NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

North Carolina Title IV-E Prevention Services Plan
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Section I: Introduction

Child Welfare Vision for Transformation and Prevention of Child Maltreatment

North Carolina's strategic vision for prevention aligns with the Children's Bureau articulation of prevention and its approach to strengthening families to prevent child maltreatment. A core tenet of this approach is embracing a whole community design, where communities work together with the public and private agencies and partners to plan, implement, and maintain integrated primary prevention networks. These approaches focus on strengthening families and preventing maltreatment before it results in trauma to children and causes them to be at imminent risk of entry into the foster care system.

North Carolina aims to keep children, youth, and families safely together while improving the well-being of children and youth by acting upon a broad range of factors and conditions in which children, youth, and families live, work, and play. Child maltreatment prevention works best by promoting healthy families, children, and communities, and when it is linked to other prevention systems. Preventing child maltreatment and other negative outcomes includes addressing the factors that increase risk of harm to children and youth and building protective factors to ensure their safety and well-being. It also requires North Carolina to address the underlying issues of poverty, food insecurity, housing instability, interpersonal violence, and other non-medical drivers of health.

North Carolina is rich in prevention-focused resources and programs, but there are genuine opportunities to effectively target statewide prevention efforts within and across the systems that support families. As a state supervised, county administered child welfare system, North Carolina relies on local communities to design and implement prevention services as capacity and resources allow. At the state level, North Carolina is working to build a comprehensive framework that aligns primary, secondary, and tertiary prevention efforts at the state, regional, and local levels in a manner that guides strategic thinking about resource investments to prevent child maltreatment and promotes optimal outcomes for children, youth, and families.

North Carolina believes that strengthening families and communities and preventing child abuse and neglect require a diverse set of public-private partnerships. These partnerships must be developed collaboratively in strategic and purposeful ways to create a prevention framework designed to meet families' needs at the right time and with the right services. North Carolina is committed to thoughtfully building implementation capacity at the state, regional, and local levels.

North Carolina is engaged in a meaningful transformation of its Child Welfare system. By 2024, North Carolina will create a comprehensive framework to strengthen families and prevent child maltreatment. To oversee this ambitious effort, the state is actively involving stakeholders in a

teaming structure. The table below outlines the teams and workgroups North Carolina has formed to offer guidance and input as it transforms its child welfare system.[1]

SLT (Senior Leadership Team)	The decision-making body that oversees child welfare system transformation (Assistant Secretary for County Operations for DHHS, Chief Operating Officer, Senior Director of Child, Family and Adult Services, Deputy Director Division of Social Services Business Operations NCDSS, and Director of Human Services Business, Information and Analytics), Responsible for setting the vision, leading the implementation, aligning policies and finances, incorporating recommendations for system learning, and ensuring transformation achieves identified outcomes.
ULT (Unified Leadership Team)	Provides a forum for state and county leaders to provide guidance, direction, and sequencing instruction for child welfare transformation.
LAT (Leadership Advisory Team)	Works with the SLT to inform and support planning, readiness, implementation prioritization, and sequencing of specific recommendations and initiatives related to recently enacted legislation to reform child welfare. Members include leadership from North Carolina Department of Health and Human Services (NCDHHS), North Carolina Department of Social Services (NCDSS), Chapin Hall at the University of Chicago (Chapin Hall), Benchmarks, Guardian ad Litem (GAL), SaySo, Medicaid, county child welfare agencies, Child Welfare Family Advisory Council (CWFAC), and other stakeholders.
CWFAC (Child Welfare Family Advisory Council)	A state-level body comprised of individuals impacted by child welfare services. Members include parents who have received child protective services, resource parents, and foster care alumni.
Design Teams	Teams tasked with making recommendations for implementing the Child and Family Services Plan. There are five teams, one for each of NC's major strategic priorities for child welfare. Members include representatives from NCDSS, courts, county child welfare agencies, CWFAC, private providers and philanthropic partners and other stakeholders.

[1] 2020-2024 Child and Family Services Plan, 64

Achieving child welfare transformation in North Carolina will create a sustainable, accountable, state-wide child welfare system where children and families experience consistent, culturally competent, trauma-informed, family-centered, and safety-focused practices that improve critical outcomes and performance indicators related to child safety, permanency, and well-being. North Carolina's 2017 Family-Child Protection and Accountability Act, 2020-2024 Child and Family Services Plan, and Family First Title IV-E Prevention Services Plan have been identified as the three "pillars" of child welfare transformation in the state. "Viewed in combination, they describe what lies ahead as North Carolina remakes its child welfare system." Vol. 26, No. 1: Child Welfare Transformation (practicenotes.org)

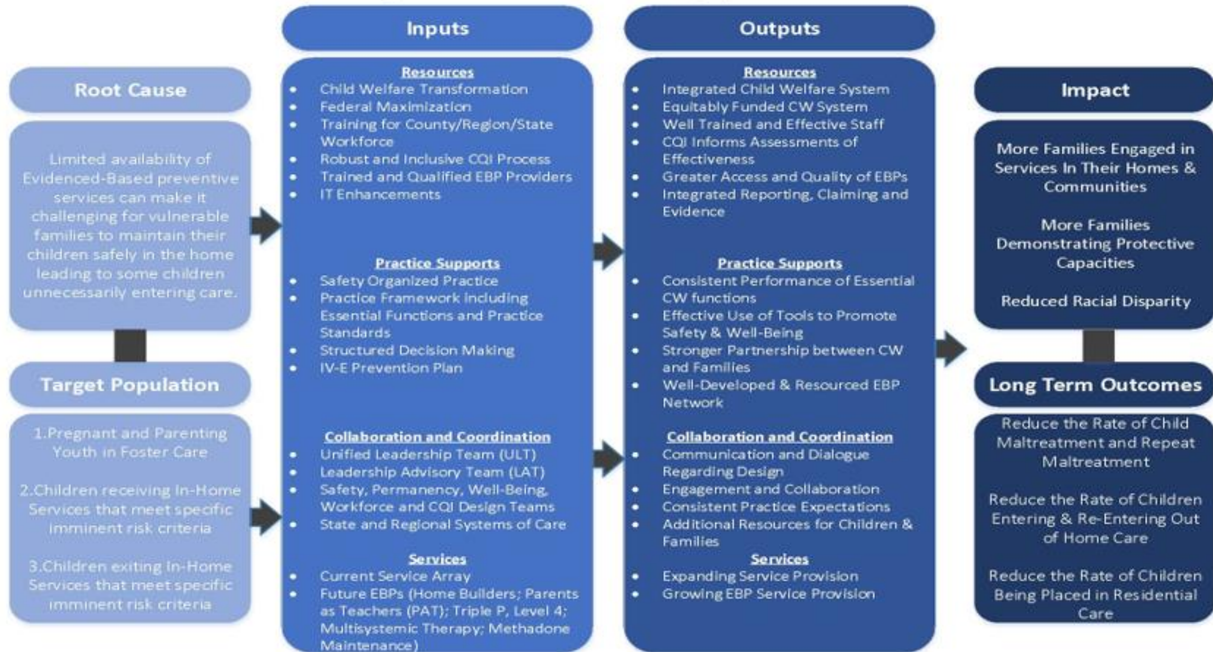
Rylan's Law

In 2017, the North Carolina General Assembly passed the Family-Child Protection and Accountability Act also known as "Rylan's Law." Key to the implementation of Rylan's Law was an independent assessment, follow through on the most pertinent, critical recommendations from the Social Services and Child Welfare work groups, and development of the Director's Dashboard. Work has been completed or is in progress on all aspects of the law.

Family First Prevention Services Act

The Family First Prevention Services Act is the critical federal law supporting transformation of the child welfare system in North Carolina. Family First will provide North Carolina with more front-end flexibility in funding services to prevent children from entering foster care; and allowing the state to use IV-E resources for prevention services such as parental substance use disorder treatment and mental health treatment. A major focus of the Family First Act is to support the safe reduction in the number of children brought into foster care and to reduce the amount of time children spend in congregate care (i.e., group homes). Family First also seeks to enact other provisions that promote safety, permanence, and well-being.

Over the past year, North Carolina has been engaged in a rigorous process to develop and prepare its Family First Title IV-E Prevention Plan. The state conducted a range of Family First readiness activities in partnership with key internal and external stakeholders and translated findings for planning. Activities included conducting a provider assessment survey to better understand the service capacity and provider agencies' ability to deliver evidence-based programming across the state. North Carolina also conducted preliminary data analyses to determine North Carolina's candidacy and target populations, along with service needs. With this information in hand North Carolina developed a theory of change for transformation.[2]



The Child and Family Services Plan

North Carolina's 2020-2024 Child and Family Services Plan (CFSP) is a five-year strategic plan for child welfare that was prepared and provided with input from diverse child welfare stakeholders and guidance by the federal Children's Bureau. The CFSP focuses on strengthening current programs and practices to improve services to children, youth, and families and is anchored by the goals of achieving safety, permanency, and well-being. It includes a timeline to guide the state's work as well as a method to allow diverse stakeholders to have input on how the state enhances the child welfare system. The stakeholders are assigned to Design Teams that are inclusive of state child welfare staff, county child welfare leaders and frontline staff, partnering public agencies—including the courts, private partners that provide child welfare services, and with a heightened focus on youth, families, and others with lived experience receiving child welfare services.

In addition, by 2024, it is envisioned that North Carolina would have accomplished key strategic objectives articulated in the CSFP. This includes completion of the Family First five-year strategic plan for prevention services. North Carolina revised its Child and Family Services Plan (CFSP), submitted on July 30, 2021. While the 2020-2024 CFSP includes benchmarks to finalize the five-year FFPSA prevention plan and begin FFPSA prevention services provision under its Safety Strategic Priority Target 3, the new strategic plan creates an independent, foundation goal: Implement the Family First Prevention Services Act (FFPSA) Plan. The new goal will include objectives and strategies towards this end.

Section II: Eligibility and Candidacy Identification

Pre-print section 9

Candidacy: North Carolina's Vision for Candidates for Family First funded Prevention Services

The two populations targeted for prevention services funded by Family First in this plan are:

- Pregnant and parenting youth who are in foster care
- Children who meet the definition to be candidates for foster care as outlined in section 471(e)(4)(A)(i) and (ii) of the Family First Act. North Carolina understands these children must be at imminent or serious risk of foster care and will document their candidacy through a written case plan that:
  - ✓ is developed together with the family
  - ✓ clearly indicates that, absent effective preventive services, foster care is the planned arrangement for the child
  - ✓ describes the services offered and provided to prevent removal of the child from the home and
  - ✓ documents why the child is at serious or imminent risk of foster care absent effective preventive services.

Within these two populations (pregnant and parenting youth in foster care and candidates for foster care), children and families will be screened for their appropriateness for referral to Family First funded prevention services in the state's service array. Homebuilders and the Parents as Teachers (PAT) EBP target population for home visitation and the agency eligibility criteria for the IV-E prevention program have much in common through the focus on family engagement and support. North Carolina envisions taking a phased approach targeting eligible children and their families for Family First funded prevention services. North Carolina envisions providing Family First funded EBPs to the following populations children and their families:

- Pregnant and parenting youth who are in foster care
- Children who meet criteria to be candidates for foster care as described above.

Although North Carolina has traditionally determined candidacy for foster care after a child has been referred to CPS In-Home Services, DHHS is currently developing policy and protocols for determining candidacy during a CPS assessment. This will allow families to be referred to Family First funded EBP prevention services much sooner after CPS reports are received. Since most children who enter foster care do so during a CPS assessment, expanding the target population to include children identified as candidates during those assessments will increase the potential of Family First funded EBPs to safely prevent removal of children from their homes.

In the process of developing this prevention plan, North Carolina heard repeatedly from stakeholders who envisioned that Family First services could be offered to a more broadly defined candidacy populations to truly make child welfare a proactive and prevention-oriented

system. In preparation for future phases, North Carolina hopes to explore options for making this vision a reality in ongoing discussions with its stakeholders and ACF.

Determining Prevention Candidacy:

As North Carolina implements FFPSA, social workers and their supervisors will be able to determine candidacy and refer to EBPs during a CPS assessment or during CPS In-Home Services. In support of the above definition of candidacy for foster care, North Carolina will provide guidance in policy to assist county child welfare staff in using their professional judgement to determine if a child is at serious or imminent risk of foster care. The guidance will differ slightly for workers conducting a CPS assessment and for workers providing in-home services because of the different information available during those two services.

CPS Assessments

Guidance for workers conducting the assessment will include consideration of whether a child is at imminent or serious risk of removal into foster care. An initial safety assessment is required in all CPS Assessments. A reassessment of safety must occur when new information is learned that may impact the child's safety in the home. Throughout, the worker will assess for imminent or serious risk of removal into foster care. When a safety assessment identifies one or more safety factors and has a "Safe with a Plan" determination, the following additional factors strongly suggest a child in that home may be at serious or imminent risk of foster care:

- The safety plan involves use of a temporary safety provider
- The safety plan includes the alleged perpetrator leaving the home, especially if the alleged perpetrator is a parent or has potential to return to the household
- The safety plan involves a protective caretaker moving to a safe environment with the children, especially when there is potential for that move to only be temporary.
- The identified safety factor would have significant potential to result in the child entering foster care were it to continue or recur
- The identified safety factor is associated with a parent's or caretaker's substance use disorder.

