

# Ohio Title IV-E Family First Prevention Plan

# Ohio Title IV-E Family First Prevention Plan

## Table of Contents

Ohio Title IV-E Family First Prevention Plan.....	1
<b>Introduction.....</b>	<b>3</b>
Strategic Direction.....	3
Investing in Children’s Services.....	3
Ohio’s Efforts to Shift Towards System Transformation.....	3
<b>Leadership Advisory Committee.....</b>	<b>4</b>
<b>Leadership Advisory Work.....</b>	<b>5</b>
Prevention Services Subcommittee.....	5
Exploration and Design Regional Forums.....	6
Youth Engagement.....	6
<b>Executive Committee.....</b>	<b>6</b>
<b>Title IV-E Waiver Demonstration History – Protect Ohio.....</b>	<b>7</b>
Kinship Supports Intervention.....	8
Family Team Meetings (FTM).....	8
Differential Response (DR).....	9
<b>The Comprehensive Addiction and Recovery Act (CARA) of 2016 Plan of Safe Care – Substance Abuse Population.....</b>	<b>10</b>
<b>Child and Family Services Review (CFSR) and Program Improvement Plan (PIP) Goals</b>	<b>12</b>
Leveraging the Family First Prevention Services Act – Proactive Approach/Continuum Review.....	13
Leveraging the Family First Prevention Services Act – Data Reference and Rationale.....	14
Leveraging the Family First Prevention Services Act – Eligibility and Case Process.....	15
Candidacy Definitions.....	16
Eligibility Determination and Case Flow.....	17
<b>Monitoring Child Safety &amp; the Child Specific Prevention Plan.....</b>	<b>17</b>
Assessment of Risk Plan and Monitoring Child Safety.....	18
<b>Title IV-E Prevention Services (Service Description and Oversight).....</b>	<b>23</b>
Evidence-Based Practice Service Array.....	23

<b>Evaluation and Continuous Quality Improvement (CQI) Strategy.....</b>	<b>28</b>
Phase 1.....	34
Phase 1 – Evidenced Based Program Service Descriptions.....	36
Phase 2.....	53
Phase 3.....	56
<b>Workforce Development, Training, and Support.....</b>	<b>58</b>
<b>Ohio Child Welfare Training Program .....</b>	<b>58</b>
<b>Technical Assistance .....</b>	<b>61</b>
Child Protection Oversight and Evaluation (CPOE) .....	61
Informal Technical Assistance .....	62
IV-E Training Plan Implications .....	63
Ohio’s Rapid Response Program.....	63
<b>Existing Feedback Loops for Support and Continuous Quality Improvement (CQI).....</b>	<b>63</b>
<b>Family First Prevention Services Caseloads.....</b>	<b>65</b>
County Break Down.....	65
<b>Assurance on Prevention Program Reporting .....</b>	<b>67</b>
<b>Conclusion .....</b>	<b>67</b>
 <b>Appendices</b>	
Phase 1 Waivers of Evaluation Requirements.....	Appendix A
Ohio START Evaluation Plan.....	Appendix B
Ohio START Executive Summary of Certification Process and Essential Components and Fidelity Standards.....	Appendix C
HFA Protocols for Working with Child Welfare Families.....	Appendix D

## **Introduction**

Ohio has a long-standing history of embracing innovation and enacting practice changes to better serve children and families. The Family First Prevention Services Act (Family First) offers a unique opportunity to re-envision how services and supports are delivered to children and families involved in the children services system in Ohio.

## **Strategic Direction**

The Ohio Department of Job and Family Services (ODJFS) and the Family First Leadership Advisory Committee have leveraged Family First as an opportunity to reframe how services are delivered in Ohio. Beyond compliance with Family First, Ohio is prioritizing children services reform, as evidenced by Governor Mike DeWine's investment in children services. Immediately upon taking office, he created the Governor's Office of Children's Initiatives. This office is tasked with coordinating and aligning the state's children's programming, advancing policy and innovation within the state's children's programs, and providing supportive services for Ohio's most in-need children and families. By executive order, Governor DeWine also elevated foster care priorities in Ohio. To achieve this, Governor DeWine created the Office of Children Services Transformation. The purpose of the Office of Children Services Transformation is to strengthen and reform the children services system in Ohio.

## **Investing in Children's Services**

The timing at which the Family First legislation was passed at the federal level is bolstered by Ohio Governor Mike DeWine's unprecedented investments to lay the groundwork for healthier children, stronger families, and safer communities. As Governor DeWine has committed his career to supporting children and families, there is no better time to leverage Family First as a part of a larger vision to transform the way we deliver services to families. Other areas of Governor DeWine's investments include:

- Promoting home visiting programs to give children the best possible start in life.
- Providing more children with early intervention programs through the Ohio Department of Developmental Disabilities (DODD).
- More than doubling the state's investment in children services.
- Establishing the Ohio Kinship and Adoption Navigator (OKAN) program.
- Expanding the Ohio Sobriety Treatment and Reducing Trauma (Ohio START) program.

## **Ohio's Efforts to Shift Towards System Transformation**

Beyond the investments made, Ohio has taken additional steps to shift towards system transformation as evidenced by the following efforts:

- Meaningful stakeholder engagement
- Title IV-E Waiver Demonstration
- Utilization of Differential Response

- Alignment of the Child & Family Services Review (CFSR) and Performance Improvement Plan (PIP) goals

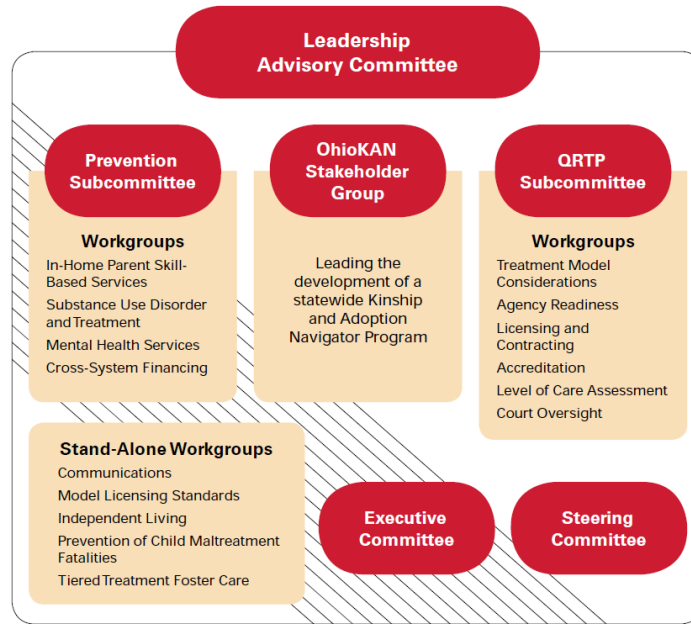
These efforts work collectively to convey the nature of Family First in Ohio. Ohio's ongoing system improvement efforts continue through the implementation planning of Family First, the development of a tiered foster care model, statewide foster and adoptive parent recruitment efforts, and a strengthened continuum of care. Fortunately, states can now be federally reimbursed for select prevention services through Family First, allowing for a shift in how resources can be allocated to prevent children from entering foster care whenever possible. Ohio's plan focuses on how Family First will be operationalized to ensure availability of evidence-based prevention programs across the state by prioritizing:

- Engaging a diverse stakeholder group to advise on statewide issues related to children and families who are involved with the child protection and foster care system.
- Further developing a shared state and county vision for agency purpose and practice.
- Thinking broadly about how Family First connects to a broader continuum of care.
- Raising the bar for all residential facilities in Ohio to ensure that those placed in a child-care institution are receiving short-term, quality supports and services.

## **Leadership Advisory Committee**

Ohio's Family First Leadership Advisory Committee was comprised of thirty public and private organizations, advocacy groups, former foster youth, and families with lived experience. The work of the Leadership Advisory Committee extended into subcommittees and workgroups which grew to include over 200 stakeholders, helping to shape the vision of Family First. As a result, the work of this group informed the planning and framework for implementation and solidified the mission and vision.

The Leadership Advisory Committee was divided into three subcommittees: The Prevention Services Subcommittee, Ohio KAN Stakeholders Group, and the Qualified Residential Treatment Program (QRTP) Subcommittee. Each subcommittee was responsible for making specific recommendations around Family First Planning as outlined below:



The Leadership Advisory Committee engaged additional stakeholders and colleagues across departments and systems to ensure collaboration. County Public Children Services Agencies (PCSAs), private agencies, associations, state agencies and individuals with lived experiences worked congruently to ensure the right balance of diversity and competency. The voting member representation for the committee is as outlined below:

<b>27%</b>	County Public Children Services Agencies (PCSAs) (8)	Cuyahoga, Guernsey, South Central, Butler, Montgomery, Erie, Franklin, Lorain
<b>20%</b>	Private Agencies (6)	Seeds 4 Life, Lighthouse Youth & Family Services, Community Teaching Homes, Homes for Kids, UMCH Family Services, Lutheran Homes Society Inc.
<b>23%</b>	Associations (7)	Ohio Grandparent Kinship Coalition (OGKC), Ohio Family Care Association, Ohio Family and Children First, National Youth Advocate Program, Ohio Children’s Alliance, Public Children Services Association, Ohio JFS Director’s Association
<b>20%</b>	State Agencies (6)	OhioMHAS, DODD, Medicaid, DYS, ODJFS, Supreme Court, Ohio Children’s Trust Fund
<b>10%</b>	Lived Expertise (3)	Foster Care Alumna, Foster Caregiver, Kinship Caregiver

## Leadership Advisory Work

### Prevention Services Subcommittee

The Prevention Services Subcommittee played a major role in creating the contents of planning for prevention services in Ohio. The subcommittee was comprised of over 80 cross-system stakeholders joined with the goal of designing a prevention services plan that aligned evidence-based practices with the needs of families and children; to keep children safe with their families whenever possible. This subcommittee included several workgroups:

- In-Home Parenting Workgroup
- Mental Health Workgroup
- Substance Use Disorder (SUD) Workgroup
- Case Pathway Workgroup

Each conducted extensive research of the evidence-based practice services in Ohio and recommended programs to build a service array to ensure that families have access to services regardless of their geographical area in the state.

### **Exploration and Design Regional Forums**

Engagement of community partners and key stakeholders is paramount to gathering insight, input and opportunities for success. Over the course of a two-week period, five Exploration and Design Regional Forums were held across the state. Participants included senior management staff who were interested in the potential for transformational change in serving children and families. Key findings were synthesized into a report to help in framing the design of the Family First Leadership Advisory Committee. The regional forums brought about many valuable insights, ideas, and recommendations that the Family First Leadership Advisory Committee continues to keep in mind as this important work progresses. In response to the suggestions that resulted from the forums, it was clear that one of the first steps needed to tackle the work ahead was to assess Ohio's readiness regarding two of the most critical components of Family First: – 1) QRTP and 2) Prevention Services.

### **Youth Engagement**

A member of the Leadership Advisory Committee, who is also a person with lived expertise in foster care, hosted a series of youth focus groups to gain insight directly from youth who are currently in foster care. After hosting the youth focus groups, the information and recommendations were shared with the Leadership Committee and relevant workgroups to elevate the youth voice in the discussions and planning.

### **Executive Committee**

The Leadership Committee recognized a need to engage executive level, cross-agency leadership from state departments throughout the planning and implementation of Family First to ensure effective cross-agency partnership and guidance. State agencies involved include:

- Ohio Department of Job and Family Services (ODJFS)
- Ohio Department of Medicaid (ODM)
- Ohio Department of Mental Health and Addictive Services (OhioMHAS)

- Ohio Department of Developmental Disabilities (DODD)
- Ohio Department of Health (ODH)
- Ohio Department of Education (ODE)
- Ohio Department of Youth Services (DYS)
- The Governor’s Office

The Executive Committee, led by ODJFS, continues to convene monthly and is comprised of cabinet leadership with the goal of creating opportunities for collective impact solutions and joint ownership while identifying and assessing intersections between departments within Ohio’s Office of Children’s Initiatives. The Executive Committee worked closely with the Family First leadership committee to:

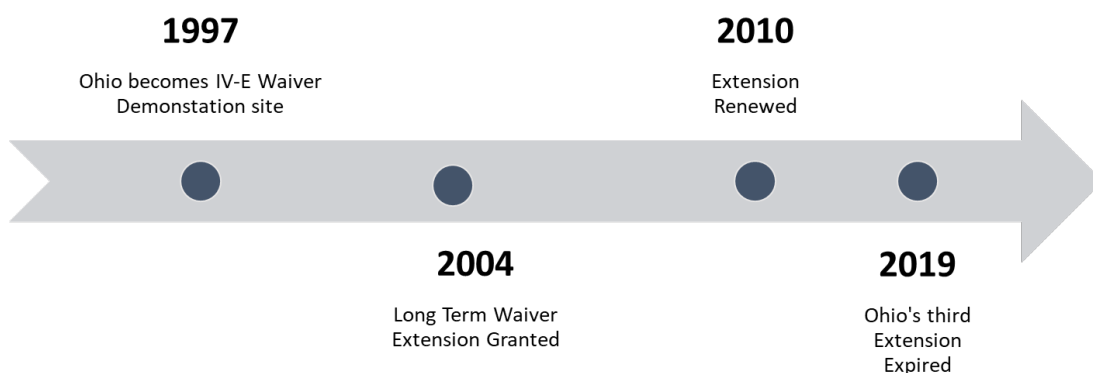
- Provide a high-level review of decisions and recommendations.
- Contribute feedback and guidance for final recommendations and implementation.
- Review barriers for both county and state level implementation.
- Identify opportunities for cross-system education and collective impact initiatives.
- Leverage respective connections, expertise, and resources to support the work.

The overarching purpose of this Executive Committee is to extend beyond the Family First work and aims to transform service delivery for children and families across all systems throughout Ohio.

## Title IV-E Waiver Demonstration History – Protect Ohio

Ohio’s Title IV-E Waiver Demonstration is an example of how Ohio leveraged an opportunity to be innovative with Title IV-E funds by establishing Protect Ohio and implementing it in 15 counties. This program was initially a five-year research and demonstration project designed to reduce the number of children in foster care, decrease the time children remain in foster care and promote adoptions. Ohio implemented multiple innovations with the flexible use of Title IV-E dollars to provide services to both IV-E eligible and non-eligible children who were in out-of-home care or who were at risk of removal.

### Timeline of Ohio’s Title IV-E Waiver History – Protect Ohio





When the waiver began, each county was able to take its own approach to reform; however, with varying approaches, it made the interventions difficult to evaluate. During each subsequent waiver extension, per federal instruction, the number of interventions was reduced. The demonstration counties ultimately narrowed their focus to two primary interventions: Kinship Supports and Family Team Meetings (FTM). Focusing on the two interventions being implemented consistently across the demonstration counties aided the evaluation team in more accurately determining the success of each primary intervention. While the primary focus of waiver counties was Kinship Supports and FTM, a few counties continued to utilize waiver funding for individualized interventions such as visitation, managed care, mental health and substance abuse treatment, and to promote reunification.

### **Kinship Supports Intervention**

The mission of the Protect Ohio Kinship Supports Intervention is to promote kinship placement as best practice, increasing attention to and support for kinship placements, caregivers, and families. The use of kinship caregivers for placement of children at risk of out of home care is the preferred practice in children's services and is promoted through federal and state legislation. This intervention has been outlined in the Kinship Support Intervention Manual. This practice manual was developed with web-based training that can be located on the Ohio Child Welfare Training Program (OCWTP) website <http://ocwtp.net/>. Ohio's Kinship Supports Intervention has been rigorously evaluated by the Human Services Research Institute. In addition, Ohio submitted an application for the Kinship Supports intervention to be considered as part of the *California Evidence-Based Clearinghouse for Child Welfare*. The Kinship Supports Intervention has shown noteworthy positive outcomes that impact the lives of kinship caregivers and the children in their care. Examples of some of those outcomes include: shorter, more stable placements, decreased time to permanency, reduced incidences of subsequent maltreatment, and reduced likelihood of re-entering out-of-home care.

### **Family Team Meetings (FTM)**

Protect Ohio also prioritized FTM as an intervention that encourages family engagement throughout the life of the agency's work with the family. During these meetings, a neutral facilitator guides the process and families are encouraged to bring relatives, community service providers or other supports to promote family engagement. A rigorous evaluation of the practice has been completed by the Human Services Research Institute. Like the Kinship Supports Intervention, the FTM intervention has a written manual and web-based coursework to develop skills and understanding of the importance of family engagement. Moreover, both the FTM and Kinship Supports Interventions are based on relative/kinship involvement as an integral part of providing family support and success. This allows the agency to develop a support plan for the family in addition to identifying potential placements with relatives should the need arise. This is critical to prevention and helps maintain children with family in lieu of placement in foster care or congregate care.

Ohio's rich history with the waiver demonstration has helped mold and shape the way all counties provide services today. The waiver county interventions have led the way to highlighting the successes of families and children served by FTMs and Kinship Supports.

## Differential Response (DR)

Ohio's DR System is another innovation that paved the way toward system transformation. Under DR, reports of child abuse or neglect are assigned to one of two pathways based on the nature of the report and the pathway assignment criteria. For many families, an alternative approach is more appropriate. DR provides children's services agencies two options for responding to accepted reports of child abuse and neglect: the Traditional Response (TR) or Alternative Response (AR). The charts below provide a summary of the criteria for each pathway.

Traditional Response (TR)	Alternative Response (AR)
<ul style="list-style-type: none"><li>✓ Required for reports of:<ul style="list-style-type: none"><li>• sexual abuse</li><li>• abuse resulting in serious injury</li><li>• serious and immediate risk</li></ul></li><li>✓ Process results in a determination/finding regarding the allegation</li><li>✓ May involve court intervention</li><li>✓ Safety, Risk and Comprehensive Family Assessment completed</li><li>✓ Case Plan developed after Family Assessment is completed for families with ongoing service needs</li></ul>	<ul style="list-style-type: none"><li>✓ Report DOES NOT allege serious or imminent harm</li><li>✓ No formal finding/substantiation of the allegation</li><li>✓ Safety-focused partnership with families</li><li>✓ Safety, Risk and Comprehensive Family Assessment completed</li><li>✓ Emphasis on "front-loading" needed services by providing services earlier and without requirement of a finding</li></ul>

A rigorous, random control evaluation of Ohio's 18-month pilot of the Alternative Response (AR) approach indicated:

- Child safety was uncompromised.
- There were fewer re-referrals to child protective services.
- Greater satisfaction with services reported by both families and workers.
- Greater involvement in decision making and increased cooperation between workers and families was reported by both workers and families.
- There was increased family engagement in services.
- Evidence of enhanced collaboration between children's services and community partners.
- Subsequent child removals were lower among AR families than the comparison control group of families receiving the Traditional Response; indicating potential for long-term cost savings.

