of Corrections – Juvenile Services (KDOC - JS) custody, and planned to shift significant resources toward evidence-based alternatives with supervised in-home services. Implementation of SB 367 successfully reduced the number of youth placed in the juvenile justice system. According to the

²⁹ <http://www.dcf.ks.gov/Agency/Documents/CrossoverYouthServicesWorkingGroupReport.pdf>

Fiscal Year Flashback³⁰, in SFY 2016 the total youth in department of corrections custody was 1121, compared to 333.6 in SFY 2019, a 30% decrease.

An unintended consequence of implementation of SB 367, as amended, might be diverting youth and their families who previously were served by the juvenile justice system to access services from other state agencies, particularly the Department for Children and Families. State agencies historically have not tracked crossover youth in their data collection systems in a manner to verify crossover youth now being served by the child welfare system at higher rates. However, child welfare contractors, law enforcement representatives, child placing agencies and other partners report high rates of undertaking increasing challenges in managing behaviors and accessing effective services for crossover youth.

Due to these reported experiences and lack of resources for crossover youth, Kansas is focusing on strong evidence-based services to target this population and maintain them in their home whenever safely possible. Therefore, Kansas selected the following services: Adolescent Community Reinforcement Approach, Seeking Safety, Family Centered Treatment, Functional Family Therapy, and Multi-Systemic Therapy. Although each of these services will not be available statewide, one or more of these programs will be available in 97 of the 105 counties in SFY 2020, with hopes of future expansion.

Section 3: Evaluation Strategy and Waiver Request *(Section 2 Pre-print)*

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

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

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

Waiver Request

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

³⁰ <https://www.doc.ks.gov/publications/juvenile/population>

Section 4: Monitoring Child Safety *(Section 3 Pre-print)*

The foundation of the Kansas child protection system starts with the Protection Report Center. The Kansas Protection Report Center (KPRC) receives information from reporters regarding allegations of abuse, neglect and Family in Need of Assessment (FINA). Reporting hotlines operate 24 hours per day and seven days a week, including holidays. Kansas also manages a website where stakeholders may make an online report³¹. KPRC is centrally managed through administration and staff are physically located in three locations: Topeka, Wichita and Kansas City. KPRC receives reports and completes an assessment to determine if the report meets criteria for further investigation. The KPRC PPS practitioner uses research based Structured Decision Making (SDM) as a tool for assessing each report. If it is determined the report meets criteria for assignment, a response time is designated for the practitioner to meet with the family. Assigned reports are forwarded to the region where the family resides and assigned to a regional PPS practitioner. The practitioner completes face-to-face interviews with the family, contacts collateral witnesses to investigate the alleged abuse and/or neglect and completes risk and safety assessments to assist in identifying service needs.

The regional PPS practitioner uses the report, agency systems and web tools to learn the history of the family. If this information is available, it allows them to understand who the members of the family are, potential collateral contacts and prior services the family may have accessed. The PPS practitioner completes this review to inform the assessment they complete with the family once they make contact.

The regional PPS practitioner contacts the family within the response time at a location where they are most likely located. Based on information from the report, this could mean seeing the child at school or day care. PPS practitioners will meet with adult family members at their residence allowing them to complete an informal home safety and risk assessment and see other children in the home who may or may not be the subject of the report. Depending on the outcome of the assessment, the PPS practitioner may complete a safety plan with the family. PPS practitioners use either the research based Structured Decision Making (SDM) tool, Signs of Safety or formal safety and risk assessment tools in the Kansas Initiative for Decision Support (KIDS) system for assessing safety and risk.

The PPS practitioner and PPS supervisor meet within three days of the initial contact with the family to discuss information gathered from the assessment. The supervisor assists the PPS practitioner with assessment of safety and risk factors, identification of support and protective factors and potential service needs. If the decision is made to offer Family First Prevention Services, the PPS practitioner and family develop a prevention plan. Services are reviewed with the family and decisions added to the prevention plan. A referral is then made for services within 24 hours of the family acceptance for services. Service referrals are not limited to abuse/neglect finding decisions. FINA and Pregnant Woman Using Substances case types are also eligible to receive services.

³¹ <http://www.dcf.ks.gov/services/PPS/Pages/KIPS/KIPSWebIntake.aspx>

Once a family has been referred to an evidence-based prevention service provider, they are contacted by the provider within 48 hours to review the prevention plan with the family and begin assessment. The PPS practitioner promotes engagement between the provider and family and may attend the initial meeting. Throughout the service period, the PPS practitioner maintains open communication with the provider. If a subsequent report regarding the family comes to the KPRC while the family is working with the provider, the PPS practitioner shares this information with the provider. The provider reviews the information and incorporates it into the work they are doing with the family. In this circumstance, the provider role is not an investigator. The shared information is to inform their assessment and service decisions. The PPS practitioner will assess the family based on the subsequent report.

Throughout the 12 months a family is eligible for Family First services, the PPS practitioner, the home-based service provider or community family services provider complete formal and informal safety assessments of the child at each critical juncture. The PPS practitioner and the service providers work collaboratively to ensure child safety by completing ongoing assessments of the family, home and individual child. PPS maintains an open case and collaborates with the community services providers as needed to ensure child safety and risk throughout the life of the open case.

At the time a family has achieved completion of the program or service, the PPS practitioner completes an assessment to determine if the child continues at risk for placement out of home. Based on the assessment, the child's prevention plan is updated to reflect service closure with safety and risk mitigated, referral to another service, service extension or lastly petition for out of home.

If initially the family refuses to engage with the provider or the family is not making progress, the provider may contact the PPS practitioner to assist with engaging the family in services. After attempts are made to engage the family and they decide to not accept services, the provider requests a referral retraction. The PPS practitioner will assess the current risk and safety concerns and review information from the provider then consult with their supervisor. The supervisor and PPS practitioner decide next steps which may include, reviewing other service options with the family, closing the prevention plan with the family or requesting a Child In Need of Care action from the county or district attorney.

Section 5: Consultation and coordination *(Section 4 Pre-print)*

Stakeholder Community Convenings

In Spring 2019, DCF leadership held community convenings and spread the Family First message. Stakeholders within child welfare as well as community stakeholders all participated and held informative discussions surrounding what the Kansas child welfare landscape looks like and ideas for future improvements.

During the convenings, participants were asked to provide feedback, specifically their worries, current successful practices, and future steps the state should take related to implementing Family First in Kansas. These powerful voices throughout communities were instrumental in selecting and structuring Family First Prevention Services in Kansas.

Conversations called attention to many programs in Kansas participants felt were successful. Specifically, programs recognized as working well in multiple convenings were: Functional Family Therapy, Parents as Teachers, Healthy Families America, and in-home substance use treatment programs, such as Parent-Child Assistance Program. This feedback, proposals received, and program goals led to selection of these services in Kansas.

Kansas community members were most concerned about the sustainability of new programming and requirements to participate in Family First programs, such as the funding for associated costs for training, infrastructure, and staffing levels. Kansas allowed for these costs and incorporated them into the funding configuration with the new service providers. Community collaboration was the most prominent theme and participants expressed a desire to strengthen resource sharing and partner in ways emphasizing each individual agency's strengths. Beginning in SFY 2020, Kansas will convene quarterly regional and statewide advisory workgroups which will bring community stakeholders together and allow for conversations centered on Family First implementation as well as bridging community collaboration.

As stated earlier in this plan, high acuity youth and/or crossover youth continue to challenge the Kansas child welfare system. The voices of the community spoke of challenges they witness and strategies around designing a continuum of behavioral supports for this population. Working in the home with parents, early interventions in the home and school environment were identified as ways to access needed services prior to an acute situation, hospitalization or foster care services. Discussions and ongoing conversations with community partners, are one of the many reasons DCF selected specific Family First Prevention Services to target this population.

Family First Workgroup, Review Teams, and Sister Agency Collaborations

The Family First Workgroup met bi-weekly from spring 2018 and continues to meet throughout implementation of the program. This workgroup consists of members from each department within DCF Prevention and Protection Services, Executive Leadership, Grants and Contracts, Foster Care Licensing and Background Checks, Office of Fiscal Management, and representatives from Kansas Department for Aging and Disabilities Services (KDADS). The workgroup contributed to planning and implementation of FFPSA by collaborating and making valuable recommendations on structuring the program.

Throughout the planning process of FFPSA, DCF communicated with other state agencies and programs both internal and external. These partnerships included Kansas Department of Health and Environment (KDHE), KDADS, Kansas Department of Corrections – Juvenile Services (KDOC-JS), and DCF Economic & Employment Services (EES). Various areas where existing services and initiatives may overlap, supplement or complement proposed FFPSA programs

were explored. PPS has also strengthened partnerships with DCF Communications and Information Technology Systems to create toolkits, graphics, and search tools for PPS practitioners. In addition, ongoing collaboration with DCF Regional leadership to discuss support for DCF staff and planning for communicating the message of Family First to law enforcement, the courts, staff, and communities.

Kansas Department of Corrections – Juvenile Services (KDCO-JS) shared information with DCF regarding their prevention program for adjudicated juvenile offenders. KDOC has been working with families and youth utilizing Functional Family Therapy (FFT). The service/program is being offered to youth and their families through KDOC-JS contracts with private providers across the state. Through collaborative communication and process discussion, KDOC-JS is exploring expansion of this service to children determined by DCF as “Candidates for Care”. This potential expansion is in addition to the selected service providers identified earlier in Section 2: Service Description and Oversight.

Prior to selecting evidence-based program providers for FFPSA, PPS had meetings with EES leadership to identify existing grants serving at-risk populations. Meetings were held to assess existing service locations and identify gaps in the state where Family First services could potentially fill.

FFPSA limits the eligibility of certain placements when a child is in foster care, accordingly states were to develop Qualified Residential Treatment Programs (QRTP). For the child’s placement in a QRTP to be Title IV-E eligible, an independent assessment must be completed to determine if placement in a QRTP best meets the needs of the child. States were challenged with securing a resource to serve as an Independent Assessor. This requirement of FFPSA prescribed the independent assessor role as a “qualified individual ... who is not an employee of the agency and not affiliated with any placement setting in which children are placed by the agency³².” This created an opportunity to collaborate with KDADS. Prior to KDADS posting the Request for Proposal (RFP) “Crisis Screening and Triage” services, DCF was able to add a service provision which included the assessment criteria for placement in a QRTP. The RFP for the “Crisis Screening and Triage” provider closed in June, a cross-agency review of the technical proposal was conducted, and services will begin October 1, 2019. Kansas will be partnering with Healthsource Integrated Solutions, based in Topeka, for the independent assessor. Healthsource Integrated Solutions will utilize the Child and Adolescent Functional Assessment Scale (CAFAS) and Kansas seeks approval of this assessment from the Secretary. The CAFAS is utilized to assess a youth’s day to day functioning and tracks changes over time. Staff completing the assessments are qualified individuals and licensed at the LMSW or LSCSW level. Refer [Appendix 7](#) for the status of beds and facilities in Kansas.

³² ACYF-CB-PI-18-07, issued July 9, 2019

Tribal collaboration

Kansas has four federally recognized tribes headquartered in Kansas. They are Iowa Tribe of Kansas & Nebraska; Kickapoo Tribe in Kansas; Prairie Band Potawatomi Nation and Sac and Fox of Missouri in Kansas and Nebraska.

DCF has, in collaboration with the tribes, implemented quarterly statewide meetings. The meetings are held in July, October, January and April each year. These meetings were created and implemented during the 2015-2019 Title IV-B Child and Family Services Plan and have proven to be helpful to all participants. The DCF Prevention Team has attended since implementation of Family First to share information about the services offered through Family First and invited the tribes to attend the Provider Meet and Greet held in October 2019. Discussions in these meetings uncovered communication barriers between tribes and DCF. In response to feedback, a Kansas Prevention Service Track Tribal Coordination graphic was created (refer to [Appendix 8](#)) with the intent to help educate the tribal social services contacts about how DCF collaborates when a Native family has identified a Kansas prevention service. Through open collaboration with the tribal social services contact and the provider staff, the aim of DCF is to foster communication to help all families succeed. The DCF Tribal Specialist will act as the point of contact for tribes to answer questions about services or connect them to proper contacts in the agency.

If a tribal social services representative works with a family and identifies a program in the Kansas Prevention Service Track they believe would help prevent foster care, the process is explained as such:

- 1) Tribal social services representative will call Kansas Protection Report Center (KPRC) and relay the following information to the intake specialist: (1) which service they have identified, (2) what is the specific concern for the family, is it related to the child's behavior problem, and/or is it related to the caregiver's inability to provide care to the child.
- 2) DCF Practitioner will contact the tribal social services representative to coordinate services. The DCF practitioner will complete the prevention plan, if applicable.
- 3) The family will receive services by the state's grantee or contractor who will coordinate and communicate with both the tribal social services director and DCF

Existing policies and procedures for accessing services will be applied.

KSNAF is a partnership between the University of Kansas School of Social Welfare (KUSSW), Prairie Band Potawatomi Nation, Sac and Fox Nation of Missouri in Kansas and Nebraska, Iowa Tribe of Kansas and Nebraska, Haskell Indian Nations University, Kansas Department for Children and Families, Kansas Department for Aging and Disability Services, and KVC Kansas. Kansas Serves Native American Families (KSNAF) seeks to improve the well-being, safety, and permanency of Native American children affected by parent and community substance abuse through implementing and assessing an evidence-based parenting skills training, Strengthening Families Program (SFP), with cultural adaptations. This program compliment Family First Prevention Services efforts. The Prevention Team met with the KSNAF team to discuss current

structure of Family First in Kansas and identify ways to align KSNAF to appropriate contacts and connect to native families through DCF Prevention Services.

Kansas tribes have shared their preference for placement order of Native American Children. Further, when a child is of Native American heritage and is a member of a federally recognized tribe, or is eligible for membership in an Indian tribe, and is the biological child of a member of an Indian tribe, the Indian Child Welfare Act (ICWA) guidelines are followed.

Policy dictates determination of the child's heritage and eligibility shall be made at the earliest possible time it appears likely the child will come into kinship care. DCF is responsible to follow the placement preference as articulated in the Indian Child Welfare Act, per statute 25 U.S.C. 1901 et seq.

- A. a member of the child's family;
- B. another family of the same tribe
- C. a family of another Native American tribe;
- D. non-Native American family

Kansas has also invited tribal social services to participate on the Family First Statewide Advisory Workgroup and will continue to explore ways to collaborate with tribal communities.

Other collaborations and support

In April 2019, Leadership from DCF attended the *Family First Learning Collaborative: 2019 Implementers* Conference, sponsored by Casey Family Programs. This conference, held in Atlanta, introduced states to the new program material, prompted networking, idea sharing, and consultation to draft plans on how to create implementation strategies.

Further, Casey Family Programs has been a resource to PPS hosting the bi-weekly FFPSA planning collaborative conference calls, involving states that were also early adopters of Family First. These calls have been helpful in navigating the new and shifting program landscape. It has been beneficial for Kansas to hear about other state's challenges and successes experienced thus far.

The Capacity Building Center for States and Children's Bureau hosted a conference June 26-27, in Virginia, focused on Family First. Kansas sent a member of the Family First Team to participate in sharing the state's barriers and challenges in implementation and to collaborate with other states.

On July 31, 2019, PPS staff met with the Court Appointed Special Advocate (CASA) directors in Wichita, Kansas to talk about the Family First Prevention Services Act. This training was a joint project of the Kansas Office of Judicial Administration and the Kansas CASA Association. The team talked to CASA staff about the federal and state government's reinvestment in prevention, emphasis on family-based placement, and the systemic partnerships required to create a stronger child welfare system.

With support and sponsorship from Aetna Better Health of Kansas, one of three Managed Care Organizations for Kansas Medicaid, Kansas has begun implementation of Kevin Campbell's Family Finding model approach. This includes two, 4-day bootcamps for Family Finding and coaching support. The first bootcamp brought together over 90 professionals from different child welfare agencies, with the second bootcamp bringing together more than 185 professionals. Family Finding, in this collaborative approach across organizations who intersect with families, amplifies safety networks for children and assures the right supports at the right time to prevent the need for foster care. Kansas has also purchased Kevin Campbell's Family Finding manual and is strategizing how to continue to infuse the collaboration of Family Finding into every facet of the Child Welfare System, including contracted agencies, juvenile justice, CASAs, and other partners.

The Prevention Team presented October 22, 2019 at the 43rd Governor's Conference for the Prevention of Child Abuse and Neglect. Presenters include a Juvenile Judge, DCF Assistant General Counsel, and Prevention team members. This legal institute will provide attendees with the statutory requirements and DCF policies on the federal Family First Prevention Services Act. The Family First Prevention Services Act has intrigued communities and offered many opportunities for collaboration. Other presentations or opportunities for collaboration have included: Mental Health Coalition on October 23rd, Douglas County Citizen Review Board and CASA Volunteer meeting on December 13th, and the State Home Visiting Leadership Group in February.

Future presentations are planned for the 23rd Annual Governor and Attorney General's Crime Victims' Rights Conference on April 2nd and the Spring 2020 Best Practices in Kansas Child Welfare Law April 6th-9th 2020.

Section 6: Child welfare workforce training and support *(Section 5 & 6 Pre-print)*

With the development of the Child Welfare Practice Model ([Appendix 2](#)), the Department for Children and Families is committed to strategies of strong resiliency and prevention networks, timely exit to permanency, and health care and wellbeing coordination to yield positive outcomes. The strategies are supported by using evidence-based practices, making informed decisions and developing a prepared, well-trained workforce. The practice model also emphasizes the importance of preserving the parent-child relationship, maintaining children safely in their home with in-home services when possible, and the importance and priority of kinship placement in the event a child cannot safely remain in the home. As Kansas adopts Family First and shines a light on prevention and the importance of believing in the family, the workforce will transform over time with new positions, opportunities, trainings, models, tools and safety networks based around this idea. Prevention will infiltrate the agency, the workforce and eventually be ingrained into staff. Training, supporting and supplying staff with tools to succeed and feel confident following program implementation has been a significant objective for the agency.