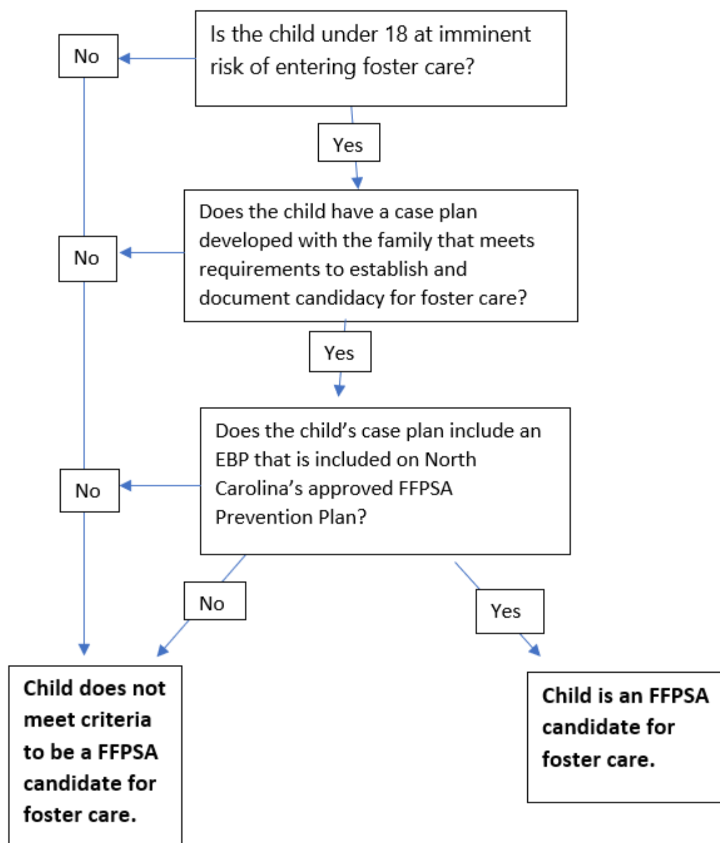
CPS In-Home

Guidance for workers providing CPS in-home services will reflect that enough information has been gathered to complete a structured risk assessment and make a case decision on the allegations contained in the CPS report. Whether a child receiving in-home services is at serious or imminent risk of foster care should take place throughout the provision of CPS in-home services. Determination of candidacy must include the results of the structured risk assessment. Workers should consider that a structured risk assessment strongly suggests that a child is at serious or imminent risk of foster care when the overall risk rating is moderate or high coupled with one of the following:

- A risk factor of prior CPS in-home or out-of-home involvement
- A risk factor of a child in the home being 3 or younger
- A risk factor of either caretaker having a drug or alcohol problem
- The maltreatment found during the CPS assessment would have a high probability of resulting in foster care if it recurred
- Either caretaker has a Mental Health diagnosis that impacts the care for a child
- Either caretaker is or has been involved in Domestic Violence

Guidance for determining whether a child receiving in-home services is at serious or imminent risk of foster care will state that the receipt of a new CPS report accepted for assessment or the completion of a safety assessment resulting in a new safety plan should also trigger consideration of whether a child is at serious or imminent risk of foster care using the considerations outlined for a child receiving a CPS assessment.

Pictured below is a flow chart for how North Carolina will determine FFPSA candidacy either during a CPS assessment or during an open in-home services case.



Identifying Pregnant and Parenting Youth

Pregnant and parenting youth in foster care and their child(ren) are also an eligible population that North Carolina will target for Family First funded prevention services. Per the Family First legislation, pregnant or parenting youth in foster care do not need to meet the imminent risk criteria or be designated a candidate for foster care to be eligible for services. For pregnant and parenting youth in foster care receiving IV-E prevention services, their foster care case managers will include the prevention services provided on the child specific prevention plan section in their Family Services Out of Home Case Plan.

Redetermination of Candidacy

Once determined, children remain candidates for Title IV-E prevention services for 12 months. Twelve (12) months from initial candidacy determination, in-home case managers and supervisors must re-evaluate prevention candidacy status for children receiving IV-E prevention services. Using the most recent SDM Risk Assessment and Risk Re-Assessment findings, in-home case managers and supervisors will assess imminent risk to determine if a prevention candidate's status will end at 12 months or be re-determined. Prevention candidacy status is re-determined if a prevention candidate continues to meet any imminent risk criteria and will be confirmed through the development of a new child-specific prevention plan in the Family Services Agreement.

Future Phases of Prevention Candidacy Expansion and Family First Implementation

As indicated in the section above outlining NC DHHS's vision for candidates receiving Family First funded services, North Carolina hopes to expand the target populations of children eligible for prevention services by considering together with its stakeholders and ACF options for how to conceptualize when children can be considered at serious risk of entry into foster care. As additional populations of children eligible for prevention candidacy are identified, DHHS will incorporate those populations through future submissions of updates to the Family First prevention plan. Concurrently, North Carolina will continue to seek to build its infrastructure and capacity to provide prevention services to more children and families funded by both Family First and other sources.

Reassessing Candidacy

NCDHSS understands that transforming child welfare will take time and involve system changes and evolution. NCDHSS anticipates and welcomes the opportunity to discuss opportunities to broaden its understanding of when children can be considered candidates for foster care to align with the evolving needs of families while remaining consistent with federal policy and

guidance. Throughout the initial phases of implementation, NCDHSS will actively seek feedback from partners, providers, and parents across the state, while also analyzing implementation data.

Validation of Structured Decision-Making Tools and Implementation of Safety Organized Practice Model

North Carolina's Child Welfare Safety Organized Practice (SOP) Model includes the SDM Safety, Risk, Risk Re-Assessment, Case Decision Summary, and Strengths and Needs assessment tools. These tools as components of the SOP Model, allows North Carolina to create the foundation for a family-centered child welfare system. The child welfare workforce will be equipped to build effective working relationships with children, youth, and families, leverage critical thinking and decision-making tools, and co-develop collaborative service plans to enhance and ensure child safety. Family First implementation will further anchor the SOP Model and SDM assessments in the state's child welfare practice and contribute to the system's overall transformation.

Section III: Title IV-E Prevention Services

Pre-print Section 1

NCDHHS has chosen a set of two prevention EBPs, HomeBuilders® and Parents as Teachers for enhancement of its prevention services. An additional three prevention EBPs, Multi-systemic Therapy, Triple P Standard Level 4, and Methadone Maintenance Therapy, will ultimately be implemented across the state. These five EBPs (outlined in Table 1 below) were chosen based on evidence that they produced outcomes that directly address reasons that children in North Carolina enter foster care. Provider readiness was assessed through a landscape scan, stakeholder feedback gathered from the LAT and federal guidance which informed the selection of the five EBPs. These programs represent essential elements of North Carolina's existing service array that would be beneficial to continue or expand.

North Carolina's Menu of Prevention Services

A phased implementation strategy will prioritize expansion of two of the five EBPs. Currently, NCDHHS is requesting reimbursement for Homebuilders® and Parents as Teachers (PAT), in the initial phase of implementation. Service needs, capacity building, and budgetary strategies to promote incremental expansion to the other three programs included in this plan will be considered throughout the five-year timeframe. NCDHHS is requesting approval for Title IV-E prevention services and administrative claiming for Homebuilders® and PAT in this initial plan. North Carolina anticipates a future prevention plan submission within the five-year plan period that will include all required elements to seek approval for Multi-systemic Therapy, Triple P (Level 4), and Methadone Maintenance Therapy (MMT).

Table 1. Summary of North Carolina's Menu of Prevention Services

Homebuilders®	**Category**: In-Home Parent Skill-Based
	Manual:
	Kinney, J., Haapala, D. A., & Booth, C. (1991). *Keeping families together: The HOMEBUILDERS model*. Taylor Francis
	Target Population:
	Families (parents/caregivers and their children) with children ages 0 to 18 at imminent risk of placement into, or needing intensive services to return from, foster care, group or residential treatment, psychiatric hospitals, or juvenile justice facilities
	Level of Evidence: Well-Supported
	Intended Outcomes:
	1. Reduce child abuse and neglect 2. Reduce family conflict 3. Reduce child behavior problems 4. Teach families the skills they need to prevent placement or successfully reunify with their children

	Evaluation and CQI Plan:
	North Carolina intends to submit an evaluation waiver and monitor implementation through a rigorous CQI strategy explained in section 6.
Parents as Teachers	**Category**: In-Home Parent Skill-Based
	Manual: Parents as Teachers National Center, Inc. (2016). *Foundational curriculum.* Parents as Teachers National Center, Inc. (2014). *Foundational 2 curriculum: 3 years through kindergarten.*
	PAT has a Model Implementation Library with resources available to those who receive PAT training related to supporting supervisors, implementation, data collection, ethical considerations, and technical assistance. Depending on the ages of the families served, the PAT Foundational Curriculum is available to support families prenatal to 3 and the PAT Foundational 2 Curriculum is available to support families 3 through kindergarten. Training Library: https://parentsasteachers.org/trainingcurriculagallery#PAT-CORE-TRAINING Requirements for Affiliates: https://static1.squarespace.com/static/56be46a6b6aa60dbb45e41a5/t/59bc3b9046c3c4ee1974b66b/1505508240435/proposed-updated-essential-requirements-18-19.pdf
	Target Population:
	New parents with children ages 0-5
	Level of Evidence: Well-Supported
	Intended Outcomes:
	1. Increase parent knowledge of primary childhood development and improve parenting practices 2. Provide primary detection of developmental delays and health issues 3. Prevent child abuse and neglect 4. Increase children's school readiness and school success
	Evaluation and CQI Plan:
	North Carolina intends to submit an evaluation waiver and monitor implementation through a rigorous CQI strategy explained in section 6.
	Category: Mental Health and Substance Use Disorder
	Manual:

Multi-systemic Therapy	Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). *Multisystemic Therapy for antisocial behavior in children and adolescents* (2nd ed.). Guilford Press. **Target Population:** Youth ages 12-17 and their families who are at risk for or are engaging in delinquent activity or substance misuse, experience mental health issues, and are at-risk for out-of-home placement. **Level of Evidence:** Well-Supported **Intended Outcomes** 1. Eliminate or significantly reduce frequency and severity of the youth's referral behavior 2. Empower parents with the skills and resources needed to: • Independently address the inevitable difficulties which arise in raising children and adolescents • Empower youth to cope with family, peer, school, and neighborhood problems **Evaluation and CQI Plan** North Carolina intends to submit an evaluation waiver and monitor implementation through a rigorous CQI strategy in a future plan submission
Triple P Standard Level 4	**Category:** Mental Health **Manual**: Sanders, M. R., Markie-Dadds, C., & Turner, K. M. T. (2013). *Practitioner's manual for Standard Triple P (2nd ed.)*. Triple P International Pty Ltd. **Target Population:** Parents and caregivers of children and adolescents from birth to 12 years old with moderate to severe behavioral and/or emotional difficulties and parents that are motivated to gain a more in-depth understanding of positive parenting **Level of Evidence:** Promising **Intended Outcomes:** • Increase competence in promoting healthy development and managing common child behavior problems and developmental issues • Reduce use of coercive and punitive methods of disciplining children • Increase use of positive parenting strategies in managing their children's behavior • Increase confidence in raising their children • Decrease behavior problems in their children (for families experiencing difficult child behaviors) • Improve partners' communication about parenting issues • Reduce stress associated with raising children

	Evaluation and CQI Plan:
	North Carolina intends to submit a prevention plan revision in the future outlining the evaluation partnership to conduct a rigorous evaluation and reflect a CQI strategy for this program.
Methadone Maintenance Therapy	**Category:** Substance Use Disorder
	Manual:
	Substance Abuse and Mental Health Services Administration (SAMHSA). (2015). *Federal guidelines for opioid treatment programs (HHS Publication No. (SMA) PEP15-FEDGUIDEOTP).*
	Target Population:
	Individuals who have an opioid disorder. Typically, individuals must be at least 18 years old to receive MMT. However, individuals under 18 may be eligible to receive MMT if they have already had two unsuccessful treatment attempts and they have parent/guardian consent.
	Level of Evidence: Promising
	Intended Outcomes:
	1. Reduce and/or end opioid dependence for parents/caregivers experiencing an opioid use disorder 2. Improve parent/caregiver and family functioning
	Evaluation and CQI Plan:
	North Carolina intends to submit a prevention plan revision in the future outlining the evaluation partnership to conduct a rigorous evaluation and reflect a CQI strategy for this program.