Ohio is looking at ways to further enhance supports and services offered through DR by incorporating Family First evidence-based practice services into the supports offered through the TR and AR pathways.

## **The Comprehensive Addiction and Recovery Act (CARA) of 2016 Plan of Safe Care – Substance Abuse Population**

CARA supports the Family First goal as it is focused on families who are impacted by substance abuse coming into the children's services system. The intent of CARA is to immediately identify families who are not receiving adequate support to address their substance use disorders. The children and families identified within this arena are at greater risk of entering the children's services system and subsequently placements within the foster care system if not appropriately served. Development of a preventative service delivery system, in a less intrusive way, by connecting families to services earlier within our system, supports the intent of CARA and Plans of Safe Care.

Education and training continue throughout Ohio on the intent of CARA and Plans of Safe Care. Training has been focused on the need for collaboration between the multi-systems who serve this population. Children's services, medical partners, substance abuse treatment agencies, behavioral health organizations, mental health providers and other community providers who serve infants and families impacted by substance abuse share the responsibility of ensuring CARA legislation and Plans of Safe Care are followed as intended by the legislation. In addition, training will focus on supporting caseworkers to help improve engagement with families and ensure linkages to services within the community, with better quality services and preventative service delivery.

ODJFS has incorporated a two-tiered process with communities. An initial training occurs with the PCSA staff to identify CARA criteria and identify the strengths and barriers within the community which impact working with children and families to ensure reporting, development of a plan of safe care and monitoring of a plan of safe care. For the second tier, the local community stakeholders attend to better understand the CARA responsibilities across systems and address processes and responsibilities for CARA to better execute at the local level. Education continues with the focus on collaboration between the medical community and children's services. ODJFS continues to present CARA via trainings, conferences, presentations, web-based trainings, in person meetings, conference calls and through information sharing via the internet. This education and training will continue to improve the understanding of CARA's required collaboration of community systems while educating the impact across systems. Enhancement of developmental resources, services and educational materials to support this goal will continue, while supporting the Family First Prevention Services Act.

Ohio's Screening Guidelines have been updated to include language which supports CARA and Plans of Safe Care. Once final approval has been given, statewide webinars will be presented to introduce the new changes which support Family First goals. The pathway for prevention for these families will be supported by screening decisions and pathway assignment.

CARA – Plans of Safe Care are supported by several funding opportunities in Ohio, which include but are not limited to the following:

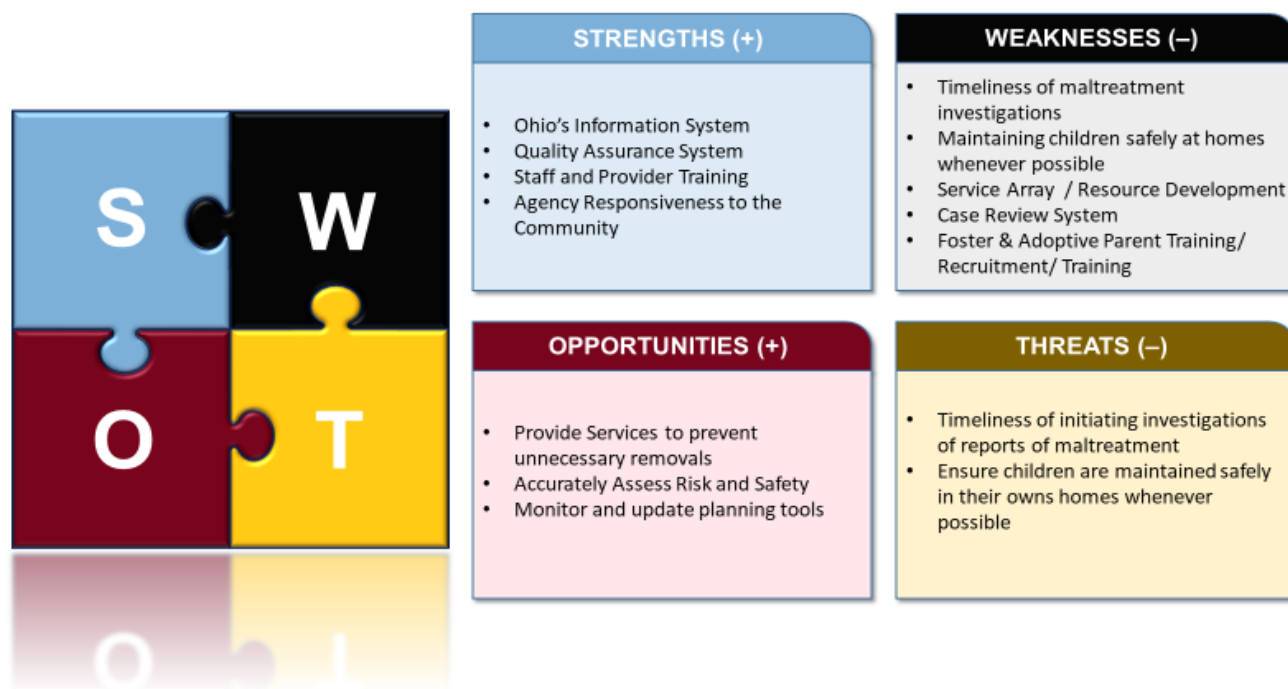
- Sobriety Treatment and Reducing Trauma (START) – Ohio START brings together children’s services, juvenile courts, and behavioral health treatment providers to support families struggling with cooccurring child maltreatment and substance abuse.
- The National Quality Improvement Center for Collaborative Community Court Teams (QIC-CCCT) – Goals and outcomes include 1.) Increase of collaboration and partnership to integrate collaborative courts into larger prevention and early intervention systems of care to support children and families from pregnancy to early childhood and beyond; and build the capacity of communities to support at risk children and families who are not children’s services involved, 2.) Provision of Family-Centered Services by supporting parent recovery and strengthening parental capacity through access to SUD treatment and parent-child evidence-based interventions; ensure the health and well-being of children through improved linkages to Early Intervention, Home Visiting, Early Childhood Care and Education and Head Start, 3.) Implementing Plans of Safe Care by identifying and engaging pregnant women and families early, supporting families before birth, allowing infants to remain at home after hospital discharge and preventing further children’s services involvement. Implementing postnatal Plans of Safe Care to ensure continuity and coordination of services across multiple systems whether or not children’s services is involved.
- Opioid Use Disorder, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative (OMNI) – Funded through the Ohio Department of Health, the goal of this initiative is to enhance collaboration between state, policy, community, and clinical partners to ensure appropriate care for reproductive aged women with substance use disorder and impacted families, and increase awareness and knowledge about plans of safe care by leveraging the work of ODJFS through implementation of at least two best practices to improve care coordination and transition care before and following delivery of the child and through the life course.
- National Center on Substance Abuse and Child Welfare, Practice and Policy Academy – The goal is to improve outcomes for pregnant and postpartum women with opioid use disorders and their infants, families, and caregivers with cross-system partners for a state specific action plan to strengthen collaboration to address the complex needs of this population.

Moving forward, goals will include:

- Continued education and training.
- Creating local infrastructure to build and sustain wrap around supports and partnerships.
- Creating partnerships with consistent practices and policies.
- Information sharing on funding opportunities which support preventative services for families impacted by substance abuse.

## Child and Family Services Review (CFSR) and Program Improvement Plan (PIP) Goals

Ohio's most recent CFSR included 164 cases in 15 counties and was conducted between April 1, 2017 and September 30, 2017. The results identified many strengths and areas for improvement as highlighted in the chart below:



To address the issues in the review, Ohio has identified seven goals to guide progress with this work:

1. Improve initial and ongoing assessment of safety, risk, family strengths, and needs.
2. Improve quality of initial and ongoing case planning with families.
3. Improve frequency and quality of face-to-face visitation between caseworker and families.
4. Improve permanency outcomes through collaboration with the Supreme Court of Ohio.
5. Improve access to care by enhancing Ohio's array of effective, family-driven treatment and supportive services.
6. Improve safety of children in out-of-home care through enhancement in monitoring of background checks for child-care providers in licensed settings.
7. Improve permanency outcomes for children and families through Interstate Compact for the Placement of Children (ICPC) enhancements.

As planning and implementation efforts for Family First continue, Ohio will need to keep an eye toward these goals as they coalesce with and are an integral part of the Title IV-E Prevention Services Plan.

To align Title IV-E Prevention Services with the services provided under Title IV-B, Ohio has focused on integrating the Family First work into Ohio's CFSP. The continuum of services described in the Title IV-B plan, specifically Goal 3, focuses on Family First Prevention Services. Ensuring alignment and integration between the Title IV-E services and Title IV-B services is an ongoing component of the CFSP and APSR work. Both the CFSP and FFPSA work will be collaborative within the Office of Families and Children (OFC) to collaborate and coordinate Title IV-B and Title IV-E services.

### **Leveraging the Family First Prevention Services Act – Proactive Approach/Continuum Review**

While Family First Prevention Services make up only a part of Ohio's prevention continuum, it serves as an opportunity to leverage and coordinate state investments. Family First has provided the opportunity to become a proactive system of support rather than a reactive system of repair. Family First has also provided the leverage to evaluate the continuum of services to work toward providing similar services statewide to ensure all children have access to the care and treatment they need, no matter the zip code in which they live. The investment in upstream prevention, including primary and secondary, and wraparound services is crucial to support candidates for foster care and their families when these services are not eligible for Title IV-E reimbursement (i.e. domestic violence services and concrete supports).

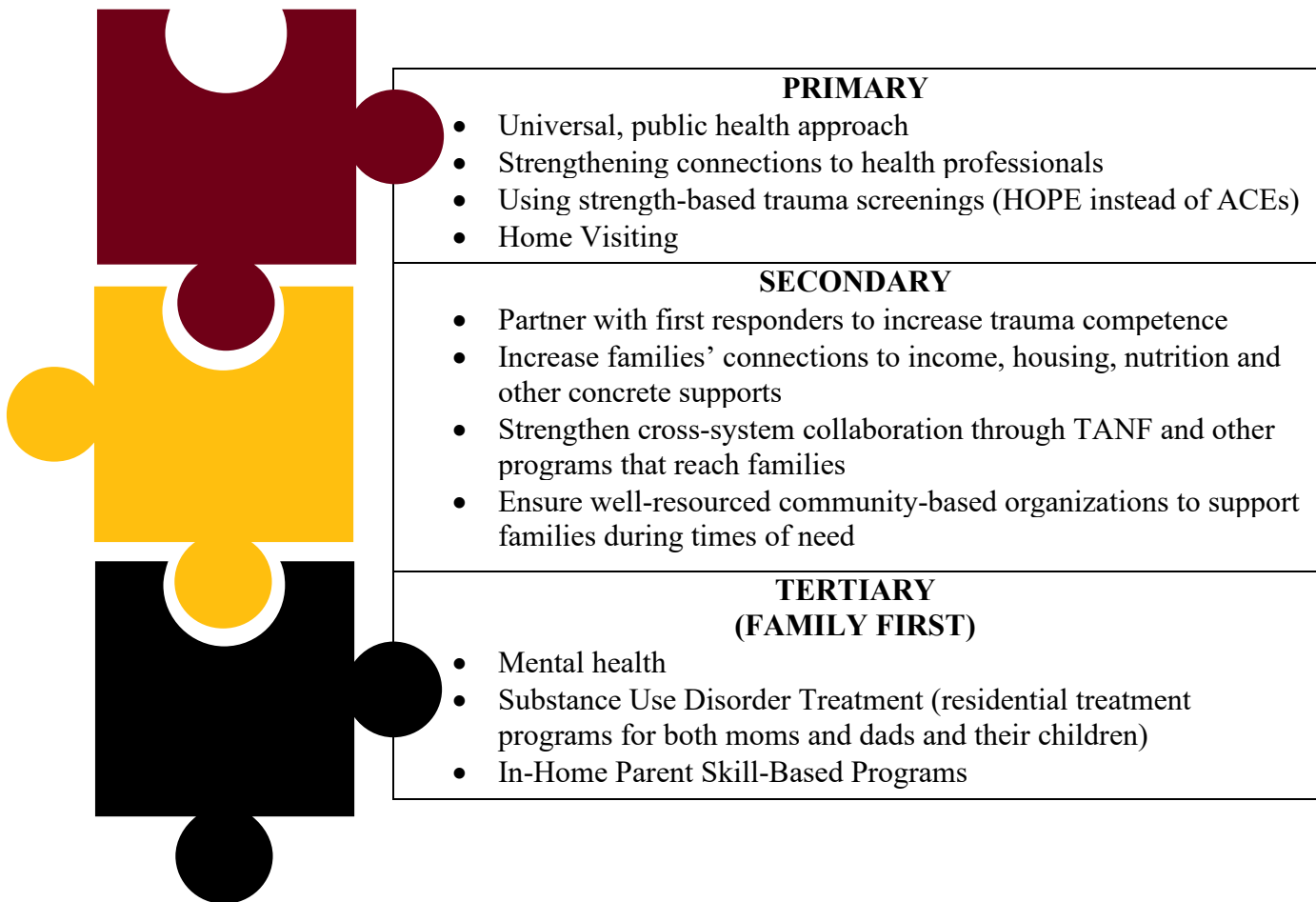
Ohio recognizes that services for candidates and their families funded through Title IV-E are not the sole mechanism for providing services to children and families in Ohio. It is critical that services for children and families meet their unique needs, which means ensuring a diverse array of services, including culturally responsive services, are available. Additionally, services included in Ohio's Title IV-E Prevention Plan are one part of Ohio's overall prevention continuum and in order to truly serve Ohio's children and families well, the state must invest in primary and secondary prevention services to prevent children from entering the children's services system. Therefore, the state is committed to providing an array of services beyond those that are eligible for Title IV-E reimbursement. An example of this is through the work of the Ohio Children's Trust Fund (OCTF). The mission of OCTF is to prevent child abuse and neglect through investing in strong communities, healthy families and safe children by:

- Providing grants to other agencies and nonprofits that provide programs in their communities.
- Providing resources and education to parents and caregivers to help them manage stress, find support and services, and build stronger foundations for their families (i.e. parenting programs and fatherhood programs, Triple P and 24/7 Dad).
- Providing training and education to professionals who provide services to families.
- Annual awareness campaigns each April to educate the public about child abuse and neglect prevention.

Additionally, through the Title IV-E waiver, data analysis, and ongoing work with children and families, it is known that children and families involved with children's services have complex needs and these needs must be addressed in a comprehensive manner. These families are also often

involved with multiple public systems. Therefore, Ohio is also committed to implementation of evidence-based services within a framework that supports:

- Creating high-fidelity wraparound programs
- Increasing families’ connections to income, housing, and nutrition supports and other concrete supports
- Developing peer support programs for families and youth to increase connections for families to people with lived experiences
- Expanding mobile response and stabilization programs
- Increasing access to respite care support for parents and caregivers
- Investing in domestic violence supports and services



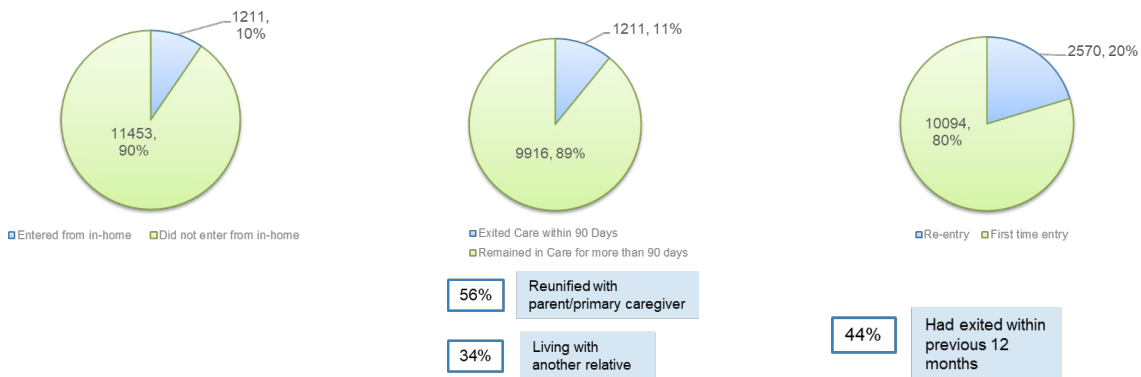
### Leveraging the Family First Prevention Services Act – Data Reference and Rationale

Approximately 34% of assessments/investigations in Ohio that are closed as “close and refer” experience a subsequent assessment/investigation within 12 months. Child needs are more often the same in the first and subsequent assessments/investigations. Self-protection, although varying across counties, is highest. The primary adult needs for assessments/investigations substantiated at case disposition include parenting practices, response to stressors, emotional/mental health functioning, domestic relations, and substance use.

The subcommittee started by looking at the data to answer the question – *Who are the children and families that are at children’s services’ front door and without services, the children may have to enter foster care?*

As shown in the charts below, the 2018 data indicated:

- More than 12,000 children and youth entered foster care.
- 2,570 children and youth re-entered care – 44% had exited care within the previous year.
- 15,783 cases closed as referred for services – 34% came back within 12 months.



The data highlighted a need for more robust prevention services as there were populations of families that were re-entering foster care after 12 months.

### Leveraging the Family First Prevention Services Act – Eligibility and Case Process

Ohio grounded the decisions about operationalizing the definition of candidacy in data provided by ODJFS, ODH, and several community providers. The prevention services subcommittee used data to define candidacy in a way that ensures the target population are those families that are at higher risk for entering or re-entering care, as well as the service needs of the target population. Lastly, the data helped to identify the evidenced-based practices (EBPs) that meet the unique and diverse needs of these families.