The Kansas Protection Report Center (KPRC) serves as the origin for contact with the Department for Children and Families. Community partners and families need to be assured the information provided is used to determine next steps concerning allegations of abuse and neglect. Early interventions can prevent further maltreatment and are important to provide families tools and resources they need to raise their children in healthy, nurturing homes free from abuse and neglect. In SFY 2020, KPRC implemented Structured Decision Making (SDM). Kansas chose this tool to support the decision-making process for staff. The goal is well-informed and consistent decisions being made across the state. In SFY 2020, Kansas will pilot SDM safety and risk assessments in targeted counties in conjunction with Team Decision Making (TDM). SDM complements other practice approaches Kansas is pursuing, such as TDM, Signs of Safety (SofS) and Family Finding.

All practitioners are required to have a four-year degree in a Human Services or Behavioral Sciences field of study to be employed as a Child Protection Specialist. Completion of the Prevention and Protection Services (PPS) Training Academy is required prior to caseload assignment. It is a four-week process which includes the completion of required online training, shadowing experiences, pre-training assignments, and two classroom courses. The first face to face course is Investigation and Assessment, which concentrates on abuse/neglect definitions, policies and procedures related to the investigation, assessment, engagement, and documentation. The second face to face course focuses on the following topics: prevention services, ethics and confidentiality, documentation, critical thinking, testifying in court, Indian Child Welfare Act, Interstate Compact on the Placement of Children, Multiethnic Placement Act, worker safety, and mandated reporting. The Academy participants are expected to complete the additional training requirements within 90 to 180 days of hire. As an additional requirement, all DCF PPS Specialists and Supervisors must complete 40 hours of continuing education, including 3 hours of ethics training bi-annually.

PPS practitioners and case management providers for Family Preservation and Foster Care services attend the Kansas Child Welfare Professional Training Program (KCWPTP) Caseworker Core Modules. The modules provide ongoing in-service trainings to ensure Kansas child welfare practitioners are equipped with the tools they need to effectively provide service to children and families in Kansas and satisfy continuing education requirements. Topics include utilizing a family-centered approach, engagement and rapport building with families, legal aspects in child welfare, assessment and safety planning, exploring fact finding principles common to all child welfare cases, case planning, child development implications, and separation, placement and reunification in family-centered child protective services.

Specialized child welfare training is conducted by DCF and the Child Welfare Case Management Providers (CWCMP) for their respective staff. Information about scheduled DCF and CWCMP trainings is shared by email and posted to the KCWPTP website^[1]. Staff from the different agencies, including tribal and military partners, are encouraged to take advantage of training opportunities, including trauma-informed care with children and families.

Kansas is taking steps to support and enhance a competent, skilled, and professional child welfare workforce to deliver trauma-informed and evidence-based services. The agency will

provide training and support for caseworkers in assessing needs, connecting to the families served, knowing how to access and deliver the needed trauma-informed and evidence-based services, and overseeing and evaluating the continuing appropriateness of the services. The addition of new courses outlined below and the need to expand and revise existing courses.

Training to Develop Appropriate Prevention Plans

Kansas currently provides PPS practitioners initial staff training to assess safety and risk utilizing Kansas Initiative for Decision Support (KIDS) safety and risk assessment tools. The KCWPTP will modify existing courses or develop a new course to incorporate the formal documentation of an eligible child's Prevention Plan. The training will also be expanded to include the Family First Prevention Services providers.

Team Decision Making - Practice implementation begins November 2019 in Kansas City and Southeast Kansas with the Annie E. Casey Foundation and National Center for Crime and Delinquency to strengthen safety planning in facilitated meetings with families, relatives, schools and community supports. This phase of the rollout includes a pilot of Structured Decision Making in Kansas City and Southeast Kansas. The next phase of TDM implementation will use the Signs of Safety assessment and planning framework to address past harm, danger statements, existing strengths and safety, safety goals and next steps.

Kansas Strong for Children and Families -The University of Kansas School of Social Welfare (KUSSW) and its partners, the Kansas Department for Children and Families and the state's network of privatized providers of adoption and foster care in concert with the Court Improvement Program (CIP), are currently in the planning period of a federal five year grant to develop and deliver Kansas Strong for Children and Families (KS Strong). Kansas Strong is a cooperative agreement between KUSSW and the U.S. Department of Health and Human Services, administration for Children and Families, Children's Bureau. Kansas is one of five grantees nationally aimed at strengthening child welfare systems to improve outcomes for children and families.

A goal of the project is to implement KanCoach, a coaching program for public and private supervisors across child welfare programs to address basic social work practices in four areas: parent and youth engagement; risk and safety assessment; relative/kin connections; and, concurrent planning. Plans include training and implementing coaching for supervisors and developing a comprehensive set of methods and tools for supervisors to deliver coaching to frontline workers.

KanCoach promotes shared principles across the child welfare system on safety and risk, assessment, and case planning:

1. Children should be maintained safely in their homes when possible.
2. Children should be safe when they reside in kinship, foster, or adoptive homes or in congregate care.

3. When a report concerning child safety staff will make a timely safety and risk assessment.
 - a. Factors to consider when assessing for safety include (but are not limited to):
 - i. Severity of harm to the child
 - ii. Imminent danger
 - iii. Child vulnerability
 - iv. Caregiver protective capacity
 - b. Factors to consider when assessing for risk include (but are not limited to):
 - i. Parent or caregiver factors
 - ii. Family factors
 - iii. Child factors
 - iv. Environmental factors
4. Information obtained during safety and risk assessments should inform the case planning process.

Training for PPS Practitioners - The prevention services concepts will be incorporated into new employee practice model training, which will include classroom training, field experience, and coaching. Additional resources will be provided to practitioners for specific evidence-based mental health, substance abuse, and in-home parent skills services included in Kansas' Title IV-E Prevention Plan to help works understand the service target population, needs the service addresses, and availability. Emphasis will be given to incorporating the assessed needs into the written prevention plan in a way which identifies strategies making it safe for the child to remain safely at home or with kin caregiver and connecting to appropriate evidence-based trauma-informed services and programs.

Training related to Structured Decision Making for Intake procedures will continue for Protection Report Center staff. Mechanisms of Childhood Injury offered by physicians from Children's Mercy Hospital will begin in early 2020. DCF is exploring Motivational Interviewing to help practitioners engage families and aid in gathering assessment information. Kansas is in the process of implementing Signs of Safety in twelve South Central counties. Beginning in December 2019, the two-day introductory course will be provided to all staff, including senior and executive leaders and key partners. This introduction will explore the principles, disciplines, tools and process of Signs of Safety practice; the application through end-to-end case examples; applying Signs of Safety to an agency case; and the implementation framework, with emphasis on learning methods supporting the practice methods.

Beginning in SFY 2020, DCF is developing and will deliver virtual training sessions on Trust Based Relational Intervention (TBRI). This attachment-based, evidenced-based, and trauma-informed intervention is designed to meet the complex needs of vulnerable children. TBRI uses Empowering Principles to address physical needs, Connecting Principles for attachment needs, and Correcting Principles to disarm fear-based behaviors. This service has been utilized in a variety of settings, including legal systems, residential treatment facilities, groups homes, foster

and adoptive homes, youth camps, and schools. TBRI is effective with children of all ages and risk levels.

Supporting Staff

With just 60 days to implementation, a motivational video³³ and accompanying handout (see [Appendix 9](#)) was distributed to PPS practitioners carrying the message of Family First with the intent to include, empower, and inspire practitioners in this exciting child welfare transformation.

To further communicate how Family First would fit into regional foster care prevention services, toolkits were individualized for regions. These toolkits offer a variety of ways to be informed about the new services, providers, and programs available to the regions³⁴. These kits contain various desk aids, service menus to discuss with families, and a web-based search tool to assist PPS practitioners when selecting and referring families to programs.

Several weeks at the end of October were reserved in various DCF Service Centers to introduce the new providers and the evidence-based programs for practitioners during an open-house booth style event (see [Appendix 10](#)). This allowed for providers and PPS practitioners to begin collaborating, strengthening and building relationships with providers.

DCF Administrative leaders also visited regional offices in October and November 2019 to initiate focused conversations with direct service practitioners regarding prevention practice. These discussions targeted how each resource implemented thus far can support staff in their work alongside families. Administrators championed this message to staff to strengthen family engagement in service decision making.

All evidence-based programs will be provided by qualified staff. The selected services each have their own training requirements and staff qualifications specific to their model. DCF requires all providers working with families to uphold staffing and training requirements specified by each model to meet fidelity of the program. Providers will be required to meet prescribed staffing ratio or needs to serve the desired population of impact with information on duration of service, number of classes or number of contacts or engagement session as applicable to the program.

In 2020, the Prevention Team organized a winter/spring “Prevention Tour” of each Kansas DCF office to deliver in-person, one-on-one training for the new Family First process and to open up communication and build relationships with the staff members working directly with families and connecting them to the new evidence-based services available in the regions. Finally, a newsletter³⁵ was developed to target staff and stakeholders, connect communities, and engage and educate following Family First implementation. The intention is to keep communication open, collaborate, and share in mutual learning of Family First.

³³ Link to DCF “Introduction to Family First” Staff Video: <https://vimeo.com/349925961/62edf21bd5>

³⁴ Family First Informational Video for Staff <https://vimeo.com/361882590/8a44ce1e6d>

³⁵ <http://www.dcf.ks.gov/services/PPS/Pages/Newsletters.aspx>

Section 7: Prevention caseloads *(Section 7 Pre-print)*

As Kansas transitions toward a prevention focused agency and implementation of Family First, impact on PPS practitioners and their caseload is very much in the forefront of the agency’s planning for staff readiness. As such, it is also important to distinguish caseload size and type for PPS practitioners and the practitioners of the evidenced based programs for which DCF establishes and awards Family First prevention grants.

DCF staffing allocation across the four regions support a caseload ratio in assessments and investigation of one worker to 15 (1:15) new reports monthly. As DCF prepared for implementation this year, a campaign to “get to zero” vacancies in the child protection workforce gained momentum and was realized in several service centers. DCF Assessment and Investigation caseloads are monitored and reported monthly to demonstrate trends and complement weekly tracking of retained and vacant positions.

June data (Table 1) reflects statewide success meeting the caseload goal with only Kansas City slightly over the target range. Caseload management within standards supports effective decision making for the right service at the right time. DCF celebrates Wichita and West regions, who have been at or near 100% fully staffed for more than 9 weeks this summer. In addition to the worker-family ratio, DCF is pursuing increasing supervisor positions in SFY20 and SFY21 to achieve a 1:5 supervisor to worker ratio. A 1:5 ratio strengthens the current 1:7 supervisor: worker ratio.

Attributes of full staffing levels, maintenance of workload standards and increased supervisor ratios improves assessment decisions and the bridge for families to the appropriate dose and scope of service.

| Table 1 Region | # Assessment & Prevention Staff | Abuse/ Neglect | Pregnant Woman Using Substances | FINA | Independent Living | ICPC | Total # of Assigned Intakes* | Ratio of Assigned Intakes/ A&P Staff |
|-------------------|---|-------------------|--|------|-----------------------|------|------------------------------------|---|
| East | 53 | 532 | 8 | 132 | 2 | 11 | 685 | 12.9 |
| Kansas City | 48 | 564 | 6 | 167 | 0 | 7 | 744 | 15.5 |
| West | 70 | 573 | 9 | 133 | 3 | 11 | 729 | 10.4 |
| Wichita | 57 | 490 | 10 | 135 | 0 | 2 | 637 | 11.2 |
| Statewide | 228 | 2,159 | 33 | 567 | 5 | 31 | 2,795 | 12.3 |

Prevention grants awarded to evidenced based programs in October 2019 will take time to fully implement depending on the provider readiness in a community. Programs established in the community may be able to receive new referrals immediately or may phase their implementation as additional practitioners are trained and ready to be case carrying. As such, a measurable volume of case referrals for an individual PPS practitioner may not occur for a few months in the first year of implementation.

DCF management and monitoring of the grant referral programs is a blend of two methods for the family's time limited period of 12 months. PPS practitioners may maintain a family within their assigned caseload for up to 45 working days as the assessment is completed or concluded. For families whose prevention service extends past the 45 workdays of assessment or conclusion date (whichever comes first), the family's prevention plan program will be monitored by either:

- A. A designated PPS practitioner or program consultant position within the region who has a dedicated liaison monitoring caseload of up to 25 referrals (families) of family first or family preservation; or,
- B. The family will be monitored by a contracted community service provider whose family first referral caseload is 15-18 families.

The family first program case monitor will perform such duties as receiving the Plan of Safe Care and other update or process documents related to the program emphasis, assure start end dates of service and other data elements are accurate in reporting systems, serve as connection for any changes in service status and may evolve to liaison with the prevention Grant Evaluator as needed or appropriate.

Over time, as the number of families receiving services from a Family First provider increases, DCF positions will shift as needed to adjust to the increase in Family First program referrals. For future state fiscal years beginning July 2020, DCF plans to request through the formal state budget process two additional positions for each DCF region to manage and monitor Family First program referrals.

Prevention caseload or workload size within prevention program providers is consistent with their evidence-based model program delivery, intensity and service setting. The grant agreement with DCF sets forth the provider's responsibility to manage caseload size in manner consistent with the model approach. Service providers coordinate with regional and administrative staff to determine frequency and pace of referrals based on family presenting situation, candidate for care determination and program intervention population focus and program capacity.

Section 8: Assurance on prevention program reporting *(Section 8 Pre-print)*

The Title IV-E Prevention Program Reporting Assurance in [Appendix 11](#) reflects Kansas' commitment to comply with all reporting requirements set forth by the Children's Bureau.

Conclusion

“Creating a child welfare system that we can be proud of as a nation and that children, families and communities will see as a source of support and strength, as opposed to a system to fear, will take collaboration across the three branches of government, as well as with states and tribes. We have a collective duty and responsibility to ensure that federal policy and funding protects children to the best extent possible, which includes living in resilient, healthy families.”³⁶ – Dr. Jerry Milner.

Kansas looks forward to the federal partnership to offer increased prevention services for families. State and federal leaders understand the trauma foster care may cause and have committed resources to improving the child welfare system. Kansas will use these resources to award seventeen new grants to serve families in the areas of mental health, substance use disorder services, kinship navigation, and parent-skill building. Kansas is eager to see how the evaluation grant and federal guidance can further improve services for families. Family First will help the Department for Children and Families achieve the agency mission of protecting children, promoting healthy families, and encouraging personal responsibility.

[Appendix 12](#) Governor’s Letter certifies that this plan was submitted to Governor Laura Kelly for her review and approval.

[Attachment 2](#) and [Attachment 3](#) provides the required applicable statutory, regulatory, and/or policy references in Attachment B of the title IV-E prevention plan pre-print.

³⁶ <https://www.acf.hhs.gov/olab/resource/testimony-of-jerry-milner-on-family-first-prevention-services-act>

Appendix 1: State Annual Maintenance of Effort (MOE) Report


Title IV-E Prevention and Family Services and Programs Plan
 State of Kansas

ATTACHMENT IV

**U.S. DEPARTMENT OF HEALTH and HUMAN SERVICES
 Administration on Children, Youth and Families
 Children's Bureau**

State Annual Maintenance of Effort (MOE) Report

| | |
|--|-----------|
| State: Kansas | FFY: 2020 |
| Baseline Year: | FFY 2014 |
| Baseline Amount: | \$0.00 |
| Total Expenditures for Most Recent FFY: | \$0.00 |

| |
|---|
| <p>This certifies that the information on this form is accurate and true to the best of my knowledge and belief.</p> <p>This also certifies that the next FFY foster care prevention expenditures will be submitted as required by law.</p> |
| <p>Signature, Approving Official:</p>  |
| <p>Typed Name, Title, Agency: Jane Meschberger, Director of PPS Kansas Department for Children and Families</p> |
| <p>Date: 9/24/19</p> |

Appendix 2: Kansas Child Welfare Practice Model

Rev. 10/14/19 TK

Child Welfare Practice Model



Strategies and Foundation

Kansas Department for Children and Families (DCF) strategies of strong resiliency and prevention networks, timely exits to permanency, and health care and wellbeing coordination yield positive outcomes. Strategies are supported by a practice model with approaches linked to better outcomes alongside families and partners in communities.