Service Description and Relevant Studies to Demonstrate Effectiveness

Homebuilders®

As defined by the Title IV-E Prevention Services Clearinghouse (Clearinghouse), Homebuilders® provides intensive, in-home counseling, skill building and support services for families who have children (0-18 years old) at imminent risk of out-of-home placement or who are in placement and cannot be reunified without intensive in-home services. Homebuilders® uses behaviorally specific, ongoing, and holistic assessments that gather information on family strengths, values, and barriers to goal attainment. Homebuilders® practitioners collaborate with family members and referents to develop intervention goals and corresponding service plans that focus on factors directly related to the risk of out-of-home placement or reunification. Safety plans and clinical strategies are used by practitioners throughout the intervention to promote and ensure safety.

Homebuilders® applies research-based intervention strategies, including Motivational Interviewing, a variety of cognitive and behavioral strategies, and teaching methods, to teach new skills and facilitate behavior change. Practitioners support families by providing concrete goods and services related to the intervention goals, collaborating with formal and informal community supports and systems, and teaching family members to advocate for themselves.

Homebuilders® services are concentrated for four to six weeks with the goal of preventing out-of-home placements and achieving reunifications. Homebuilders® therapists typically have small caseloads of two families at a time so that they can be available to family members 24 hours per day, 7 days per week. Families typically receive about 40 or more hours of direct face-to-face services. Treatment services primarily take place in the client's home. Providers are required to have a master's degree in social work, psychology, counseling, or a closely related field or a bachelor's degree in social work, psychology, counseling, or a closely related field with at least two years of related experience.

North Carolina will leverage Homebuilders® to serve families with children ages 0 to 18 at imminent risk of placement into or needing intensive services to return from, foster care, group or residential treatment, psychiatric hospitals, or juvenile justice facilities. North Carolina will use the manual *Keeping families together: The HOMEBUILDERS model* (Kinney, et al., 1991) and will not use any adaptations to Homebuilders®.

Key outcomes of Homebuilders® are to:

1. Reduce child abuse and neglect
2. Reduce family conflict
3. Reduce child behavior problems
4. Teach families the skills they need to prevent placement or successfully reunify with their children

Studies reviewed by the Title IV-E Clearinghouse observed a reduction in out-of-home placements, an increase in planned permanent exits, and an increase in economic and housing stability. North Carolina will monitor for a reduction in out-of-home placements and expects the same positive outcomes for children and families who receive Homebuilders®.

North Carolina will also use measure proximal outcomes by monitoring reports available through IFD. North Carolina will monitor for when safety concerns are identified that family safety is increased during the provision of Homebuilders; that Homebuilders therapist are helping families increase their motivation to change; and that family members are acquiring needed skills during their Homebuilders intervention.

Homebuilders® is rated a well-supported practice by the Clearinghouse. The following three relevant studies demonstrate the effectiveness of Homebuilders®:

- Walton, E., Fraser, M. W., Lewis, R. E., & Pecora, P. J. (1993). In-home family-focused reunification: An experimental study. *Child Welfare, 72*(5), 473-487.
- Fraser, M. W., Walton, E., Lewis, R. E., Pecora, P. J., & Walton, W. K. (1996). An experiment in family reunification: Correlates outcomes at one-year follow-up. *Children and Youth Services Review, 18*(4-5), 335-361. doi: https://doi.org/10.1016/0190-7409(96)00009-6

- Westat, Chapin Hall Center for Children, & James Bell Associates. (2002). *Evaluation of Family Preservation and Reunification Programs: Final Report.* Washington, DC: U.S. Department of Health and Human Services.

Parents as Teachers

As defined by the Clearinghouse, Parents as Teachers (PAT) is a home-visiting parent education program that teaches new parents skills intended to promote positive child development and prevent child maltreatment. Based on the premise that "all "children will learn, grow, and develop to realize their full potential", PAT was developed to serve any family during primary childhood in any community and aims to increase parent knowledge of primary childhood development, improve parenting practices, promote primary 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: personal home visits, supportive group connection events, child health and developmental screenings, and community resource networks. PAT is designed to be delivered to diverse families with diverse needs, although PAT sites typically target families with specific risk factors. Services are offered on a biweekly or monthly basis, depending on family needs. Sessions are typically held for one hour in the family's home, but can also be delivered in schools, childcare centers, or other community spaces. Each participant is assigned a parent educator who must have a high school degree or GED with two or more years of experience working with children and parents. Parent educators must also attend five days of PAT training.

North Carolina will leverage PAT to serve families with children ages 0 to 5 in high-risk environments, such as services to teen parents in the custody of the state, low income, parental low educational attainment, history of substance abuse in the family, and chronic health conditions to improve family functioning. North Carolina will use the *Foundational Curriculum* (2016) manual or *Foundational 2 Curriculum: 3 years through kindergarten* (2014) manual, whichever is appropriate based on the age of the child, and will not use any adaptations to PAT.

Key outcomes of PAT relevant to North Carolina are to:

1. Increase parent knowledge of primary childhood development and improve parenting practices
2. Provide primary detection of developmental delays and health issues
3. Prevent child abuse and neglect

Studies reviewed by the Title IV-E Clearinghouse observed a reduction in reports to the child welfare agency, an increase in the child's social functioning, and an increase in the child's cognitive functions and abilities. North Carolina will monitor for a reduction in reports to the child welfare agency for children who receive PAT and expects the same positive outcomes for children and families receiving PAT.

North Carolina will also monitor certain proximal measures. PAT reports expected short term outcomes are an increase parent knowledge of age-appropriate child development; improved parenting capacity, parenting practices, and parent-child relationships; and improved family

health and functioning as demonstrated by a quality home environment, social connections, and empowerment.[2] North Carolina will monitor these outcomes through fidelity reports available through Parents and Teachers and quarterly monitoring with providers which is described further in Section VI of this plan.

PAT is rated a well-supported practice by the Clearinghouse. The following four relevant studies demonstrate the effectiveness of PAT:

- Neuhauser, A., Ramseier, E., Schaub, S., Burkhardt, S. C. A., & Lanfranchi, A. (2018). Mediating role of maternal sensitivity: Enhancing language development in at-risk families. *Infant Mental Health Journal, 39*(5), 522-536. doi: http://dx.doi.org/10.1002/imhj.21738
- Wagner, M., Clayton, S., Gerlach-Downie, S., & McElroy, M. (1999). A*n evaluation of the Northern California Parents as Teachers demonstration.* SRI International Menlo Park, CA.
- Chaiyachati, B. H., Gaither, J. R., Hughes, M., Foley-Schain, K., & Leventhal, J. M. (2018). Preventing child maltreatment: Examination of an established statewide home-visiting program. *Child Abuse & Neglect, 79,* 476-484.
- Wagner, M., Spiker, D., Gerlach-Downie, S., & Hernandez, F. (2000). *Parental engagement in home visiting programs: Findings from the Parents as Teachers multisite evaluation.* Menlo Park, CA: SRI International.

Multi-systemic Therapy

As defined by the Clearinghouse, Multisystemic Therapy (MST) is an intensive treatment for troubled youth delivered in multiple settings. This program is developed to promote pro-social behavior and reduce criminal activity, mental health symptomology, out-of-home placements, and illicit substance use in youth between the ages of 12 and 17. The MST program addresses the core causes of delinquent and antisocial conduct by identifying core drivers of the behaviors through an ecological assessment of the youth, his or her family, and school and community. The intervention strategies are tailored to address the identified drivers. The program is delivered for an average of three to five months, and services are available 24/7, which allows for timely crisis management and for families to choose which times will work best for them. Master's level therapists from licensed MST providers take on only a small caseload at any given time so that they are available to meet their clients' needs. North Carolina will use MST for children and families experiencing challenging behavioral issues and use the manual *Multisystemic Therapy for antisocial behavior in children and adolescents* (2nd ed.) (Henggeler et al., 2009) and will not use any adaptations to MST.

Key outcomes of MST are to:

1. Eliminate or significantly reduce the frequency and severity of the youth's referral behavior(s)

[2] Parents as Teachers. Evidence-Based Home Visiting Logic Model. Available at: https://static1.squarespace.com/static/56be46a6b6aa60dbb45e41a5/t/5a3aaf5424a694d9ee7a9e93/1513795412874/LogicModel_Web.pdf

2. Empower parents with the skills and resources needed to:
   - Independently address the inevitable difficulties that arise in raising children and adolescents
   - Empower youth to cope with family, peer, school, and neighborhood problems

Studies reviewed by the Title IV-E Clearinghouse observed a decrease in out-of-home placements, an increase in the behavioral and emotional functioning of children, a decrease in child substance abuse, a decrease in child delinquent behaviors, an increase in caregiver's positive parenting practices, an increase in caregiver mental or emotional health, and an increase in family functioning. North Carolina expects the same positive outcomes for children and families receiving MST and will monitor for the same when seeking reimbursement.

MST is rated a well-supported practice by the Clearinghouse. The following five relevant studies demonstrate the effectiveness of MST:

- Scherer, D. G., Brondino, M. J., Henggeler, S. W., Melton, G. B., & Hanley, J. H. (1994). Multisystemic Family Preservation Therapy: Preliminary findings from a study of rural and minority serious adolescent offenders. J*ournal of Emotional and Behavioral Disorders, 2*(4), 198-206. doi: http://dx.doi.org/10.1177/106342669400200402
- Asscher, J. J., Dekovic, M., Manders, W. A., van der Laan, P. H., & Prins, P. J. M. (2013). A randomized controlled trial of the effectiveness of Multisystemic Therapy in the Netherlands: Post-treatment changes and moderator effects. *Journal of Experimental Criminology, 9*(2), 169-187.
- Weiss, B., Han, S., Harris, V., Catron, T., Ngo, V. K., Caron, A., . . . Guth, C. (2013). An independent randomized clinical trial of Multisystemic Therapy with non-court-referred adolescents with serious conduct problems. J*ournal of Consulting and Clinical Psychology, 81*(6), 1027-1039. doi:10.1037/a0033928
- Fonagy, P., Butler, S., Goodyer, I., Cottrell, D., Scott, S., Pilling, S., . . . Haley, R. (2013). Evaluation of Multisystemic Therapy pilot services in the Systemic Therapy for At Risk Teens (START) trial: Study protocol for a randomized controlled trial. *Trials, 14*(1), 1-9. doi:10.1186/1745-6215-14-265
- Mann, B. J., Borduin, C. M., Henggeler, S. W., & Blaske, D. M. (1990). An investigation of systemic conceptualizations of parent-child coalitions and symptom change. *Journal of Consulting and Clinical Psychology, 58*(3), 336-344. doi: http://dx.doi.org/10.1037/0022-006X.58.3.336

Triple P Standard Level 4

As defined by the Clearinghouse, Triple P Standard Level 4 (Triple P) is a parenting intervention for families with children who exhibit behavior or emotional difficulties. As a part of Triple P parents engage in one-on-one sessions with a practitioner that includes parent training to learn strategies to promote social competence and self-regulation in their children and decrease problem behavior. Parents are encouraged to develop a parenting plan using these strategies and tools and track their children's behavior, as well as their own behavior. This process promotes reflection on their parenting plan and collaboration with a practitioner to modify and adapt the plan as needed. Triple P practitioners are trained to work with parents' strengths and

to provide a supportive, nonjudgmental environment where a parent can continually improve their parenting skills. North Carolina will leverage Triple P to serve children experiencing moderate to severe behavioral and/or emotional difficulties and their parents. North Carolina will use the manual *Practitioner's manual for Standard Triple* P (2nd ed.) (Sanders, et al., 2013) and will not use any adaptations to Triple P.

Key outcomes of Triple P are to:

1. Increase competence in promoting healthy development and managing common child behavior problems and developmental issues
2. Reduce use of coercive and punitive methods of disciplining children
3. Increase use of positive parenting strategies in managing their children's behavior
4. Increase confidence in raising their children
5. Decrease behavior problems in their children (for families experiencing difficult child behaviors)
6. Improve partners' communication about parenting issues
7. Reduce stress associated with raising children

Studies reviewed by the Title IV-E Clearinghouse observed an increase in the child's behavioral and emotional functioning, an increase in the caregiver's positive parenting practices, and an increase in the caregiver's emotional or mental health. North Carolina expects the same positive outcomes for children and families receiving Triple P and will monitor for the same when seeking reimbursement.