All children who are identified as candidates for foster care must, at a minimum, have a referral that is screened-in by a county Public Children Service Agency (PCSA). Additionally, the PCSA



is responsible for determining a child's eligibility based on the candidacy definition. For some families who are newly coming to the attention of the children's services agency, less intensive children's services case management services and intensive support from service providers (i.e., mental health, substance use, parenting skills) can mitigate risk and prevent foster care. For families that have an open children's services case, including in-home cases and expectant and parenting youth in foster care, Family First creates an opportunity for Ohio to finance prevention services using new federal dollars for these existing open cases. In these cases, case management processes will continue to be governed by existing policies with some changes to how information is documented. In cases where a child achieves permanency, there is a new opportunity to promote stability and decrease the risk of re-entry into foster care through a Family First Prevention Case.

## **Candidacy Definitions**

In defining candidacy, the goal is to target families identified in the data (see Data Reference and Rationale) as possibly in need of additional services. The criteria to define candidacy for prevention services in Ohio are outlined below:

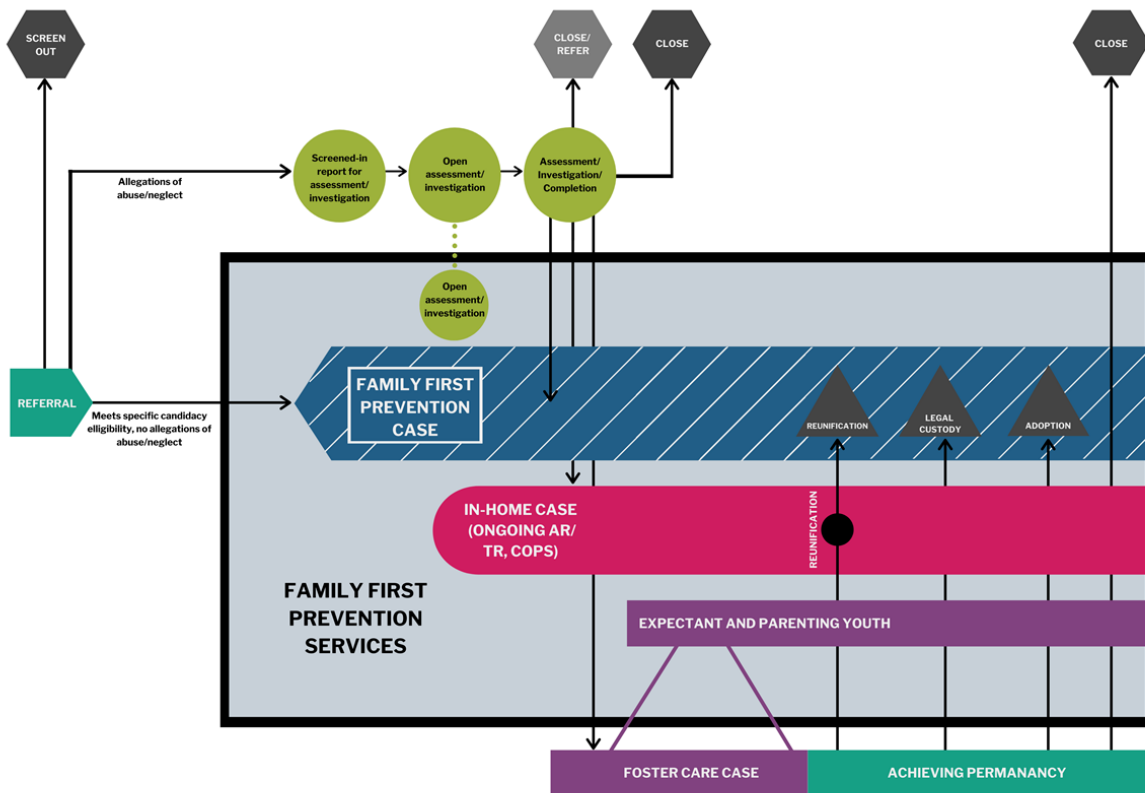
- A child who has an open in-home children's services case and is receiving services. This includes the following types of open in-home cases: court ordered protective supervision, voluntary cases, children with an in or out of home (including with kinship) safety plan, and children who are involved in multiple systems including juvenile justice, behavioral health, and developmental disabilities.
- Infants with an inadequate plan of safe care in accordance with CARA who have been screened-in at the hotline and have assessed safety and risk concerns/identified for Family First services by the Title IV-E Agency.
- Siblings and other children in the home of a child in foster care who are: 1) living with the parent who the child in foster care was removed from, and 2) there is an open case with a goal of reunification for the child who is in foster care with the removal parent.
- Siblings and other children in the home of a child who has experienced a screened in fatality with a substantiated or indicated report disposition and has had an assessment of safety and risk completed with identified concerns are eligible for Family First services by the Title IV-E Agency.
- Siblings and or the child and siblings of a child who has experienced a screened in near-fatality who has a substantiated or indicated report disposition and has had an assessment of safety and risk completed with identified concerns are eligible for Family First services by the Title IV-E Agency.
- Children who have discharged from Public Children Services Agency (PCSA) custody and achieved permanency, including with a relative, within the last 12 months and the parent/caregiver agrees to ongoing services.
- Children who have been adopted within the last 12 months and an assessment of safety and risk has indicated concerns are eligible for Family First services by the Title IV-E Agency.
- Children who are at-risk of experiencing a dissolution of an adoption.
- Pregnant and parenting youth in foster care, including those who are in extended foster care.

## Eligibility Determination and Case Flow

Family First requires the children’s services agency determine a child’s eligibility for services and monitor their risk and safety while receiving services to prevent them from entering foster care. Ohio engaged key subject matter experts to help in identifying, assessing, linking, and providing ongoing support and supervision to children who are candidates and their families.<sup>1</sup>

The goals in creating a case flow process include:

- Developing a new, less intrusive way to provide services to families in need.
- Connecting families to services earlier.
- Developing better quality services and real preventative service delivery.
- Creating a structure where case workers have support from someone with lived experience to help improve engagement with families and ensure enhanced linkages to services.



## Monitoring Child Safety & the Child Specific Prevention Plan

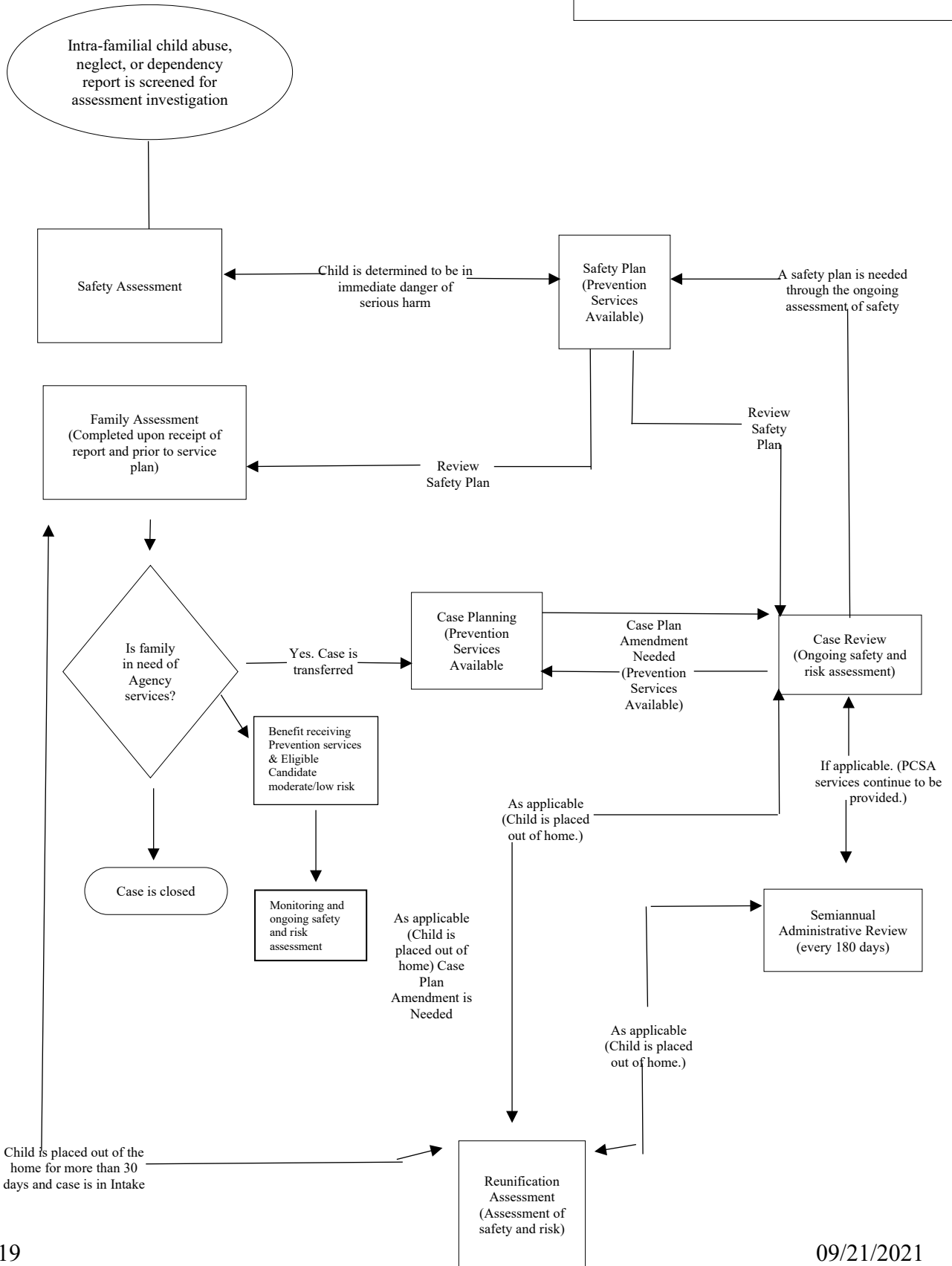
<sup>1</sup> Of note, pregnant and parenting youth in foster care are also eligible to receive prevention services through FFPSA however the process for identification, linkage to services, and monitoring of risk and safety are already included within Ohio’s current practice.

### **Assessment of Risk Plan and Monitoring Child Safety**

Decisions regarding child safety and risk of maltreatment, family functioning, and a family's ability to resolve concerns have profound consequences for the family system. The assessments contained in the Comprehensive Assessment Planning Model – Interim Solution (CAPMIS) offer Ohio's caseworkers a structured process to support and document critical decisions involving children and their families. Using the CAPMIS model, a child specific prevention plan may include a safety assessment, a safety plan, a family assessment, and a family case plan.

The following chart depicts the relationship of the CAPMIS tools within Ohio's child protective services case flow from the time a report is screened in by a Public Children Services Agency (PCSA) throughout the provision of ongoing services.

Comprehensive Assessment Planning Model- I.S.  
(CAPMIS)



The following provides a description and purpose of each CAPMIS tool.

- A **Safety Assessment** is conducted in response to a child abuse and/or neglect report, a dependency report, or any other instances in which safety needs to be assessed throughout the life of a case. The assessment of safety and the decision-making process is documented in the Safety Assessment tool and is a point in time documentation of safety. The completed Safety Assessment tool documents the evaluation of signs of present danger, history, child vulnerability, and adult protective capacities to determine the most appropriate safety response.
- A **Safety Plan** is implemented immediately when the assessment of safety determines a child needs immediate protection. The Safety Plan is a specific and concrete strategy for protecting a child from immediate, serious harm by controlling active safety threats.
- The **Family Assessment** assists workers in assessing risk and identifying the strengths and needs present in the family system to inform case outcome decisions and what service needs may be present. The Family Assessment is conducted in response to a child abuse and/or neglect report or dependency report. The Family Assessment includes a safety review, a description of child harm, strengths and needs assessment, a description of the family's perception, an actuarial risk assessment, and service planning recommendations. The family assessment contains both a clinical and actuarial risk assessment. The actuarial risk assessment is a research-based structured decision-making tool identifying the likelihood of future child maltreatment in the family system. Ohio's Family Assessment utilizes the actuarial risk assessment tool to assign a risk level for the family and provides recommendation for service provision post assessment/investigation.
- A **Family Case Plan** is a comprehensive action plan for services and activities to affect behavioral change in the family to reduce risk contributors, enhance adult family members' protective capacities, reduce risk of maltreatment, and strengthen family functioning. The Family Case Plan identifies a goal for the family.
- A **Case Review** assists caseworkers in reviewing the degree to which case plan services have led to desired case outcomes, and decision-making regarding the status of the case. The services and activities identified in the Family Case Plan are designed to address the causal and/or contributing factors that must be reviewed to determine if services are having the anticipated impact on identified concerns. The Case Review is a re-examination of safety, strengths, needs, risk, and a discussion of the impact service provision has on the family system.
- A **Semiannual Administrative Review** contains a case progress review, child well-being assessment, review of independent living services, review of substitute care, protective supervision, in-home supportive services issues, review of permanency planning, and a review of permanency goal status.

- A **Reunification Assessment** helps caseworkers make decisions of whether, when, and how to reunite children with their families. The Reunification Assessment includes a review of the original and any subsequent safety threats, and an assessment of the family's readiness for reunification. The Reunification Assessment also guides caseworkers in identifying potential changes in family dynamics that may occur should a child be returned and assists the worker in planning with the family how to address changes and challenges inherent in reunifying a child with his/her family.
- A **Specialized Assessment/Investigation Tool** assists worker in capturing the investigative requirements for investigations involving out-of-home care child abuse and/or neglect, involving out-of-home care settings, and involving an alleged perpetrator who has access to the child by virtue of his/her employment or affiliation with an institution. An assessment of safety has been included to help evaluate safety threats and safety responses in out-of-home care settings.

Ohio will weave Family First into the existing case flow structure utilizing the existing CAPMIS tools while capitalizing on SACWIS functionality in the determination of eligibility, consistent assessment of safety and risk, service planning and review. It is important eligibility determination and re-determination occur seamlessly for families and casework staff alike. Upon determination of an eligible candidate, approved evidence-based practice services will be available to the family regardless of where the family's case is in the child protective services continuum.

Families can be served with Prevention Services through the existing Ongoing case category or the new Prevention Services case category. The Ongoing case category utilizes the Family Case Plan and the Prevention Services case category utilizes the Prevention Services Plan.

The provision of prevention services is currently accessed and provided through the CAPMIS Family Case Plan or Prevention Services Plan. Families receiving prevention services through either category have had a Family Assessment completed prior to the development of the Family Case Plan or Prevention Services Plan. The Family Assessment includes an assessment of safety, an actuarial assessment of risk and a clinical assessment of risk. All Family Case Plans and Prevention Services Plans are reviewed every 90 days through the CAPMIS Case Review and Prevention Plan Review respectively. The Case Review contains an assessment of safety, assessment of risk and a review of the services. The identified evidenced-based practice services will be an addition to the service selection and can be added to either the family's case plan or Prevention Services Plan. The existing process will remain primarily unchanged but evidence-based practice services may now be offered for family members when children are able to remain safely within the family or kinship environment and reimbursed through the Title IV-E program.

PCSAs are not permitted to close a case with an open safety plan. A safety plan is implemented to control an active safety threat to a vulnerable child when it cannot be mitigated by the caregiver's protective capacities. A safety plan can be developed and implemented at any point across the continuum of child protective services. When a safety plan exists post the completion of the assessment/investigation, typically 45-60 days post the date the report was screened in, the family case plan is required to be developed and implemented with the family. The safety plan is actively implemented in tandem with the family case plan for the duration that an active safety threat is

present and cannot be controlled by the caregiver's protective capacities. The family case plan identifies and activates services for the family to impact behavioral change of household members. The family case plan addresses the risk factors for the family, while the safety plan controls the active safety threat. Families with an active safety plan must be served in the Ongoing case category. Families being served in the Prevention Services case category will be transferred to the Ongoing case category if a safety plan is implemented; however, the provision of prevention services will continue.

County PCSAs will determine eligibility for the provision of prevention services by completing an assessment. Upon completion of the assessment, and determination of eligibility for candidacy, the family may be offered approved evidence-based practice services through a prevention services plan. The prevention services plan will be developed with the family and include the most fitting evidence-based practice services to meet their specific needs. The prevention services plan must contain at least one approved evidence-based practice service. The prevention services plan will be able to assist in working with families that do not need more intensive ongoing voluntary services but would benefit from service interventions which would assist the family's needs. Families served in the Prevention Services case category through a prevention services plan will have monitoring requirements and regulatory review.

The PCSA is required to have at least one face to face contact with each parent, guardian, or custodian and child involved in the Prevention Services Plan every other month in the child's home. During contact the PCSA is to: assess child safety; review the Prevention Services Plan; obtain the family's perception and experiences with the service provider; and determine if there are any desired changes to the service plan. The PCSA is also required to have minimum monthly contact with each service provider involved in the Prevention Services Plan. During monthly contact the PCSA is to obtain actions and activities completed by the provider and the family; desired service outcomes and progress of the family; presenting concerns regarding child safety within the family; and changes to the provider's service plan delivery.

The PCSA is responsible for the ongoing assessment of safety and risk through the provision of prevention services to a family. The caseworker is responsible for the ongoing assessment of safety and implementing a safety plan if an active safety threat exists during the provision of services. If a voluntary safety plan is implemented or a court order of protective supervision is requested by a PCSA for a case assigned to the Prevention Services case category, the case category must be transferred to the Ongoing case category. The monitoring and visitation requirements of a Safety Plan or court interventions are best supported through the Ongoing case category.

Ohio is primed for the provision of prevention services through Family First. Eligible candidates for services are currently received through the PCSA via a screened in report and receive a completed assessment of safety and risk. Ohio's vision for the provision of prevention services is to be seamless throughout the continuum of children's services for eligible candidates while easily accessed by casework staff and families. Prevention services will be provided to eligible candidates regardless of the initial intake type categorization or pathway assignment in Ohio's Differential Response system. Eligible candidates receive services post the assessment of safety and risk and through ongoing service planning tools.

The provision of prevention services in Ohio will be implemented with pensive programmatic design and implementation. The diversity in service availability, as well as the provision of services to families among county PCSAs, requires a staged approach to best assist each county in cultural change as Ohio forges ahead with the implementation of Family First to successfully attain long term goals and successful outcomes. The provision of prevention services will shift Ohio's children's services culture in providing eligible services to moderate and low risk families which have historically been closed/referred for services post assessment, but from our data review show they are coming back to the attention of children's services. PCSAs who have work capacity and service availability will have the opportunity to opt into the provision of prevention services to families. Ohio plans to incorporate a staged implementation in the provision of prevention services. PCSAs will be able to access eligible services for identified candidates to the current population of families being served by children's services, which will achieve a long-term goal of consistent service availability to be implemented and provided statewide. Provision of services to families currently receiving services will be about a shift in how workers serve families.