Principles and Approach

| | | |
|--|-----------------------------------|---|
| | Family Finding | <ul style="list-style-type: none"> • Alignment • Engagement • Healing and Development • Sustained Stability: Create Lifetime Networks |
| | Team Decision Making™ | <ul style="list-style-type: none"> • Facilitation • Families alongside support network and DCF • Inclusivity and transparency • 'TDM' |
| | Child Protection Framework | <ul style="list-style-type: none"> • Engagement • KPRC Intake Structured Decision Making® • Safety and Risk Structured Decision Making® • Signs of Safety® • Reliability, Equity |

(Continued)



Family Finding: DCF, Grantees & CASA

- Develop statement of need, concerns & goals
- Includes youth and family search and engagement tools
- Creates lifetime networks
- Co creation driven
- Achieves permanency and stability for healing and development
- Support from Aetna Better Health of Kansas and Casey Family Programs



Team Decision Making™: (TDM) KC, Pittsburg, then state

- Facilitated meeting before a child is moved to determine if a child needs to be separated from their parent(s)/primary caregiver due to the parent(s)/primary caregiver behavior threatening a child's safety
- Families invite their support network
- Creates and results in strongest plan for safety



Signs of Safety® Wichita, RN, HV, then statewide

- Assessment and Engagement through 3 Columns Mapping
- Asks what are we worried about, what's going well and what needs to happen?
- Alongside families and safety network create harm and danger statements
- Children's Tools to gain child and youth's voice
- Includes a system of meaningful measures, supervisor coaching and QA
- Support from Casey Family Programs



Structured Decision Making® (SDM) KC and Pittsburg areas

- Assessment and Engagement
- Focused on a sequence of key decision points and helps us to be intentional about decisions
- Safety is actions of protection taken by the caregiver that mitigate the danger, demonstrated over time
- Structured scoring for abuse and neglect indices

(Continued)

DCF PPS Practice Model Implementation Timeline Rev. TK 11/3/19

Key ● = Planned, ▲ = possible/aspiration, → = July 2020 or later

| Approach | Geography | Who | 2019 | | 2020 | | | | | |
|---------------------------------|-------------------------------|--|------|-----|------|-----|-----|-----|-----|-----|
| | | | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
| Family Finding | | | | | | | | | | |
| Bootcamp | Statewide | 100 seats DCF, CASA, FC grantees | ● | | | | | | | |
| Leads Action Plan Cascading | Statewide | 20 Leads | | ▲ | ▲ | ▲ | | | | |
| Cascade Approach Curriculum | Statewide | DCF, FC Grantees | | | | ▲ | ● | ● | ● | ● |
| Explore Youth Bootcamp | Statewide | 50 seats? | | | | | | ▲ | ▲ | ▲ |
| Explore Coaching via Casey FP | Statewide | Virtual learning exchange | | | | ▲ | ▲ | ▲ | ▲ | ▲ |
| TDM | | | | | | | | | | |
| Initial Implementation | CR, CK, JO, & WY | DCF front line, community orientations | ● | ● | | | | | | |
| Initial Implementation | Wichita Region + HV, RN | DCF front line, community orientations | | | ● | ● | ● | | | |
| Initial Data Management Reports | 4 counties, then SC Hub | Leads and Data Mgr. SIT, RIT | | | ▲ | ▲ | ▲ | ▲ | ▲ | ▲ |
| Initial Implementation | West (remaining) | DCF front line, community orientations | | | | | | ▲ | ▲ | ▲ |
| Initial Implementation | East (remaining) | DCF front line, community orientations | | | | | | | | ▲ |
| Initial Implementation | KC (remaining) | DCF front line, community orientations | | | | | | | | → |
| DV Session | Statewide | Facilitators and Sups | | | | ▲ | ▲ | ▲ | ● | ● |
| Older Youth Session | Statewide | DCF frontline | | | | | ▲ | ▲ | ● | ● |
| Signs of Safety | | | | | | | | | | |
| Initial Planning and Exposure | SC Hub Wichita Rg + HV, RN | DCF front line, community orientations | ● | ● | | | | | | |
| Coaching | SC Hub, then other TBD | DCF front line, sups | | | ▲ | ▲ | ▲ | ▲ | ▲ | ▲ |
| Initial Planning and Exposure | West (remaining) | DCF front line, community orientations | | | ▲ | ▲ | ▲ | | | |
| Initial Planning and Exposure | East | DCF front line, community orientations | | | | | | ▲ | ▲ | ▲ |
| Initial Planning and Exposure | KC | DCF front line, community orientations | | | | | | | | → |

(Continued)

DCF PPS Practice Model Implementation Timeline Rev. TK 11/3/19

Key ● = Planned, ▲ = possible/aspiration, → = July 2020 or later

| SDM | | | | | | | | | | |
|--|------------------|-------------------------------|------------|------------|------------|------------|------------|------------|------------|------------|
| Initial Implementation | CR, CK, JO, & WY | DCF front line & Sup | ● | | | | | | | |
| System | CR, CK, JO, & WY | Dec 16 th launch | | ● | | | | | | |
| KAN Coach | | | | | | | ● | ● | ● | ● → |
| Alignment Work | | | | | | | | | | |
| Explore Stop Doing | | | ● | ● | | | | | | |
| KIDS | | | ● | ● | | | | | | |
| Policy Manual | | | ● | ● | | | | | | |
| <i>(reserved for future use)</i> | | | | | | | | | | |
| Initial QA SOS | SC Hub | TBD | | | ▲ | ▲ | ▲ | | | |
| Initial QA SDM | 4 counties | TBD | | | ▲ | ▲ | ▲ | | | |
| Approach Specific QA/PI | | TBD | | | | | ▲ | ▲ | ▲ | |
| Joint Calls | SOS, TDM, SDM | TBD | | ▲ | | ▲ | | ▲ | | |
| Coordinate Collab annual meetings of developers? | State | Aetna, CFP, NCCD, SafeGen, KU | | | | | | | ▲ | ▲ → |
| <i>Approach</i> | <i>Geography</i> | <i>Who</i> | <i>Nov</i> | <i>Dec</i> | <i>Jan</i> | <i>Feb</i> | <i>Mar</i> | <i>Apr</i> | <i>May</i> | <i>Jun</i> |
| | | | 2019 | | 2020 | | | | | |

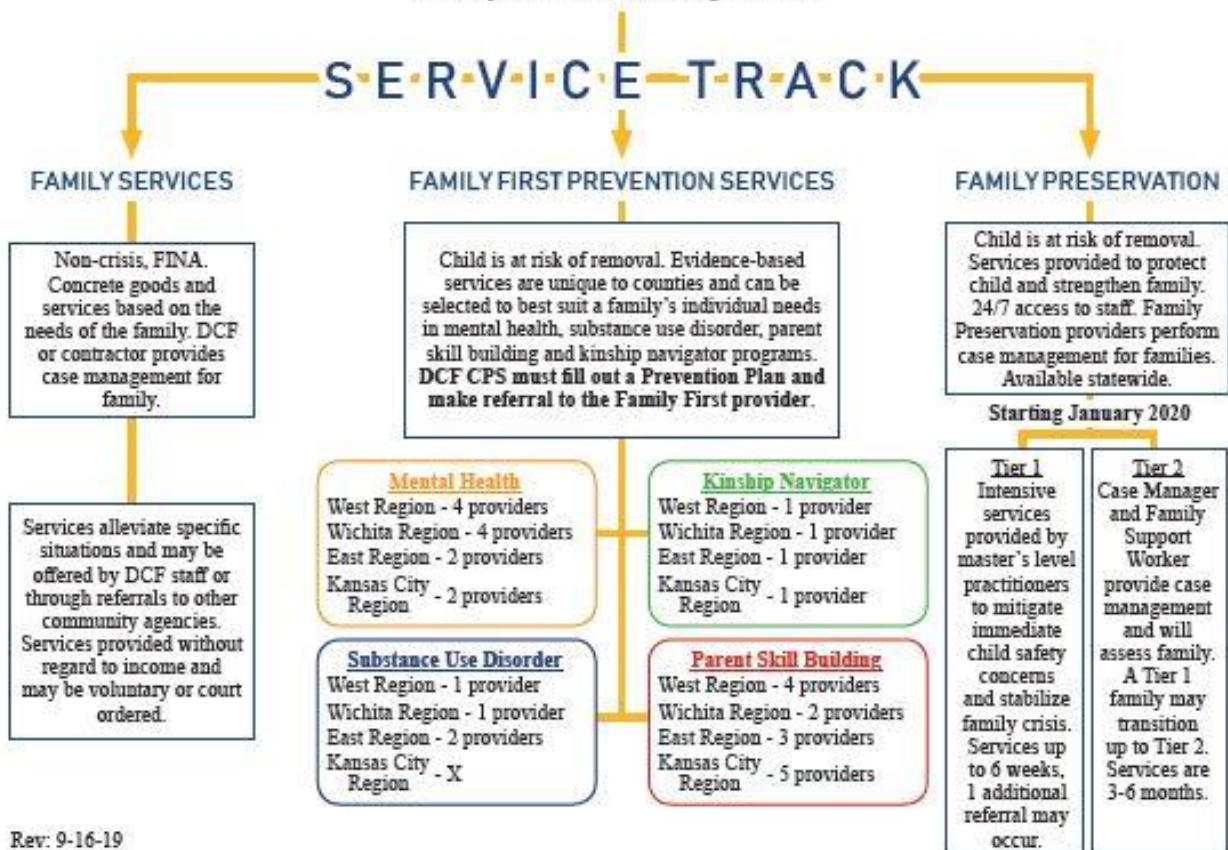
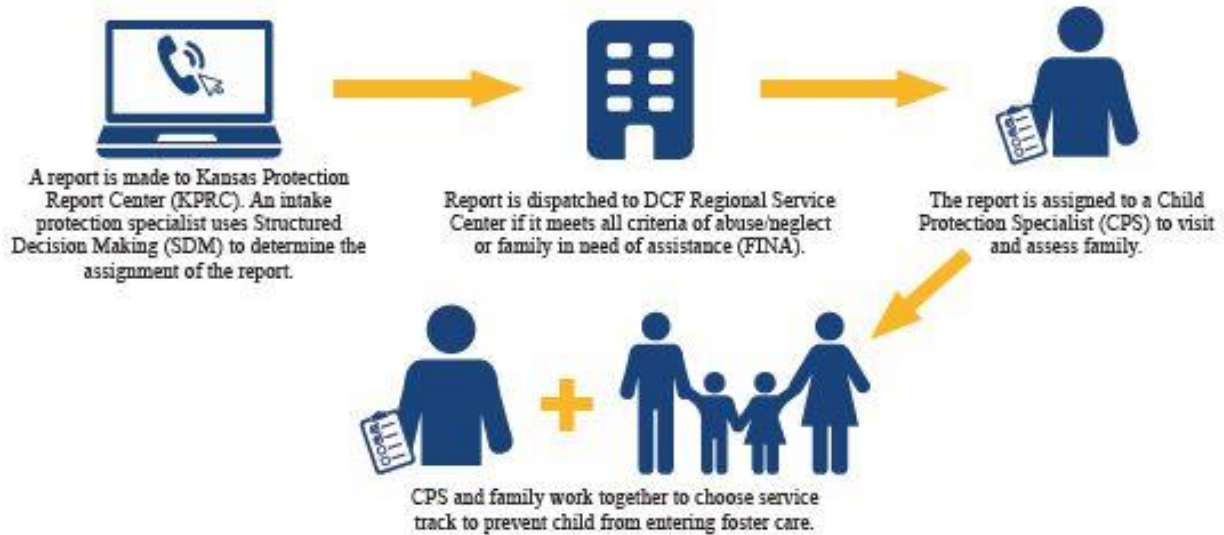
Appendix 3: Timeline for Family First in Kansas

| | |
|--------------|--|
| Summer 2018 | Children’s Alliance of Kansas City and Casey Family Programs began convening, Advocacy with Child Welfare Task Force around prevention resources for FFPSA, DCF Policy Review, background check and project planning |
| Fall 2018 | Surveys to YRCII Group Homes regarding QRTP readiness, explore provider agreements for inpatient SUD treatment for children in care with a parent in need of SUD treatment |
| Winter 2018 | Governor’s Budget Recommendations for \$13.9 Million for FFPSA |
| Winter 2018 | Legislative action to amend CINC code for QRTP court review approval |
| Spring 2019 | Kansas held 6 community convenings to hear the voices of stakeholders and providers about services needed in their areas. |
| Spring 2019 | Kansas a request for information (RFI) to obtain additional feedback about services that currently exist, Family First RFP closed in May 2019. |
| Spring 2019 | Kansas pass HB2103 – is passed 60-day judicial review of QRTP |
| June 2019 | Started conversations with five substance use disorder facilities to partner and provide room and board for child in custody while parent is seeking treatment. |
| July 2019 | 37 QRTP beds have been established in Salina and Kansas City. Pending beds located in Topeka, Olathe, and Goddard. |
| August 2019 | RFP Review Teams met to consider proposals |
| October 2019 | Family First is implemented statewide |

Appendix 4: Prevention Services Track

KANSAS PREVENTION SERVICES TRACK

Department for Children and Families





Tier 1 & Tier 2 Family Preservation Services

Beginning January 1, 2020, PPS Assessment/Prevention staff may choose between Tier 1 and Tier 2 when referring families to Family Preservation Services. The referral period will no longer be for 365 days.

TIER 1

INTENSIVE IN-HOME FAMILY PRESERVATION SERVICES

- Provided by a master’s level practitioner with the intent to mitigate immediate child safety concerns, stabilize family crisis and assess the family’s needs.
- Services last approximately six weeks.
- Will meet with the family intensively, consistent with the applied evidence-based model.

POTENTIAL REFERRAL EXAMPLES

- A pregnant woman using alcohol and/or substances during pregnancy
- A family whose infant is born substance-exposed or substance-affected
- A family with a child placed in police protective custody
- A family who has a child with serious emotional or behavioral concerns and the family expresses they can no longer cope without intervention
- A family who has participated in less intensive, unsuccessful interventions and the family is experiencing a crisis

TIER 2

SHORT-TERM FAMILY PRESERVATION CASE MANAGEMENT SERVICES

- Provided by a worker dyad consisting of an assigned Case Manager and a Family Support worker, assessing for existing risk and emergent safety issues and when identified, initiative services to stabilize and support the family.
- Services shall last three to six months.
- The case manager will meet with the family at a minimum of one hour face-to-face weekly.
- Family Support workers will assist the family with learning skills to strengthen the family system.

POTENTIAL REFERRAL EXAMPLES

- A family with affirmed or substantiated abuse or neglect finding a moderate to high risk of subsequent maltreatment
- A family with a child with truancy issues
- A family lacks adequate parenting skills to care for a child with difficult behavior at home or school, placing that child at risk for out of home placement or in-patient mental health treatment without services

Appendix 6: State Assurance of Trauma-Informed Service-Delivery

Title IV-E Prevention and Family Services and Programs Plan
State of Kansas

ATTACHMENT III

State Assurance of Trauma-Informed Service-Delivery

Instructions: This Assurance may be used to satisfy requirements at section 471(e)(4)(B) of the Social Security Act (the Act), and will remain in effect on an ongoing basis. This Assurance must be re-submitted if there is a change in the state's five-year plan to include additional title IV-E prevention or family services or programs.

Consistent with the agency's five-year title IV-E prevention plan, section 471(e)(4)(B) of the Act requires the title IV-E agency to provide services or programs to or on behalf of a child under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma and in accordance with recognized principles of a trauma-informed approach and trauma-specific interventions to address trauma's consequences and facilitate healing.

The Kansas Department for Children and Families assures that in accordance with section 471(e)(4)(B) of the Act, each HHS approved title IV-E prevention or family service or program identified in the five-year plan is provided in accordance with a trauma-informed approach.

Signature: This assurance must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

9/24/19
(Date)

Jane Meschberger
(Signature and Title)
Director of PPS

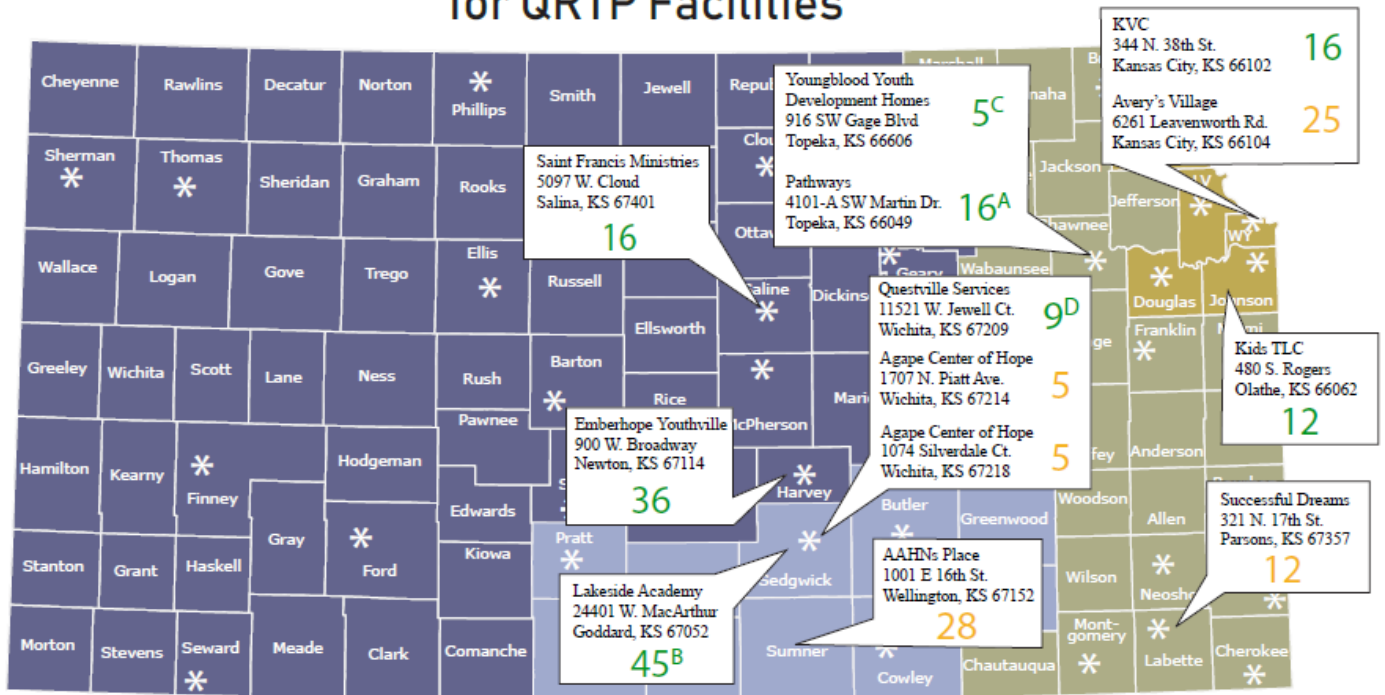
4/30/2020
(CB Approval Date)

[Signature]
(Signature, Associate Commissioner, Children's Bureau)