Triple P is rated a promising practice by the Title IV-E Prevention Services Clearinghouse. The following two relevant studies demonstrate the effectiveness of Triple P:

- Sanders, M. R., Markie-Dadds, C., Tully, L. A., & Bor, W. (2000). The Triple P-Positive Parenting Program: A comparison of enhanced, standard, and self-directed behavioral family intervention for parents of children with primary onset conduct problems. J*ournal of Consulting and Clinical Psychology, 68*(4), 624-640. https://doi.org/10.1037/0022-006X.68.4.624
- Bor, W., Sanders, M. R., & Markie-Dadds, C. (2002). The effects of the Triple P-Positive Parenting Program on preschool children with co-occurring disruptive behavior and attentional/hyperactive difficulties. *Journal of Abnormal Child Psychology, 30*(6), 571-587. https://doi.org/10.1023/A:1020807613155

Methadone Maintenance Therapy

As defined by the Clearinghouse, Methadone Maintenance Therapy (MMT) combines therapy with a methadone treatment that aims to reduce the use of heroin and other opioids for individuals who have an opioid use disorder. Methadone is an opioid medication and is prescribed and administered at levels calibrated to avert painful withdrawal symptoms and be tapered slowly to reduce or end opioid dependence. MMT must be administered by clinicians in federally certified and licensed treatment programs and includes counseling and social support services. States individually determine appropriate staff-to-patient ratios for delivery of this treatment. Methadone dosage and the length of treatment vary according to the

individuals' needs. Most people receive methadone once per day for at least one year. Methadone is typically administered in a clinical setting, but individuals who have progressed further into treatment may be allowed to take methadone at home between visits. To meet federal requirements, MMT programs must be certified through the Substance Abuse and Mental Health Services Administration (SAMHSA) Division of Pharmacologic Therapies (DPT). SAMHSA DPT also offers training courses, webinars, workshops, and reference publications to MMT clinicians. North Carolina will leverage Methadone Maintenance to serve families experiencing an opioid use disorder. North Carolina will use the manual *Federal guidelines for opioid treatment programs (HHS Publication No. (SMA) PEP15-FEDGUIDEOTP)*(SAMHSA, 2015) and will not use any adaptations to Methadone Maintenance.

Key outcomes of MMT are to:

1. Reduce and/or end opioid dependence for parents/caregivers experiencing an opioid use disorder
2. Improve parent/caregiver and family functioning

Studies reviewed by the Title IV-E Clearinghouse observed a reduction in caregiver substance use. North Carolina expects the same positive outcome for children and families receiving MMT and will monitor for the same when seeking reimbursement.

MMT is rated a promising practice by the Clearinghouse. The following two relevant studies demonstrate the effectiveness of MMT:

- Gruber, V. A., Delucchi, K. L., Kielstein, A., & Batki, S. L. (2008). A randomized trial of 6-month methadone maintenance with standard or minimal counseling versus 21-day methadone detoxification. *Drug and Alcohol Dependence, 94*(1-3), 199-206. https://doi.org/10.1016/j.drugalcdep.2007.11.021
- Aiken, L. S., Stein, J. A., & Bentler, P. M. (1994). Structural equation analyses of clinical subpopulation differences and comparative treatment outcomes: Characterizing the daily lives of drug addicts. *Journal of Consulting and Clinical Psychology, 62*(3), 488-499. http://dx.doi.org/10.1037/0022-006X.62.3.488

Rationale for Selected Services

The five EBPs North Carolina is including in its Prevention Plan are currently rated by the Clearinghouse as having achieved an approvable evidence rating. For each program, North Carolina will implement the same model version as reviewed and approved by the Clearinghouse and will not apply any adaptations or alterations to the model. To reiterate, North Carolina will begin with a phased in implementation of EBPs seeking approval for two programs, Homebuilders and PAT.

Several key considerations related to the selected EBPs' scope, target populations, and availability informed the initial menu of prevention services. DHHS carefully assessed which EBPs already existed within the state's service array that would best meet the unique needs of North Carolina's children and families and reduce entry into foster care. In partnership with the Duke

Endowment, a private foundation and Chapin Hall at the University of Chicago, DHHS conducted an EBP landscape scan to understand the array of prevention services available across the state and in which counties. Over 181 providers, including those with current contracts with local divisions of social services and those that might potentially contract following implementation of Family First, responded to the survey to provide information on provider capacity to implement EBPs in a trauma-informed framework, target populations served through prevention services, and current continuous quality improvement (CQI) efforts and data use. The scan showed that all of North Carolina 's 100 counties are served by at least one EBP. The scan's findings were used to identify gaps in prevention services across the state and inform decision-making for the selection of EBPs to include in this prevention plan that would best meet the needs of North Carolina's children and families. In addition to data-driven approaches for EBP selection, DHHS collaborated with several key stakeholders within the agency and provider community with expertise in prevention services, mental and behavioral health programs, substance use interventions, and home visiting programs, to leverage their expertise and recommendations for EBPs to include in this first iteration of the prevention services menu.

In an effort to select EBPs that would be particularly effective at preventing entry into foster care, DHHS consulted with its university partners to best understand the unique drivers in North Carolina for family involvement in the child welfare system. This analysis revealed that the top eight contributory factors for child welfare involvement in North Carolina are parent/caretaker substance use, parent/caretaker and child mental and behavioral health issues, household domestic violence, parent/caretaker lack of childhood development knowledge, and household financial challenges. North Carolina believes that the five-family based EBPs on its initial menu of prevention services will address most of these factors by nature of their target populations and will improve family functioning and stability.

DHHS also carefully considered the availability of services across the state and selected these initial five EBPs to further expand their reach and align with North Carolina's existing initiatives to scale them across the state. DHHS assessed the adequacy of these EBP provider network's ability to meet the unique needs of child welfare-involved families. In doing so, DHHS can leverage existing funding sources for these EBPs, including Medicaid and other state funding or grants, to further maximize their impact and capacity to serve candidates under Family First.

Implementation Approach: Prevention Services Menu

Through this plan, North Carolina intends to build the foundation for a menu of prevention services to best meet the needs of its children. The state will continue to modify and develop its service array menu based on lessons learned from initial Family First implementation. In endeavoring to align the menu with the needs of North Carolina's candidate population, DHHS will continue to consider additional EBPs reviewed by the Clearinghouse for inclusion in the menu of prevention services. To further support the implementation of Family First DHHS is

adding eight additional positions to provide focused and deliberate attention to building a system of care within regions and across the state.

The five EBPs included in this plan are already deployed across the state through a variety of funding streams and contract mechanisms. To maximize the positive impact of Family First for its children and families, North Carolina intends to leverage its current service array capacity and other transformation initiatives using a regional contracting model. This approach aligns with the state's contracting strategy for its Community-Based Child Abuse Prevention (CBCAP) grant programs. Through regional contracts for these prevention EBPs and CBCAP programs, the state will enable agencies to develop relationships with providers within and across regions, thereby creating a prevention framework of provider networks to facilitate families' access to quality services across the state. In addition, North Carolina is critically reviewing the EBPs in its Medicaid Plan and those currently provided through its local management entities-managed care organizations (LME-MCOs). Through conversations with its community and provider stakeholders, North Carolina has identified the LME-MCO networks as a critical piece for successful statewide implementation of the five EBPs included in this plan. The LME-MCOs already contract with a network of providers that administer these EBPs and there is an opportunity to further develop these contracts to support Family First implementation across the state.

North Carolina will phase the scale up of the prevention EBPs included in this plan by first releasing requests for applications to providers able to implement Homebuilders ® and PAT. North Carolina has identified these two EBPs for initial scale up due to known provider capacity across the state and these programs' alignment with the service needs of North Carolina's target populations for candidacy. The procurement for Homebuilders ® services will consist of a two-step process by first issuing a Request for Quotes (RFQ) to contract with the Institute for Family Development to provide training, technical assistance, and continuous quality improvement services required as the program purveyor followed by a Request for Application to secure direct service providers to provide Homebuilders ® across North Carolina regions. An analysis of need across the state supports an initial implementation launch of 11 Homebuilders ® teams consisting of one team in each service region and an additional four teams in more populous regions to meet the service coverage need. North Carolina's intent is to implement both Homebuilders® and PAT statewide within North Carolina's seven defined regions.

MST, Triple P, and MMT will be included in the next phase of EBP scale up as North Carolina continues to assess statewide clinical provider capacity for implementing MST and MMT and identify an evaluation partner for Triple P and MMT. North Carolina will only establish or continue contracts for these services with approved IV-E prevention services providers and ensure that appropriate claiming codes are in place to track required client and payment information.

Trauma-Informed Delivery of Prevention Services

North Carolina is dedicated to delivering prevention services through a trauma-informed framework and intends to leverage its current trauma-informed approach, known as Project Broadcast. Project Broadcast is a partnership between the Center for Child and Family Health and NCDSS with a mission to train and develop a trauma-informed child welfare workforce across the state. Key project activities have included implementing a trauma-related needs assessment for departments of social services and disseminating a trauma screening tool specific to child welfare contexts. In addition, the partnership has provided a variety of trainings on trauma-informed practices for child welfare workforce and facilitation of the National Child Traumatic Stress Network's Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents. To further integrate Project Broadcast's trauma-informed approach across North Carolina, DHHS will incorporate Project Broadcast's trauma screening tool into the Family First service delivery process to ensure that EBPs are delivered within a trauma-informed framework. For more information on Project Broadcast, please see: https://www.ccfhnc.org/programs/project-broadcast/

All evidence-based programs selected as part of North Carolina's Title IV-E Prevention Plan will be administered with a trauma-informed framework through external prevention providers. As part of the provider readiness assessment survey outlined earlier in this plan, providers described their compliance with the trauma informed requirements of the Family First legislation in addition to their EBP service availability, capacity, and internal continuous quality improvement systems. Prevention providers will be responsible for their own workforce training regarding trauma-informed service delivery and EBP fidelity. Oversight and monitoring of these requirements will occur via the contract compliance division with NCDSS utilizing the contract monitoring tool as well as the Continuous Quality Improvement (CQI) processes outlined in this plan.

Oversight and Monitoring

In addition to the detailed CQI strategy in section 6, implementation fidelity and outcomes monitoring for all EBPs in this plan will be conducted continuously through DHHS's existing CQI processes. DHHS will require all EBP providers to report and adhere to the state's CQI and fidelity monitoring processes. This will entail regular contact and communication between DHHS and service providers in addition to standardized, monthly reporting on each EBP's key performance and implementation measures, including those related to reach, fidelity, capacity, and outcomes. DHHS will monitor implementation fidelity and performance for all five EBPs in this plan by conducting ongoing contract monitoring with providers selected to deliver any of the five EBPs. This will ensure that each service is delivered with fidelity to its model and that progress measures meet the standards established. Findings from these monitoring activities will be used to inform improvement strategies and contracting decisions to refine and strengthen practice and service delivery.

- CQI Team will monitor fidelity using instruments identified by the purveyors and implementation science tools

- Data from NC's child welfare technology systems (current and future) will be joined to data from EBP providers for analysis of fidelity. NC DHHS has established a Business Intelligence Data Platform (BIDP) where the backbone for this data blending will occur, and NC DHHS child welfare data from both NC FAST and the legacy systems is currently in the process of being integrated within the BIDP
- Within the BIDP, child welfare child and case data will be analyzed to observe trends and outcomes related to the experiences of children and families receiving these EBP services
- Those observations, along with the fidelity instruments, will help inform NC's CQI processes around FFPSA and the EBPs supporting the target populations.

North Carolina is requesting waivers for the evaluation of Homebuilders and PAT, which have been designated by the Clearinghouse as well-supported practices. See Attachment ll State Request for Waiver of Evaluation Requirement for a Well-Supported Practice for the two waivers requested. In the future, DHHS intends to identify an appropriate evaluation partner to conduct a rigorous process and outcome evaluations for Triple P and MMT, both rated as promising practices by the Clearinghouse. These evaluation strategies along with an evaluation waiver for MST, will be included in a subsequent plan submission by NCDSS. More details on North Carolina's evaluation and CQI strategy for the two EBPs in this plan are included in section 6.

NCDSS is submitting Attachment II, Request for Waiver of Evaluation Requirement for a Well-Supported Practice, for the following well-supported services for which the evidence of the effectiveness of the practice is compelling: Homebuilders and Parents as Teachers. Documentation of compelling evidence for each program or service is described below.

HomeBuilders®

HomeBuilders® is a home and community-based intensive family preservation service designed to avoid unnecessary placement of children in foster care, group care, psychiatric hospitals, or juvenile justice facilities. When working with families involved in child welfare due to neglect, activities focus on improving the physical condition of the home, improving supervision, decreasing parental depression and/or alcohol and substance abuse, and helping families access needed community supports. This program is typically delivered in a four to six-week time frame and serves families with children ages 0-17. HomeBuilders® is clearly defined, replicable, and formal support is available for implementation. The following are relevant studies that demonstrate the effectiveness of HomeBuilders.

1. Fraser, M. W., Walton, E., Lewis, R. E., Pecora, P. J., & Walton, W. K. (1996). An experiment in family reunification: Correlates outcomes at one-year follow-up. *Children and Youth Services Review, 18*(4/5), 335-361.
2. Fraser, M. W., Pecora, P.J., and Haapala, D.A. (Eds.) (1991), Families in Crisis: The Impact of Intensive Family Preservation Services. New York: Aldine de Gruyter.

3. Fraser, M., Walton, E., Lewis, R., Pecora, P., Walton, W., (1996), An Experiment in Family Reunification Services: Correlates of Outcomes at One Year Follow Up. Children and Youth Services Review, Vol. 18, Nos. 4/5 pp. 335-361.
4. Kirk, R.S. & Griffith, D.P., (2004), Intensive family preservation services: Demonstrating placement prevention using event history analysis. Social Work Research, Vol. 28, No. 1, pp. 5-15.
5. Blythe, B. & Jayaratne, S., (2002), Michigan Families First Effectiveness Study.