Effective relationships and processes between PCSAs and service providers within each county must be established to implement a seamless structure to serve children who are receiving ongoing services with Family First funding. The COE vendor will assist PCSAs in identifying available service providers, building capacity for evidence-based practice services, and providing training.

Planning and development of the existing Comprehensive Assessment and Planning Model – Interim Solution (CAPMIS) tools will continue while being mindful of impacts to the Family First initiative. The CAPMIS tools will be enhanced to further engage casework staff in critical thinking when conducting assessment and service planning which will include revisions to the Actuarial Risk Assessment. Collaboration has begun by developing an internal workgroup to continue with revisions to the Safety Assessment. This will include Ohio continuing to collect and review in depth data regarding cases that are “closed” and “closed and referred to community services.” Once the internal workgroup convenes, the plan will be to collaborate externally with PCSAs to receive additional recommendations for the tool enhancements. Training, technical assistance services and community relationships being established are imperative in order to best support serving families identified as needing further services but are not currently receiving voluntary PCSA services.

## **Title IV-E Prevention Services (Service Description and Oversight)**

### **Evidence-Based Practice Service Array**

The programs that are included in Ohio's Title IV-E Prevention Plan were chosen based on the quantitative data highlighting the identified needs of Ohio's children and families, including expectant and parenting youth in foster care, as well as quantitative data from community members and providers. To ensure a robust decision-making process, the Prevention Subcommittee workgroups and the Prevention Subcommittee conducted a scan of existing programs in Ohio, as well as reviewed those programs that had been rated in the Title IV-E Clearinghouse but are not currently available in Ohio. Members of the Prevention Subcommittee and associated workgroups reviewed data from multiple sources including SACWIS, Behavioral Health Juvenile Justice



(BH/JJ) Initiative, ODH, Family and Children First Councils, the Cuyahoga County Division of Children and Family Services Quality Improvement Center for LGBTQ2S project, and KINNECT.

This included statewide data on:

- The demographics of candidate children and families, including those who return home within the first 90 days or entry into care
- Overlap with other systems (including BH/JJ)
- Child needs
- Parent needs
- Kinship caregiver needs
- Services currently provided across the state and funded by multiple agencies including ODJFS, Family and Children First Councils, the Ohio Children’s Trust Fund, ODH, BH/JJ, the Ohio Commission on Fatherhood.

In a review of over 73,000 cases, Ohio broke down the top child and family needs found in the case review. A summary of these needs is below.

	Adult: Cognitive Abilities	Adult: Physical Illness	Child: Emotional Behavior	Adult: Emotional/Mental Health Illness	Adult Domestic Violence	Adult: Substance Abuse	Adult: Stress	Adult: Parenting Difficulties	Adult: Victim of Abuse	Adult: Caretaker Abuse	Child: Physical Cognitive Social Difficulties	Number of Cases
Percent of Cases	10%	17%	47%	38%	37%	39%	36%	40%	25%	36%	37%	
Total Cases	7,363	12,111	34,036	27,919	27,303	28,484	25,987	29,453	18,435	26,485	27,351	73,179

The top child and family needs identified were Child: Emotional Behavior, Adult: Parenting Difficulties, Adult: Substance Use, and Adult: Emotional/Mental Health Illness.

Based on this in-depth review, the Prevention Subcommittee identified over 40 programs that had demonstrated, through quantitative and qualitative data, to be effective in meeting the identified needs of candidate children, their caregivers, and/or expectant and parenting youth in foster care.

The long-term goal is to include as many of these programs as necessary to comprehensively meet the needs of all candidate children, their caregivers and expectant and parenting youth. However, Ohio recognizes the need to utilize a phased approach to implementation. Therefore, in order to maximize the ability to implement effective prevention services timely, the state assessed the initial list of over 40 programs based on the following questions:

- Is there existing capacity in Ohio to provide this service to children and families?
- Is this evidence-based practice currently rated/undergoing a review for rating in the Title IV-E Clearinghouse?
- Are there current resources available in the state or under contract by the state to provide training in order to increase service capacity?
- If the program is currently being implemented in the state, are tools in place to ensure fidelity?

- If the program is currently being implemented in the state, are tools in place to evaluate the outcomes?
- How is the program currently being financed?

Based on data gathered in response to these guiding questions and ongoing conversations with partner agencies on the Executive Team, ODJFS decided to move forward with a phased approach. The programs Ohio has included in its Title IV-E Prevention Plan are an array of evidence-based practices that will ensure services are available to meet the needs of adolescents, young children and parents and that Ohio has the flexibility to invest in programs that meet their community's needs. The programs identified below will also maximize Ohio's ability to draw down federal dollars for prevention activities while the state continues to leverage other funding sources (i.e. ODM, ODH, OhioMHAS, ODYS and local levy funds) to support additional therapeutic interventions (i.e. Trauma-Focused Cognitive Behavioral Therapy, Parent Child Interaction Therapy, and Child Parent Psychotherapy).

Ohio is seeking approval for Phase 1 services. Phases 2 and 3 are included in this plan for informational and planning purposes only. The chart below indicates the programs Ohio will implement in Phase 1 through this Title IV-E Prevention Plan.

<b>Model</b>	<b>Intervention Type</b>	<b>Target Population</b>	<b>Rating in the Title IV-E Clearinghouse</b>	<b>Child/Adult Needs Addressed</b>
Multisystemic Therapy (MST)	MH/SUD	Youth aged 12-17 who are at risk of out-of-home placement due to delinquent behavior.	Well-Supported	-Child out-of-home placement -Child behavioral and emotional functioning -Child substance use -Delinquent behavior -Adult well-being -Positive parenting practices -Parent/caregiver mental or emotional health -Family functioning
Functional Family Therapy (FFT)	MH	Youth aged 11 to 18 who have been referred for behavioral or emotional problems.	Well-Supported	-Child behavioral and emotional functioning -Child substance use -Delinquent behavior -Family functioning
START	SUD	Families with children ages 0-6 struggling with co-occurring child maltreatment and substance use disorders.	Promising	-Child out-of-home placement
Healthy Families America (HFA)	Parenting	Families (during pregnancy or at the time of birth and on) who may have histories of trauma, intimate partner violence, mental health issues, and/or substance use issues. Current eligibility includes families at or below 200% of the Federal Poverty Level (FPL). For HFA sites, in order	Well-Supported	-Child safety -Child behavioral and emotional functioning -Child cognitive functions and abilities -Delinquent behavior -Educational achievement and attainment -Adult well-being -Positive parenting practices

		to enroll families with a baby over 3 months of age, an application will need to be approved through Healthy Families America for the provider to implement the Child Welfare Protocols. This approval will allow Ohio to serve families at or below 200% of FPL with a referral from the local Public Children's Service Agency (PCSA) until the baby is 24 months.		-Parent/caregiver mental or emotional health -Family functioning
Parents as Teachers (PAT)	Parenting	New and expectant parents. Families at or below 200% of the FPL with a baby up to 24 months of age.	Well-Supported	-Child safety -Child social and cognitive functions

Currently, the state has some existing programming for these services and is utilizing Family First Transition Act (FFTA) dollars to enhance capacity across the state. In enhancing and improving capacity for these programs across the state, ODJFS is partnering with other public agencies that are currently supporting these programs to ensure statewide alignment and coordination of service provision, training, fidelity monitoring, and evaluation as appropriate. An example of this is highlighted in Ohio's Early Childhood Home Visiting Program. A collaborative partnership at the federal, state, and community levels, the overall goal of Ohio's Early Childhood Home Visiting Program is to improve child and family outcomes by implementing evidence-based home visiting within the program. The Early Childhood Home Visiting (ECHV) system includes our Central Intake and Referral, Help Me Grow (HMG) Home Visiting, Maternal Infant and Early Childhood Home Visiting Initiative (MIECHV), and Moms and Babies First: Ohio's Black Infant Vitality Program. The ECHV system provides comprehensive health and wellness assessments, linkage and referral to identified community-based supports, and research-informed parenting education curriculum for eligible Ohio families. As lead agency, the Ohio Department of Health (ODH) is charged with execution of the statutory purposes and requirements of the home visiting program. Beginning in 2013, the Ohio ECHV program implemented three evidence-based home visiting models: Healthy Families America (HFA), Nurse-Family Partnership (NFP), and Parents as Teachers (PAT). Model developers provide detailed guidance, resources, technical assistance and oversight to ensure service delivery meets program model fidelity requirements. Ohio ECHV staff coordinate with NFP and PAT National Service Office (NSO), and Healthy Families America (HFA) Central Office staff to complement and not duplicate quality assurance monitoring processes; thereby, achieving effective use of resources.

As Ohio moves forward with implementation of prevention services through Family First, the state is committed to continuously reviewing data regarding the needs of candidate children and their caregivers and the services newly rated on the Title IV-E Clearinghouse so that additional programs can be added to Ohio's Title IV-E Prevention Plan. Currently in Ohio's system, services are delivered within a trauma-informed framework and Ohio will continue to ensure this through training and contracts with community-based providers.

## **Evaluation and Continuous Quality Improvement (CQI) Strategy**

Family First requires that each program in the Prevention Plan have a well-designed and rigorous evaluation strategy, unless a state is granted a federal waiver of the requirement. Ohio will be introducing evidence-based practices in phases in order to ensure statewide alignment and coordination of service provision, training, fidelity monitoring, and evaluation as appropriate. Ohio is currently only seeking approval for Phase 1 services.

Ohio worked across child serving agencies to develop a Center of Excellence (COE) to assist with capacity building, coaching, mentoring, fidelity monitoring and evaluation. The COE launched in early 2021 and will be used for all services thereafter. Case Western Reserve University's Center for Innovative Practices has been selected and Ohio has begun work with the vendor.

The COE will create a cross-system, cross-agency effort with a focus on expanding the continuum of care and building service capacity to serve Ohio's highest need children and youth; modernizing the way care is delivered for these children and youth, prioritizing young people in the custody of children's services; and preventing custody relinquishment.

This vendor will be responsible for building and maintaining capacity for the EBPs in Phase 1, fidelity and evaluation monitoring, processing Transition Act payments to EBP providers, and providing training and technical assistance. Ohio is confident that work with this vendor will strengthen the Prevention Services work and our cross-system collaboration efforts. Data gathered by the COE will be used as part of the CQI process described below. The COE is currently focused on services in Phase 1 and future contract renewals may include services in future phases. ODJFS is also working with ODH to integrate and coordinate our efforts around Healthy Families America and Parents As Teachers to ensure monitoring and compliance.

Ohio is tracking fidelity measures and continuous monitoring outcomes to ensure each EBP is meeting ongoing fidelity and showing desired results for the children and families served. These measures and data will be a part of the ongoing CQI process and feedback loops.

Program	Fidelity Measures	Continuous Monitoring Outcome Measures	Data Collection	Domains
MST	<ul style="list-style-type: none"> <li>-Staff qualifications</li> <li>-Staff successful completion of required model training</li> <li>-24-hour availability</li> <li>-Services provided in family's home or other places convenient to the family</li> <li>-Services are intensive, with intervention sessions being conducted from once per week to daily</li> <li>-Caseload limit: maximum six families per therapist at one time, 12-15 families per year per therapist</li> <li>-Case length: three to five months</li> <li>-TAM-R (Therapist Adherence Measure-Revised)</li> <li>-SAM (Supervisor Adherence Measure)</li> <li>-Required and recommended MST program practices</li> </ul>	<ul style="list-style-type: none"> <li>-Eliminate or significantly reduce the frequency and severity of the youth's referral behavior(s)</li> <li>-Empower parents with the skills and resources needed to: <ul style="list-style-type: none"> <li>• Independently address the inevitable difficulties that arise in raising children and adolescents</li> <li>• Empower youth to cope with family, peer, school, and neighborhood problems</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>-TAM-R completed by one caregiver from each family monthly (target 70% of TAMs due are completed) and entered into MST Institute's (MSTI) secure website</li> <li>-SAM completed by each therapist every other month and entered into MSTI's secure website</li> <li>-Case discharge form completed by MST Therapist in collaboration with MST Supervisor &amp; Consultant and entered into MSTI</li> <li>-Program Review form completed by supervisor in consultation with consultant every 6 months</li> <li>-Program Implementation Review (is a detailed report written by MST Consultant and Supervisor every 6 months that reports on the fidelity, program practices and outcomes) and is shared with program administrators and external stakeholders such as referral sources and funders.</li> </ul>	<ul style="list-style-type: none"> <li>-Child out-of-home placement</li> <li>-Child behavioral and emotional functioning</li> <li>-Child substance use</li> <li>-Delinquent behavior</li> <li>-Adult well-being</li> <li>-Positive parenting practices</li> <li>-Parent/caregiver mental or emotional health</li> <li>-Family functioning</li> </ul>
FFT	<ul style="list-style-type: none"> <li>-Staff qualifications</li> </ul>	<ul style="list-style-type: none"> <li>-Eliminate youth referral problems (i.e.,</li> </ul>	<ul style="list-style-type: none"> <li>-Completion rates collected via Global Therapist Rating (GTR)</li> </ul>	<ul style="list-style-type: none"> <li>-Child behavioral and emotional functioning</li> </ul>

	<ul style="list-style-type: none"> <li>-Staff successful completion of required model training</li> <li>-Frequency and number of sessions/progress notes</li> <li>-Family Self Report (FSR) and Therapist Self Report (TSR)</li> <li>-Client Outcome Measure-Caregiver and Youth version (COM-Y, COM-C)</li> <li>-Therapist Outcome Measure (TOM)</li> <li>-Rate of staffing and consultations with supervisors</li> <li>-Global Therapist Rating (GTR)</li> <li>-Fidelity and Dissemination Adherence</li> <li>-Family, client, and therapist exit survey</li> <li>-Length of treatment: 3-5 months</li> <li>-Caseloads: goal no less than 5 cases, no more than 15</li> <li>-Weekly sessions that vary in length and frequency depending on risk factors</li> </ul>	<ul style="list-style-type: none"> <li>delinquency, oppositional behaviors, violence, substance use)</li> <li>-Improve prosocial behaviors (i.e., school attendance)</li> <li>-Improve family and individual skills</li> <li>-Increase youth remaining in a community setting</li> </ul>	<ul style="list-style-type: none"> <li>and the TriYearly Performance Evaluation (TYPE)-or custom reports as needed</li> <li>-Rates of meetings and number of sessions tracked in custom reports and TYPE</li> <li>-Rate of staffings is in the TYPE and can be pulled in a customized report</li> <li>-GTRs are done every 4 months</li> </ul>	<ul style="list-style-type: none"> <li>-Child substance use</li> <li>-Delinquent behavior</li> <li>-Family functioning</li> </ul>
START	<ul style="list-style-type: none"> <li>-START certification and recertification every 3 years by CFF to include certification of the state</li> </ul>	<ul style="list-style-type: none"> <li>-Reduce parental substance abuse</li> <li>-Reduce out-of-home placements</li> </ul>	<ul style="list-style-type: none"> <li>-OSU Needs Portal and Dashboard</li> </ul>	<ul style="list-style-type: none"> <li>-Child out-of-home placement</li> </ul>



	<p>infrastructure (PCSAO) and local jurisdiction fidelity of the essential components (PCSAO monitoring START counties).</p> <p>(*see Appendix C for the Executive Summary of the Certification Process and Essential Components and Fidelity Standards)</p>	-Reduce child maltreatment	**Currently in early discussions to identify and plan for SACWIS enhancements to streamline data collection needs for long term sustainability.	
HFA	<ul style="list-style-type: none"> <li>-Staff qualifications</li> <li>-Staff successful completion of required model training</li> <li>-Reflective supervision</li> <li>-Consistent use of family-centered assessment</li> <li>-Consistent documentation of parent goals</li> <li>-Consistent use of standard curriculum and visit plans</li> <li>-Visit completion rate</li> </ul>	<ul style="list-style-type: none"> <li>-Increase parent knowledge of early childhood development and improve parenting practices</li> <li>-Provide early detection of developmental delays and health issues</li> <li>-Prevent child abuse and neglect</li> <li>-Increase children's school readiness and school success</li> </ul>	-The Ohio Department of Health collects assessment, visit completion rate, family goal planning and referral data through the OCHIDS system	<ul style="list-style-type: none"> <li>-Child safety</li> <li>-Child behavioral and emotional functioning</li> <li>-Child cognitive functions and abilities</li> <li>-Delinquent behavior</li> <li>-Educational achievement and attainment</li> <li>-Adult well-being</li> <li>-Positive parenting practices</li> <li>-Parent/caregiver mental or emotional health</li> <li>-Family functioning</li> </ul>
PAT	<ul style="list-style-type: none"> <li>-Staff qualifications</li> <li>-Staff successful completion of required model training</li> <li>-Reflective supervision</li> <li>-Consistent use of family-centered assessment</li> </ul>	<ul style="list-style-type: none"> <li>-Increase parent knowledge of early childhood development and improve parenting practices</li> </ul>	The Ohio Department of Health collects screening and assessment, visit completion rate, family goal planning and referral data through the OCHIDS system	<ul style="list-style-type: none"> <li>-Child safety</li> <li>-Child social and cognitive functions</li> </ul>

	<ul style="list-style-type: none"> <li>-Consistent documentation of parent goals</li> <li>-Consistent use of standard curriculum and visit plans</li> <li>-Visit completion rate</li> </ul>	<ul style="list-style-type: none"> <li>-Provide early detection of developmental delays and health issues</li> <li>-Prevent child abuse and neglect</li> <li>Increase children's school readiness and school success</li> </ul>		
--	---	---	--	--

## Phase 1

Five evidence-based practices will be utilized as part of Phase 1 of Family First implementation. Four of the five practices are rated as well-supported on the Title IV-E Prevention Services Clearinghouse. The chart below lists the five Phase 1 services.