Appendix 7: QRTP Facilities and Bed Numbers Map

Rev: 02-17-20

Kansas Bed Numbers for QRTP Facilities

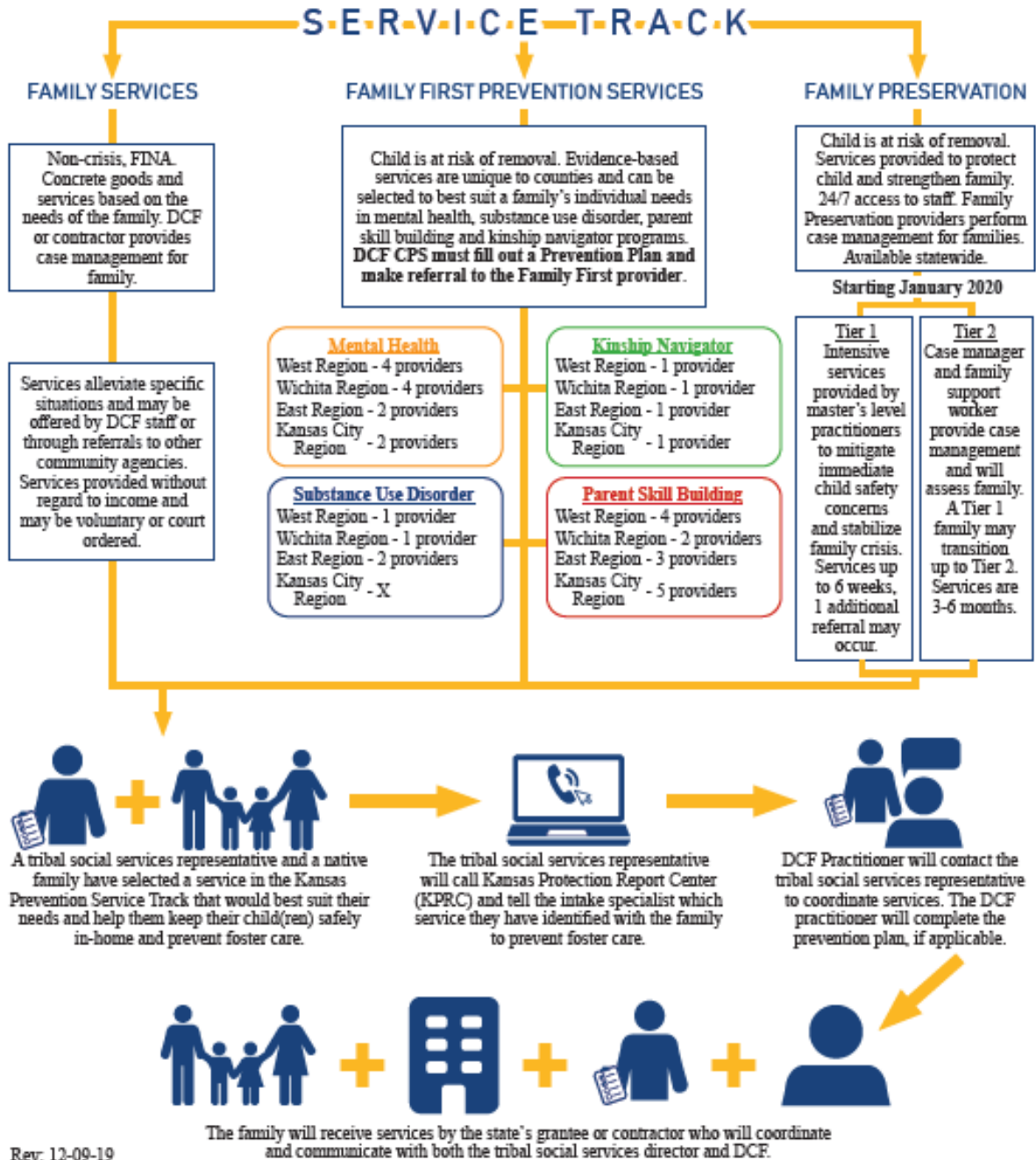


* DCF Service Center

- Available QRTP beds
- Pre-QRTP status/pending beds
- A Beds currently inaccessible due to ADA compliance renovations
- B Facility for males ages 12-18
- C Has exception for 4 over capacity
- D Beds reserved for females

Appendix 8: Tribal Service Track

Kansas Department for Children and Families
KANSAS PREVENTION SERVICES TRACK
TRIBAL COORDINATION



Rev: 12-09-19

Family First Prevention Services Act



Who does FFPSA serve?

- ✓ Children at “imminent risk” of removal who can remain safely at home with services
- ✓ Their parents/caregivers
- ✓ Pregnant and parenting youth in foster care
- ✓ A variety of living situations may qualify
 - Child is with parent(s) but at imminent risk
 - Formal or informal kinship placements, if there is imminent risk of disruption or dissolution
 - Aftercare services for reunified and post-permanency youth

Qualifying Prevention Services



Appendix 10: Open House Event



Prevention Services Meet and Greet: Get to Know Our Providers!

Learn about the new evidence-based programs and the partners helping serve Kansas families.



*** This event is for DCF staff and Kansas Prevention Providers**

The first half-hour of each event is a presentation, followed by open-house

Tues., October 29, 9:30 am—Noon: Topeka DCF Service Center, *Room 147-148*

Wed., October 30, 9:30 am—Noon: Chanute DCF Service Center, *Kansas Room*

Thurs., Oct. 31, 9:30 am—Noon: Wyandotte DCF Service Center, *1050 North & South*

Thurs., Oct. 31, 1:30–4pm: Johnson County DCF Service Center, *Sunflower East & West*

Tues, November 5, 9:30 am—Noon: Colby DCF Service Center, *Bison Room*

Wed., Nov. 6, 9:30 am—Noon: Garden City DCF Service Center, *Room 315*

TBD November TBD - Wichita DCF Service Center, *Conf. Room 300*

Questions? Contact: DCF.FamilyFirst@ks.gov
or caroline.hastings@ks.gov for Family Preservation



Appendix 11: State Program Reporting Assurance

Title IV-E Prevention and Family Services and Programs Plan
State of Kansas

ATTACHMENT I

State Title IV-E Prevention Program Reporting Assurance

Instructions: This Assurance may be used to satisfy requirements at section 471(e)(5)(B)(x) of the Social Security Act (the Act), and will remain in effect on an ongoing basis. This Assurance must be re-submitted if there is a change in the assurance below.

In accordance with section 471(e)(5)(B)(x) of the Act, Kansas Department for Children and Families, is providing this assurance consistent with the five-year plan to report to the Secretary such information and data as the Secretary may require with respect to title IV-E prevention and family services and programs, including information and data necessary to determine the performance measures.

Signature: This assurance must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

9/24/19
(Date)

Jane Meschberger Director of PPS
(Signature and Title)

4/30/2020

(CB Approval Date)

[Signature]

(Signature, Associate Commissioner, Children's Bureau)

Appendix 12: Governor Kelly's Approval

Capitol Building
Room 241 South
Topeka, KS 66612



Phone: (785) 296-3232
governor.kansas.gov

Laura Kelly, Governor

September 30, 2019

Administration for Children and Families (ACF)
Children's Bureau

As Governor of the State of Kansas, I, Laura Kelly, confirm that I am in receipt of a copy of the proposed Five-Year Prevention Plan prepared by Kansas Department for Children and Families (DCF), Title IV-E agency in Kansas, and anticipated to be submitted by said agency to ACF. Submission of the Prevention Plan to ACF is required pursuant to the federal Family First Prevention Services Act.

The Title IV-E Plan was submitted to me as Governor of Kansas for my review and I approve same in accordance with 45 CFR 1356.20(c)(2) and 45 CFR 204.1.

Thank you for your attention to this matter.

Respectfully,

A handwritten signature in blue ink, appearing to read "Laura Kelly", is written over a horizontal line.

Governor Laura Kelly

Appendix 13: Acronym Guide

| | |
|---|---|
| ABC- Attachment and Biobehavioral Catch-up | KIDS- Kansas Initiatives Decision Support |
| AECF- Annie E. Casey Foundation | KIN-Tech- Kinship Interdisciplinary Navigation Technologically Advanced Model |
| A-CRA- Adolescent Community Reinforcement Approach | KPRC – Kansas Protection Report Center |
| BSRB- Behavioral Sciences Regulatory Board | KUSSW- University of Kansas School of Social Welfare |
| CASA – Court Appointed Special Advocate | KCWPTP- Kansas Child Welfare Professional Training Program |
| CAPS – Child Advocacy and Parenting Services | KPATA – Kansas Parents as Teachers Association |
| CEBC - California Evidence Based Clearinghouse | MI – Motivational Interviewing |
| CIP- Court Improvement Plan | MST- Multisystemic Therapy |
| CMHC- Community Mental Health Center | NCCD- National Center for Crime and Delinquency |
| CPI – Continuous Performance Improvement | NPP - Nurturing Parenting Program |
| CWCMP- Child Welfare Case Management Provider | OOH – Out of Home |
| CPS- Child Protection Specialist | PAT- Parents as Teachers |
| CSS – Child Support Services | P-CAP- Parent-Child Assistance Program |
| DCF- Department for Children and Families | PCIT- Parent-Child Interaction Therapy |
| EBP- Evidence Based Program | PPS – Prevention and Protection Services |
| EES- Economic & Employment Services | QRTP – Qualified Residential Treatment Program |
| FACTS- Family and Child Tracking System | RFI – Request for Information |
| FCT- Family Centered Treatment | RFP – Request for Proposal |
| FFT- Functional Family Therapy | RS – Rehabilitation Services |
| FPS – Family Preservation Services | S.B. – Senate Bill |
| FFPSA - Family First Prevention Services Act | SDM- Structured Decision Making |
| HFA- Healthy Families America | SFY – State Fiscal Year |
| H.R. – House of Representatives | SS- Seeking Safety |
| KCSL – Kansas Children’s Service League | SUD – Substance Use Disorder |
| KCWPTP – Kansas Child Welfare Professional Training Program | TBRI- Trust Based Relational Intervention |
| KDADS- Kansas Department of Aging and Disability | TDM – Team Decision Making |
| KDHE- Kansas Department of Health and Environment | YRCII – Youth Residential Center |
| KDOC-JS- Kansas Department of Corrections Juvenile Services | |

Attachment 1: Attachment B

B. STATE PLAN FOR TITLE IV-E OF THE SOCIAL SECURITY ACT: PREVENTION SERVICES AND PROGRAMS

STATE OF Kansas

U.S. Department of Health and Human Services
Administration for Children and Families
Children's Bureau
November 2018

- SECTION 1. Service description and oversight
- SECTION 2. Evaluation strategy and waiver request
- SECTION 3. Monitoring child safety
- SECTION 4. Consultation and coordination
- SECTION 5. Child welfare workforce support
- SECTION 6. Child welfare workforce training
- SECTION 7. Prevention caseloads
- SECTION 8. Assurance on prevention program reporting
- SECTION 9. Child and family eligibility for the title IV-E prevention program

- 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

As a condition of the receipt of Prevention Services and Program funds under title IV-E of the Social Security Act (hereinafter, the Act), the

Kansas Department for Children and Families

(Name of State Agency)

submits here a plan to provide, in appropriate cases, Prevention Services and Programs under title IV-E of the Act and hereby agrees to administer the programs in accordance with the provisions of this plan, title IV-E of the Act, and all applicable Federal regulations and other official issuances of the Department. This Pre-print is provided as an option for title IV-E agencies to use over the course of the five years that the Prevention Services and Programs Plan is in effect.

The state agency understands that if and when title IV-E is amended or regulations are revised, a new or amended plan for title IV-E that conforms to the revisions must be submitted.

| Federal Regulatory/Statutory References ³⁷ | Requirement | State Regulatory, Statutory, and Policy References and Citations for Each |
|--|---|--|
| Section 1. Services Description and Oversight | | |
| 471(e)(1) | <p>A. SERVICES.</p> <p>The state agency provides the following services or programs for a child and the parents or kin caregivers of the child when the need of the child, such a parent, or such a caregiver for the services or programs are directly related to the safety, permanence, or well-being of the child or to preventing the child from entering foster care:</p> <ol style="list-style-type: none"> 1. MENTAL HEALTH AND SUBSTANCE ABUSE PREVENTION AND TREATMENT SERVICES.—Mental health and substance abuse prevention and treatment services provided by a qualified clinician for not more than a 12-month period that begins on any date described in paragraph (3) of Section 471(e) with respect to the child. 2. IN-HOME PARENT SKILL-BASED PROGRAMS.—In-home parent skill-based programs for not more than a 12-month period that begins on any date described in paragraph (3) of Section 471(e) with respect to the child and that include parenting skills training, parent education, and individual and family counseling. | <p>PPM 4300 (Jan 2020) PPM 0160 (Jan 2020) PPM 4360 (Jan 2020)</p> |
| 471(e)(5)(B)(i) | <p>B. OUTCOMES. The state agency provides services and programs specified in paragraph 471(e)(1) is expected to improve specific outcomes for children and families.</p> | <p>PPM 4330 (Jan 2020)</p> |
| 471(e)(5)(B)(iii)(I)(IV) 471(e)(4)(B) | <ol style="list-style-type: none"> 1. the services or programs selected by the state, and whether the practices used are promising, supported, or well supported; 2. how the state plans to implement the services or programs, including how implementation of the services or programs will be continuously monitored to ensure fidelity to the | <p>PPM 0160 (Jan 2020)</p> |

³⁷ Statutory references refer to the Social Security Act. Regulatory references refer to Title 45 of the Code of Federal Regulations (CFR).

| Federal Regulatory/Statutory References ³⁷ | Requirement | State Regulatory, Statutory, and Policy References and Citations for Each |
|--|---|--|
| | <p>practice model and to determine outcomes achieved and how information learned from the monitoring will be used to refine and improve practices;</p> <ol style="list-style-type: none"> 3. how the state selected the services or programs; 4. the target population for the services or programs; 5. an assurance that each prevention or family service or program provided by the state meets the requirements at section 471(e)(4)(B) of the Act related to trauma-informed service-delivery (states must submit Attachment III for each prevention or family service or program); and 6. how each service or program provided will be evaluated. | <p>PPM 4300 (Jan 2020) PPM 4310 PPM 4330 (Jan 2020) PPM 4370 (Jan 2020) Attachment III</p> |
| Section 2. Evaluation strategy and waiver request | | |
| 471(e)(5)(B)(iii)(V) | <p>A. PRACTICES. With respect to the prevention family services and programs specified in subparagraphs (A) and (B) of paragraph 471(e)(1), information on the specific practices state plans to use to provide the services or programs, including a description of how each service or program provided will be evaluated through a well-designed and rigorous process, which may consist of an ongoing, cross-site evaluation approved by the Secretary, unless a waiver is approved for a well-supported practice; and</p> | <p>PPM 4330 (Jan 2020) PPM 4370 (Jan 2020)</p> |
| 471(e)(5)(C)(ii) | <p>B. REQUEST FOR WAIVER OF WELL DESIGNED, RIGOROUS EVALUATION OF SERVICES AND PROGRAMS FOR A WELL-SUPPORTED PRACTICE. The state must provide evidence of the effectiveness of the practice to be compelling and the state meets the continuous quality improvement requirements included in subparagraph 471(e)(5)(B)(iii)(II) with regard to the practice.</p> | <p>Kansas is not requesting a waiver, see PPM 4330. Kansas is contracting with an external evaluator.</p> |
| Section 3. Monitoring child safety | | |

| Federal Regulatory/Statutory References ³⁷ | Requirement | State Regulatory, Statutory, and Policy References and Citations for Each |
|---|---|---|
| 471(e)(5)(B)(ii) | The state agency monitors and oversees the safety of children who receive services and programs specified in paragraph 471(e)(1), including through periodic risk assessments throughout the 12-month period in which the services and programs are provided on behalf of a child and reexamination of the prevention plan maintained for the child under paragraph 471(e)(4) for the provision of the services or programs if the state determines the risk of the child entering foster care remains high despite the provision of the services or programs. | PPM 4320 (Jan 2020) |
| Section 4. Consultation and coordination | | |
| 471(e)(5)(B)(iv) and (vi) | <p>A. The state must:</p> <ol style="list-style-type: none"> 1. engage in consultation with other state agencies responsible for administering health programs, including mental health and substance abuse prevention and treatment services, and with other public and private agencies with experience in administering child and family services, including community-based organizations, in order to foster a continuum of care for children described in paragraph 471(e)(2) and their parents or kin caregivers and 2. describe how the services or programs specified in paragraph (1) of section 471(e) provided for or on behalf of a child and the parents or kin caregivers of the child will be coordinated with other child and family services provided to the child and the parents or kin caregivers of the child under the state plans in effect under subparts 1 and 2 of part B. | <p>Not applicable</p> <p>PPM 4330 (Jan 2020)</p> |
| Section 5. Child welfare workforce support | | |
| 471(e)(5)(B)(vii) | <p>The state agency supports and enhances a competent, skilled, and professional child welfare workforce to deliver trauma-informed and evidence-based services, including—</p> <ol style="list-style-type: none"> A. ensuring that staff is qualified to provide services or programs that are consistent with the promising, supported, or well supported practice models selected; and | PPM 4330 (Jan 2020) |

| Federal Regulatory/Statutory References ³⁷ | Requirement | State Regulatory, Statutory, and Policy References and Citations for Each |
|--|--|---|
| | B. developing appropriate prevention plans, and conducting the risk assessments required under clause (iii) of section 471(e)(5)(B). | PPM 2753 |
| Section 6. Child welfare workforce training | | |
| 471(e)(5)(B)(viii) | The state provides training and support for caseworkers in assessing what children and their families need, connecting to the families served, knowing how to access and deliver the needed trauma informed and evidence-based services, and overseeing and evaluating the continuing appropriateness of the services. | PPM 4330 (Jan 2020) |
| Section 7. Prevention caseloads | | |
| 471(e)(5)(B)(ix) | The state must describe how caseload size and type for prevention caseworkers will be determined, managed, and overseen. | Not applicable |
| Section 8. Assurance on prevention program reporting | | |
| 471(e)(5)(B)(x) | The state provides an assurance in Attachment I that it will report to the Secretary such information and data as the Secretary may require with respect to the provision of services and programs specified in paragraph 471(e)(1), including information and data necessary to determine the performance measures for the state under paragraph 471(e)(6) and compliance with paragraph 471(e)(7). | Attachment I |
| Section 9. Child and family eligibility for the title IV-E prevention program | | |

| Federal Regulatory/Statutory References ³⁷ | Requirement | State Regulatory, Statutory, and Policy References and Citations for Each |
|---|--|--|
| 471(e)(2) | <p>A. CHILD DESCRIBED. —For purposes of the title IV-E prevention services program, a child is:</p> <ol style="list-style-type: none"> 1. A child who is a candidate for foster care (as defined in section 475(13)) but can remain safely at home or in a kinship placement with receipt of services or programs specified in paragraph (1) of 471(e). 2. A child in foster care who is a pregnant or parenting foster youth. | <p>PPM 0160</p> <p>PPM 4310</p> |

Title IV-E Plan – State of Kansas

PLAN SUBMISSION CERTIFICATION

Instructions: This Certification must be signed and submitted by the official authorized to submit the title IV-E plan, and each time the state submits an amendment to the title IV-E plan.