The request for a waiver for Homebuilders® in North Carolina is based on evidence that Homebuilders® is shown to keep children in their homes, reunify children with their parents in a shorter amount of time, and resulted in lower placement costs.

A study by Wood, S., Barton, K. & Schroeder, C. (1988)[3] showed that when using Families First, now Homebuilders®, as compared to families receiving usual or normal services that 74% of the treatment group remained at home and placement costs were lower than the comparison group when placed.

A study by Fraser, M., Walton, E., Lewis, R., Pecora, P., Walton W. (1996)[4] showed when using a Homebuilders® model that 92% of the treatment group returned home from out-of-home placement.

A study by Kirk, R.S. & Griffith, D.P. (2004)[5] in North Carolina demonstrated that Homebuilders® was effective at preventing imminent out of home placement with 81% of the treatment group in that study avoiding placement.

Similarly, a study by Blythe,B. & Jayaratne, S. (2002)[6] demonstrated the effectiveness of Homebuilders® in avoiding imminent out-of-home placement with 93% of the treatment group avoiding placement.

North Carolina is, in part, targeting a reduction of entries into foster care through implementation of the Family First Prevention Services Act. Based on the research, with one study being conducted in North Carolina, North Carolina expects that Homebuilders® will be effective in decreasing the number of out-of-home placements.

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[3] Wood, S., Barton K., & Schroeder, C. (1988) In-home treatment of abusive families: Cost and Placement at One Year. Psychotherapy, 25(3), 409-414.
[4] Fraser, M., Walton, E., Lewis, R., Pecora, P., Walton, W., (1996), An Experiment in Family Reunification Services: Correlates of Outcomes at One Year Follow Up. Children and Youth Services Review, Vol. 18, Nos. 4/5 pp. 335-361.
[5] Kirk, R.S., & Griffith D.P., (2004), Intensive Family Preservation Services: Demonstrating Placement Prevention Using Event History Analysis. Social Work Research, Vol. 28, No. 1 pp. 5-15.
[6] Blythe, B. & Jayaratne, S. (2002), Michigan Families First Effectiveness Study

Parents as Teachers (PAT)

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

A review of PAT research by the Title IV-E Prevention Services Clearinghouse shows that PAT had favorable impacts on child safety as well as child social and cognitive functions[7], which are key outcomes DSS is seeking to attain through its prevention service array and corresponds to needs of parents with young children identified through the NCDSS Child and Family Engagement Tool. Also of importance, according to the Title IV-E Prevention Services Clearinghouse review, PAT has produced very limited unfavorable impacts on outcomes. A summary of this review's findings can be found in the table below.

[7] Chaiyachati, B.H., Gaither, J.R., Hughes, M., Foley-Schain, K., & Leventhal, J.M. (2018). Preventing Childre Maltreatment: Examination of an established statewide home-visiting program. Child Abuse & Neglect, 79, 476-484. Wagner, M., Clayton.S., Gerlach-Downie, S., & McElroy, M. (1999). An evaluation of the Northern California Parents as Teachers Demonstration. SRI International Menlo Park, CA. Wagner, M.M., & Clayton, S.L., (1999). The Parents as Teachers program: Results from Two Demonstrations. The Future of Children, 9(1),, 91-115. Neuhauser, A., Ramseier, E., Schaub, S., Burkhardt, S.C.A., & Lanfranchi, A. (2018). Mediating role of maternal sensitivity. Enhancing language development in at risk families. Infant Mental Health Journal, 39(5), 522-536. Doi:http://dx.doi.org/10.1002/imhj.21738

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

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

In addition, current studies of PAT show a significant impact on several outcomes vital to the child welfare system. In March of 2019, Parents as Teachers published a Fact Sheet, Prevention of Child Abuse and Neglect, reporting the following impacts of PAT on child abuse and neglect[8]:

- 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.[9]

- 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.[10]

[8] Available at: https://static1.squarespace.com/static/56be46a6b6aa60dbb45e41a5/t/5c9d2c9deb39313e7359ded9/1553804446421/Fact-Sheet_ChildAbuseandNeglectPrevention.pdf

[9] Id. Citing Chaiyachati, B., Gaither, J., Hughes, M., Foley-Schain, K., & Leventhal, J. (2018). Preventing child maltreatment: Examination of an established statewide home-visiting program. Journal of Child Abuse and Neglect, 49: 476-484

[10] Id. Citing Jonson-Reid, M., Drake, B., Constantino, J., Tandom, M., Pons, L., Kohl, P., Roesch, S., Wideman, E., Dunnigan, A., Auslander, W. (2018). A Randomized Trial of Home Visitation for CPS-Involved Families: The Moderating Impact of Maternal Depression and CPS History. Child Maltreatment, 23: 281-293

- 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.[11]

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

[11] Id. Citing (n.d.). 2014 Maine Home Visiting Summary Report. Augusta, MN: Maine Department of Health and Human Services.

Section IV: Child Specific Prevention Plan

Pre-print Section 4

Developing the Child-Specific Prevention Plan

As discussed in section 2, to be eligible for Title IV-E prevention services, candidacy determination and prevention services provided will be recorded in the family's Family Services Agreement, NCDHHS's formal service planning tool. Documentation of the prevention services that will benefit each candidate child in the Family Services Agreement will form the child-specific prevention plan for each candidate child in the family. For pregnant and parenting youth in foster care receiving IV-E prevention services, their foster care case managers will include the prevention services provided in their Foster Youth Services Plan in addition to the foster care prevention strategy for their child(ren).

Assessing Need and Selecting Services

Assessment case mangers will conduct the family's initial assessments using the following SDM assessment tools and trauma screening tool:

1. **SDM Risk Assessment:** The North Carolina Family Risk Assessment of Abuse / Neglect (DSS-5230) must be completed on the home of the alleged perpetrator. In cases where both parents are alleged perpetrators and they live in separate homes, a North Carolina Family Risk Assessment of Abuse / Neglect (DSS-5230) must be completed for each home. The North Carolina Family Risk Assessment of Abuse must be completed based on all information obtained during the assessment (including information associated with a new report), including face-to-face interviews with and/or observation of parents, caregivers, others living in the child(ren)'s home, children in the home and pertinent collateral contacts.
2. **SDM Safety Assessment:** A North Carolina Safety Assessment (DSS-5231) must be developed during CPS Assessments to address the safety issues and the caretaker's capacity to ensure safety for the children.

   The Safety Assessment must be completed and documented at the following intervals:

   - at the time of the initial contact, during a home visit, and prior to allowing the child to remain in the household;
   - prior to the case decision;
   - prior to the removal of a child from the home;
   - prior to the return home of a child in cases where the caretaker temporarily arranges for the child to stay outside of the home as a part of the safety intervention;
   - at any point a new CPS report is received; and
   - at any other point that safety issues are revealed during the assessment phase.
3. A safety agreement must be used when there is a specific safety factor or risk of harm identified. **SDM Case Decision Summary/Initial Case Plan:** Prior to or at the time of the case decision, the CPS Assessment case decision must be documented on the Case Decision Section of the CPS Assessment Documentation Tool (DSS-5010) **SDM Strengths and Needs**

Assessment: The North Carolina Family Assessment of Strengths and Needs (DSS-5229) must be completed during the CPS Assessment based on all information obtained during the assessment (including information associated with a new report), including face-to-face interviews with and/or observation of parents, caregivers, others living in the child(ren)'s home, and children; and pertinent collateral contacts. The SDM Strengths and Needs Assessment identifies the needs to be included in the case plan, as well as the most appropriate EBP to support the reduction of imminent risk.

4. **Project Broadcast Trauma Screening Tool**: This tool is used with families to screen children for possible trauma. There are two age-specific tools, one for the screening of children under six years of age and one for children ages 6-21. The tool for children under six asks questions of the caregiver and case manager to identify any trauma events that may have taken place in the child's life. The screening tool for children ages 6-21 asks questions of the child, caregiver, and case manager to identify any trauma events that may have taken place in the child's life. If both sections one and two have any items checked, the child should be referred for a trauma-informed mental health assessment. If only one section has items checked, the case manager and the team should have a case staffing to determine the most appropriate next step.

NCDHHS is dedicated to providing appropriate prevention services to best meet the needs of children, youth, and their families. Findings from the five above assessment and screening tools help to identify potential priority prevention needs and compatibility with available services in North Carolina's menu of prevention services. While findings from assessments and screenings are applied in the development of the Family Services Agreement and selection of appropriate prevention services, NCDHHS recognizes that family voice in service planning is critical for authentic family engagement and equitable and unbiased decision-making. Assessment and screening findings are utilized along with families' perspectives and child welfare case managers' professional judgment and experience. This application of assessment findings enhances and strengthens the collaborative working relationships between case managers and families. NCDHHS is committed to applying a family-centered, culturally competent, strengths-based approach for prevention service planning. Families, in-home case managers, and supervisors will collaborate to co-develop the Family Services Agreement, using findings from the five assessments to frame and inform decision-making. In doing so, the family's prevention needs will be matched with the most appropriate prevention EBPs available.

The Family Services Agreement will include documentation of the selected prevention services provided to the family. prevention services for each prevention candidate in a family will be detailed in each child's child-specific prevention plan, nested within the Family Services Agreement. The family's case goals, and other Title IV-B services provided to the family are also included in the Family Services Agreement. By leveraging this tool to also document the Title IV-E prevention services, NCDHHS can provide an authentic system of care and service coordination between services provided to families under the Title IV-B and Title IV-E programs. NCDHHS is in the process of hiring seven (7) Regional Prevention Specialists who will connect

DSS county leadership and frontline staff to available services through child welfare, Medicaid, and the community within their region and county. The Regional Prevention Specialists will provide ongoing technical assistance to their assigned regions to ensure that families are linked to the most appropriate service, regardless of how that service is funded.

The in-home services case manager will document the following in the Family Services Agreement for prevention candidates:

1. The name of each candidate child and the identified imminent risk criteria for entry into foster care
2. Prevention service(s) provided to prevent the candidate child(ren)'s entry into foster care and which candidate child the service(s) will benefit (this will serve as the child-specific prevention plan)
3. Service category of each prevention service provided (Mental Health, Substance User, and) Parenting correlating with the Family Child Strengths and Needs Assessment
4. Identified need(s) of each candidate child and caregivers
5. Start and end dates for each prevention service provided
6. Completion status (if service not completed, document the reasons why)
7. Case goals for the caregivers to address imminent risk (reasons agency's involvement and prevention services)

The Family Services Agreement, inclusive of the child-specific prevention plan of each candidate child in the family, can be modified at any time, but must be modified in accordance with state policy every 90 days to monitor service progress. Additionally, in-home case managers will assess prevention candidates' safety and risk at all encounters and if the EBP is not bringing about the desired risk reduction a Child and Family Team Meeting (CFT) will be convened to address safety concerns and necessary steps to reduce risk or address the need for placement.

Out-of-home case managers and their supervisors will follow the same process for pregnant and parenting foster youth to ensure that they are matched with the appropriate prevention EPBs to prepare them to parent and/or strengthen their parenting skills. The prevention services provided for pregnant and parenting youth in foster care along with the foster care prevention strategy for their child(ren) will be documented in their Foster Youth Service Plan, NCDHHS's formal service planning tool for out-of-home permanency case plans. On-going assessment will occur every 90 days or more often if there is a material change in circumstances for the pregnant and parenting youth in foster care. If it is determined that the EBP is not bringing about the desired risk reduction a CFT will be convened to address safety concerns. Necessary steps to reduce risk or address the need for placement will be taken as indicated.

Updated assessments will inform Family Service Agreement reviews and modifications. In alignment with service planning procedures, in-home services will review Family Service Agreements, inclusive of candidate children's prevention plans, every 90 days to monitor and

track progress during the provision of services. Out-of-home services case managers will review the Family Services Out of Home Case Plan of pregnant and parenting foster youth receiving prevention EBPs every 90 days to monitor and track progress during the provision of prevention services.

Providing Service Referrals and Ensuring Service Linkage

Prevention candidates, their families, and pregnant and parenting youth in care may receive direct referrals to non-clinical providers for non-clinical EBPs. For eligible populations for whom EBPs provided in clinical, or Medicaid settings are appropriate, the in-home case managers and out-of-home case managers will provide referrals for comprehensive clinical assessments (CCA) to ensure eligibility for the clinical EBPs. CCAs are not necessary for Triple P, Homebuilders, and PAT, but are for MST and MMT.

Findings from the Project Broadcast Trauma Screening tool will be shared with EBP providers working with families and pregnant and parenting foster youth to ensure that services are provided using a trauma-informed approach. NCDHHS will provide training on the Project Broadcast Trauma Screening tool to the child welfare workforce.