<b>Evidence-Based Practice</b>	<b>Current Rating</b>
Multi-Systemic Therapy	Well-Supported
Functional Family Therapy	Well-Supported
START	Promising
Healthy Families America	Well-Supported
Parents as Teachers	Well-Supported

Ohio is requesting an evaluation waiver for the four well-supported programs for which the State is requesting Title IV-E reimbursement in Phase 1 of implementation. A waiver is permitted for an evidence-based practice designated at the well-supported evidence level by the Clearinghouse if the evidence of effectiveness of the practice is deemed compelling and the continuous quality improvement requirements of Section 471(e)(5)(B)(iii)(II) are met. Ohio is requesting waivers for Functional Family Therapy, Health Families America, Multi-Systemic Therapy, and Parents as Teachers. Upon approval, Ohio will assess program implementation and fidelity through a robust Continuous Quality Improvement (CQI) process through continued work with our Family First Executive agencies and the COE vendor to support fidelity monitoring and CQI.

As will be outlined in more detail later in Ohio's plan, the ODJFS' Office of Families and Children (OFC) has a CQI Advisory Team dedicated to improving outcomes for the children and families served by Ohio's children's services system. The Advisory Team serves as an ongoing leadership forum to provide guidance on Ohio's statewide system of CQI and promotes a sustained focus on advancing practice and improving outcomes for children and families. This team meets on a quarterly basis to review data and information related to statewide children's services practice trends and outcomes and makes recommendations to OFC about potential strategies to improve outcomes and the formation of ad hoc workgroups to address specific CQI topics. This CQI process offers an opportunity to monitor service utilization and capacity among evidence-based practices contained in Ohio's service array.

The COE vendor will be responsible for fidelity monitoring of EBP providers for MST and FFT. As the Ohio MST Network Partner, the COE is fully equipped to monitor fidelity to the model through existing processes. The COE will also work with FFT LLC to share data and reports on fidelity and adherence to FFT in Ohio. Every program implementing MST or FFT is required to submit appropriate information to their respective models. This information is used to inform QI/QA and coaching and consultation activities by the model at the program level. Data from the COE will be shared with ODJFS through a data sharing agreement will be incorporated into the CQI process for each evidence-based practice in Phase 1. The CQI Advisory Team will also utilize data from process and outcome measures to determine what is working well and what adjustments

need to be made. Ohio is committed to making revisions as needed based on data and will provide ongoing feedback to the COE on any adjustments. ODJFS will monitor any adjustments through ongoing review of the data and the CQI process.

As noted in the Title IV-E Prevention Services section above, the Ohio Department of Health is the lead agency for Ohio's Early Childhood Home-Visiting Program which, in 2013, incorporated Healthy Families America and Parents as Teachers into the program's service array. The Ohio Early Childhood Home Visiting (ECHV) program quality assurance monitoring process has two major goals and two components to address these goals. The first goal and component relate to adherence to evidence-based practice model fidelity requirements. Each provider has an agreement with the program model developer to deliver home visiting services that meet model fidelity. Each model developer has guidelines for monitoring provider service delivery and ensuring compliance with model fidelity. The second goal and component of the quality assurance monitoring process is to ensure compliance with Ohio ECHV System state and federal program requirements, including both programmatic and administrative infrastructure components.

In addition to model fidelity reviews conducted, Ohio ECHV has specific programmatic goals and compliance requirements. These goals and requirements are provided in the Health Resources and Services Administration (HRSA), The Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) benchmarks; the HHS Grants Policy Statement, the Provider's agreement; the Ohio ECHV Data Plan, Policies and Procedures; and the ODH Grants Administration Policies and Procedures manual. This quality assurance monitoring process includes four essential areas of operations: program implementation, data collection, administrative, and fiscal requirements. These areas are monitored throughout the year and are included on at least one site visit.

The Ohio Department of Health is the Healthy Families America (HFA) Central Administrative Agency and is responsible for the delivery of policy, training, quality assurance, technical assistance, evaluation, and administrative guidance to the statewide system. Through this role ODH assists sites in meeting the best practice standards. Affiliates for both HFA and PAT are required to complete initial affiliation paperwork, training and annual reports until they go through a rigorous accreditation/Blue Ribbon Quality Endorsement and Improvement process.

The Ohio ECHV programs are relationship-based, culturally sensitive, family-centered, and rooted in trauma-informed principles and practice. Data from ODH will be shared with ODJFS through a data sharing agreement will be incorporated into the CQI process for HFA and PAT. The CQI Advisory Team will also utilize data from process and outcome measures to determine what is working well and what adjustments need to be made. Ohio is committed to making revisions as needed based on data and will provide ongoing feedback to the ODH on any adjustments. ODJFS will monitor any adjustments through ongoing review of the data and the CQI process.

Ohio's CQI process is further outlined below and will be tailored to each of the Phase 1 EBPs. The CQI process will include information from the COE, ODH, and Ohio START to promote

continuous monitoring for all services. The Ohio START fidelity monitoring is outlined in the evaluation plan in Appendix B.

See appendix A for waivers.

## **Phase 1 – Evidenced Based Program Service Descriptions**

### **Multi-Systemic Therapy (MST)**

Multisystemic Therapy (MST) is an intensive family and community-based treatment for serious juvenile offenders with possible substance use issues and their families. The target population is 12 to 17-year-olds who are at risk of out-of-home placement due to delinquent behavior. MST is rated Well-Supported with the Title IV-E Prevention Services Clearinghouse. Ohio has implemented MST in 13 counties thus far, with 14 teams practicing the intervention.

Thirty-eight MST therapists service approximately 335 Ohio youth and families per year. Fidelity data is reported by Ohio’s MST service agencies to the Multisystemic Therapy (MST) Institute. The Center for Innovative Practices (CIP) accesses the fidelity data and provides ongoing coaching to quality assurance adherence thresholds. Additionally, MST supervisors conduct case consultations with MST clinicians to determine adherence, and CIP employs several MST experts that provide ongoing support and training for community MST teams.

Monthly adherence measures are tracked through the MST Institute, including:

- Therapist Adherence Measure (TAM-R)
- Supervisor Adherence Measure (SAM)
- Consultant Adherence Measure (CAM)

The benchmarks above are used to measure adherence to implementation of the MST model at multiple levels. This information, along with global outcomes, is reported to local stakeholders twice yearly (PIR Program Implementation Review). The following is taken from the MST Operational Manual ((MST Services (2018). Multisystemic Therapy® (MST®) Organizational Manual. Charleston, SC: Author, 30-37.) to explain how fidelity is needed on multiple levels of intervention.

*“Research on MST has consistently demonstrated a strong correlation between fidelity to the MST treatment model (i.e., following the principles and processes of MST) and positive client outcomes. The research also suggests that close monitoring of clinical practice is required to assure treatment fidelity. Each organization implementing MST needs to develop a specific strategy to gain and maintain adherence to the model. This strategy should include a variety of elements including task-oriented, on-site MST clinical supervision, continuous training and support for the therapists through weekly consultation and quarterly booster training by MST experts for both therapists and supervisors, measurement of therapists’ adherence to the model, and long-term case outcome-tracking. The following aspects of program implementation can have a substantial impact on fidelity to the MST treatment model:*

***At the clinical level:***

- *Monitoring adherence using the youth's primary caregiver/parent's report should be implemented in all MST programs. In the clinical trials of MST, a high level of adherence by therapists on the Therapist Adherence Measure - Revised (TAM-R) has been correlated with positive long-term case outcomes. The TAM-R and the implementation protocol are available at the MST Institute website, [www.mstinstitute.org](http://www.mstinstitute.org).*
- *MST Therapists must track progress and outcomes on each case weekly by completing MST-specific case paperwork and evaluating progress and outcomes in team MST clinical supervision and MST consultation.*
- *Supervision for MST teams should include weekly team MST clinical supervision (conducted in accordance with the MST Supervisory Manual, Henggeler & Schoenwald, 1998) and weekly consultation. Individual clinical supervision should be minimized and reserved for case crises and individual professional development.*
- *MST Supervisors must be assigned to the MST program a minimum of 50% time per MST team. It is strongly recommended that MST Supervisors be full-time in the role, due to the critical influence of the MST Supervisor on therapist and program adherence, outcomes for families, and overall program health. A single full-time supervisor can supervise two MST teams. It is recommended that supervisors who supervise only one team be assigned to the MST program full-time and carry a reduced caseload. The best workload allocation for MST Supervisory responsibilities varies depending on a number of factors, including the following: size of the team, number of communities served and community stakeholders involved with the team, level of complexity and investment the supervisor will need to dedicate to collaboration with stakeholders, other administrative tasks the supervisor may have, including paperwork and reporting to funders, drive times in the community, typical knowledge and skill level of therapist candidates in the community, and number of hours in a regular work week for the organization. An appropriate rule of thumb is that the supervisor should be able to sufficiently attend to all of their tasks, both clinical and administrative/program management, in their role as MST Supervisor. For additional information reference the [Worksheet for MST Team Supervisor and Organizational Leadership Responsibilities, Salaries, and Time Allocation](#)*
- *MST Supervisors should have both clinical authority and administrative authority (i.e., authority to hire/fire and impact staff compensation) over the MST Therapists they supervise.*
- *Job performance evaluations for MST clinicians should incorporate data regarding adherence and case outcomes.*
- *MST Therapists must operate in teams of at least two and at most four therapists (plus the MST supervisor).*
- *The duration of MST treatment is generally 3 to 5 months.*
- *The average MST caseload should not go below four families or exceed six families per therapist.*

***At the organizational level:***

- *There must be a commitment to implement MST fully within the organization/agency. It is not possible to partially implement MST or to develop an “MST-lite” program. To get positive, long-term outcomes with youth, who have serious antisocial and delinquent behaviors, the implementation of MST has proven to be an all-or-nothing endeavor.*
- *The leadership within the host agency should have sufficient understanding of MST to develop and endorse policies and procedures that encourage adherence by supervisors and clinicians to the MST model.*
- *The MST program must target MST-compatible populations and have clearly defined referral criteria, including both inclusionary and exclusionary criteria.*
- *MST Therapists should be highly motivated mental health professionals with either a master’s degree or equivalent training. The rationale for these recommendations is discussed in the Recruiting, Hiring and Retaining Staff section of this manual.*
- *MST supervisors should have very strong clinical backgrounds in applicable areas (i.e., structural, strategic and functional family therapies, cognitive behavioral techniques, etc.), have strong leadership skills, and be master’s-level professionals. The rationale for these recommendations is discussed in the Recruiting, Hiring and Retaining Staff section of this manual.*

***At the interagency level:***

- *There must be sufficient funding in place to sustain the program.*
- *MST Therapists need to be able to “take the lead” in clinical decision-making for the families they serve, even when personnel from other agencies have mandated involvement with these client families.*
- *MST Supervisors and MST Therapists need to have extensive skills in order to collaborate effectively with staff in other community agencies.”*

Ohio providers wishing to maintain or expand MST services will consider fidelity to the MST programming on all levels in order to ensure positive outcomes for Ohio’s children and families. The positive results research as demonstrated can only be assured when fidelity is maintained on all intervention levels. ODJFS will oversee model fidelity through the contract with the Center of Excellence (COE). Case Western Reserve University (CWRU), the COE vendor, is also the network partner for MST in Ohio. CWRU will monitor fidelity of individual MST providers and provide this information to ODJFS.

Ohio will utilize the MST manual, Multisystemic Therapy for antisocial behavior in children and adolescents (2<sup>nd</sup> ed.) and will not use any adaptations to the MST model (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham (2009)).

**MST Evidence of Effectiveness**

Multiple studies have demonstrated the effectiveness of Multi-systemic Therapy (MST). MST is also included in multiple clearinghouses, including the Title IV-E Prevention Services Clearinghouse and the California Evidence-Based Clearinghouse for Child Welfare. Ohio chose to include MST as the studies and clearinghouse ratings have shown that this would be an effective

practice for our children’s services population. This is supported by the Title IV-E Prevention Services Clearinghouse’s Summary of Findings.

[MST](#) has 85 published outcome, implementation, and benchmarking studies, including 28 randomized trials. Four studies are specific to maltreating families. These studies have shown a reduction of out-of-home placements by a median of 54% across all MST studies.

The review by the Title IV-E Prevention Services Clearinghouse shows that MST had favorable effects on child out-of-home placement, child behavioral and emotional functioning, child substance use, and delinquent behavior. MST also had favorable effects on adult well-being, including positive parenting practices, parent/caregiver mental or emotional health, and family functioning. Unfavorable effects were minimal. These outcomes mirror outcomes that Ohio expects to see in our children’s services population. As noted in the case review data above, Child: Emotional Behavior was present in 47% of cases, Adult: Emotional/Mental Health Illness was present in 38% of cases, and Adult: Parenting Difficulties was present in 40% of cases. MST was also a part of Ohio’s Behavioral Health/Juvenile Justice project. According to the [BH/JJ report](#), youth reported a significant decrease in trauma symptoms, the Ohio Scales indicated that the caregiver, worker, and youth all reported increased youth functioning and decreased problem severity, decreased substance use, and a decrease in youth at risk for out of home placement, from 56% at entry to 25% at termination. The findings from the Title IV-E Prevention Services Clearinghouse are summarized in the table below.

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child permanency: Out-of-home placement	0.24 9	3 (5)	1471	Favorable: 2 No Effect: 3 Unfavorable: 0
Child well-being: Behavioral and emotional functioning	0.22 8	7 (82)	1415	Favorable: 23 No Effect: 58 Unfavorable: 1
Child well-being: Social functioning	0.03 1	4 (14)	1002	Favorable: 0 No Effect: 14 Unfavorable: 0
Child well-being: Cognitive functions and abilities	0.13 5	1 (3)	486	Favorable: 0 No Effect: 3 Unfavorable: 0
Child well-being: Substance use	0.09 3	2 (14)	610	Favorable: 1 No Effect: 13 Unfavorable: 0



Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child well-being: Delinquent behavior	0.27 10	10 (82)	2467	Favorable: 17 No Effect: 62 Unfavorable: 3
Adult well-being: Positive parenting practices	0.12 4	2 (46)	816	Favorable: 12 No Effect: 34 Unfavorable: 0
Adult well-being: Parent/caregiver mental or emotional health	0.29 11	3 (5)	826	Favorable: 3 No Effect: 2 Unfavorable: 0
Adult well-being: Family functioning	0.16 6	4 (21)	912	Favorable: 5 No Effect: 16 Unfavorable: 0

### Functional Family Therapy (FFT)

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 that impact the adaptive development of 11 to 18-year-old youth who have been referred for behavioral or emotional problems. The program is organized in five phases that consist of: (1) developing a positive relationship between therapist/program and family, (2) increasing hope for change and decrease 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. Ohio will utilize the FFT manual, Family Therapy for Adolescent Behavioral Problems, and will not use any adaptations to the FFT model (Alexander, Waldron, Robbins, & Need, 2013).

The California Evidence Based Clearinghouse for Child Welfare (CEBC) identifies the following two primary fidelity criteria for FFT:

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

*Global Therapist Ratings: Three times a year the clinical supervisor rates each therapist’s overall adherence and competence in FFT. The Global Therapist Rating (GTR) allows for the supervisor to provide feedback to the therapist on their overall knowledge and performance of each Phase and general FFT counseling skills. The GTR specifically targets time period measures with the*

*hope of displaying therapist growth. With respect to the GTR, we encourage supervisors to utilize the comments box under each Phase to target specific strengths and specific Phase areas of growth.”*

Ohio’s implementation of FFT will include providers certified by Family Functional Therapy Inc. The providers will ensure that the Weekly Supervision Checklist and Global Therapist Ratings are an integral part of service delivery to Ohio’s families.

FFT is currently utilized by five teams in Ohio, located in Cincinnati, Dayton, Columbus, Bowling Green, and Toledo. Each therapist has the capacity to serve 36 youth per year. Currently quality assurance tools created by the model developer are utilized to monitor fidelity. Model developer QA tools are used to monitor fidelity. FFT may be trained to provide internal QA services for teams. Individual client outcome measures aligned with 3 of 6 MIECH statutorily defined benchmark standards; school/ academic, crime reduction and coordination/ referrals to other community-based services and supports.

ODJFS will oversee model fidelity through the contract with the Center of Excellence (COE). Case Western Reserve University (CWRU), the COE vendor, will continue to partner with FFT LLC to monitor fidelity in Ohio. CWRU will monitor fidelity of individual FFT providers and provide this information to ODJFS.

### **FFT Evidence of Effectiveness**

Multiple studies have demonstrated the effectiveness of Functional Family Therapy (FFT). FFT is also included in multiple clearinghouses, including the Title IV-E Prevention Services Clearinghouse, the California Evidence-Based Clearinghouse for Child Welfare, and the Pew’s Results First Clearinghouse. Ohio chose to include FFT as the studies and clearinghouse ratings have shown that this would be an effective practice for our children’s services population. This is supported by the Title IV-E Prevention Services Clearinghouse’s Summary of Findings.

A randomized control [trial](#) of FFT showed that for therapists with a high adherence to model fidelity, there was a 35% reduction in felonies, 30% reduction in violent crime, and a 21% reduction in misdemeanor recidivisms.

The review by the Title IV-E Prevention Services Clearinghouse shows that FFT had favorable effects on child behavioral and emotional functioning, child substance use, child delinquent behavior, and family functioning. Unfavorable effects were minimal. These outcomes mirror outcomes that Ohio expects to see in our children’s services population. As noted in the case review data above, Child: Emotional Behavior was present in 47% of cases and Adult: Parenting Difficulties was present in 40% of cases. Adult stress was also present in 36% of cases. FFT was also a part of Ohio’s Behavioral Health/Juvenile Justice project. According to the [BH/JJ report](#), youth reported a significant decrease in trauma symptoms, the Ohio Scales indicated that the caregiver, worker, and youth all reported increased youth functioning and decreased problem severity, decreased substance use, and a decrease in youth at risk for out of home placement, from 56% at entry to 25% at termination. The findings from the Title IV-E Prevention Services Clearinghouse are summarized in the table below.

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child well-being: Behavioral and emotional functioning	0.15 6	4 (26)	390	Favorable: 2 No Effect: 23 Unfavorable: 1
Child well-being: Substance use	0.49 18	1 (18)	52	Favorable: 10 No Effect: 8 Unfavorable: 0
Child well-being: Delinquent behavior	0.05 2	5 (20)	8636	Favorable: 2 No Effect: 16 Unfavorable: 2
Adult well-being: Positive parenting practices	0.11 4	2 (9)	163	Favorable: 0 No Effect: 9 Unfavorable: 0
Adult well-being: Family functioning	0.30 11	1 (15)	52	Favorable: 2 No Effect: 13 Unfavorable: 0

**START**

Sobriety Treatment and Recovery Teams (START) is a specialized child welfare service delivery model that has been shown, when implemented with fidelity, to improve outcomes for children and families affected by parental substance use and child maltreatment. The model uses a variety of strategies to promote collaboration and systems-level change within and between child welfare agencies, substance use and mental health treatment providers, the judicial system, and other family-serving entities.