I Jane Meschberger (name) hereby certify that I am authorized to submit the title IV-E Plan on behalf of the State of Kansas (state). I also certify that the title IV-E plan was submitted to the governor for his or her review and approval in accordance with 45 CFR 1356.20(c)(2) and 45 CFR 204.1.

Date 12-9-19 _____ Jane Meschberger _____

(Signature)
KS Dept for Children & Families
Director of Prevention + Protection Services
(Title)

APPROVAL DATE:
4/30/2020

EFFECTIVE DATE:
10-1-2019

[Signature]

Signature, Associate Commissioner, Children's Bureau

Attachment 2: Supporting Documentation for Attachment B

The following edits will be implemented at the next policy revision period January 1, 2020.

~~Gray Strikethrough~~ = language being removed

Yellow Highlight = language being added

Unless otherwise noted, policy not highlighted is current policy already in place

0160 Glossary

Candidate for Care: A child is determined a candidate for care when any one of the following situations apply: 1) a child or youth who PPS determines is at imminent risk of foster care and out of home placement but can be safe at home with prevention services; 2) a child or youth who exited foster care to adoption or permanent custodianship/guardianship, or who was reunified with parents is at risk of entering foster care and out of home placement; 3) a child or youth temporarily or permanently residing with a relative or kin caregiver; 4) a child or youth living with parents but needs to be with a relative caregiver with prevention services in place; 5) pregnant and parenting youth in foster care and in an out of home placement.

2753 Eligibility and Criteria for Referral to Family First Prevention Services

The Family Based Assessment, per PPM section 2700, assists in identifying needed services for families. The following provides criteria to consider a referral to Family First Prevention Services for families.

A. Child(ren) and Families Eligible for Family First Prevention Services:

1. A child(ren) or youth residing with a parent, relative, or non-related kin (NRKIN) who PPS determines is at imminent risk of foster care, and out of home placement, but can be safe at home with prevention services.
2. A child(ren) or youth who exited foster care to adoption, permanent custodianship, guardianship, or who was reunified with parents and at risk of entering foster care and out of home placement.
3. A child(ren) or youth residing formally or informally with relative caregivers.
4. A child(ren) or youth residing in the home with siblings in out of home placement who is at risk of entering out of home placement.
5. Pregnant and parenting youth in the custody of the Secretary with infant/child not in the custody of the Secretary (Reference PPM 5238).

B. Risk and Safety Assessment Decision Guidance for Family First Prevention Services:

To help guide the decision for Candidacy of Care and determining a child at imminent risk of foster care, the KIDS assessment decisions are:

1. Risk Level = High to Intense (SDM where available = High to Very High)

2. Safety Decision = Conditionally Safe (SDM where available = Safe with immediate safety plan)

C. Family Criteria for Referral

A family is eligible for a referral to Family First Prevention Services, if the family meets eligibility criteria outlined above and the answer to questions 1-3 below is “yes”; and questions 4-7 are either “yes” or “NA.” The Prevention Services screen is documented on the Family Based Assessment Summary PPS 2030F, Section III.

1. The family is at risk of having a child(ren) removed; and
2. A parent/caregiver is available to protect the child; and
3. A parent/caregiver is willing and able to participate in services.
4. A family with chronic problems has experienced a significant change which makes them able to progress.
5. A parent/caregiver with mental/emotional health issues has been stabilized.
6. A parent/caregiver with limitations demonstrates an ability to care for self and children.
7. A parent/caregiver with substance abuse issues functions adequately to care for children.

D. Completion of Prevention Plan

Utilizing the guidance provided above and the service needs of the family, Child Protection Specialists should determine whether the family would be best served by Family First Prevention Services or Family Preservation Services. (reference PPM 4000). If the decision is made to refer to Family First Prevention Services, the Child Protection Specialist shall complete the Prevention Plan (PPS 4300) with the family in advance of the referral (PPS 4310). The Prevention Plan shall include:

1. Candidate for Care determination for all children. At least one child must be identified as a candidate for care to refer to Family First Prevention Services, unless the prevention plan is for a pregnant and parenting youth in the custody of the Secretary with infant/child not in the custody of the Secretary.
2. The foster care prevention strategy for the child(ren) so the child may remain safely at home, live temporarily with relative or non-related kin caregiver until the child can safely return to their parent(s)/caregiver(s), or live permanently with a relative or non-related kin caregiver.
3. The services or programs to be provided to or on behalf of the child is clearly documented to ensure the success of that prevention strategy.

If a new service is identified for the family during the open Family First Prevention Services case, the CPS Specialist shall update the PPS 4300 Prevention Plan with the new service and complete the referral to the new service per PPS 4310.

4300 Family First Prevention Services Grants

Family First Prevention Services (FFPS) grants support families in their communities with the goal to prevent children from entering the custody of the Secretary and foster care placement through implementation of evidence-based programs. Grantees apply an approach using approved evidence-based or emerging programs.

Foster Care prevention approaches are family-centered, safety-focused and provide voice to and for a child and family's safety network. Family-centered practice is characterized by mutual trust, respect, honesty and open communication between parents and service providers. Families are active participants in the discussion of program improvement, service referrals and evaluation. They are active decision-makers in selecting services for themselves and their children. Family and child assessments are strengths-based and solution-focused. Specified services are community-based and build upon formal and informal supports and resources.

Programs were evaluated, scored and rated by a multidisciplinary Grant Peer Review Panel. Family First Grants were awarded to selected partners with specialization in evidence-based treatments provided by qualified clinicians in the arenas of:

~~Family First Prevention grants provide services in the following areas:~~

1. Mental Health
2. Substance Use
3. Parent Skill Building
4. Kinship Navigation

Family First Prevention Services grants are awarded to multiple organizations across and within communities whose services demonstrate the ability to make a community impact to prevent the need for entry into foster care. Program boundaries or service areas may be any jurisdiction, catchment area, collection of jurisdictions or existing population parameters of an organization (e.g. judicial district, collection of counties or neighborhoods).

4310 Family First Prevention Grant Service Population and Referral

A. Prevention Services for Child(ren) deemed Candidates for Care

CPS Specialists will refer families to the Family First Prevention Services (FFPS) Grantees. CPS Specialists completing child protection assessments and investigations make this determination. A referral to the program is consistent with the family's needs related to the program's evidence-based intervention population when a child is at imminent risk of entering foster care. CPS Specialist will complete the Prevention Plan with the family prior to referral. In the referral, PPS will list each child or youth name who is determined a candidate for care (See 0160 Glossary and 3229 Determination/Redetermination Candidacy for Care). Eligible families to refer for grant program or treatment services include:

1. A child(ren) or youth residing with a parent, relative, or non-related kin (NRKIN) who PPS determines is at imminent risk of foster care, and out of home placement, but can be safe at home with prevention services.
 2. A child(ren) or youth who exited foster care to adoption, permanent custodianship, guardianship, or who was reunified with parents and at risk of entering foster care and out of home placement.
 3. A child(ren) or youth residing formally or informally with relative caregivers.
 4. A child(ren) or youth residing in the home with siblings in out of home placement who is at risk of entering out of home placement.
- B. Pregnant and Parenting Youth in the Custody of the Secretary

Pregnant and parenting youth in the custody of the Secretary with infant/child not in the custody of the Secretary are eligible for Family First Prevention Services. The CWCMP will complete the Prevention Plan which is integrated in the child's Permanency Plan and will notify the PPS Foster Care Liaison to make the appropriate referral to needed services. (Reference PPM 5238)

4320 DCF Responsibilities for Open Family First Prevention Service Cases

Following the referral to Family First Prevention Services grantee, the CPS Specialist (unless otherwise noted) shall be responsible to:

- A. Provide current information for data entry into FACTS.
- B. Assist the family in connecting with the grantee to begin service relationship.
- C. Assist in the engagement process with the family as requested.
- D. Participate in the initial meeting held within 48 business hours of referral with the grantee and family as requested.
- E. Complete all child abuse/neglect assessments in accordance with PPM section 2000.
- F. Inform the grantee of ongoing child abuse/neglect investigations and assessments.
- G. Inform the grantee of any new report received by the Kansas Protection Report Center involving a child receiving services by the grantee. Grantee may consider and incorporate the information into the work with the child and family as appropriate. The role of grantee is not to investigate or determine validity of report.
- H. Provide the grantee a copy of the PPS 2012. Inform the provider of the status of appeal, if applicable.
- I. Meet with the family and grantee to discuss options if there is a refusal of services.
- J. Provide reports to the court as indicated.
- K. Review the PPS 4310 Referral/Case Status form, when submitted by the grantee. Based on the information provided and progress made by the family, the Child Protection Specialist and Supervisor shall determine if follow-up is needed. Follow-up may include: determining no action is required, attempting to re-engage the family with the CWCMP, or contacting the County Attorney/District Attorney and requesting a petition for Child in Need of Care.

4330 Family First Prevention Services Grantee Responsibilities

Grantees shall accept all referrals from DCF when the program has openings. Following the referral to the Family First Prevention Services (FFPS), the grantee shall:

- A. Acknowledge receipt of the FFPS referral within 24 hours.
- B. Complete or continue a Plan of Safe Care for families served who have an infant to support families affected by substance use disorders. If, initially, criteria for a Plan of Safe Care was not met, but, during the life of the case, additional information becomes available, which indicates criteria for a Plan of Safe Care may be met, the requirements per PPM 2050 shall be followed. The needs of the infant and family shall be documented on the PPS 2007 Plan of Safe Care and submitted to DCF.
- C. Meet with the family within 48 business hours of referral to begin initial assessment and review prevention plan. Submit PPS 4310 outlining date of contact to referring CPS Specialist and FACTS unit.
- ~~D. Review Prevention Plan for other family first services provided to the family.~~ Request necessary releases be signed by family to coordinate services, reduce service duplication and ensure family's needs are met. Verify provision of necessary services, when applicable, with other Family First Grantees, Family Services, Family Preservation Services, or Foster Care/Reintegration/Adoption Contractor.
- E. Notify referring CPS Specialist if any child in the family is a runaway or missing.
- F. Participate in a Team Decision Making meeting, if requested by PPS.
- G. Complete and submit the PPS 4310 with case closure reasons and summary of closure to referring CPS Specialist and FACTS unit. Grantee may request retraction of services within 5 days of referral due to non-engagement by the family and/or in-eligibility of family in services. Retractions are not included in grantees outcomes. Grantee shall submit the PPS 4310 with retraction request and complete summary of why retraction is needed.
- H. Maintain case information on a timely basis reflecting complete and current history of assessment information, services provided and progress of services for the family.
- I. Review any forwarded report from DCF involving a child receiving services by the grantee. The grantee may consider and incorporate the information into the work with the child/family as appropriate. The role of grantee in this circumstance is not to investigate or determine validity of report.
- J. Make available, develop or accept DCF process or procedure of releases so all client records and information may be shared with DCF. The following are examples of when this may occur: if a child in the home enters foster care, at case closure, to obtain status reports, to provide court

updates, service case is a part of case review sample and/or as needed. Make available all client records and information to DCF within 24 hours of a request, whether written or verbal.

K. Participate and cooperate in the DCF performance improvement process, including interviews when requested.

L. Participate in regional, local, and statewide meetings to promote program and maintain orientation to referral process.

M. Work with external evaluator to provide data, implement other quality assurance, success factor or evaluation tools such as surveys of families served, case file reviews or other tools. Provide access to existing quality assurance tools or case files for respective evidence-based programs for children served in the PPS grant referred program or service. The external evaluator shall work with the grantee to develop an evaluation plan for each program.

N. Provide direct services supporting the implementation of evidence-based strategies resulting in improvements in targeted State-or community-level factors, while contributing to and monitoring the following outcomes:

1. Families are engaged timely;
2. Children are maintained safely at home.

Additional outcomes related to safety and well-being may be identified by the external evaluator.

O. ~~N.~~ Participate in stakeholder, statewide or regional meetings regarding implementation of Family First Prevention Services.

P. Ensure all direct service or program staff have training and meet qualifications required consistent with evidence-based programs.

4370 Duration of Family First Prevention Services

Family First Prevention Services can be provided for up to 12 months beginning on the date the state identifies the child as either a “candidate for foster care” or a pregnant or parenting foster youth in need of those services in the prevention plan. Services may continue beyond 12 months on a case by case basis. If it is believed the child(ren) may need to continue with services, the CPS Specialist and the supervisor shall evaluate the current risk and safety concerns. Services may be extended when the following conditions are present:

- A. the family is making progress on achieving the service goals, and
- B. the child(ren) remains a candidate for care.

If an extension of services is needed, the CPS Specialist shall review and update the PPS 4300 Prevention Plan prior to service extension

Evaluation Plan for Family First Prevention Services
2019-2022

Prepared for the
Kansas Department for Children and Families

Evaluation Led by
The University of Kansas School of Social Welfare
Center for Public Policy and Research

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1. Intervention, Target Population, and Evaluation Goals and Rationale

Interventions

Below are the interventions being implemented for Kansas' Family First Prevention Services.

1. Adolescent Community Reinforcement Approach (A-CRA)
2. Attachment and Biobehavioral Catch-Up (ABC)
3. Family Centered Treatment (FCT)
4. Functional Family Therapy (FFT)
5. Healthy Families America (HFA)
6. Motivational Interviewing (MI)
7. Multisystemic Therapy (MST)
8. Nurturing Parenting Program (NPP) includes Fostering Prevention and Family Mentor Program
9. Parents as Teachers (PAT)
10. Parent Child Assistance Program (PCAP)
11. Parent Child Interaction Therapy (PCIT) includes Grow Nurturing Families
12. Seeking Safety (SS)

For a description of each intervention please refer to Section 2: Service Description and Oversight within the Kansas Prevention Plan.

Target Populations

For a description of the target populations for each intervention please refer to Section 2: Service Description and Oversight within the Kansas Prevention Plan.

Evaluation Goals and Rationale

The evaluation plan is guided by a utilization-focused approach that includes two major components: (1) a process evaluation, and (2) an outcomes evaluation. Collectively, these interrelated components, which are guided by the overall FFPSA logic model, will examine the implementation and impact of the FFPSA interventions in Kansas. Thus, the evaluation plan will be both formative (by examining outputs and process-oriented success indicators and short-

term outcomes) and summative (by examining long-term outcome measures). The primary audience of the evaluation comprises state child welfare administrators, child welfare providers, and other stakeholders interested in the prevention of foster care and the stability and well-being of families.

The proposed research questions for Kansas FFPSA directly pertain to the activities, outputs, and outcomes delineated in the overall logic model. The research questions, which are categorized into several broad categories, are provided in Table 1. By addressing these questions, the FFPSA evaluation will provide data needed to understand the implementation of FFPSA in Kansas and whether outcomes are achieved. In addition to overarching research questions, we will assess each program individually. Individual program research questions are outlined in Table 2. The evaluation will also point to specific populations or areas where positive outcomes were most likely. The findings, then, may be able to inform decisions around expanding and sustaining specific interventions.

Table 1. FFPSA Overarching Research Questions

| Evaluation Component | Overarching Research Question |
|-----------------------------|---|
| Process | <ol style="list-style-type: none"> 1. To what extent did the FFPSA interventions and implementation strategies achieve expected outputs? 2. To what extent did the FFPSA interventions achieve implementation success indicators of readiness and capacity, adoption, reach, fidelity, system integration, and collaboration? 3. To what extent did the FFPSA interventions achieve service delivery success indicators of engaging families in FFPSA interventions timely and having families complete the interventions? |
| Outcomes | <ol style="list-style-type: none"> 4. To what extent did the FFPSA interventions improve child well-being, parent functioning (e.g. parenting, mental health, and substance use), and permanency outcomes? |

Table 2. FFPSA Program Specific Outcome Research Questions

| Program | Program Specific Research Questions |
|---|---|
| Adolescent Community Reinforcement Approach (A-CRA) with Motivational Interviewing (MI) | <ol style="list-style-type: none"> 1. To what extent did A-CRA paired with Motivational Interviewing improve child well-being and the parent functioning domains of parenting, mental health, and substance abuse? 2. To what extent did A-CRA paired with Motivational Interviewing improve child permanency outcomes of children maintaining safely at home one-year post-referral? |
| Parent-Child Assistance (PCAP) | <ol style="list-style-type: none"> 1. To what extent did Parent-Child Assistance improve child well-being and the parent functioning domains of mental health and substance use? 2. To what extent did Parent-Child Assistance improve child permanency outcomes of children maintaining safely at home one-year post-referral? |
| Seeking Safety (SS) | <ol style="list-style-type: none"> 1. To what extent did Seeking Safety improve child well-being and the parent functioning domains of parenting, mental health, and substance use? 2. To what extent did Seeking Safety improve child permanency outcomes of children maintaining safely at home one-year post-referral? |
| Family Centered Treatment (FCT) | <ol style="list-style-type: none"> 1. To what extent did Family Centered Treatment improve child well-being and the parent functioning domains of parenting and mental health? 2. To what extent did Family Centered Treatment improve child permanency outcomes of children maintaining safely at home one-year post-referral? |
| Functional Family Therapy (FFT) | <ol style="list-style-type: none"> 1. To what extent did Functional Family Therapy improve child well-being and the parent functioning domain of parenting? 2. To what extent did Functional Family Therapy improve child permanency outcomes of children maintaining safely at home one-year post-referral? |
| Parent-Child Interaction Therapy (PCIT) | <ol style="list-style-type: none"> 1. To what extent did Parent-Child Interaction Therapy improve child well-being and the parent functioning domains of parenting and mental health? 2. To what extent did Parent-Child Interaction Therapy improve child permanency outcomes of children maintaining safely at home one-year post-referral? |
| Multisystemic Therapy (MST) | <ol style="list-style-type: none"> 1. To what extent did Multisystemic Therapy improve child well-being and the parent functioning domain of parenting? 2. To what extent did Multisystemic Therapy improve child permanency outcomes of children maintaining safely at home one-year post-referral? |
| Attachment and Biobehavioral Catch-up (ABC) | <ol style="list-style-type: none"> 1. To what extent did Attachment and Biobehavioral Catch-up improve child well-being and the parent functioning domain of parenting? 2. To what extent did Attachment and Biobehavioral Catch-up improve child permanency outcomes of children maintaining safely at home one-year post-referral? |
| Family Mentoring Program – Nurturing Parenting Program (NPP) | <ol style="list-style-type: none"> 1. To what extent did Nurturing Parenting Program improve child well-being and the parent functioning domains of parenting and mental health? 2. To what extent did Nurturing Parenting Program improve child permanency outcomes of children maintaining safely at home one-year post-referral? |
| Health Family America (HFA) | <ol style="list-style-type: none"> 1. To what extent did Healthy Family American improve child well-being and the parent functioning domain of parenting? 2. To what extent did Healthy Family American improve child permanency outcomes of children maintaining safely at home one-year post-referral? |
| Parents as Teachers (PAT) | <ol style="list-style-type: none"> 1. To what extent did Parents as Teachers improve child well-being and the parent functioning domain of parenting? 2. To what extent did Parents as Teachers improve child permanency outcomes of children maintaining safely at home one-year post-referral? |