NCDHHS understands that the appropriate prevention services may not always be available to meet the needs of Title IV-E eligible populations. In these events, in-home services case managers will indicate on the child-specific prevention plan of the Family Services Agreement when no appropriate prevention services for the candidate child are available. Out-of-home case managers will follow the same process for pregnant and parenting foster youth using their Foster Youth Service Plans. NCDHHS intends for the menu of prevention services to expand and evolve to align with the needs of Title IV-E eligible population over time., NCDHHS will use the information gathered on needed, but unavailable services, to inform further development of the prevention services menu.

North Carolina will also employ seven Regional Prevention Specialists. The Regional Prevention Specialist will be responsible for building prevention networks and ensuring that NCDSS offices in catchment areas are aware of all available services that NCDSS funds or supports including those services funded by IV-B. The Regional Prevention Specialist will also work to create a shared site describing where programs are located and how they may be accessed. This shared site will be available to relevant NCDSS staff. NCDSS staff also have access to NCCARE 360 which is a statewide network that unites healthcare and human services organizations and enables a coordinated, community-oriented, person-centered approach for delivering services. The Regional Prevention Specialists will provide ongoing technical assistance to their assigned regions to ensure that families are linked to the most appropriate service, regardless of how that service is funded.

Section V: Monitoring Child Safety

Pre-print Section 3

NCDHHS will ensure that the safety and risk of each prevention candidate are monitored accurately, regularly, and comprehensively throughout the 12-month period they and their caregivers receive prevention EBP services. NCDHHS safety and risk assessment protocols for children receiving in-home services and for youth in foster care are outlined in North Carolina's long-standing policies and procedures and will be followed for the Title IV-E eligible populations specified in this plan.

North Carolina currently uses the following SDM tools: intake assessment, safety assessment, risk assessment, case plan tool/family strength and need assessment tool, reunification assessment and risk reassessment. The workforce is trained in using these tools for decision-making support.

In keeping with state policy, in-home services case managers will use the formal assessment tools, SDM Safety Assessment, SDM Risk Assessment, Strengths and Needs Assessment, and the SDM Risk Reassessment to monitor safety and risk of prevention candidates every 90 days following case opening and at critical moments during the case. All required state forms will be completed, signed, and dated by in-home case managers and their supervisors throughout the life of the case. Additionally, in-home services case managers will informally assess prevention candidates' safety and risk through observations of and conversations with prevention candidates and their families during bimonthly, face-to-face visits. The out-of-home services case manager will apply the same risk and safety assessment process to monitor safety and risk of pregnant and parenting foster youth receiving prevention EBPs.

The Family Risk Reassessment is a tool used to assist the CPS In-Home and Out-of-Home Services case manager in determining risk of future abuse and/or neglect. Together with the Family Strengths and Needs Assessment and the progress made in the service agreement, it assists the case manager in determining the required service level intensity. Reassessments are performed at established intervals as long as the case is open. Case reassessment ensures that both risk of maltreatment and family service needs will be considered in later stages of the service delivery process and that case decisions will be made accordingly.

At each reassessment, the case manager reevaluates the family, using instruments which help systematically assess changes in risk levels. Case progress will determine if a case should remain open or if the case can be closed. While the initial risk assessment has separate scales for abuse and neglect, there is only one risk scale for reassessment. The focus at reassessment is the impact of services provided to the family during the period assessed or on whether certain events in the family have occurred since the last assessment.

Ongoing Risk and Safety Monitoring Using Formal Tools and Case Contacts

Assessment case managers will use the formal assessment tools, the SDM Risk Assessment and SDM Safety Assessment, for initial assessments of prevention candidates. Once prevention candidates have cases opened in-home services, their cases will be staffed as related to the risk rating in accordance with the In-Home State Policy. Case staffing will be primarily documented in the record by the relevant case manager and supervisor with signatures of both on the staffing form.

While the public agency case is still open during the 12-month candidacy period, the in-home case manager or out-of-home case manager will coordinate and collaborate with EBP service providers serving candidate children and pregnant and parenting foster youth to ensure that ongoing informal risk and safety assessments are conducted through conversations and observations with the family. NCDSS will utilize their contractual relationship with EBP prevention providers to address the administrative activities required by the Family First legislation. A close collaboration and continuous communication of ongoing risk and assessments, service provision, and data reporting will occur between the providers and NCDSS to modify child-specific prevention plans throughout the 12-month candidacy period. Providers will also reassess the need for continued services and re-determination at the end of the 12-month period.

To promote family stability and prevent foster care entry, the in-home services case manager will monitor safety and risk assessment findings in tandem with the family's progress toward case goals, outlined in the Family Services Agreement by the responsible in-home case manager or service provider. If the assessments indicate that the prevention candidate's risk of foster care entry is not decreasing at a reasonable rate as prevention EBPs services are provided, the Family Services Agreement, inclusive of the child-specific prevention plan, will be re-assessed and modified in partnership with the family and the EBP provider. NCDHHS recognizes that there is no standard rate of diminishing foster care entry risk as each prevention candidate's risk will vary according to the context of the case, family circumstances, and the required duration of each prevention EBP provided. Based on the consultation, the case manager and supervisor will utilize their professional expertise to determine if a prevention candidate's risk of entry into foster care is decreasing in a timely and appropriate manner and whether modifications to the Family Services Agreement are needed during the 12-month period of prevention candidacy.

In-home case contact requirements are outlined in Table 2 below.

Table 2. In-Home Case Contact Requirements

All Cases	Moderate Risk of Maltreatment Rating	High Risk of Maltreatment Rating
WITHIN 7 DAYS OF CASE DECISION:	• Twice monthly contact with all victim children	• Weekly contact with all victim children

• Contact with all family members (assessment case manager should do introduction)	• At least one contact must be in home unless child is placed with TSP	• At least two contacts must be at home unless the child is placed with TSP
WITHIN 30 DAYS: • IH-FSA development/signed agreement with family to mitigate safety risks	• Twice monthly contact with parent caregivers	• At least weekly contact with parents/primary caregivers
• Monthly contact with non-residential parents without safety concerns	• Monthly contacts with non-victim children and other household members	• At least twice monthly contact with non-victim children and other household members
• At least twice monthly collateral contacts		

Section VI: Evaluation Strategy and Waiver Request

Pre-print Section 2

Overall Approach to Evaluation and Continuous Quality Improvement (CQI)

Family First requires each EBP service submitted in a state's Prevention Plan to include a well-designed and rigorous evaluation strategy. The Children's Bureau may waive this requirement for a well-supported EBP if the state provides compelling evidence of the effectiveness of the EBP and meets the CQI requirements.

North Carolina will use a phased strategy to implement five evidence-based programs with the support of a state Director of FFPSA, as well as seven (7) Regional Consultants. The use of Homebuilders and PAT will be implemented across the state on a regional basis through state contracts with providers. During the initial phase of prevention plan implementation, the focus will be to support the needs of children and families in North Carolina's target population for candidacy: children receiving in-home services, and pregnant and parenting youth in foster care. The implementation of MST, Triple P, and MMT will be implemented as part of the next phase of EBP scale up as North Carolina continues to assess statewide clinical provider capacity for implementing MST and MMT and identify an evaluation partner for Triple P and MMT.

North Carolina is seeking an evaluation waiver for Homebuilders and PAT; both are rated as well-supported programs. Evidence of effectiveness for each EBP was provided in Section III of this plan and evaluation waiver requests for both interventions are attached.

Overall CQI Approach

A consistent statewide CQI strategy will be utilized to monitor North Carolina's prevention plan. This strategy will align with the planned implementation of a statewide CQI model as part of North Carolina's CFSP. Specifically, North Carolina will employ a CQI measurement framework that lays out metrics to understand the ***reach*** of the proposed interventions, to monitor the ***fidelity*** of the proposed interventions, and to assess if the intervention-specific and overall Family First desired ***outcomes*** are achieved. The CQI process for the well-supported interventions will address a common set of cross-cutting research questions.

North Carolina will use the following core set of cross-cutting research questions to guide the CQI process for Family First implementation and ongoing monitoring for effectiveness:

a. Cross-cutting research questions for **reach**:
   i. Are Family First candidate children/families being identified and referred to EBP services?
   ii. Are referred children/families receiving EBP services?
   iii. What are the characteristics of referred children/families receiving EBP services and do they differ from referred children/families not receiving services?

iv. What is the length of time from referral to the start of services for children/families?

v. Are children/families completing services?

vi. Are there regional variations in EBP referrals, service receipt, and service completion?

b. Cross-cutting research questions for **fidelity**:

i. Do the referred children/families meet the eligibility requirements for each specific EBP model?

ii. Are the EBP services delivered as prescribed by each specific EBP model and guiding manual/curriculum (e.g., fidelity to the model)?

iii. How many EBP service sessions took place and is this consistent with the EBP model?

c. Cross-cutting research questions for **outcomes**:

i. *Child safety outcomes:*

1. Does EBP service *receipt* reduce maltreatment? Are children re-referred for suspected child maltreatment within 12 months of the child-specific prevention plan start date? Within 24 months?
2. Does EBP service *completion* reduce maltreatment? Are children re-referred for suspected child maltreatment within 12 months of EBP service completion? Within 24 months?

ii. *Child permanency outcomes:*

1. Does EBP service *receipt* reduce foster care entry? Do children enter foster care within 12 months of the child-specific prevention plan start date? Within 24 months?
2. Does EBP service *completion* reduce foster care entry? Do children enter foster care within 12 months of EBP service completion? Within 24 months?

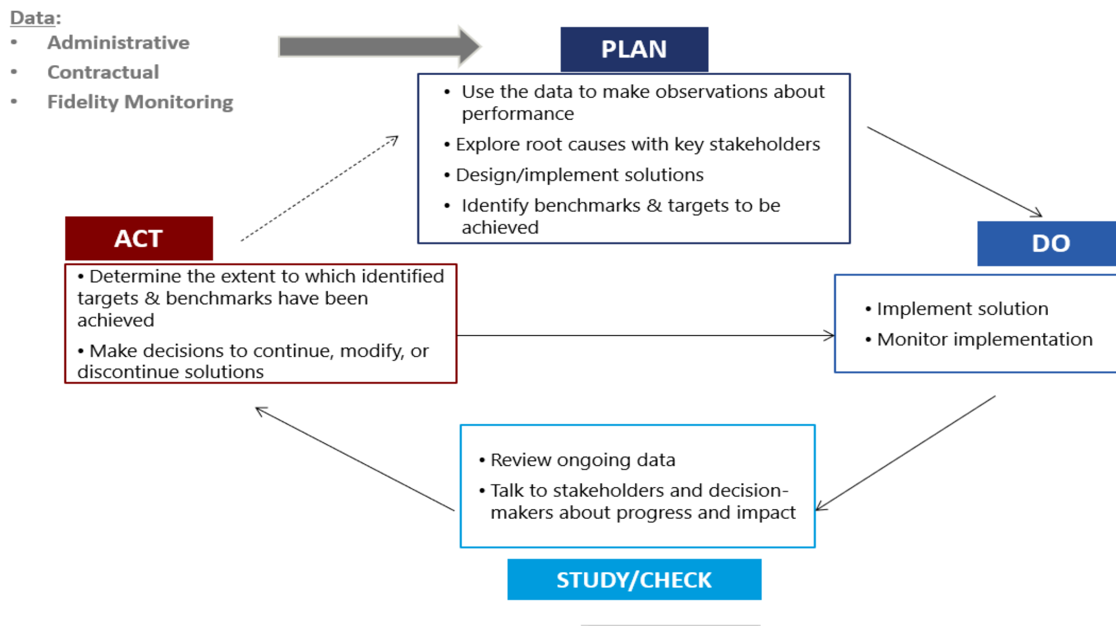
The Business Information and Analytics department will be making the IT system adjustments needed to collect and report data to answer the cross-cutting research questions related to reach. Data needed to answer the cross-cutting research questions related to fidelity will be collected using data from the EBP contract and fidelity monitoring processes outlined in the section below, and the research questions related to outcomes are currently captured.