The goals of START are to

- Ensure child safety and well-being
- Prevent and/or decrease out-of-home placements
- Increase parental recovery
- Increase parenting capacity and family stability
- Reduce repeat maltreatment
- Improve system capacity for addressing parental substance use and child maltreatment

START was submitted to the Title IV-E Prevention Services Clearinghouse by Children and Family Futures (CFF) and rated as a promising practice in December of 2020. CFF approved Ohio as a START affiliate and supported the implementation of a START pilot with 14 counties in Appalachian Ohio in 2017.

Ohio has expanded START and is currently being implemented in 52 counties. Each county program employs at least one START caseworker and one START Family Peer Mentor who partner to serve a caseload of 10-12 families. If all 52 counties were serving at full capacity, each county would have one dyad and serve 10-12 families or 520 families at any given time. To date, the program has served 1870 Ohioans and 1044 children.

CFF has been an integral part of the implementation of START in Ohio, providing ongoing support, technical assistance and training to Ohio's team at Public Children Services Association of Ohio (PCSAO). Ohio has the largest approved adaptation of START in that all cases are eligible for START services regardless of the age of the child. However, approximately seventy percent of Ohio's START cases align with START as approved by the Title IV-E Prevention Services Clearinghouse of having at least one child in the family under the age of six. Ohio is requesting approval to seek reimbursement for families with children ages 0-6 through the national START model.

PCSAO has partnered extensively with CFF to design an implementation framework, training and technical assistance structure, and certification processes to ensure model fidelity. Each county START caseworker, supervisor and family peer mentor is required to attend specialized START training. The training program offers four (4) Foundational trainings through partnership with CFF to teach Ohio's START implementors the essential elements of the model and START case management. Ohio's START training also offers core trainings that are required for all members of the local START teams: Intervention of Substance Use Disorders (UNCOPE); Trauma & Resilience; and Family Team Meetings. In addition to the required trainings in Ohio, START provides trainings on related topics that will help to advance practice of the Ohio's START teams such as: Break the Cycle: Understanding and Treating Generational Trauma; Nurturing Parenting; Introduction to Motivational Interviewing; Secondary Traumatic Stress & Provider Resilience; Navigating Relationship Dynamics; and Understanding the Culture of Poverty.

In addition to training, a technical assistance (TA) consultant is assigned to each county with the goal of meeting monthly to create and work through an individualized Implementation Training and Technical Assistance (ITTA) plan. This plan provides information on each required element of the model, the PCSA's status for meeting each element and next steps to work towards reaching element fidelity. PCSAO has partnered with The Ohio State University to create an online data collection system, called the Needs Portal, to collect all data required for model fidelity tracking. OSU has created fidelity reports from the START data dashboard to measure county progress on meeting model fidelity. The dashboard fidelity reports will be issued quarterly and paired with the ITTA plan and TA process to assist each agency in preparing for CFF certification.

Furthermore, START provides program wide TA through monthly coaching and affinity calls, quarterly consortium meetings and an annual summit. During these program-wide meetings, topics of interest for all constituents are discussed. These meetings ensure that all PCSAs are

receiving timely and important information regarding the START model and continue to focus on fidelity. The final portion of the TA infrastructure for Ohio's START is the provision of county-to-county technical assistance. Our county-to-county TA is a great tool for peers to learn from one another.

PCSAO is currently in the process of developing a two-step certification process. First, the state of Ohio will be certified and then individual PCSAs will be certified. Certification will be achieved through collaboration of all Ohio's START partners including the PCSAO, county PCSAs, the Ohio Department of Job and Family Services (ODJFS), and Ohio Department of Mental Health and Addiction Services (OMHAS).

For state certification, Ohio will work closely with CFF to ensure the state infrastructure meets model fidelity in three key areas: state leadership, continuous quality improvement, and competency. START in Ohio will be required to show that it has built a state level leadership infrastructure, has a sufficient program evaluation that measures model fidelity and outcomes, has put into place a case review tool, has training that aligns with the national START manual, provides ongoing TA and coaching and has the capacity to reliably assess fidelity. Ohio is currently working with CFF toward state level certification.

To certify local county PCSAs, the Ohio's START team will first conduct certification side-by-side with CFF to ensure the Ohio START team is reliably assessing fidelity. Once the Ohio team shows interrater reliability sufficient to meet state certification requirements it will then begin to certify PCSAs on its own. Ohio's START certification team will be comprised of several members representing PCSAO, PCSAs, ODJFS and OMHAS. Members of the certification team will be trained in the model by CFF and Ohio's START team. Each member of the certification team will use their expertise to evaluate the PCSA's performance in that specified area. The team will work jointly to combine all individual areas of evaluation to produce the final certification decision. To achieve certification, each PCSA will be required to show their local START program meets model fidelity in each of the essential elements. Certification will last for 3 years at which time each PCSA will be required to undergo a recertification process. Ohio will work to certify up to six counties per year. The county certification process will be ongoing.

In Ohio, START is receiving regular technical assistance meetings with CFF to assist in preparing for START implementation with new counties and in the development of the certification process, TA structures and evaluation processes. In addition, The START statewide structure in Ohio includes a leadership council, and two (2) workgroups focused on guidance related to training and technical assistance and data. All include representation from PCSAO, ODJFS, OMHAS and PCSAs.

In Ohio, START is currently under evaluation by The Ohio State University's College of Social Work and the Voinovich School of Leadership and Public Affairs at Ohio University. The objectives of the current study are to:

- Identify how the START model is implemented in each county and the degree to which counties have implemented Ohio START with fidelity

- Evaluate whether the implementation of START is related to better children’s services outcomes, including not being placed in out-of-home care, less time in foster care, increased reunification rates and fewer re-referrals for children’s services investigation rates



Ohio utilizes the CFF manual for START, Willauer, T., Posze, L., & Huebner, R. A. (Eds.). (2018). *The Sobriety Treatment and Recovery Teams (START) Model: Implementation Manual*. Lake Forest, CA: Children and Family Futures.

See appendix B for a full description of Ohio’s START evaluation plan. In addition, Ohio will assess program implementation and fidelity through a robust Continuous Quality Improvement (CQI) process through continued work with our Family First Executive agencies and the COE vendor to support fidelity monitoring and CQI. The vendor will need to be familiar with and support elements of START ). This will include understanding the program specifications; meeting with existing vendors to understand existing capacity and current fidelity, data collection and evaluation processes; understanding Ohio’s future expansion service capacity in existing county implementation; understanding the ongoing training and technical assistance to ensure quality service provision and best practices in the treatment of substance use disorders; understanding the ongoing support and implementation of CFF’s certification and re-certification requirements; and understanding the family peer mentor certification processes to enhance Ohio’s capacity for billable Medicaid services.

**START Evidence of Effectiveness**

The review by the Title IV-E Prevention Services Clearinghouse shows that START had favorable effects on child permanency: out-of-home placement. Unfavorable effects were minimal. These outcomes mirror outcomes that Ohio expects to see in our children’s services population. As noted in the case review data above, Adult: Substance Abuse was present in 39% of cases. Adult: Emotional/Mental Health Illness was also present in 38% of cases. Ohio’s START [Impact Report](#) also shows that the average adult trauma score for adults in Ohio START is four times the national average. All START participants in Ohio are screened because of the link between trauma and substance abuse. The findings from the Title IV-E Prevention Services Clearinghouse are summarized in the table below.

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child safety: Child welfare administrative reports	-0.08 -3	1 (2)	134	Favorable: 0 No Effect: 2 Unfavorable: 0

Outcome	Effect Size and Implied Percentile Effect  	N of Studies (Findings)	N of Participants	Summary of Findings
Child permanency: Out-of-home placement	0.51 19	2 (2)	992	Favorable: 1 No Effect: 1 Unfavorable: 0

**Healthy Families America (HFA)**

Healthy Families America (HFA) is a home visiting program model designed to work with families who may have history 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. Goals of the program are to 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, and enhance family functioning by reducing risk and building protective factors. HFA has been implemented in all regions of Ohio (Central, Eastern, Great Lakes, Northeast, Northwest, Southeast, Southwest, Western).

Currently 73 counties have the capacity to serve approximately 6,900 families. The Ohio Department of Health (ODH) is currently creating an HFA Multi-Site Accreditation which designates the agency as the entity to manage, monitor and train on model fidelity for all HFA sites in Ohio. HFA will complete a site visit in Ohio every five years and will include 30% of Ohio sites in the model fidelity review. Additionally, ODH reviews HFA required spreadsheets on a monthly basis and completes an annual review of all performance standards for each site. As part of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) monitoring process, ODH must demonstrate a monitoring process is in place and that there is documentation of the provider meeting model fidelity and affiliation expectations. There are currently 24 counties with HFA MIECHV funded slots through 18 agencies.

Additionally, ODH uses funding to support training for each new staff person, requires ACEs training as part of the credentialing process, requires completion of Joyful Together curriculum, and all home visitors are required to be credentialed.

Ohio will utilize the HFA Best Practice Standards, Healthy Families America. (2018) *Best practice standards*. Prevent Child Abuse America, and is working to implement the Child Welfare Protocols.

The HFA Best Practice Standards outline HFA model fidelity requirements. These standards are focused on twelve research-based elements that form the foundation of the HFA model. Each element includes policies, procedures, and practices to clearly outline implementation to HFA sites. Sites are expected to implement a continuous quality improvement process around these elements and regularly participate in HFA’s Accreditation process.

As outlined in the HFA Best Practice Standards, HFA sites are committed to providing high quality home visiting services and demonstrating model fidelity. Model fidelity is monitored through ongoing quality assurance and periodic Accreditation site visits. HFA sites are also expected to engage in continuous quality improvement processes. Each standard is evaluated to ensure model fidelity.

ODJFS will oversee model fidelity through an existing data sharing agreement with the Ohio Department of Health (ODH). This data sharing agreement will be reviewed regularly to ensure all necessary data is included for fidelity monitoring. ODH is the network partner for HFA in Ohio. ODH will monitor fidelity of individual HFA providers, in conjunction with HFA Accreditation process, and provide this information to ODJFS.

### **HFA Child Welfare Protocols**

Ohio is in the process of expanding HFA eligibility through the Child Welfare Protocols. ODJFS and ODH are working closely together on this expansion. A [Fact Sheet](#) from Healthy Families America on the Family First Prevention Services Act outlines eight studies that show that HFA has early impacts on child maltreatment prevention for children ages 1 to 3, which would include the population Ohio plans to serve through the Child Welfare Protocols. These outcomes include fewer substantiated reports with families who engage in services, fewer hospitalizations for child abuse, and less emotional and physical abuse, neglect, and harsh discipline. A study also showed that school age children of young, first time moms who enrolled in HFA early in pregnancy were 49% less likely to experience an indicated Child Protective Services (CPS) report. It also showed that HFA prevents the recurrence of maltreatment by one third in families with prior CPS involvement.

Implementation of the Child Welfare Protocols includes the use of the Best Practice Standards, with programs giving special consideration to additional professional development needs home visiting staff may have in order to best support families involved in the child welfare system, and potential case load capacity as family needs may be more intensive. HFA provides sites with extra technical assistance to support community level work with child welfare referred families. The model's original design allows for programs to offer services up to the time the child is five years of age, thus this age group is currently included in the rigorous evaluations leading to the well-supported rating by the Title IV-E Clearinghouse. Implementation of the Child Welfare Protocols will allow for the expanded enrollment criteria for children up to 24 months. HFA providers are accredited by the national office and will follow the Best Practice Standards related to enrollment, eligibility, and implementation. Additional information on HFA's Child Welfare Protocols can be found in appendix D.

This evidence shows that expanding Ohio's HFA offerings to children up to 24 months would allow more families to benefit and would support Ohio's Prevention Services goals. Traditional HFA eligibility only allows families to begin receiving services if identified before the child is three months old. Families may not come to the attention of children's services during the traditional eligibility window, and expanding that eligibility for families in our system could prevent future recurrence.



In the HFA Ohio: Voluntary Home Visiting and Parent Education fact sheet, HFA reports 49% fewer substantiated child protective service reports among young, first-time moms who enrolled early in pregnancy with children between 5-7 years old, a reduction in the recurrence of maltreatment by one third, and more positive discipline with less yelling and less physical punishment. In 2019, HFA served 7,346 families in Ohio and found that 4,073 of those families scored at risk for child abuse and neglect.

As noted in the case review data above, Child: Emotional Behavior was present in 47% of cases, Child: Physical Cognitive Social Difficulties were present in 37% of cases, Adult: Emotional/Mental Health Illness was present in 38% of cases, and Adult: Parenting Difficulties was present in 40% of cases. Adult stress was also present in 36% of cases. This data shows that the HFA child welfare protocols will meet some of the top child and family needs identified in Ohio's children's services population through a review of over 73,000 cases. More detail on how HFA's child welfare protocols will meet the needs of Ohio's children and families is outlined below.

### **HFA Evidence of Effectiveness**

Multiple studies have demonstrated the effectiveness of Healthy Families America (HFA). Ohio chose to include HFA as these studies and Title IV-E clearinghouse rating have shown that this would be an effective practice for our children's services population. This is supported by the Title IV-E Prevention Services Clearinghouse's Summary of Findings.

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

Healthy Families New York (HFNY) completed a [randomized trial](#) to evaluate the effects of Healthy Families America on parenting behaviors. The study had a sample of 1173 families at risk for child abuse and neglect, randomly assigning them to either the intervention group or control group.

Mothers utilizing HFA reported one-quarter as many acts of serious abuse at age 2 as the control mothers. First time mothers receiving HFA were less likely to engage in minor physical aggression and harsh parenting. HFA mothers were also one-quarter as likely to report engaging in serious abuse and neglect as control mothers.

Another randomized control [study](#) on HFNY looked at the effectiveness of HFA in promoting parenting competencies and preventing maladaptive parenting behaviors in mothers at risk for child abuse and neglect. This study focused on mothers and children in their third year of life. The study found that HFA "was successful in promoting positive parenting among mothers at risk for child abuse and neglect, which may reflect the program's strength-based approach." It also showed a decrease in harsh parenting, preventing the initiation of child abuse and neglect.

A randomized control [trial](#) of HFA included mothers who had at least one substantiated child protective services report within five years prior to enrolling into the HFA program. During the

time between the child’s fourth and seventh birthdays, the rates of additional CPS reports increase more slowly for the parents participating in the HFA program. By the child’s seventh birthday, mothers in the HFA group were half as likely as the control group mothers to be confirmed subjects for physical abuse or neglect. Over time, the recurrence of maltreatment was found to steadily reduce for the mothers participating in the HFA program. The use of the HFA model was also found to significantly lower the rate of child welfare services related to foster care placement. This study supports the extension of the program to those families that are involved in the child welfare system.

A fourth randomized control [trial](#) on HFA was conducted with 704 first time mothers. Of the 52% of families who experienced initial CPS reports, 53% experienced additional CPS reports. Children of mothers in the home visiting group were less likely to receive a second report and had a longer period of time between initial and second reports. The trial found that HFA reduced the recurrence of CPS maltreatment report by 32% and increased the length of time between initial and additional CPS reports.

The review by the Title IV-E Prevention Services Clearinghouse shows that HFA had favorable effects on child safety as well as child behavioral and emotional functioning, cognitive functions and abilities, delinquent behavior, and educational achievement and attainment. HFA also had favorable effects on adult well-being, including positive parenting practices, parent/caregiver mental or emotional health, and family functioning. These outcomes mirror outcomes that Ohio expects to see in our children’s services population. As noted in the case review data above, Child: Emotional Behavior was present in 47% of cases, Child: Physical Cognitive Social Difficulties were present in 37% of cases, Adult: Emotional/Mental Health Illness was present in 38% of cases, and Adult: Parenting Difficulties was present in 40% of cases. Adult stress was also present in 36% of cases. The findings from the Title IV-E Prevention Services Clearinghouse are summarized in the table below.

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child safety: Child welfare administrative reports	0.05 1	5 (43)	5522	Favorable: 0 No Effect: 43 Unfavorable: 0
Child safety: Self-reports of maltreatment	0.15 5	4 (44)	2044	Favorable: 5 No Effect: 38 Unfavorable: 1
Child safety: Maltreatment risk assessment	Not Calculated	1 (7)	180	Favorable: 0 No Effect: 7 Unfavorable: 0

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child safety: Medical indicators of maltreatment risk	-0.10 -3	3 (11)	1895	Favorable: 0 No Effect: 11 Unfavorable: 0
Child permanency: Out-of-home placement	-0.04 -1	4 (6)	4752	Favorable: 0 No Effect: 6 Unfavorable: 0
Child well-being: Behavioral and emotional functioning	0.10 3	2 (7)	1146	Favorable: 5 No Effect: 2 Unfavorable: 0
Child well-being: Social functioning	0.04 1	1 (2)	897	Favorable: 0 No Effect: 2 Unfavorable: 0
Child well-being: Cognitive functions and abilities	0.08 3	3 (9)	1555	Favorable: 2 No Effect: 6 Unfavorable: 1
Child well-being: Physical development and health	0.09 3	2 (6)	816	Favorable: 0 No Effect: 6 Unfavorable: 0
Child well-being: Delinquent behavior	0.64 23	1 (1)	793	Favorable: 1 No Effect: 0 Unfavorable: 0
Child well-being: Educational achievement and attainment	0.20 7	1 (3)	577	Favorable: 1 No Effect: 2 Unfavorable: 0
Adult well-being: Positive parenting practices	0.12 4	4 (27)	1518	Favorable: 3 No Effect: 24 Unfavorable: 0
Adult well-being: Parent/caregiver mental or emotional health	0.12 4	4 (19)	2053	Favorable: 3 No Effect: 16 Unfavorable: 0
Adult well-being: Parent/caregiver substance use	0.09 3	3 (15)	1876	Favorable: 0 No Effect: 15 Unfavorable: 0
Adult well-being: Family functioning	-0.06 -2	4 (32)	2132	Favorable: 3 No Effect: 28 Unfavorable: 1

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Adult well-being: Economic and housing stability	-0.08 -3	3 (6)	1876	Favorable: 0 No Effect: 5 Unfavorable: 1

### Parents as Teachers (PAT)

Parents as Teachers (PAT) is a home-visiting parent education program that teaches new and expectant parents skills intended to promote positive child development and prevent child maltreatment. PAT aims to increase parent knowledge of early childhood development, improve parenting practices, promote early detection of developmental delays and health issues, prevent child abuse and neglect, and increase school readiness and success. The PAT model includes four core components, which include personal home visits, supportive group connection events, child health and developmental screenings, and community resource networks. PAT is designed so that it can be delivered to diverse families with diverse needs, although PAT sites typically target families with specific risk factors. Additionally, within the PAT model, there are training resources for home visitors working with teen parents and parents of children with special needs.