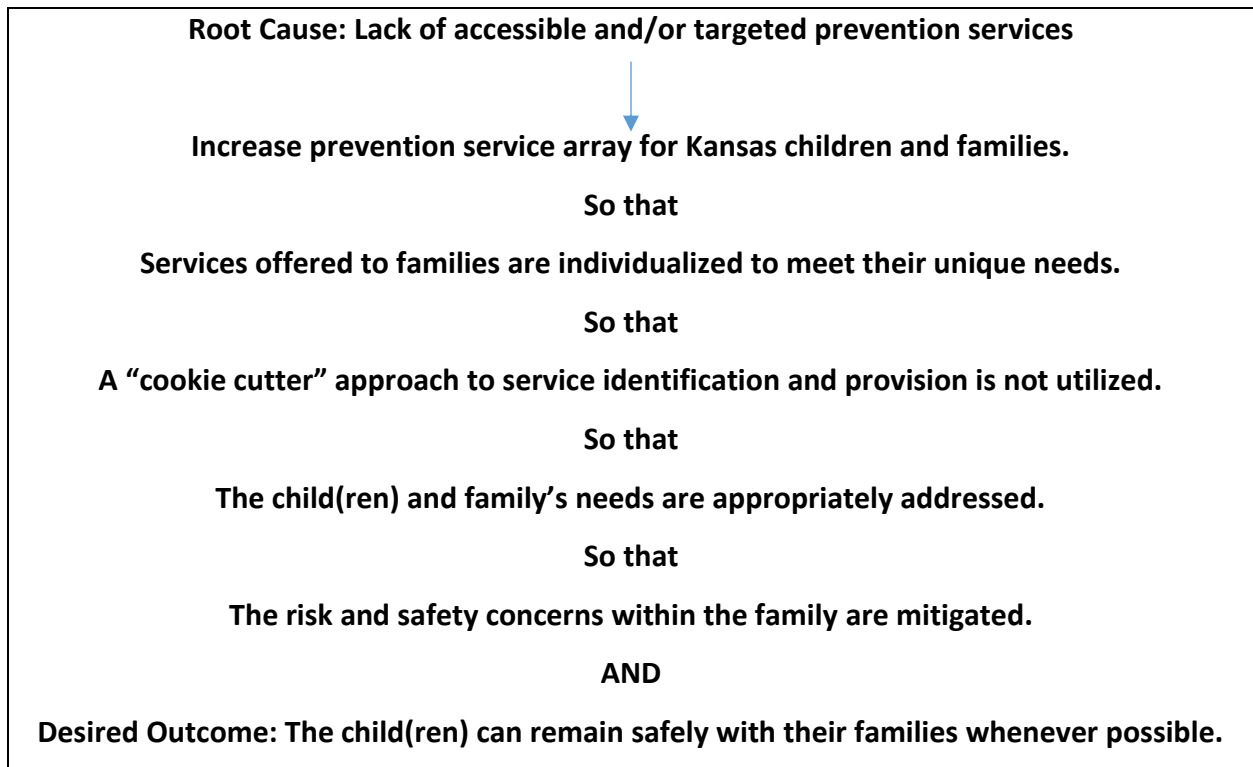
2. Theory of Change

The Family First Prevention Services Act is timely and responsive to substantial growth in the state's foster care population. The number of children in the Kansas foster care system has risen dramatically in recent years. Trend data show a percent change of 47% from 5,190 children in care in state fiscal year (SFY) 2011 to 7,614 children in SFY 2019. Additionally, national comparisons indicate that Kansas's removal rate per 10,000 children (4.6 per 10,000 children) is 13th highest in the nation. On September 30, 2017, the national rate of children in care was 59 per 10,000 children; in contrast, Kansas's rate was closer to double this at 109 per 10,000 children.

As outlined in Section 2, subsection Rationale for Selected Services, within Kansas's five year Prevention Plan, analysis of both qualitative and quantitative data was conducted prior to service selection. The following three factors were highly influential when selecting the chosen services: 1. Data outlining reasons for removal and ages of those children; 2. Geography of services and gaps in services; and 3. Targeted services for crossover youth. In sum, our analyses indicate efforts to prevent foster care entry need to be individualized and targeted to young children as well as teens.

With the growing number of children in care, it is evident there is a need for partnerships alongside families in communities with local organizations, private providers, and other stakeholders working together. The goal is to generate innovations to reduce entry into foster care and increase the array of evidence-based services available to serve the needs of Kansas families. Increased access to prevention services is crucial for addressing the most common risk factors for abuse and neglect and ensuring children can remain safely in their homes. With additional targeted prevention services, it is anticipated in time the number of children able to remain safely in their homes will increase.

Figure 1. Theory of Change



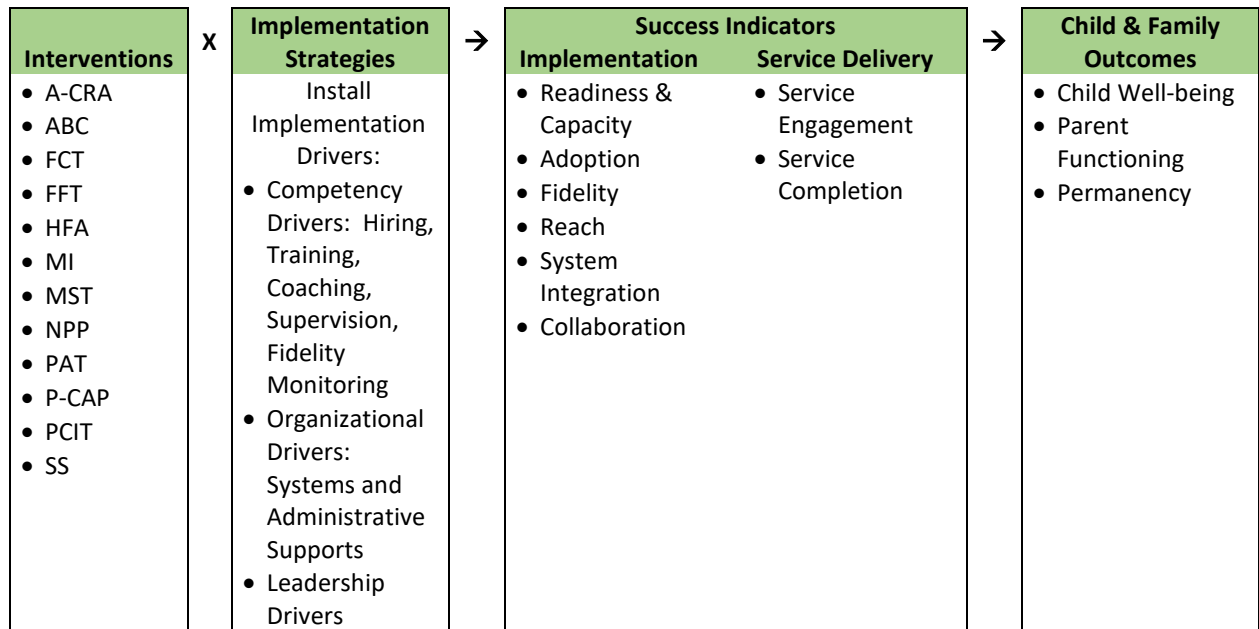
The theory of change is shown in the Logic Model as follows: Children and their families at risk of involvement with the foster care system require robust supports and interventions that have been shown to produce positive outcomes for similar families. These well-supported interventions must be implemented with high implementation integrity and fidelity to achieve the intended outcomes. By installing implementation drivers (competency, organizational, and leadership drivers), the system will demonstrate success indicators of implementation (readiness/capacity, collaboration, adoption, reach, fidelity, system integration) and service delivery (timely engagement and service completion). Successful implementation of the well-supported interventions will strengthen families by improving children’s well-being and parents’ functioning. Consequently, children will be maintained safely at home with their families, avoiding placement into foster care, and promoting permanency for children and families.

3. Evaluation Design

The evaluation plan is guided by a utilization-focused approach that includes two major components: a process evaluation and an outcomes evaluation. Collectively, these interrelated components, which are guided by the overall FFPSA logic model, will examine the implementation and impact of the FFPSA interventions in Kansas. The evaluation includes the use of rigorous, data-informed, sampling strategies; complementary data collection modalities; sound measurement approaches; and sophisticated analytics. The evaluation plan will be implemented and monitored in close collaboration among the KU evaluation team, Kansas DCF, and the provider agencies.

Using an implementation science framework, the evaluation design applies an adapted version of The Conceptual Model of Implementation Research developed by Proctor and colleagues (2009) to organize the process and outcomes evaluations. This heuristic model is informed by three different frameworks in implementation research (i.e., stage, pipeline models; multi-level models of change; and models of health service use), resulting in a framework that distinguishes but connects key interventions, implementation strategies, success indicators for implementation and service delivery, and child and family outcomes. Additionally, this model is well-aligned with quality improvement perspectives that will support a utilization-focused evaluation (see Figure 2).

Figure 2. Conceptual Model of Implementation Research



Adapted from: Proctor et al., 2009

Key Components of the Evaluation

Process Evaluation

The process evaluation has a **longitudinal mixed-methods design** and involves multiple data collection strategies, including focus groups, surveys, interviews, and process tracking and documentation. The process evaluation will focus on documenting the implementation strategies of providers and the success indicators of implementation and service delivery. This design is advantageous because it supports a utilization-focused evaluation that seeks to routinize feedback loops that will inform and facilitate successful implementation of the FFPSA interventions. Using a combination of quantitative and qualitative data, the following research questions will be answered.

1. What implementation strategies were used by providers to implement the interventions? [**Implementation Strategies**]
2. How did providers or communities prepare for implementation (increase readiness and build capacity) of the interventions? [**Readiness & Capacity**]
3. What interventions were implemented [**Adoption**] and to what extent were they delivered to children and families? [**Reach**]

4. To what extent were interventions implemented in adherence to model fidelity? [**Fidelity**]
5. To what extent were the interventions integrated within the existing system? [**System Integration**]
6. What was the degree of collaboration between partnering organizations and the extent to which interagency collaborations affected the outcomes? [**Collaboration**]
7. To what extent were families engaged in the interventions timely? [**Service Engagement**]
8. To what extent did families complete the interventions? [**Service Completion**]

Outcomes Evaluation

The outcomes evaluation concentrates on child, parent, and permanency outcomes. The outcomes evaluation will collect primarily quantitative data to answer the research question of: **“To what extent did children and parents served by the interventions experience improvements in child, parent, and permanency outcomes?”**. Additionally, these outcomes data will be analyzed to consider whether differences existed among important child and family populations as well as geographic areas of the state. To determine the influence of the interventions on child, family, and permanency outcomes we will use a **longitudinal approach and repeated measures design** with annual statewide and program-specific cohorts. This design was selected primarily due to its feasibility and fit with the service delivery structure that has been established for implementing FFPSA interventions statewide. Designs with control or comparison groups, such as randomized controlled trial and propensity score matched groups, are not possible because in most areas the population would not be large enough to support the required sample size for an intervention group and a comparison group. Additionally, the catchment area across FFPSA interventions are overlapping, resulting in high potential for services as usual comparison pools to consist of families receiving services determined to be well-supported by the Title IV-E Clearinghouse.

As a supplement to the repeated measures design, the evaluators will use an approach suggested by Dr. Allen Rubin (2014) that compares effect sizes of interventions in real-world settings to effect sizes identified in meta-analyses of the well-supported interventions. While

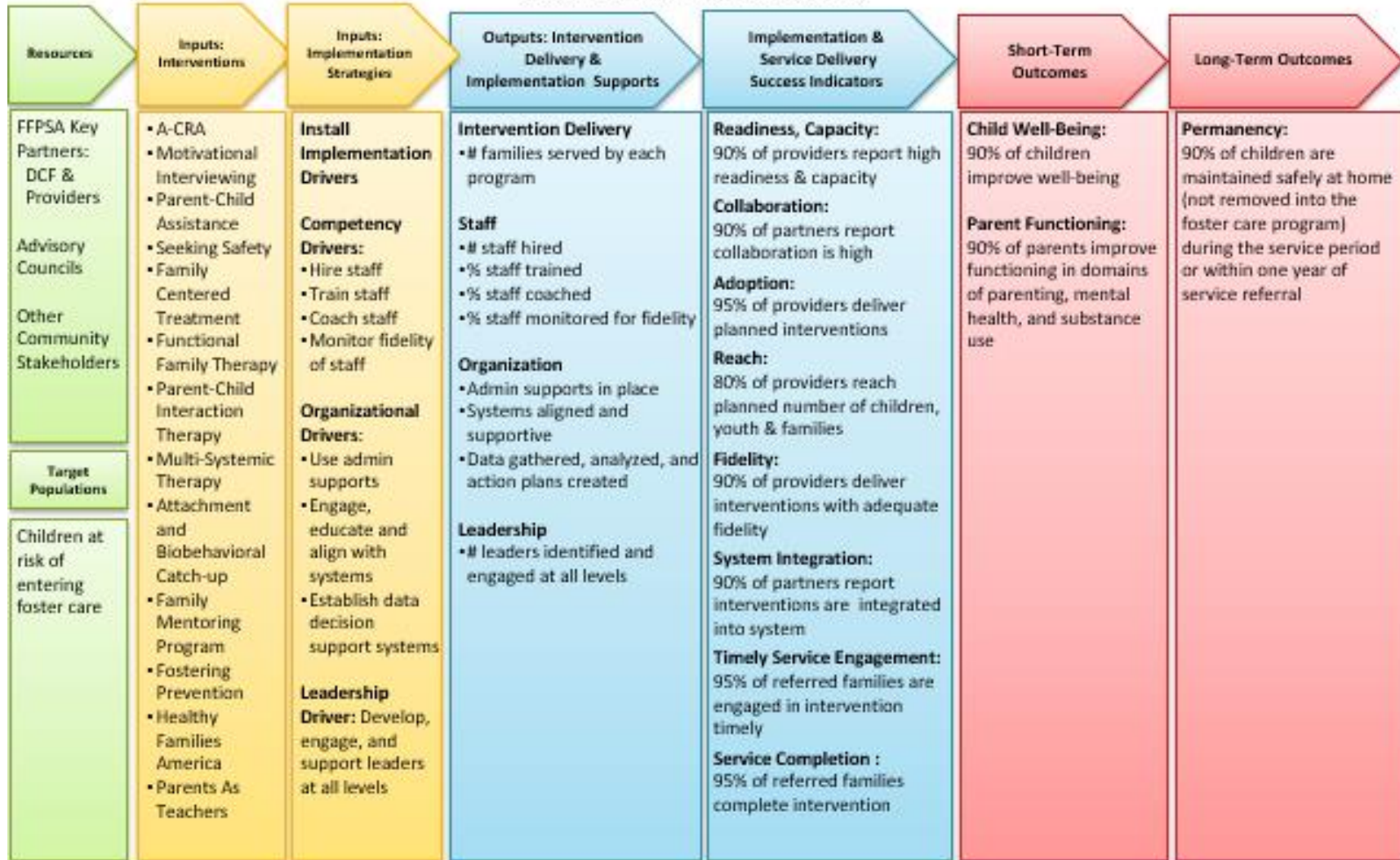
this approach is not equivalent to the inferential power of randomized controlled trials, it provides a benchmark to which agencies can compare their performance with a well-supported intervention and do so with an empirical basis for continuing to provide the intervention, modifying it, or choose a different intervention.

To address issues of timing, provider agencies will administer evaluation instruments for measuring child and parent outcomes during the 12-month service window to capture overarching domains that encompass specific outcomes targeted by individual interventions. Permanency outcomes may be readily tracked with administrative data. Finally, performance targets are shown on the Kansas FFPSA Logic Model.

4. Logic Model

The FFPSA Logic Model is shown on Page 10. The logic model demonstrates the connections between target populations, resources, the inputs of interventions and implementation activities, outputs of interventions and implementation activities, success indicators of implementation and intervention delivery, and short-term and long-term outcomes. It also visually represents our theory of change related to the interventions and implementation strategies and provides the framework for our evaluation questions to assess delivery of the interventions, implementation progress, and effectiveness. The **interventions and implementation strategies** (yellow shading) identify the well-supported interventions and key implementation strategies that will be used to implement them. **Outputs** and **success indicators** are presented in the logic model in blue shading. Outputs are delineated for the intervention delivery by tracking service numbers as well as outputs for the implementation strategies. Next, indicators that align with and operationalize the key constructs of the process evaluation's constructs of successful service delivery and implementation supports are shown. Six of the success indicators link to implementation strategies (i.e., readiness and capacity, collaboration, adoption, reach, fidelity, and system integration) and two of the success indicators link to the service delivery of the interventions (i.e., service engagement and service completion). **Outcomes**, shown in red shading, represent child and parent outcomes as short-term outcomes; and, permanency outcomes as long-term outcomes. As described below, the evaluation design includes elements to measure all aspects of the logic model.

KANSAS FFPSA LOGIC MODEL



Assumptions/Theory of Change: Children and their families at risk of involvement with the foster care system require robust supports and treatments that have been shown to produce positive outcomes. These well-supported interventions must be implemented with high implementation integrity and fidelity to achieve the intended outcomes. By installing implementation drivers (competency, organizational, and leadership drivers), the system will demonstrate success indicators of implementation (readiness/capacity, collaboration, adoption, reach, fidelity, system integration) and service delivery (timely engagement and service completion). Successful implementation of the well-supported interventions will strengthen families by improving children's well-being, parents' functioning, and families' functioning. Consequently, children will be maintained safely at home with their families, avoiding placement into foster care, and promoting permanency for children and families.