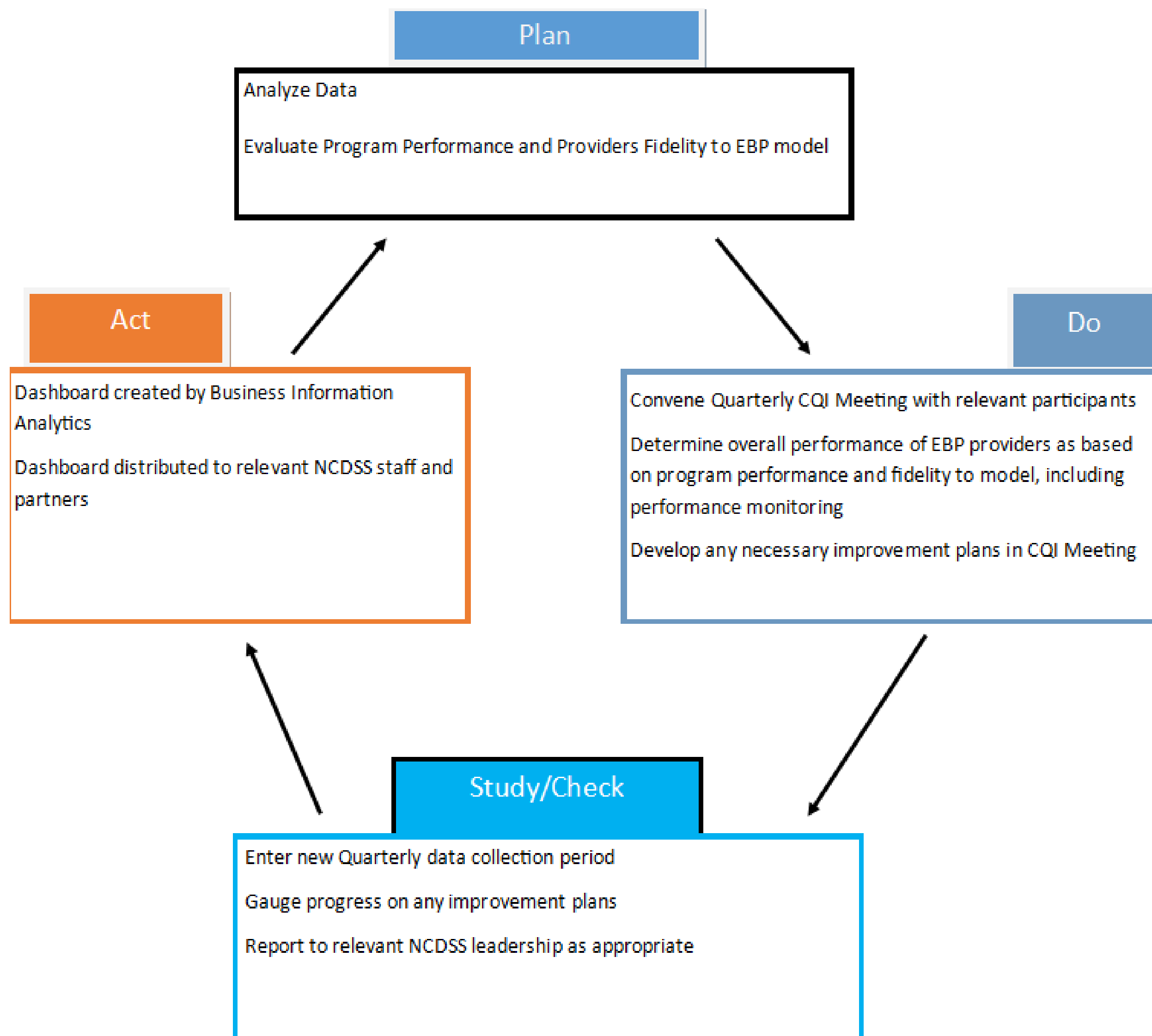
The Business Information and Analytics department will produce user-friendly dashboards that will be made available to Section Chiefs, local NCDSS Directors and Regional CQI Specialists. CQI specialists will analyze dashboard data and confer with Family Support Program Consultants regarding contractual performance and fidelity monitoring for EBP service providers in their assigned counties on a quarterly basis. CQI Specialists and Program Consultants will collaborate

to convene CQI meetings at the county and regional levels with NCDSS Directors, in-home NCDSS staff and providers that consist of sharing data reports and facilitating performance improvement discussions using North Carolina's CQI Four-Step Framework. The Framework entails the following:

1. Using multiple types of data to **identify performance issues**
2. **Researching and deciding on solutions** that are a good fit for the state, region, and/or county
3. **Implementing the solution** along with any necessary implementation supports, and
4. **Monitoring and evaluating the solution** to assess impact

The framework will be operationalized using the Plan-Do-Study Act (PDSA) rapid cycle improvement planning process.





Within the overall North Carolina CQI structure, efforts will be directed to support the comprehensive and focused implementation of Family First. Integration with North Carolina's overarching CQI Plan will be critical. Additional efforts will include the development of a Family First CQI team beginning at the County level and reaching up to the Regional and State leadership level. This Family First CQI team will also include EBP providers, youth, and families with a focus on the successful implementation of North Carolina's IV-E Prevention Plan. Teams will meet on a quarterly and annual basis using data to solve problems and improve outcomes. Emphasis will be placed on establishing clear feedback loops regarding key phases of implementation including installation, initial implementation and full implementation, processes for reporting findings and a mechanism for communicating lessons learned.

EBP Fidelity Monitoring

Quality, trauma-informed prevention programs that strengthen family resilience and protective factors offer great promise for improving a child's overall well-being. When delivered with model fidelity, evidence-based programs can increase the capacity of caregivers to care for their children, help children develop healthy coping mechanisms, improve caregiver-child relationships, and reduce family stress. Based on prevention research, North Carolina will fund family support models that provide community-based outreach, support and services to children and their families identified as being at-risk of compromised health and safety to reduce those risks by promoting protective factors. Community agencies contracted to provide evidence-based programs as part of North Carolina's prevention plan must meet the following requirements:

1. Provide voluntary services based on the Principles of Family Support Practice.
2. Demonstrate a commitment to meaningful parent engagement and leadership opportunities.
3. Provide prevention services that target populations most at risk of child abuse or neglect.
4. Promote the five protective factors linked to lower incidence of child abuse and neglect.
5. Promote racial equity, diversity and inclusion within the agency and programs.
6. Use evaluation tools to demonstrate positive outcomes for children and families.
7. Provide a plan to maintain program fidelity through implementation support through the integrated efforts of the State and Regional FFPSA Consultants, Contracting Monitoring staff and Regional CQI staff.

The NCDSS Community Prevention Programs uses a variety of tools and strategies to regularly monitor both financial and programmatic information from contracted agencies during each contract year and will carry out a similar process for EBP contracts.

Contract Monthly Monitoring:

Fiscal monitoring will take place monthly as contracted agencies submit invoices and general ledger to the Program Consultant. The Program Consultant will use this information to ensure that costs are allowable and reasonable. Additionally, Family Support Programs EBP providers will be required to enter program information monthly into a unique EBP database that will track the EBPs' start and end dates, participant attendance dates, and participant demographic data, including child's age, race and ethnicity. The Program Consultant will complete a data check each month to ensure that agencies have entered their data.

The NCDSS Program Consultant will facilitate regular meetings for EBP providers) to participate in peer sharing and learning. During these meetings, the Program Consultant will not only share program and agency information, but also assess providers strengths, challenges, and capacity to determine ongoing technical assistance needs.

Contract Quarterly Monitoring:

NCDSS will require all EBP providers to complete and submit a Performance Monitoring Report every quarter. The report will require cumulative outputs and outcomes specific to the program being delivered, questions regarding fiscal management, programming, and program outcome information. In addition, the report includes several open-ended questions that agencies respond to in a narrative format. These questions will allow agencies to share strengths, successes, challenges and barriers their programs experienced during the quarter. Agencies will also be asked to share how they plan to address the challenges/barriers. During the FFPSA planning process the unique challenges of rural counties access to services was just one example of specific challenges that will need to be addressed by providers and monitored by the Contract Monitoring staff. Other narrative questions will request information related to how the EBP provider has implemented or promoted parent engagement and leadership, collaboration with partner agencies, protective factors, cultural competency/racial equity, and implementation support during the quarter. By reviewing quarterly Performance Monitoring Reports, the Program Consultant will assess how the provider is performing regarding output, outcome, and compliance requirements of the contract. The Program Consultant will work with each EBP Provider to ensure that the model fidelity tools, or essential requirements are being utilized in the manner and method as identified by the purveyor. Information gathered throughout these, and other processes will also be shared through the statewide CQI process.

The NCDSS Consultant will offer quarterly call/meetings to provide technical assistance and share information, as well as gain information from providers regarding areas where they are experiencing successes, as well as any challenges. This information helps determine topics for individual and group technical assistance and program monitoring.

Contract Annually Monitoring:

A Monitoring *Call will* occur annually with each provider agency after the NCDSS Program Consultant has reviewed the first or second quarterly report. This Monitoring Call allows the Program Consultant to ask deeper questions about service delivery, database entry, outputs, implementation support, collaboration, protective factors, and racial equity. After each Monitoring Call, a *Risk Evaluation Matrix* will be completed based on the information gained from the Monitoring Call. NCDSS will use risk assessment scores to prioritize monitoring reviews for the year. Agencies who fall into the high-risk category may receive ongoing monitoring on a more frequent basis.

Monitoring Review: Every three years during the grant cycle:

A *Monitoring Review (either on-site or virtually)* occurs with each contracted agency at least once during the three-year grant cycle. If there are concerns regarding an agency's performance an on-site monitoring visit may occur more than once. The monitoring visit includes a review of the Fiscal, Organizational Capacity and Programmatic information, as well as an interview with agency/program staff. A pre-identified time frame is determined by the Program Consultant and is shared with the agency in a monitoring notification letter, for them to gather needed documents and materials for the On-Site visit. These visits may occur on site or virtually.

General Ongoing Monitoring:

Through regular phone and email contacts with agencies, the Program Consultant is constantly monitoring contract and program compliance, successes and any challenges contracted providers may be experiencing. Model fidelity is a critical component to successfully implementing evidence-based programs, ensuring that the program is delivered consistently as the developer intended to achieve desired outcomes. All contracted agencies will be required to maintain model fidelity. These tools and strategies will be reviewed and updated as needed to include model specific EBP fidelity measures that will be monitored in the CQI process. North Carolina's Prevention and Safety Section Chief and County Operations Section Chief will provide contract oversight for implementation, fidelity measures and EBP specific outcomes.

Parents as Teachers (PAT)

There are currently 42 PAT affiliate programs in North Carolina operating in 44 counties. North Carolina plans to partner with the PAT national organization for data collection and CQI. The PAT national organization collects data and monitors PAT fidelity through annual reviews of the affiliated PAT providers. Their CQI process covers tracking and evaluating service delivery and outcomes as well as monitoring staff requirements, including supervision, training and workload. PAT-affiliated providers are required to meet specific CQI measures referred to as Essential Requirements and Quality Standards. To meet these CQI measures, affiliates use a PDSA (Plan, Do, Study, Act) model. Together, the Essential Requirements and Quality Standards form the basis for the PAT Quality Endorsement and Improvement Process (QEIP), which is the process that affiliates go through to demonstrate their commitment to high-quality services and to potentially earn a "Blue Ribbon" designation.

The PAT national organization expects affiliates to engage in CQI of operations and service delivery on an ongoing basis and use a recognized CQI method to make improvements. PAT also provides technical assistance to its affiliates to assist with fidelity monitoring throughout the year. There is a year-end report due annually. If affiliates are not meeting certain benchmark percentages of the Quality Standards and Essential Requirements, they need to complete a "Success Plan," which outlines how they will improve in areas where they did not meet the benchmark measurements. If an affiliate requires a "Success Plan," they are labeled a "Provisional Affiliate," and will be expected to participate in rapid CQI processes using PAT worksheets and to participate in Technical Assistance (TA) work with an assigned PAT staff person. Once the minimum benchmark measures have been met, they will return to being a regular affiliate. North Carolina will partner with the PAT Support Specialist to obtain PAT fidelity monitoring reports and other performance information. The benchmark tools put forth by the PAT national organization will be the primary form of fidelity monitoring.

Homebuilders

North Carolina will issue a request for proposals (RFP) to develop 11 Homebuilder teams across all seven social service regions. NCDSS will contract with the Institute for Family Development (IFD) model purveyor, to provide training, implementation support, and ongoing fidelity monitoring. Practitioners, supervisors, and program managers receive initial and ongoing training, consultation, and support to deliver quality services and ensure fidelity to the Homebuilders model. The

Homebuilders Quality Enhancement System (QUEST) includes start up consultation and technical assistance, webinars, 15 -17 days of workshop training for all staff during the first two years, an additional two to four days of workshop training for supervisors and program managers, ongoing team and supervisor consultation with a highly trained and experienced Homebuilders' consultant, fidelity reviews and site visits. North Carolina will partner with the IFD purveyor to obtain fidelity monitoring reports and other performance information. QUEST and other tools put forward by IFD will be the primary form of fidelity monitoring conducted through a partnership with IFD. Reports generated by IFD will be the primary fidelity monitoring tool and North Carolina will monitor all IFD reports that are necessary to ensure fidelity to the model.

Section VII: Child Welfare Workforce Training and Support

Pre-print Section 5

A long-standing partnership between the University of North Carolina (UNC) at Chapel Hill, North Carolina State University, and the training division at NCDSS has established a training consortium that provides core and specialized training to the child welfare workforce including frontline case managers, supervisors, and foster parents. NCDSS and its partners are committed to a child welfare transformation that supports and enhances a competent, skilled, and professional child welfare workforce.