Ohio has current capacity in 11 counties, with one additional county in process, and capacity to serve approximately 450 families. PAT is currently implemented in Fairfield, Hancock, Hardin, Lucas, Madison, Morgan, Morrow, Paulding, Putnam, Washington and Wyandot counties with Licking County in process for implementation of PAT. Currently, the ODH monitors rules and works with the PAT National Office to obtain current information regarding affiliation status and model monitoring. Ohio is in discussions with the National PAT Office about becoming a “State Office,” which means that technical assistance and model fidelity will be monitored by ODH staff instead of national PAT staff.

ODJFS will oversee model fidelity through an existing data sharing agreement with the Ohio Department of Health (ODH). This data sharing agreement will be reviewed regularly to ensure all necessary data is included for fidelity monitoring. ODH is the network partner for PAT in Ohio. ODH will monitor fidelity of individual PAT providers, in conjunction with the national PAT office, and provide this information to ODJFS.

Ohio will utilize the Parents as Teachers National Center, Inc. (2016). *Foundational curriculum*, and will not use any adaptations to the PAT model.

### PAT Evidence of Effectiveness

Multiple studies have demonstrated the effectiveness of Parents as Teachers (PAT). Ohio chose to include PAT as these studies and Title IV-E clearinghouse rating have shown that this would be

an effective practice for our children’s services population. This is supported by the Title IV-E Prevention Services Clearinghouse’s Summary of Findings.

In March of 2019, Parents As Teachers published a [Fact Sheet](#), Prevention of Child Abuse and Neglect, reporting the following impacts of PAT on child abuse and neglect:

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

A [study](#) also found a 22% decreased likelihood of CPS substantiations for families receiving PAT. It also found that families in PAT received their first substantiations later in the child’s life and a trend toward decreased out-of-home placements.

The review by the Title IV-E Prevention Services Clearinghouse shows that PAT had favorable effects on child safety as well as child social and cognitive functions. These outcomes mirror outcomes that Ohio expects to see in our children’s services population. As noted in the case review data above, Child: Emotional Behavior was present in 47% of cases and Child: Physical Cognitive Social Difficulties were present in 37% of cases. The findings from the Title IV-E Prevention Services Clearinghouse are summarized in the table below.

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child safety: Child welfare administrative reports	-0.05 -1	1 (4)	4560	Favorable: 2 No Effect: 2 Unfavorable: 0
Child safety: Medical indicators of maltreatment risk	0.38 14	1 (2)	265	Favorable: 0 No Effect: 1 Unfavorable: 0
Child permanency: Out-of-home placement	0.16 6	1 (1)	4560	Favorable: 0 No Effect: 1 Unfavorable: 0

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

## Phase 2

Ohio has taken an intentional approach to implementation of evidence-based practices in the state and recognizes the need and desire to expand the services included in the state IV-E plan by phasing in services. Ohio identified additional programs to phase in over time but recognizes this may be revised as the state engages in CQI processes and more evidence-based practices are reviewed and rated on the Clearinghouse. Therefore, the phased approach featured below for Phases 2 and 3 outline Ohio's current direction for continuing to build and expand the prevention services array. In moving forward, Ohio will plan to submit amendments to seek approval for future phases and to include additional programs as appropriate.

Ohio plans to implement the following interventions in Phase 2:

Evidence-Based Practice	Current Rating
Seven Challenges	Does Not Meet
High Fidelity Wrap Around	N/A
Incredible Years	Promising/Does Not Meet
Motivational Interviewing	Well-Supported
Triple P	Promising

Ohio is requesting an evaluation waiver for the one well-supported program for which the State is requesting title IV-E reimbursement in Phase 2 of implementation. A waiver is permitted for an evidence-based practice designated at the well-supported evidence level by the Clearinghouse if the evidence of effectiveness of the practice is deemed compelling and the continuous quality improvement requirements of Section 471(e)(5)(B)(iii)(II) are met. Ohio is requesting a waiver for Motivational Interviewing. Upon approval, Ohio will assess program implementation and fidelity through a robust Continuous Quality Improvement (CQI) process through continued work with our Family First Executive agencies to develop an RFP/RFA for a vendor to support fidelity monitoring and CQI. Waiver requests for Phases 2 and 3 were included in Ohio's original plan submission. They have been removed and will be included when the plan is resubmitted to request approval for future phases.

### **Seven Challenges**

The Seven Challenges is designed for adolescents (13-25 years old) with substance use. Seven Challenges seeks to motivate program participants to evaluate their lives, consider the changes they would like to make, and then implement the changes. Seven Challenges is currently being used by 15 agencies in Ohio. Montgomery County uses the model in partnership with FFT. There is a pilot in Clermont County. If Seven Challenges is not determined to be a well-supported practice prior to the Phase 2 implementation date, Ohio will issue a Request for Proposal (RFP) to obtain a vendor to perform an evaluation of the program.

### **High Fidelity Wrap Around**

High Fidelity Wrap Around is a mental health intervention program for adolescent youth. Currently in Ohio, High Fidelity Wrap Around is being implemented statewide with the Center for Innovative Practices (CIP) having trained participants across 61 counties. The OhioMHAS has trained entities in all Ohio counties. OhioMHAS currently provides resources for training, coaching, and learning communities and funds are issued to the service provider for training. OhioMHAS has developed 16 high fidelity wrap around trainings. Fidelity to the model is monitored through Washington State University and Wraparound Fidelity Index-EZ – has been used in some counties. OhioMHAS has developed and implemented coaching and fidelity tools unique to Ohio (Ohio coaching Practice Level Targets and Ohio Supervisor Level Targets). Additionally, the Ohio Department of Medicaid (ODM) utilizes Case Western Reserve University for fidelity reviews and the Ohio Department of Youth Services (ODYS) leverages them for quality assurance and local training when needed. If High Fidelity Wrap Around is not determined to be a well-supported practice prior to the Phase 2 implementation date, Ohio will issue a Request for Proposal (RFP) to obtain a vendor to perform an evaluation of the program. In preparation for the launch of High Fidelity Wrap Around the State is investing additional funding to expand training opportunities for the local community partners. The goal is to use this training to assist with building grassroots infrastructure at the local level to ensure appropriate wrap around services and supports will be provided.

### **The Incredible Years**

The Incredible Years is a mental health intervention for children ages birth to age five. The program is guided by developmental theory and the interaction of risk and protective factors in the development of conduct problems. The programs promote emotional, social, and academic competence to prevent, reduce, and treat behavioral and emotional problems in young children. Ohio currently has program capacity in the following regions: Central, Great Lakes, Northeast, and Southwest. If the Incredible Years is not determined to be a well-supported practice prior to the Phase 2 implementation date, Ohio will issue a Request for Proposal (RFP) to obtain a vendor to perform an evaluation of the program.

### **Motivational Interviewing**

Motivational Interviewing (MI) is a client-centered, directive method designed to enhance a person's internal motivation to change, to reinforce this motivation, and develop a plan to achieve change. Motivational Interviewing (MI) is rated as well-supported in the Clearinghouse as a substance abuse intervention. The EBP is designed for caregivers with substance use. Many counties have staff trained in MI and some Child and Family Services Review counties are implementing MI as part of their Program Improvement Plan. Juvenile Courts currently using MI include Clermont, Brown, Montgomery, Greene, Delaware, Lucas, Crawford, Jefferson, Columbiana, Van Wert, Mercer, and Seneca. ODYS is providing funds (RECLAIM Ohio) to juvenile courts to support Motivational Interviewing use and training. Consultants and trainers at the Center for Evidence-Based Practices (CEBP) provide this service. Juvenile Courts frequently use Michael Clark and the Motivational Interviewing Implementation and Practice Manual. ODYS's Bureau of Community Reinvestment review MI program materials and implementation outcomes captured by the juvenile court. ODJFS and OhioMHAS are partners with the Hazelden Betty Ford Foundation to train over 150 county caseworkers, supervisors, and leaders in MI. This training series concluded in September 2020. Motivational Interviewing training is also a part of the Ohio START (Sobriety, Treatment & Reducing Trauma) Program. Counties implementing Ohio START receive Motivational Interviewing training and sustain this practice. Motivational Interviewing is an EBP identified in Ohio's services array and includes fundamental skills in engagement and practical strategies for engaging children and families.

Upon approval, Ohio will assess program implementation and fidelity through a robust Continuous Quality Improvement (CQI) process through continued work with our Family First Executive agencies to develop an RFP/RFA for a vendor to support fidelity monitoring and CQI.

### **Triple P**

Triple P is a mental health intervention designed for parents and caregivers of children from birth to age 16. Currently, Ohio has implemented the program capacity in the following regions of the state: Central, Eastern, Great Lakes, Northeast, Northwest, Southeast, Southwestern, and Western. In 2018, 100 Early Childhood Mental Health (ECMH) providers completed training on the model. The Ohio Children's Trust Fund (OCTF) allocates dollars to provide training for the program and OhioMHAS supports ECMH consultants. Quality assurance tools are available from the model



developer who works directly with providers to ensure fidelity. Additionally, OCTF works with the Ohio State University to evaluate the program in the Central Region of the state.

### Phase 3

Ohio plans to implement the following interventions in Phase 3 and is requesting an evaluation waiver for the three Phase 3 well-supported services.

Evidence-Based Practice	Current Rating
Brief Strategic Family Therapy	Well-Supported
Child-Parent Psychotherapy	Promising
Nurse-Family Partnership	Well-Supported
Parent-Child Interaction Therapy	Well-Supported
Trauma-Focused Cognitive Behavioral Therapy	Promising

Ohio is requesting an evaluation waiver for the three well-supported programs for which the State is requesting title IV-E reimbursement in Phase 3 of implementation. A waiver is permitted for an evidence-based practice designated at the well-supported evidence level by the Clearinghouse if the evidence of effectiveness of the practice is deemed compelling and the continuous quality improvement requirements of Section 471(e)(5)(B)(iii)(II) are met. Ohio is requesting waivers for Brief Strategic Family Therapy, Nurse-Family Partnership, and Parent-Child Interaction Therapy. Upon approval, Ohio will assess program implementation and fidelity through a robust Continuous Quality Improvement (CQI) process through continued work with our Family First Executive agencies to develop an RFP/RFA for a vendor to support fidelity monitoring and CQI. Waiver requests for Phases 2 and 3 were included in Ohio’s original plan submission. They have been removed and will be included when the plan is resubmitted to request approval for future phases.

#### Brief Strategic Family Therapy

Brief Strategic Family Therapy is designed to treat behavioral issues in youth ages 6-18 years while restructuring problematic family interactions. It is a culturally competent, strength-based model that uses a structured, problem-focused, directive, and practical approach to treat conduct problems. Ohio is requesting an evaluation waiver for Brief Strategic Family Therapy as it is designated well-supported. Upon approval, Ohio will assess program implementation and fidelity through a robust Continuous Quality Improvement (CQI) process through continued work with our Family First Executive agencies to stand up a Center of Excellence (COE).

#### Child-Parent Psychotherapy

Child Parent Psychotherapy is a mental health intervention for children ages birth – six years and their caregivers. The intervention is designed to support family strengths and relationships and help families heal and grow after difficult experiences. It also respects the family’s cultural values. Child-Parent Psychotherapy is currently provided in the following areas: Franklin County (Nationwide Children's); Southeast Region (Hopewell Health Centers); Cuyahoga County (OhioGuidestone); and Wood County (Children's Resource Center). If Child-Parent

Psychotherapy is not is not determined to be a well-supported practice prior to the Phase 3 implementation date, Ohio will issue a Request for Proposal (RFP) to obtain a vendor to perform an evaluation of the program.

### **Nurse-Family Partnership**

Nurse Family Partnership (NFP) is a home-visiting program where nurses provide support related to individualized goal setting, preventative health practices, parenting skills and educational and career planning, based on the needs/requests of the parent. It targets young, first-time, low-income mothers from early pregnancy through the child's first two years. Ohio currently has NFP in eight counties with the capacity to serve approximately 1,000 families; Butler, Cuyahoga, Franklin, Hamilton, Mahoning, Montgomery, Portage, Preble and Summit. ODH has a credentialing process and provides \$3,000 for each new staff person and has \$3,000 available for agencies to support training and start-up costs. Adverse Childhood Experiences (ACEs) is a requirement of the credentialing process. Every home visitor in Ohio is required to be credentialed (NFP specific training and see required trainings listed under PAT). In addition, ODH produces a training bulletin each year where additional training topics are provided such as Domestic Violence, Parental Rights and Responsibilities, Motivational Interviewing, Mandated Reporting and ACEs. ODH monitors rules and works with NFP's National Service Office and the local providers to obtain current information regarding affiliation status and model monitoring. There are currently four counties with NFP MIECHV funded slots through four agencies. As required through the MIECHV monitoring process, ODH must demonstrate a monitoring process is in place and documentation of the provider meeting model fidelity and affiliation expectations is working with the NFP National Service Office to streamline the data entry and reporting process for the NFP providers. Ohio is requesting an evaluation waiver for NFP as it is designated well-supported.

### **Parent-Child Interaction Therapy**

Parents are coached by a trained therapist in behavior-management and relationship skills in Parent-Child Interaction Therapy (PCIT). PCIT is a program for two to seven-year old children and their parents or caregivers that aims to decrease externalizing child behavior problems, increase positive parenting behaviors, and improve the quality of the parent-child relationship. During weekly sessions, therapists coach parents and caregivers in skills such as child-centered play, communication, increasing child compliance, and problem-solving. Parents and caregivers progress through treatment as they master specific competencies, thus there is no fixed length of treatment. Currently 30 providers provide this service in Ohio. Ohio is requesting an evaluation waiver for this service as it has already been determined to be well-supported. Upon approval, Ohio will assess program implementation and fidelity through a robust Continuous Quality Improvement (CQI) process through continued work with our Family First Executive agencies to stand up a Center of Excellence.

### **Trauma Focused Cognitive-Behavioral Therapy**

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events. The target age is three to 18 years old. The model incorporates trauma-

sensitive interventions with cognitive behavioral, family, and humanistic principles. Ohio currently has over 70 providers in mostly metro areas who are able to practice TF-CBT, but not all providers have been certified by the developer. DYS funds TF-CBT through the BHJJ project in Summit County. The model developer uses QA tools to monitor fidelity, and individual client outcome measures are aligned with 3 of 6 MIECHV statutorily defined benchmark standards; school/academic, crime reduction and coordination/referral to other community-based supports. Tools are available on the [website](#). If Trauma Focused Cognitive-Behavioral Therapy is not determined to be a well-supported practice prior to the Phase 3 implementation date, Ohio will issue a Request for Proposal (RFP) to obtain a vendor to perform an evaluation of the program.

## **Workforce Development, Training, and Support**

The Ohio Department of Job and Family Services (ODJFS) provides training and support to the workforces of public and private agencies serving Ohio's children and families through an established system of training, technical assistance, and quality improvement feedback loops. ODJFS intends to utilize these existing mechanisms to provide support in the implementation of Family First. Ohio's technical assistance and training emphasizes trauma informed service delivery, which provides a foundation for supporting Family First and the associated implementation of evidence-based practices (EBPs). ODJFS will have existing courses modified and/or support the creation of new content to include the Family First providers to ensure the providers receive the necessary training as it relates to Family First. This work may include collaborating with other state agencies to educate service providers who are carrying out the Family First EBPs. Ohio will assess program implementation and fidelity through a robust Continuous Quality Improvement (CQI) process through continued work with our Family First Executive agencies and the COE vendor to support fidelity monitoring and CQI.

### **Ohio Child Welfare Training Program**

ODJFS supports the training of agency staff, foster caregivers, adoptive parents, and kinship caregivers through many programs, including the Ohio Child Welfare Training Program (OCWTP). The OCWTP will be the mechanism by which staff statewide receive training regarding Family First and continue to receive vital information about EBPs and trauma informed service delivery. The OCWTP, whose mission is to promote best children's services practice through comprehensive skill development, strategic partnerships, and effective advocacy, has been training Ohio's children's services professionals since 1987.

The OCWTP is a Comprehensive Competency-Based In-service Training System (CCBIT) and uses a universe of competencies (statements of skill and knowledge needed for specific job functions) as the cornerstone of the program. Competencies are used to identify training needs and develop training curricula. The competencies were developed by reviewing pertinent literature and conducting focus groups for task analyses of job functions and identification of corresponding skills and knowledge needed to fulfill those job functions. This list of competencies is the criteria used to assess individual training needs, and to guide the development of all training courses and curriculum content. The universe of competencies guides curricula development, ensuring course

content areas represent the content needed by staff to do their jobs, and includes only training essential to job performance. Competencies are periodically reviewed and revised using the same process; they include trauma informed services and shall be adapted to provide training for Family First.

## **Core Competencies**

Upon hire, caseworkers must complete Caseworker Core training. The Caseworker Core series has a total of eight modules and was recently updated to include information regarding Family First. The updates include:

- Comprehensive Assessment Planning Model-Interim Solution (CAPMIS).
- Differential Response (DR) and Practice Profiles.
- Statewide Automated Child Welfare Information System (SACWIS).
- Family First Prevention Services Act.
- Normalcy (ORC 5103.162 Qualified immunity of foster caregiver and ORC 2151.315 Participation in extracurricular, enrichment, and social activities).
- The Comprehensive Addiction Recovery Act (CARA) legislation.
- The impact of trauma on child development/child vulnerability.
- Differentiating assessment of safety and risk.
- Least restrictive interventions and placement.
- Collaborative and family led strength-based engagement of families, understanding, and applying family case plans, etc.