5. Data Collection, Sampling, and Analysis Plans

Data Collection Plan

Table 5, below, provides an overview of the data collection plan, identifying the evaluation component, research questions, corresponding benchmarks (which are also shown on the logic model), and the type of data collection tool along with its planned frequency of use and sample.

Indicators for Outputs and Outcomes

As guided by the FFPSA Logic Model, the data collection plan identifies specific indicators for each output and outcome. Outputs have been established with two categories: outputs and success indicators (see blue shading on the logic model). Outputs include tracking number of families served by each intervention and tracking data on implementation strategies, such as number of staff hired, percent of staff trained, and percent of staff monitored for fidelity. Benchmarks for each of the outputs are unique to each program and, therefore, not shown on the overall Kansas FFPSA logic model. Under success indicators, benchmarks are provided for each of the implementation and service delivery constructs (e.g., 90% of providers will report high readiness and capacity, 95% of referred families are engaged in intervention timely). Finally, indicators with benchmarks are also presented for short-term outcomes of child well-being and parent functioning; and, the long-term outcome of permanency.

Tools for Collecting Data

In determining which measures or tools to use for data collection, several criteria were considered. In addition to gold standard criteria related to psychometric properties (reliability and validity), we also assessed measures in terms of the following practical criteria:

- Cost, prioritizing no-cost tools
- Fit with population, including age range of children
- Provision of useful and actionable data relevant to stated program goals
- Training requirements/ease of use by local providers
- Burden for children and families (e.g., time)
- Burden on providers based on existing measurement requirements

Outputs and Success Indicators. The process evaluation centers on the outputs and success indicators, which will largely be collected through tracking tools that will be developed by DCF and the evaluation team and used by provider agencies. Most of these tracking tools will be integrated into the administrative data at DCF, including tools for research questions 1, 4, 8, and 9. Four other research questions (2, 3, 6 and 7) will be addressed with focus groups that are held in Year 3. A protocol for focus group questions will be developed in late Year 2 as informed by the empirical literature and the implementation experience with the Kansas FFPSA. Research questions 3 and 7 will include the focus groups above as well as data collected through surveys. The survey for research question 3 will be developed from a Readiness and Capacity tool from the Center for States and used with a Children’s Bureau funded project in Kansas under the Strengthening Child Welfare Systems cluster (i.e., Kansas Strong for Children and Families). The survey for research question 7 is the Wilder Collaboration Factors Survey, which is widely used across the country and numerous studies. Once data are available, both surveys will be analyzed for reliability (testing internal consistency) and validity (examining factor analysis). Finally, research question 5 on fidelity will use the fidelity processes and tools specific to each well-supported intervention.

Outcomes. In order to select outcomes of interest across a large number of diverse programs that also serve the goal of measuring individual program targets, we examined program goals to assess for commonalities. Table 1Table 3 details how the individual program goals of each program described in in Section 2, subsection Rationale for Selected Services within Kansas’s five year Prevention Plan align with overarching outcome domains of *Child Well-Being*, and *Parent Functioning* (inclusive of *parenting*, *mental health*, and *substance use* sub-domains). As all program goals across all grantees are encompassed within these domains (Table 3), we plan to administer a set of common measures across programs, as applicable to individual program targets, to measure outcomes at the statewide aggregate level, as well as the individual program and subpopulation level. All programs will be assessed on child well-being and permanency regardless of target as these outcomes are key prevention-focused indicators. Other short-term outcomes in the family functioning subdomains will be assessed as indicated in Table 3 and illustrated in Figure 3.

Table 3. Program Goals by Domain

| | Child Well-Being | Parent Functioning | | |
|---|----------------------------------|--|---|--|
| | | Parenting | Mental Health | Substance Use |
| Adolescent Community Reinforcement Approach (A-CRA) with Motivational Interviewing (MI) | Teach adolescent problem-solving | <p>Improved relationships with family</p> <p>Promote caregiver support of adolescent’s abstinence</p> <p>Provide information about effective parenting practices</p> | <p>Promote positive social activity</p> <p>Promote positive peer relationships</p> | <p>Promote abstinence</p> <p>Create environment conducive to recovery</p> <p>Motivate caregiver participation in the treatment process</p> |
| Parent-Child Assistance (PCAP) | | | <p>Link mothers to community resources to maintain healthy family life</p> | <p>Assist mothers in obtaining treatment and maintain recovery</p> <p>Help mothers prevent births of future alcohol and drug-affected children</p> |
| Seeking Safety (SS) | Reduce trauma symptoms | Increase safe coping in relationships | <p>Reduce trauma symptoms</p> <p>Increase safe coping in thinking</p> <p>Increase safe coping in behavior</p> <p>Increase safe coping in emotions</p> | Reduce substance abuse symptoms |
| Family Centered Treatment (FCT) | | <p>Enable changes to family functioning</p> <p>Reduce hurtful or harmful behaviors</p> <p>Enable changes to family system</p> <p>Enable family stability</p> | <p>Develop emotional balance and coping to resolve challenges</p> <p>Enable use of intrinsic strengths</p> | |

| | Child Well-Being | Parent Functioning | | |
|---|---|---|---------------|---------------|
| | | Parenting | Mental Health | Substance Use |
| Functional Family Therapy (FFT) | Eliminate youth problems (i.e. delinquency, oppositional behaviors, violence, substance use) Improve prosocial behaviors (i.e. school attendance) | Improve family skills | | |
| Parent-Child Interaction Therapy (PCIT) | Help children feel safe and calm Increase organizational and play skills Decrease frustration and anger Enhance child self-esteem Improve children's social skills (i.e. sharing and cooperation) Decrease problematic child behaviors | Build close parent/child relationships using positive attention Foster warmth and security between parents and children Educate parent to teach child without frustration Teach parents to communicate within child attention span Teach parents discipline techniques Teach parents to be consistent and predictable Help parents develop confidence managing child behavior | | |
| Multisystemic Therapy (MST) | Eliminate or significantly reduce frequency and severity of youth's referral behavior | Empower parent parents with skills and resources | | |

| | Child Well-Being | Parent Functioning | | |
|--|--|---|--|---------------|
| | | Parenting | Mental Health | Substance Use |
| Attachment and Biobehavioral Catch-up (ABC) | Increase child attachment security and decrease disorganized attachment Increase child behavioral and biological regulation | Increase caregiver nurturance, sensitivity, and delight Decrease caregiver frightening behaviors | | |
| Family Mentoring Program – Nurturing Parenting Program (NPP) | Gains in child self-worth Gains in child empowerment | Gains in parental empathy toward meeting child needs Use of dignified, non-violent discipline | Gains in parent self-worth Gains in parental empathy and meeting own adult needs in healthy ways Gains in parent empowerment | |
| Fostering Prevention – Nurturing Parenting Program (NPP) | | Increase in family cohesion Increase in nurturing and safety capabilities | | |
| Healthy Family America (HFA) | Promote healthy childhood growth and development | Cultivate and strengthen nurturing parent-child relationships Enhance family functioning by reducing risk and enhancing protective factors | | |
| Parents as Teachers (PAT) | Early detection of developmental delays and health issues Increase children’s school readiness and school success | Increase parent knowledge of early childhood development Improve parenting practices Prevent child abuse and neglect | | |

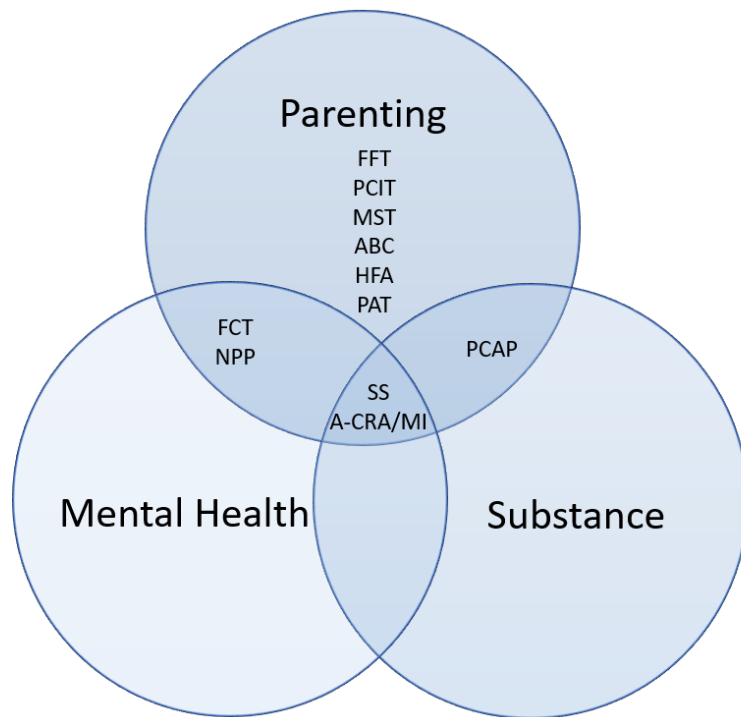


Figure 3. Programs Measurement by Parent Functioning Subdomains

Below, and shown in Table 4, are the proposed validated measures for each intervention and corresponding short-term outcome. All of these measures have demonstrated adequate reliability and validity in multiple research studies.

- Child Well-being
 - *Children ages 0-5 years old:* We will use the **Ages and Stages Questionnaire Social-Emotional-2 (ASQ:SE-2)** (Squires, Bricker, & Twombly, 2015). The ASQ:SE-2 is a caregiver report of their young child’s social-emotional behavior and functioning. It is a low cost and widely used measure for very young children. The ASQ:SE-2 consists of a series of questionnaires to be answered by the primary caregiver (administered by the child welfare caseworker) and has nine intervals for children at 2, 6, 12, 18, 24, 30, 36, 48, and 60 months. Each questionnaire contains between 19 to 33 items that assess seven social and emotional areas, including self-regulation, compliance, adaptive behavior, autonomy, affect, social-communication, and interactions with people.

- *Children ages 3-18 years old:* We will use the **Strengths and Difficulties Questionnaire (SDQ)** (Goodman, 1997). The SDQ parent report form will be used. It is a free and widely used measure of child behavior that comprises 5 scales (emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems, prosocial behavior) and 25 items.
- Parent Functioning
 - *Parenting:* Parenting will be assessed with the **Parenting Sense of Competence scale (PSOC)** (Gilmore & Cuskelly, 2008). The PSOC is a 17-item scale that includes satisfaction with parenting and efficacy. The satisfaction section examines parents' anxiety, motivation, and frustrations while the efficacy section considers competence, capability levels, and problem-solving abilities in the parental role.
 - *Mental Health: Depression Anxiety Stress Scale (DASS-21)* (Henry & Crawford, 2005) will be used to assess parent emotional functioning around depression, anxiety and stress. It is a 21-item scale used to assess the presence and severity of these symptoms occurring over the past week.
 - *Substance Use:* We will assess parent substance use using two brief measures; the **Drug Abuse Screening Test (DAST-10)** (Skinner, 1982) and the **Alcohol Use Disorders Identification Test (AUDIT)** (Bradley, Bush, & Epler, 2003). The DAST-10 is a ten-item scale used to derive an index of the degree of consequences resulting from substance use. The AUDIT is a ten-item instrument for screening alcohol use that identifies hazardous drinking and active alcohol use disorders, including abuse and dependence.
- Permanency
 - To evaluate permanency, DCF has defined an outcome indicator as the percentage of children served who are maintained safely with their families and do not enter foster care during the service period or within one year of service referral. These outcomes will be tracked through administrative data that are shared through a secure transmission with the evaluators on a monthly basis.

Table 4. Validated Measures Proposed for Each Intervention’s Short-Term Outcomes

| Intervention | Target Age | Validated Measures for Short-Term Outcomes | | | |
|---------------|--------------------|--|--------------------|---------------|-------------------|
| | | Child Well-being | Parent Functioning | | |
| | | | Parenting | Mental Health | Substance use |
| A-CRA with MI | 12-18 years | SDQ | PSOC | DASS-21 | DAST-10 and AUDIT |
| PCAP | Prenatal – 1 year | ASQ-SE | -- | DASS-21 | DAST-10 and AUDIT |
| SS | 0-17 years | ASQ-SE or SDQ | PSOC | DASS-21 | DAST-10 and AUDIT |
| FCT | 0-17 years | ASQ-SE or SDQ | PSOC | DASS-21 | -- |
| FFT | 11 - 18 years | SDQ | PSOC | -- | -- |
| PCIT | 2 - 7 years | ASQ-SE or SDQ | PSOC | -- | -- |
| MST | 12 - 17 years | SDQ | PSOC | -- | -- |
| ABC | 6 months – 4 years | ASQ-SE | PSOC | -- | -- |
| NPP | 0-17 years | ASQ-SE or SDQ | PSOC | DASS-21 | -- |
| HFA | Prenatal - 3 years | ASQ-SE | PSOC | -- | -- |
| PAT | Prenatal - 3 years | ASQ-SE | PSOC | -- | -- |

Table 5. Summary of Data Collection Plan for Each Research Question and Benchmark

| Evaluation Component | Research Question | Benchmark | Data Collection Tool (Planned Frequency) [Sample] | | | |
|----------------------|--|---|---|--|--------------------------------------|------------------------------|
| | | | Document | Survey or Other Tool | Interviews or Focus Groups | Admin Data |
| Process Evaluation | 1. To what extent did providers achieve expected intervention outputs? [Monitoring Intervention Delivery] | <ul style="list-style-type: none"> Intervention: # families served by each intervention | | | | Track (Monthly) [Entire pop] |
| | 2. To what extent did providers fully install implementation supports for the interventions? [Monitoring Implementation Supports] | <ul style="list-style-type: none"> Competency driver: # staff hired; % staff trained, coached, monitored for fidelity Organizational drivers in place Leadership: # leaders identified/ engaged | Track (Monthly) [Entire pop] | | Focus Groups (Year 3) [Stakeholders] | |
| | 3. How did providers or communities prepare for implementation (increase readiness and build capacity) of the interventions? [Readiness/Capacity] | <ul style="list-style-type: none"> 90% of providers report high readiness & capacity, | | Readiness Tool (Annually) [Stakeholders] | Focus Groups (Year 3) [Stakeholders] | |
| | 4. What interventions were implemented [Adoption] and to what extent were the delivered to children and families? [Reach] | <ul style="list-style-type: none"> 95% of providers deliver planned interventions 80% of providers reach planned number of children and families | | | | Track (Monthly) [Entire pop] |
| | 5. To what extent were interventions implemented in adherence to model fidelity? [Fidelity] | <ul style="list-style-type: none"> 90% of providers deliver interventions with adequate fidelity as defined by purveyor | | Fidelity Tool (Quarterly) [Staff, random] | | |
| | 6. To what extent were the interventions integrated within the existing system [System Integration] | <ul style="list-style-type: none"> 90% of partners report interventions are integrated into system | | | Focus Groups (Year 3) [Stakeholders] | |
| | 7. What was the degree of collaboration between partnering organizations and the extent to which interagency collaboration affected the outcomes? [Collaboration] | <ul style="list-style-type: none"> 90% of partners report collaboration is high | | Wilder Collab Survey (Annually) [Stakeholders] | Focus Groups (Year 3) [Stakeholders] | |
| | 8. To what extent were families engaged in the services timely? [Service Engagement] | <ul style="list-style-type: none"> 95% of referred families are engaged in services timely | | | | Track (Monthly) [Entire pop] |
| | 9. To what extent did families complete the interventions? [Service Completion] | <ul style="list-style-type: none"> 95% of referred families complete the interventions | | | | Track (Monthly) [Entire pop] |
| Outcomes Evaluation | 10. What effects did the interventions have on child well-being, parent functioning, and permanency? [Child, Parent, & Permanency Outcomes] | <ul style="list-style-type: none"> 90% of children improve well-being 90% of parents improve functioning in relevant domains 90% of children are maintained safely at home (not removed into foster care) during svc period or within 1 year of svc referral | | Validated Measures (Baseline, Post-Tx, Follow-up) [Entire pop] | | Track (Monthly) [Entire pop] |

Sampling

Sampling Methods

Depending on the data collection strategy, different sampling approaches will be used, including entire population, randomly selected samples, and purposeful samples. As shown in Table 5, the evaluation plan proposes three sampling approaches.

1. Entire population: The entire population of providers and the children and families they serve will be used for all monthly tracking related to monitoring the intervention delivery, monitoring the implementation supports, and determining the extent to which two of the success indicators were attained (adoption and reach). Additionally, entire population will be used to evaluate the short-term outcome of child well-being and long-term outcome of permanency for one-year cohorts. We will evaluate short-term outcomes of parent functioning using the entire population for whom specific measures are relevant, meaning we will evaluate parenting, mental health, and substance use among the entire population for which each of those measure align with program goals for one-year cohorts.
2. Randomly selected sample: For the fidelity tool, randomly selected samples of staff will be used to assess fidelity to the intervention. Due to feasibility and cost issues related to assessing fidelity of all sessions/intervention components and/or all practitioners, we propose this approach of using a random sample of practitioners.
3. Purposeful samples: Several research questions will be addressed with purposeful samples of stakeholders, including all of the data collection approaches involving focus groups and those involving the readiness assessment tool and the collaboration tool. The samples will draw from all individuals who have been involved with implementing and supporting the implementation of Kansas FFPSA program across multiple stakeholder groups.

Sample Size Requirements of the Outcomes Study

Given that the evaluation plan proposes to use the entire population of children and families served, the evaluators will conduct post-hoc power analyses to determine the power of

the study. In the case that the sample is underpowered, the evaluators will explore the use of Bayesian statistical approaches to address this limitation to the extent possible. We will also include indication of the effect size required for the actual sample to detect a statistically significant difference in our analyses.