As NCDSS' child welfare transformation is unfolding, one of the primary strategies is revamping the core training curriculum for the current workforce. Embedded in the training redesign will be incorporation of transformation components both individually and comprehensively so that all will understand how Family First embeds into the agency's larger transformational vision and their work. Incorporation of the SOP practice model and specific Family First training will aid in this transformation. The following section will outline the current training and support as well as those that will be developed to align and support the Family First implementation.

EBP provider workforce

All evidence-based programs selected as part of North Carolina's Title IV-E Prevention Plan will be administered with a trauma-informed framework through external prevention providers. As part of the provider readiness assessment survey outlined earlier in this plan, providers described their compliance with the trauma informed requirements of the Family First legislation in addition to their EBP service availability, capacity, and internal continuous quality improvement systems. Prevention providers will be responsible for their own workforce training to ensure trauma-informed service delivery and EBP fidelity. Oversight and monitoring of these requirements will occur via the contract compliance division with NCDSS utilizing the contract monitoring tool as well as the Continuous Quality Improvement (CQI) processes outlined in this plan. Request for Proposals (RFP) and contract language will incorporate Family First Prevention Services Act services quality and data collection requirements including all administrative activities allowable for the community pathways post closure of the child welfare agency case. Partnerships with sister agencies and existing provider networks will support an incremental expansion of evidence-based prevention services. Integral to the EBP provider's ability to provide trauma informed service delivery is timely and appropriate sharing of information during the referral process. NCDSS agency staff will share summary documentation from the SDM assessment tool and trauma screening tool findings.

Additionally, North Carolina will contract with purveyors of Homebuilders and PAT to train the provider staff for proper administering of the program and ensure fidelity monitoring oversight including staff training and certification. North Carolina Staff Development staff will train county staff on the assessment and referral process to EBPs.

Also, research shows that programs are most effective when providers receive regular, on-going implementation support. Agencies benefit from specific implementation support around developing recruitment plans to attract, enroll, and retain eligible program participants; hiring skilled and experienced staff; delivering curricula content; strengthening adherence to model fidelity; making program material relevant to participants, and increasing practitioners' confidence and competence in delivering programs.

All EBP contractors must obtain and participate in implementation support during each contract year to ensure continued model fidelity and program sustainability. In addition to participating in implementation supports required by the model, contractors may also participate in learning collaboratives, pre and post capacity questionnaires, coaching calls, goal development and monitoring, site visits, observation, videotaping, and learning collaboratives.

North Carolina will provide all contractors with an annual Prevention Action Network membership. The Prevention Action Network is an affiliation of organizations, professionals and concerned citizens who are committed to strengthening and supporting families. Members represent diverse fields such as primary childhood, education, public health, mental health, child protection, medicine, domestic violence prevention, law, and family support. The Prevention Action Network offers members access to training, resources, and networking opportunities to help them strengthen their capacity to serve North Carolinians.

North Carolina's child welfare training

Training requirements are currently in place for all child welfare case managers, supervisors, and foster parents. Training requirements have evolved to a system requiring pre-service and in-service training, which teaches child welfare staff to ensure safety, permanence, and well-being for children Child welfare services workers shall complete a minimum of 72 hours pre-service training and additional position specific training before assuming direct client contact responsibilities.

Child Welfare in North Carolina: Pre-service is a three-week competency based **pre-service** curriculum that is designed to provide new case managers and supervisors with an overview of the child welfare system. This 100-series, foundational course is required of all new NCDSS child welfare case managers and supervisors prior to direct client contact. Participants will complete self-paced online learning modules and attend eight classroom days of training. There is no prerequisite for this course. Here is how the course is organized:

- Week 1 – in the agency – self-paced online component (13 learning modules)
- Week 2 – four classroom training days
- Week 3 – four classroom training days

The 200 series training events are divided into Tier 1 and Tier 2. Courses in this series provide more in-depth knowledge and application of social work theories, procedures, and practice. The target audience for these training events is case managers and supervisors who have no more

than one year of experience. These training courses include but are not limited to the following courses to support the implementation of North Carolina's Prevention Plan:

- **Reasonable Efforts: What Supervisors Need to Know**
- **Advocating for Child and Adolescent Mental Health Services**
- **Child Development and Effects of Trauma**
- **Substance Use: How to Work with Families Affected by Drugs and Alcohol**
- **Navigating Child and Family Teams**
- **Preventing Premature Case Closures in CPS In-Home Services: A Course for Supervisors**

For comprehensive information regarding NCDSS child welfare workforce training, please see the North Carolina Training Plan 2020-2024 submitted with the North Carolina CFSP 2020-2024. North Carolina's 2020-2024 plan identifies a multi-year training commitment to enhance case managers' skills related to connecting to families served, specifically through the development of a Practice Model and Practice Standards.

Trauma informed child welfare workforce

NCDSS is committed to infusing trauma-informed and trauma-responsive practices across all child welfare policies, procedures, and community-based programming. North Carolina's current training curricula consists of the following trauma related courses:

1. ***Trauma Screening 101***
   Format: Online On-demand course (One hour)
   Required: During pre-service
   Audience: Child Welfare workers (case managers, supervisors, program managers and administrators, and directors) employed in a NC county child welfare agency.
   Description: Course familiarizes learners with the Project Broadcast Trauma Screening Tool, provides video demonstrations of its use, and outlines possible next steps for counties considering implementation.
   Title IV-E Administrative Functions this Training Addresses: Social work practice, case management
   Duration: Full- time (offered 24/7 on an ongoing basis)
   Provided by: Family and Children's Resource Program, Jordan Institute for Families, UNC

2. ***Child Development and Effects of Trauma***
   Format: Online On-demand course (Six hours)
   Required: Within first year of employment
   Description: This six-part series focuses on how caregivers can support healthy child development in infancy, primary childhood, school-age, and adolescence. It also explores ways to support youth whose development has been disrupted by trauma.
   Title IV-E Administrative Functions this Training Addresses: Case management

Duration: Full-time (offered 24/7 on an ongoing basis)
Provided by: Family and Children's Resource Program, Jordan Institute for Families, UNC

Family First Prevention Services Act training

New Family First specific training will begin in the fall of 2022 via a virtual platform. The initial training launch phase will be deployed to all existing staff and phased in to in-person training to include all new onboarding staff in early, 2023. The training will include the agency's vision for family services and how the Family First legislation will serve as a lever for child welfare system transformation. Core elements of the Family First training will include candidacy determination, child-specific prevention plan development, EBP programming selection and referral process, ongoing risk and safety assessment, Project Broadcast, and documentation requirements. As indicated above, all staff will receive Family First specific training.

The University of North Carolina will assist in developing three (3) hour long webinars that will assist staff in understanding the necessary components of Family First. The first webinar will focus on the identification of candidates for foster care and requirements for claiming Title IV-E funds. The second webinar will focus on the development of a child specific prevention plan. The third webinar will focus on evidence-based services and how family serving staff can ensure the ongoing appropriateness of the service. A post-test will be required for the child specific prevention plan webinar. Participants must obtain a passing score to complete the training. All training will be conducted and created through a trauma-informed lens.

All staff will be required to complete the training within ninety (90) days of the training being posted and new staff will complete the training within sixty (60) days of assuming case management responsibilities. DHHS will work to embed the Family First specific training into pre-service and foundational courses which will ensure all new staff are trained prior to serving children and families. These Family First specific trainings will additionally support case manager's in assessing if families meet the referral criteria, assessing eligibility criteria for the specific EBP, understanding and ability to develop child specific prevention plans, case manager's abilities to assess children and families' needs, case manager's ability to support families they work with, and how case managers can access trauma-informed and evidence-based services.

North Carolina is cognizant of the complexities of developing training to support worker's understanding and decision making related to

- Candidacy decisions
- Development of the prevention plan
- SDM
- Matching of child and family needs to relevant EBPs
- Support and participation of the case manager in the implementation of the identified EBPs and
- Skills to balance family support and child safety.

The Department is engaged in developing an enhanced curriculum and anticipates working with purveyors and providers to develop basic EBP training and support for case managers.

The Department is working with Casey Family Programs to develop work force training around racial diversity, equity and inclusion. Additional training to specifically support supervisors in their role of assisting case managers in identifying family first candidates, family engagement, and service alignment and linkage will be offered to strengthen the workforce. Coaching for case managers, supervisors, resource parents, and other stakeholder groups, along with modifications to existing training will be embedded in this work to support Family First prevention services implementation.

All child welfare staff currently have access to a one-hour on demand online course specific to Rylan's Law and the Family First Prevention Services Act.

1. ***Family First Prevention Services Act***

   Format: Online On-demand course (One hour)

   Audience: Child Welfare workers (case managers, supervisors, program managers and administrators, and directors) employed in a NC county child welfare agency.

   Description: This course provides information on child welfare reform in North Carolina, including an overview of Rylan's Law and Family First Prevention Services Act. These are important state and federal laws that, once implemented, will transform how child welfare programs are supervised and administered in North Carolina.

   Title IV-E Administrative Functions this Training Addresses: Case management

   Duration: Full-time (offered 24/7 on an ongoing basis)
   Provided by: **Family and Children's Resource Program, Jordan Institute for Families, UNC-CH**

Safety Organized Practice Model

The SDM tool and integration of the Safety Organized Practice (SOP) model will promote a more consistent, equitable, and accurate decision-making process leading to better outcomes for children, youth, and families. Improved integration of quality risk and safety assessments into the agency's existing policy, practice, training and CQI activities will support a more consistent practice model and identify clearer pathways to community prevention services. A three-phase multiyear process will be supported by Evident Change® in the implementation for the practice model redesign. The three phases consist of pre-implementation activities, implementation activities, and sustainability activities.

Innovative practices offered through the SOP practice model will be implemented with the SDM tools to facilitate rigorous engagement and strength-based partnership with families. Top priorities of the SOP include safe stabilization and preservation of families, safe and quick

reunification of children to their families of origin, and safe creation of new culturally safe and permanent families for children. The design of an SOP implementation plan will include training and coaching on tools consistent with North Carolina's values of being safety-focused, trauma-informed, family-centered, and culturally competent. The practice model design will be integrated with North Carolina's implementation of the Family First Prevention Services Act to further support case managers with high quality assessment processes and improved engagement with families in the identification EBP need, candidacy determinations, development of child-specific prevention programs, and service linkage.

Implementation Teams, Training, and Coaching

Newly created statewide and regional implementation teams will help inform the implementation of the practice model in a consistent manner that considers the big picture as well as local needs. They provide strategic input to strengthen partnerships with stakeholders, bridge communication, and support consistency to model fidelity.
The agency workforce will be further supported through an accessible and hands-on coaching program development. Training and coaching are core components of the enhanced practice model and will include the following training:

- SOP Leadership Orientation*:* Half day for *all* agency leaders and any invited partners
- SOP Foundational Training: Three days for *all* agency staff and any invited partners
- Facilitative Supervisor Training: Two days for all leaders and supervisors
- SOP Intensive Series: One day long training per month over eight to 10 months. It is expected that practice leaders would be prioritized for the eight intensive module sessions so that they can act as mentors and ongoing support to other workers
- Working With and Across Difference: Two-day workshop for *all* agency leaders, then staff to follow
- Coaching Institute: Three days for all managers, supervisors, and practice leaders or external coaches. Follow up with onsite and distance coaching-of-coaches to build local coaching capacity
- Refresher Trainings: Annual refresher trainings to expose new staff and revitalize practice for all staff and invited partners

Once North Carolina's child welfare practice model is complete, statewide training will occur and the practice standards and tools will be used to assess skill-based core competencies to develop the skills of leaders, supervisors, and frontline staff. Although a specific timeline is not yet developed, it will occur in phases and be aligned carefully with the implementation of the Family First Prevention Services Act. Collaboration between the Evident Change team and the training team will produce new and enhanced curriculum development and training plans including training-for-trainers along with trainer support calls.

Section VIII: Prevention Caseloads

Pre-print Section 7

Public agency in-home ongoing case managers and community-based private prevention providers work in close partnership to serve families. Caseload size is an important factor in effective case management. NCDSS has established processes to determine, manage, and oversee caseload size and type for prevention case managers. NCDSS CPS in-home case managers have an established caseload ratio of 1:10 or less in their work with families. Supervisors and case managers determine, manage, and oversee caseload ratios through consultation and factors including worker experience, caseload type, and need. As Family First is implemented, County Directors will continue to monitor the caseloads of their staff. County Directors will have the discretion to monitor and adjust caseload distribution as necessary in order to align with current policy standards. Ongoing case consultation will assess any adjustment to prevention services or support for families and staff.

Community-based private prevention providers will maintain caseloads in accordance with the individuals EBP model. Fidelity to the model will be monitored and overseen as part of the contract monitoring within the contract compliance division within NCDSS. Requirements specific to caseload, staffing, trauma-informed model, and training will all be embedded within contractual documents and monitored through site visits, meetings, and report reviews utilizing the contract monitoring tool.

Prevention staff	Caseload standard
In-home NCDSS case manager	1: 10 or less
EBP community provider	In accordance with individual EBP caseload standards