Some of the Caseworker Core Modules cover content particularly relevant to Family First implementation. Examples of these include:

- Module 2: One day training and one learning lab day entirely centered around learning and practicing the tenants of strength-based family engagement strategies.
- Module 4: Assessment of Safety and Risk are covered extensively. This includes two days of training and two days of learning labs practicing the skills. Linking families to appropriate services through referral and delivery in response to assessments is covered.
- Module 6: Family Case Planning and ensuring child specific planning is completed. This module is three days plus one day practicing skills in a learning lab. Strengths based family engagement is emphasized again in this module as well as service delivery to meet specific family needs.

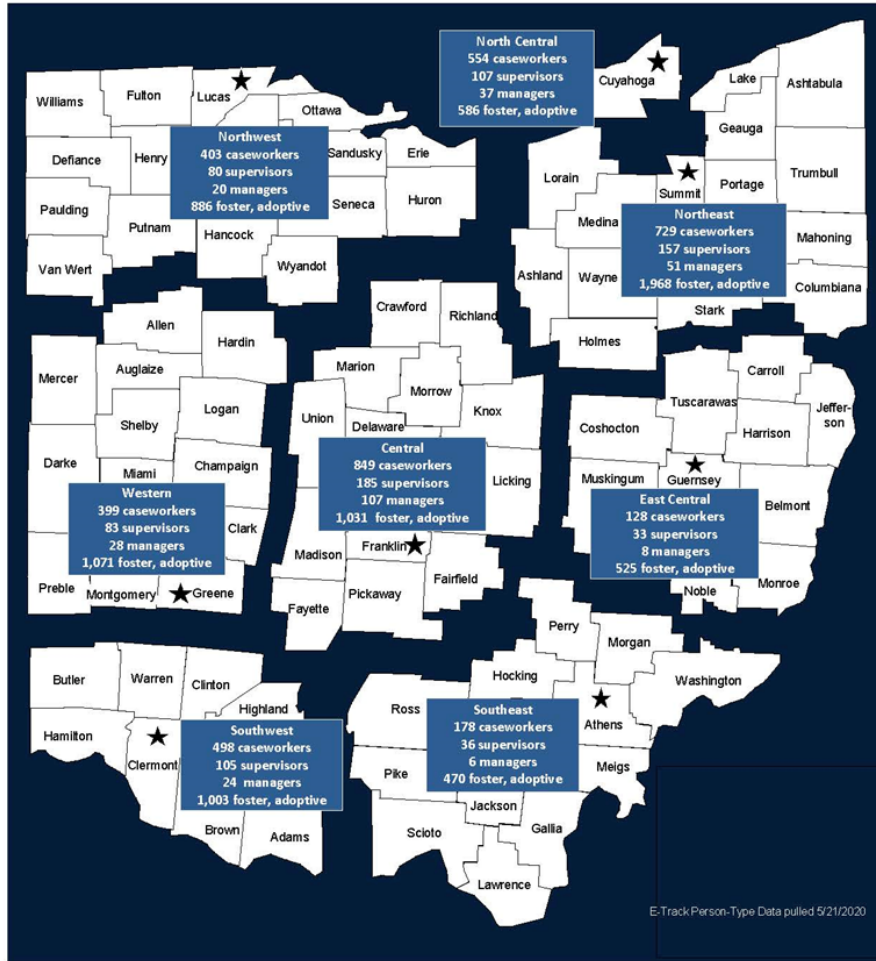
The following chart outlines the training requirements for initial training and what the OCWTP offers to meet these requirements.

<b>Population to be Trained</b>	<b>ORC Requirement</b>	<b>OCWTP Offerings</b>
<b>New Caseworkers</b>	New caseworkers complete 102 hours of Core training within the first year of employment.	Caseworker Core
<b>New University Partnership Program (UPP) Caseworkers</b>	New UPP caseworkers complete legal aspects of CPS and 36 hours of ongoing training (if Core is waived) within the first year of employment.	Caseworker Core Module 3 Ongoing
<b>New Supervisors</b>	New supervisors complete a minimum of 60 hours of Core training in the first year of employment as a supervisor; and they complete an additional 12 hours of Core in the second year.	Supervisor Core

Below are the annual training requirements for ongoing staff training and the OCWTP offerings to meet those requirements. These trainings expand upon the Caseworker Core series and allow caseworkers to enhance their knowledge of critical children’s services practices. Caseworkers will have opportunity through these trainings to further their knowledge of EBPs, trauma informed service delivery, and best practices related to Family First as practices advance.

<b>Population to be Trained</b>	<b>ORC Annual Requirement</b>	<b>OCWTP Offerings</b>
Ongoing training for caseworkers	Caseworkers are required to attend 36 hours of ongoing training each year	Specialized and Related Trainings
Ongoing training for supervisors	Supervisors are required to attend 30 hours of ongoing training each year	Specialized and Related Trainings

The map below shows a count of staff, foster parents, and adoptive parents the Regional Training Centers (RTCs) could serve in State Fiscal Year (SFY) 2020 (July 1, 2019 – June 30, 2020).



## Staff Training Needs Assessment

During SFY 2020, the OCWTP continued to identify skill and knowledge needs, improve staff learning interventions, support transfer of learning (TOL), and improve OCWTP operations. One element of learning needs, caseworkers must be able to identify needs associated with trauma focused services, EBPs, etc.

## Technical Assistance

### Child Protection Oversight and Evaluation (CPOE)

Ohio’s quality assurance system, Child Protection Oversight and Evaluation (CPOE), is designed to improve services and outcomes for families and children. CPOE provides a statewide mechanism for providing critical technical assistance to all 88 county agencies. ODJFS will utilize this platform to provide technical assistance related to Family First, including trauma informed service delivery, EBPs, and critical concepts to the program such as understanding candidate for foster care definitions.

CPOE is authorized by Ohio Administrative Code and requires Public Children Service Agencies (PCSAs) to participate with ODJFS staff in CPOE monitoring/Quality Improvement activities no less than once every twenty-four months. PCSA strengths and opportunities for improvement are supported through the provision of technical assistance by ODJFS staff. Measurement of PCSA practice is based upon agency-specific data gathered from Ohio's State Automated Child Welfare Information System (SACWIS) and through on-site case reviews. Following completion of the reviews, if there are areas identified as needing improvement, ODJFS requires the development of what is now called a Plan for Practice Advancement (PPA). The PPA is developed collaboratively with the PCSA and is monitored on a quarterly basis for at least twelve (12) months. Throughout the process, ODJFS and the PCSA engage in systematic and focused problem-solving by analyzing data to determine achievement of outcomes.

### **Informal Technical Assistance**

ODJFS takes substantial pride in fostering quality working relationships with children's services agencies in each of Ohio's 88 counties. These relationships provide the foundation for providing technical assistance as the need arises in county agencies. Counties reach out with questions and the Office of Families and Children (OFC) staff are in contact with counties to provide updates and new resources. These continuously growing relationships will play a vital role in supporting Ohio's implementation of Family First and the development of Family First capabilities of Ohio's CPS workforce.

ODJFS utilizes a technical assistance structure to include staff from many different program areas working together to provide more coordinated assistance to county partners in response to the identified need. This approach allows ODJFS to leverage knowledge across program areas in order to maximize responsiveness in meeting the specific needs of agencies. The teams may consist of SACWIS specialists, policy and fiscal staff, and field office staff, including technical assistance specialists and licensing specialists. Together, OFC strives to do the following:

- Be partner-centered and acknowledge, respect and build on partners' culture and strengths.
- Focus on solutions.
- Be accountable to team members, partners and the OFC.
- Promote the principles of teamwork through cooperation and collaboration.
- Generate knowledge across program areas.
- Improve communication.
- Encourage innovation through the ongoing sharing of ideas.
- Empower decision-making at the lowest appropriate denominator.
- Generate support through group decision-making.
- Move staff toward shared goals and values.
- Work from a strength-based perspective.

- Support a holistic approach.
- Encourage relationships without relying on a single individual.

#### **IV-E Training Plan Implications**

Defining “Candidate for Foster Care” for prevention services and providing training on the definition, purpose, eligibility, timeframes and documentation will be important work for supporting Ohio’s workforce. As bureaus within ODJFS collaborate to provide comprehensive training and support to county and private agencies around Family First, the topic will be covered within OCWTP Trainings, Onboarding, and discussed utilizing our CQI feedback loops.

#### **Ohio’s Rapid Response Program**

Ohio’s Governor Mike DeWine recently set aside funding creating a special program at ODJFS that provides additional support to children’s services agencies needing assistance. The program provides a natural opportunity to provide agencies with insights into where Family First can be implemented in the county along with insights into how EBPs would be beneficial to the children and families being served. The program is also responsible for developing onboarding programming which will provide new caseworkers across the state with foundational knowledge of Family First and trauma informed service delivery. This onboarding program introduces foundational principles relevant to Family First including:

- CAPMIS Family Case planning, including child specific planning.
- Conducting risk and safety assessments utilizing Ohio’s CAPMIS model.
- Strength-based family engagement practices as the foundation of practice.
- Linking families to appropriate evidence-based services.

### **Existing Feedback Loops for Support and Continuous Quality Improvement (CQI)**

OFC is committed to implementing an integrated statewide CQI framework that accomplishes two overarching goals:

- Establishes an infrastructure to implement the CQI process on a statewide basis. This infrastructure must support local and state partners in jointly addressing statewide or regional challenges.
- Assists public and private agencies and their partners in developing or growing their own CQI systems at the local level.

#### **Statewide CQI Advisory Team**



The OFC CQI Advisory Team is a leadership body dedicated to improving outcomes for the children and families served by Ohio's children's services system. The Advisory Team serves as an ongoing leadership forum to provide guidance on Ohio's statewide system of CQI and promotes a sustained focus on advancing practice and improving outcomes for children and families. Family First has been discussed at each quarterly CQI meeting since originally announced.

The CQI Advisory Team meets on a quarterly basis to review data and information related to statewide children's services practice trends and outcomes. The Advisory Team makes recommendations to OFC about potential strategies to improve outcomes and the formation of ad hoc workgroups to address specific CQI topics. As workgroups are approved by OFC leadership and formed, the Advisory Team will hear periodic progress reports and provide guidance to the workgroups on the completion of their assigned tasks.

The Advisory Team's membership includes a range of partners essential to improving children's services outcomes. Members include representatives of public children services agencies; representatives of private children's services agencies; staff of the ODJFS' OFC; the Public Children Services Association of Ohio; the Ohio Association of Child Caring Agencies; the Ohio Child Welfare Training Program; the Supreme Court of Ohio; and other partners as needed to serve the purposes of the Advisory Team.

### **CQI Feedback Loops**

Feedback loops have continued to be an important part of the Statewide CQI process. The committee has been able to continue identifying examples of innovative best practices and unique CQI practices from around the state. Once identified, these practices are presented to the overall committee which participants find to be beneficial. These best practices can be adapted in counties and often inspire experimentation with new approaches while ensuring adherence to model fidelity. Additional feedback loops included quarterly presentations about the Family First planning, Ohio's CFSR PIP activities, and Ohio's CPOE process and findings. The Statewide CQI process continues to be an excellent mechanism for gathering feedback, sharing ideas, as well as sharing outcomes.

The CQI feedback loops provide opportunity for updates from different OFC bureaus to county and private practitioners. This will provide an important avenue for providing Family First updates to county and private practitioners.

CQI processes are critical to promoting the success of FFPSA prevention services in Ohio. CQI processes promote quality and transparency in the provision and implementation of services and can improve the impact of prevention services in supporting children who are candidates and their families in remaining safely in their homes and communities by highlighting: 1) what's working well; and 2) where adaptation is needed to promote the desired results (i.e., preventing children from entering foster care and supporting them in their homes and communities by ensuring access to necessary supports).

The first step in implementing CQI processes is to define the overarching goal. Ohio has already developed initial goals of:

- Preventing FFPSA candidates from entering foster care
- Increasing access to prevention services for FFPSA candidates and their families and pregnant and parenting youth in foster care

The second step in implementing CQI processes is to identify key process and outcomes measures that will support Ohio in knowing if they are achieving the identified desired results. In planning of the CQI framework, it is critical that specificity is applied to each of the identified process and outcome measures. For example, tracking of the number of existing prevention services cases newly opened each quarter and the recurrence of maltreatment in prevention services cases within six months of case closure.

As Ohio begins implementation of the CQI framework, it is critical that these process and outcome measures and strategies for collecting the data are included in implementation plans including contracts with providers to make sure that the infrastructure exists and is established for future data analysis. Ohio has identified process and outcome measures and plans to disaggregate all data by key child and family factors, such as race, ethnicity, geographic region, and age of the child to inform necessary changes.

As outlined in the chart above, Ohio will be tracking fidelity measures and continuous monitoring outcomes as a part of the ongoing CQI process. These measures and ongoing feedback loops will be a part of Ohio's ongoing process of quality improvement. As noted in the evidence of effectiveness of each EBP, adherence to the fidelity measures and ongoing monitoring of the continuous monitoring outcomes should yield similar positive results for Ohio's children and families. Regular review of these measures and data will inform what is working well in Ohio and any adjustments that need to be made.

## **Family First Prevention Services Caseloads**

Ohio's children's services system is structured as a state supervised, county administered system with 88 counties. The Ohio Department of Job and Family Services (ODJFS) supervises the county Departments of Job and Family Services and Children Services Boards. County Commissioners, under Section 307.981 of the Ohio Revised Code, are responsible for determining which agency within their county will provide public children services to their communities. Each county public children services agency is individually structured resulting in a wide range of caseload assignment guidelines.

### **County Break Down**

Ohio's 88 county agencies are further grouped into 5 categories: Major Metro (3), Metro (10), Large (15), Medium (21), Medium Small (15), and Small (24). Across these groups, variance in county employee structure is pronounced. Major Metro counties often have entire departments that specialize in Assessment & Investigation (A/I), Ongoing In-Home Services, Ongoing, and Foster Care and Adoption Services, among others, while a Small County worker might complete the investigation and then remain the primary worker for the case's duration. The Major Metro counties have casework staff numbers that range from 200 to 400, while Small counties generally have less than 15 casework staff. In larger counties, there are support staff to assist with tasks such as supervised visitation, data entry, and coverage of court hearings. These supports are often not

available in smaller counties. Most of Ohio's population is centered around urban zones (78%), with the rest of the state's rural areas often experiencing significant challenges with needed resources and services.

The differences in caseworker counts and demographic makeup will require each county to develop a framework for the specific cases receiving prevention services. While Major Metro counties may be able to assign specific units or workers as Prevention Units/Workers, smaller more rural counties may have to incorporate prevention cases into their existing workloads. Additionally, cases that are flagged as "Prevention" may look significantly different from a strengths/needs perspective depending on the demographic and rural/urban makeup of that county and the services available to the county worker.

From a state and county perspective, the large size and agency structural differences coupled with the varied county demographics present unique caseload challenges at the state level. Caseworker retention has been a priority of the state and local governments for several years. Governor Mike DeWine and the Ohio General Assembly invested an additional \$50M into the State Budget beginning SFY20 for State Child Protective Services allocation. This additional funding is, in part, to allow county agencies to invest in caseworker retention strategies.

This infusion of budgetary capital required quantitative measurement for transparency and performance review purposes. Governor DeWine, the Ohio General Assembly, the Ohio Department of Job and Family Services, including both state and county stakeholders, the Public Children Services Association of Ohio and the Ohio's Director's Association, worked together to create Performance Measure dashboards that track various benchmarks of casework practice, case outcomes and systemic trends. These systemic trend dashboards include "Caseworker Counts" and "Caseworker Caseload Estimates."

The provision of prevention services in Ohio will require a steady and calculated approach. The diversity in service availability as well as the provision of service to families among county PCSAs requires a staging approach to best assist each county in cultural change as Ohio forges ahead with the implementation of Family First in successfully attaining long term goals and successful outcomes. Ohio has determined the prevention caseload sizes can be maintained at their current rates given that the candidates for prevention services will initially be limited to the population of children who receive In-Home Services and pregnant and parenting foster youth. Each county will continue to structure caseworker workload and caseload size, with caseworkers continuing to manage Prevention Services cases. Supervisors will continue to monitor Prevention Services cases and caseloads, with ongoing oversight county leadership. Based on statewide data, case ranges are anticipated between 10-12. Recognizing variations in county size, population and workforce capacity, Ohio looked at current data, anticipating that counties may carry caseloads as few as 5 or as many as 27. Because of the variance of county caseload and workload structure, these numbers are estimated. According to the 2018 CWLA Caseload and Workload [report](#):

"Perhaps the clearest result from synthesizing the array of materials for this report is that the determination of a caseload number to set a standard, in term of the number of children and families that can be reasonably and effectively served by a worker, is inadequate

because of the complexity of the work – and there are many factors regarding a ‘case’ worker, community, and agency that should be taken into account.”

Additionally, for PCSAs with work capacity and service availability will have the opportunity to opt into the provision of prevention services to families. This service would permit the PCSAs to provide eligible services to families which have been closed/referred for services post assessment.

## **Assurance on Prevention Program Reporting**

As required, ODJFS will comply with all prevention program reporting requirements put forward by the Children’s Bureau. The Children’s Bureau reporting requirements to date are contained in the Title IV-E Prevention Program Data Elements, Technical Bulletin #1, issued on August 19, 2019. Consistent with this guidance (or subsequent guidance), ODJFS will provide the following information for each child that receives Title IV-E prevention services:

- The service types provided to the child and/or family.
- The total expenditures for each of the services provided to the child and/or family.
- The duration of the services provided.
- The child’s identification as a candidate or pregnant/parenting youth.
- The child’s foster care status, as applicable prior to receiving services, and at 12 and 24 months after receiving services.
- Basic demographic information (e.g., age, sex, race/Hispanic or Latino ethnicity).

## **Conclusion**

Through the support of Governor DeWine and his continued investments in children and families, Ohio is well positioned to implement the Family First Prevention Services Act with a phased approach to prevention services. By focusing on the services already available throughout the state, Ohio is poised to serve families and children in need and to continue building capacity for expanded service delivery statewide. Interventions will be added in each phase and our Center of Excellence will facilitate capacity building, training, technical assistance, fidelity monitoring and evaluation.

Family First gives Ohio the opportunity to build on existing children’s services system work and cross-system collaboration with our sister agencies through Executive Committee, implementation teams, and other stakeholder groups. Ohio will continue engaging stakeholders throughout implementation of each phase and will use feedback to inform continuous quality improvement. This five year plan will be amended as needed as the state continues to respond to the need for additional services and updates to the Title IV-E Clearinghouse ratings.