Data Analysis Plan

Quantitative Analysis

Univariate, bivariate, and multivariate statistical analysis in SPSS version 26 or Stata version 15 will be used to examine child, parent, and permanency outcomes. In addition to the evaluation questions, the measurement level of variables (e.g., continuous or categorical/discrete), the number of dependent and independent variables included in the analyses, and whether covariates are used will determine the statistical analysis to be conducted (Tabachnick & Fidell, 2012). When missing data are present, the evaluation team will assess the missingness and choose modern and appropriate strategies for addressing it (e.g., multiple imputation). To examine the effect of the interventions on child and parent outcomes, repeated measures analysis of variance (ANOVA) and/or a multivariate analysis of variance MANOVA will be used comparing entry scores (annual cohorts) to 12 months later. The degree of association among variables will be assessed through Pearson correlations and crosstabs (Chi-square). Significance of group differences will be assessed through t-test, one-way ANOVA, factorial ANOVA (as well as factorial ANCOVA and MANCOVA when covariates are used). Effect sizes will be reported whenever possible. Logistic regression will be used to examine associations between the interventions and dichotomous outcome of keeping children out of foster care, while controlling for a range of covariates. Time course events analysis (e.g., Cox regression) may also be used to examine time variables, such as time to removal. Fidelity data will also be analyzed by using descriptive (e.g. means, frequencies) statistics. Evaluators will also present fidelity results to providers for co-interpretation and refinements.

Qualitative Analysis

The evaluation team will approach qualitative data by applying thematic analysis as guided by conceptual framework of the evaluation as well as themes that emerge inductively from the data. This approach was selected due to its robustness in instances of time restrictions

and suitability for member checking and data triangulation using multiple stakeholder sources and different data collection methods (e.g., data from quantitative surveys). These data will be analyzed and preliminary themes will be developed and will be presented to partner organizations for reflection and refinement as part of a process of co-interpretation prior to finalizing findings.

Interpretation of Results

To ensure results are presented in a balanced and objective manner the evaluation plan incorporates specific strategies that can be used to promote a collaborative as well as rigorous evaluation. These strategies include: (a) articulating a clear logic model with SMART process and outcome objectives (i.e., include prospectively determined benchmarks); (b) using multiple informant and multiple sources of data to inform formative and summative conclusions; (c) seeking input from external sources to confirm data-based decisions and conclusions; and, (d) using transparent reporting of evaluation methods.

6. Study Limitations

As noted, we are using a process and outcome evaluation to evaluate each intervention selected over time. This longitudinal approach with repeated measures is the most feasible evaluation plan for each intervention to achieve the goal of building evidence and knowledge of the continuum of interventions being delivered, and to scale those interventions statewide. We have developed a rigorous evaluation plan that allows for emergent knowledge on best practices for each evaluation while also maximizing economies of scale for a state-level cross-site evaluation using aligned measures.

A feasibility review precluded designs with control or comparison groups, such as randomized controlled trial and propensity score matched groups, because in most areas the population would not be large enough to support the required sample size for an intervention group and a comparison group. Small sample sizes limit our ability to test for causality with an experimental design; however, repeated within-group design and measures allow for evaluating change longitudinally for each intervention as sample sizes increase. Additionally, statewide implementation and overlapping catchment areas and service populations among

FFPSA grantees compounds the difficulty of identifying a comparison group as outcomes for treatment as usual candidates may be confounded by the receipt of other well-supported evaluations. Therefore, despite limitations associated with a longitudinal and repeated measures approach, the context of the evaluation restricts our design options to the proposed approach. Thus, we have incorporated strategies and approaches such as effect size comparison and Bayesian statistical approaches discussed previously to mitigate these limitations.

Feasibility concerns also make it impossible for the evaluation design to include time and labor-intensive observational methods with each provider, intervention, staff member and family. We will rely on model-specific accreditation monitoring and provider-based fidelity assurance methods and administrative data to corroborate the quality and fidelity of service delivery of each intervention and include such findings in our evaluation.

Selection bias is also a limitation given the criteria for inclusion in the interventions are set through federal requirements rather than the voluntary approach to engagement in services these interventions typically adhere to in their model development and fidelity. As sample sizes increase within interventions, we can conduct some comparative analyses of the effects found in this targeted sample with those found in the literature with voluntary participation and/or compared to effects found in other state funded intervention populations (if applicable; e.g. KS MIECHV benchmarks). We will also assess the process prevention staff use for referring specific families to specific interventions to ensure alignment across DCF staff and offices in the state in how intervention selection and referrals are standardized using common criteria and decision-making structures and tools.

Our planned approach of using post-hoc power analyses to determine study power introduces additional limitations. However, our capacity for a priori estimations of sample size is limited by state and program context. Though the statewide prevention plan is targeting service to more than 2,300 families, some individual program service goals are quite modest, with goals of as few as 15 families served. Therefore, we must assess power for individual analyses based on the constellation of programs and subpopulations included, individually, by analysis, adjusting methods accordingly. When feasible, we will apply sophisticated statistical

methods. Additionally, we will apply methodological approaches (e.g. Bayesian methods, etc.) to maximize our capacity to derive actionable findings from data with limited power.

Finally, as intervention implementation and evaluation plans begin, we will review our design, measurement, and monitoring approach on a quarterly basis with emergent findings and changing state/local contexts to identify opportunities to strengthen rigor in key evaluation areas (e.g., measurement, comparative analyses, progress metrics, and methods for evaluating effectiveness and impact over time). Finally, we will work with ACF technical assistance providers and attend any relevant federal grantee meeting sessions to share and improve our evaluation plan and methodological approaches as relevant and necessary and to apply federal guidance on reporting and data collection.

7. Reporting, Disseminating, and Using Findings

Critical components of our utilization-focused evaluation approach include data **literacy** and **use** as our reporting and disseminating frame: Reports and findings must be understandable and accessible in language, meaning, style, and format to broad audiences and the information contained within must be actionable for families, providers, and stakeholders. To that end, we will present findings, lessons learned, and areas of improvement in ways that are timely and relevant to practice, programmatic impact, and policy implications.

In partnership with DCF, local providers, and state stakeholders, we will develop a formal reporting and dissemination plan that is responsive to the unique needs of each audience and transparent in sharing strengths and opportunities to improve practice and service delivery with fidelity to the intervention. To inform this plan, we will present our evaluation plan, proposed progress monitoring metrics, outcomes, and our logic model to targeted audiences to gauge shared understanding and receive feedback on the dissemination methods that serve shared purpose and intent. We will focus on translating findings and results in language and framing so that evaluation data and information creates meaning and advances understanding of the impact of these interventions. We will augment all dissemination products with visuals that are intuitive, explanations in plain language, and conclusions that draw connections between implementation drivers, practice and intervention delivery, quality improvements, and intended impact. All front-facing dissemination products will be created in

website-accessible formatting for readers with visual impairments. We will work with DCF to develop protocol for posting materials to their website in accordance with their communication and marketing requirements. The table below presents an initial overview of our dissemination plan:

Table 6. Summary of Dissemination and Reporting Plans

| Evaluation Product | Intent | Frequency | Format | Audience |
|--------------------------------------|---|--------------------------|---|--|
| Progress Monitoring Reports | Ensure timely delivery of services, metrics on children/families referred and served | Monthly | <ul style="list-style-type: none"> Email | <ul style="list-style-type: none"> DCF |
| Continuous Quality Improvement Plans | Customized plans and metrics tailored based on practice area for improvement | Quarterly (or as needed) | <ul style="list-style-type: none"> Email Technical Assistance Calls Web metrics | <ul style="list-style-type: none"> Providers DCF |
| Presentations | Communicate progress and findings to broader audiences | As scheduled | <ul style="list-style-type: none"> Stakeholder Meetings Webinars Conference Presentations Website accessible | <ul style="list-style-type: none"> State agencies Providers, associations, advocates Legislators Parent groups |
| Practice Briefs | Knowledge transfer on focused topics: culturally competent practices; implementation drivers; best practices; family engagement; model fidelity; data use and interpretation; coordinated services; professional development; systems alignment; intervention-specific adaptations or innovations | Quarterly | <ul style="list-style-type: none"> 1-2 pg White papers Blogs Newsletters/email Webinars Website accessible | <ul style="list-style-type: none"> Providers & Staff Community Partners Field |
| Annual Report | Present on-going results of process and outcome evaluation: Indexed Report; Executive Summary; Key Findings | Annually | <ul style="list-style-type: none"> Website Accessible PDFs Snapshots and soundbites Infographics | <ul style="list-style-type: none"> DCF/ACF Stakeholders Families Public |
| Publications | Share and disseminate knowledge, findings and | As complete | <ul style="list-style-type: none"> Peer-reviewed journal articles, briefs, editorials | <ul style="list-style-type: none"> Field |

| Evaluation Product | Intent | Frequency | Format | Audience |
|--------------------|---|-----------|--------|----------|
| | results of this evaluation with the field | | | |

Throughout the evaluation, we will use quarterly workgroups and communication avenues (e.g., newsletter, website, webinars) with providers to disseminate briefs targeted with emerging findings from the evaluation or the field to address gaps in knowledge or practice. Based on progress monitoring and intervention-specific fidelity/implementation measures, we will use data, best practices, implementation drivers, and innovation to co-create continuous quality improvement plans with providers to guide data-driven improvements aligned with the intervention delivered and the organizational capabilities.

8. Data Security and Privacy, Informed Consent Procedures, and Institutional Review Board Approval

Data Security and Privacy

The evaluation team will operate to observe high standards for data privacy, security, and confidentiality. Several steps will be taken to minimize the risks associated with electronic data security, to establish and maintain data privacy, and to hold all confidential data securely. First, the research team will observe the security measures stipulated in the Data Sharing Agreement and in the Business Associates Agreement between Kansas DCF and the University of Kansas. To increase protection against potential risks associated with protected health information, all personnel on the research team maintain Human Subjects Research and HIPPA-certified training in safe-guarding sensitive information and data, including individually-identifiable data, careful orientation of potential participants as to the nature, risk and benefits of the research, strict adherence to study protocols, and regular surveillance for adverse events. Second, to protect the confidentiality of focus group and interview participants, all identifying information or potential links to any individual informant will be removed from the transcripts. Third, survey data will be collected in an anonymous fashion. Fourth, steps will be undertaken to safeguard the identifying and sensitive information belonging to children and

families included in the data (primary or secondary), complying with HIPAA standards. Personal identifiers, including names, case, client, and plan IDs, are currently used to accurately link a variety of child welfare information from multiple sources, such as removal (reasons for removal and removal dates), case plan goal, parental rights termination, discharge (discharge dates and reasons for discharge), adoption, adoption finalization date, and relationship to adoptive parent(s). Thus, digital security is of utmost importance for the evaluation.

Electronic data will be stored at the KUSSW, which maintains HIPAA-compliant data protection security features, including (a) protection by a 128-bit secure socket layer (SSL) encryption system and Cerberus NT authentication software; (b) server access limited to analysts with proper approval and housed in a secure room with keypad entry; (c) identification code and a password required for users to access the system; and, (d) a user level system to ensure that only information relevant to the individual user's needs is accessible and to limit data entry to only certain users. Child welfare secondary data files will be stored in a directory on the KU secure server. Dual factor authentication will be required to access the data to allow access only to the evaluation team who will have username and password.

Informed Consent Procedures and IRB

Informed consent procedures will be determined with provider agencies during the pre-implementation phase. The KUSSW team has conducted multiple evaluation and research projects and have extensive experience writing and executing cooperative research protocols approved by the IRB. Before evaluation data are collected, the evaluation team will seek approval from the University of Kansas Institutional Review Board (IRB). Considering that some of the data collection strategies proposed in this study involve the participation of human beings or collecting their information from a database (e.g. child welfare database, agency database), IRB review will be necessary. KUSSW has a Business Associate Agreement and a Data Sharing Agreement with DCF. In addition, where indicated, KUSSW will sign Data Sharing Agreements with partner agencies.

9. Evaluation Roles and Responsibilities

Key Evaluation Staff

This evaluation project will bring together two qualified KU entities with experience and expertise in child welfare, community-based child abuse prevention, early childhood, behavioral and mental health, and substance use disorder programming. The KU School of Social Welfare (SSW) and KU Center for Public Partnerships and Research (CPPR) will collectively bring their diverse, complementary expertise to evaluate and support FFPSA in Kansas. This KU partnership has a history of collaborative relationships with DCF, the Kansas Department of Health and Environment (KDHE), the Kansas Children’s Cabinet and Trust Fund (KCCTF), the Kansas State Department of Education (KSDE), the Kansas Department for Aging and Disability Services (KDADS), as well as state associations comprised of providers in the field of child protection and prevention services, public health, behavioral health, substance use disorders, and child/family serving organizations. The KU FFPSA evaluation team will work closely with DCF and its contracted providers to develop and implement a responsive and comprehensive evaluation approach for FFPSA that is rigorous and grounded in community-based practice and research. We will leverage our existing partnerships, areas of expertise, community-based engagement across Kansas, and involvement in state-level efforts to inform this evaluation and align efforts and data for maximum utility at the state and local levels. SSW will serve as the primary lead with CPPR staff embedded within the FFPSA evaluation team. Senior-level staff/subject matter experts directing the work are identified below.

The evaluation plan, data collection, data management, and data analyses and reporting will be overseen by the Principal Investigator, Dr. Kaela Byers. Dr. Byers is an Associate Research Professor at the University of Kansas School of Social Welfare. She has served as a Principal Investigator or evaluator on numerous research projects, has expertise in child welfare, program implementation, and evaluation, and has published in the areas of child well-being, child welfare, and permanency. Dr. Byers will serve as Principal Investigator of the KU FFPSA evaluation team, directing all design, deliverables, and fiscal management.

Evaluation Responsibilities by Data Collection Activity

The data collection plan calls for four types of data collection activities: tracking of inputs/outputs, surveys and other tools (including fidelity), focus groups, and data extraction (administrative data). Table 7 provides an overview of evaluation responsibilities by showing the individuals responsible for leading or assisting with each of the main data collection activities and the individuals who will participate (respond to) in the data collection activities.

Table 7. Summary of Evaluation Responsibilities by Data Collection Activity

| Data Collection Activity | Children & Families | Multiple Stakeholders | Provider Staff | Provider Admin | DCF | Evaluation Team |
|---------------------------------|--------------------------------|------------------------------|-----------------------|-----------------------|------------|------------------------|
| Tracking inputs and outputs | | | ✓ | ✓ | ✓ | ✓ |
| Focus Groups | ● | ● | ● | ● | ● | ✓ |
| Survey: Readiness Assessment | | ● | ● | ● | ● | ✓ |
| Survey: Collaboration Factors | | ● | | ● | ● | ✓ |
| Survey: Fidelity Tools | | | ● | ✓ | | ✓ |
| Validated Tools | ● | | ✓ | ✓ | ✓ | ✓ |
| Data Extracts (FACTS) | | | | ✓ | ✓ | ✓ |

● - Participant of data collection activity; ✓ - Responsibility for assisting with or leading data collection efforts

Infrastructure for Accessing Data

This plan calls for the sharing of data through two primary mechanisms. First, tracking data will be delivered by the providers to DCF via a secure SharePoint. The KU evaluation team will also have access to this SharePoint. Second, administrative child welfare data will be provided from DCF to the KU evaluation team via an existing secure server (known as ROM). A data sharing agreement will be developed and executed to support the sharing of these data. Given that KU and DCF have several existing projects that require data sharing, exemplar agreements are available on which to build the agreements needed for this evaluation.

10. Timeline

Table 8, below, shows the timeline for major evaluation activities.

Table 8. Timeline for Major Evaluation Activities

| Activities | Performance Measure | Responsible | Year 1 | | | | | | | | | | |
|--|--------------------------------|-------------------|--------|----|----|----|----|----|----|----|----|---|---|
| | | | M1 | M2 | M3 | M4 | M5 | M6 | M7 | M8 | M9 | | |
| Revise and confirm the proposed evaluation design | Evaluation design confirmed | DCF, Grantees, KU | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | |
| Identify additional outcomes or success indicators based on FFPSA selected interventions, as needed or recommended | Additional indicators selected | DCF, KU | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | |
| Submit to KU Institutional Review Board (IRB) and obtain human subjects approval for evaluation plan as required | IRB approval received | KU | | | | | | | ✓ | | | | |
| Hire and/or select candidates for open positions | Candidates hired | KU | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | |
| Establish protocol for data collection standards | Protocol developed | DCF, KU | | | ✓ | ✓ | | | | | | | |
| Finalize measurement tools and protocols | Tools and protocols in place | DCF, KU | | | | | | | ✓ | | | | |
| Identify data collection/quality training needs for grantees | Training plan developed | DCF, KU | | | | ✓ | ✓ | | | | | | |
| Conduct data collection/quality training with grantees | Trainings conducted | KU | | | | | | | ✓ | ✓ | | | |
| Establish, convene, and facilitate Statewide and Regional Advisory Workgroup meetings | # of workgroup meetings held | KU | | | | ✓ | | | | ✓ | | | |
| Prepare and submit Status Reports, Budget Transaction Reports, and Budget Itemization Reports to DCF. (Monthly) | Timely reports submitted | KU | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Collect, aggregate, and analyze required FFPSA Title IV-E Prevention Services Data Elements | Data elements report submitted | KU | | | | | | | | ✓ | | | |

| Activities | Performance Measure | Responsible | Years 2-3 | | | | | | | |
|--|--------------------------------|-------------|-----------|----|----|----|----|----|----|----|
| | | | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| Carry out continuous reporting and monitoring of short-term and intermediate outcomes | Outcomes analyzed and reported | KU | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Convene, facilitate, and synthesize feedback from Statewide and Regional Advisory Workgroup meetings | # of workgroup meetings held | KU | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Prepare and submit Status Reports, Budget Transaction Reports, and Budget Itemization Reports to DCF (Monthly) | Timely reports submitted | KU | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Conduct outcomes evaluation of short-term, intermediate, and long-term outcomes | Evaluation conducted | KU | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Aggregate, analyze, and report on required Family First Title IV-E Prevention Services Data Elements | Data elements report submitted | KU | | ✓ | | ✓ | | ✓ | | ✓ |
| Conduct CQI activities | CQI plan implemented | Grantees | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Preparation of quarterly Evaluation Progress Reports | Progress reports completed | KU | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Preparation of final evaluation report of findings and program impact | Final report completed | KU | | | | | | | ✓ | ✓ |
| Preparation of presentations and publications of findings to disseminate program impact | Findings disseminated | KU | | | | | | | ✓ | ✓ |