THE COMPREHENSIVE PREVENTION PLAN LEARNING SERIES

casey family programs

IMPLEMATIX

CALTRIN California Training Institute

CDSS CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

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A brief survey will be available after the training.

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CALTRIN
California Training Institute

Hi. We're CalTrin!

Who we are

- The California Training Institute
- Funded by the State of California, Dept. of Social Services, Office of Child Abuse Prevention (OCAP)
- We support child abuse prevention in California through professional development and extended learning.

Training Domains

- Direct Service Delivery Skills
- Evidence-Based/ Evidence-Informed Service Delivery
- Management & Leadership Development
- Trauma-Informed Systems

This training was made possible with funding from the California Department of Social Services, Office of Child Abuse Prevention. Any opinions, findings, conclusions, and/or recommendations expressed are those of the CEBC /CalTrin and do not necessarily reflect the views of the California Department of Social Services.

THE COMPREHENSIVE PREVENTION PLAN LEARNING SERIES

THE COMPREHENSIVE PREVENTION PLAN
LEARNING SERIES

TODAY'S TOPIC:

ENSURING QUALITY AND FIDELITY TO ACHIEVE OUTCOMES

THE COMPREHENSIVE PREVENTION PLAN LEARNING SERIES

Dan Edwards, PHD, Licensed Clinical Psychologist; EBP Consultant

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Kelly Winston, LCSW; Chief, Family Centered Safety and Support Bureau, California Department of Social Services

Moderator: **Khush Cooper,** MSW, PHD, President & CEO Implematix

OUR PRESENTERS

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AGENDA

- Introduction to the Service Quality and Outcomes Domain – 10:15 am
- The Role of CQI in FFPSA Implementations - 10:25 am
  - Laying a foundation for continuous quality improvement (CQI)
  - Overview of a Prevention Services Measurement Framework to monitor progress
- BREAK – 10:55 am
- EBPs & Cross-Walk with FFPSA – 11:05 am
  - The Challenge with EBPs
  - What is model fidelity?
  - Purveyor Examples
- BREAK – 11:45 am
- Activating the Improvement Planning Process - 11:55 am
  - Strategies for planning and implementing improvements
- CDSS Framework for Improving Practice & Model Fidelity: Monitoring of EBPs - 12:15 pm
  - Plan Graphic
  - Stakeholder
- Concluding Thoughts – 12:30 pm
- Q&A (time permitting)

SERVICE QUALITY & OUTCOMES DOMAIN

Khush Cooper

READINESS DOMAINS

1. Governance (Jul 20, 2022)	2. Stakeholder Collaboration (Jul 20, 2022)	3. Fiscal and funding (Jun 29, 2022)
4. Program design and service array (August 17), 2022	5. Service quality and outcomes TODAY	6. Workforce training and development • County • Service providers
7. Policies, rules, and regulations	8. Reporting	9. Automation

ELEMENTS OF THIS DOMAIN

Integration strategy with existing Continuous Quality Improvement (CQI) system

Process metrics and reporting

Process improvement practices (as metrics suggest)

All CQI, fidelity monitoring, and/or evaluations required by purveyors of selected EBPs

Any locally desired evaluation and benchmarking of outcomes, especially the reduction of disproportionality

Any future statewide evaluation of prevention outcomes, especially the reduction of disproportionality

CONSIDERED READY IF/WHEN:

Written guidance has been developed for:

- Measures and outcomes that align with the state CQI requirements (in development) and specific EBP requirements
- Additional prevention measures or outcomes the Title IV-E Agencies or CDSS deems necessary to track for improvements to coordination and quality of services
- Process and cadence by which these measures and outcomes will be collected, stored, reviewed, acted upon, and shared
- The tools to be utilized to measure outputs and outcomes are consistent and align with the required outcome measures defined by the purveyor, state and the Title IV-E Agencies
- The required fidelity and outcome measures Title IV-E Agencies have been shared with EBP providers
- A process is in place which ensures data is shared with the state for a statewide evaluation

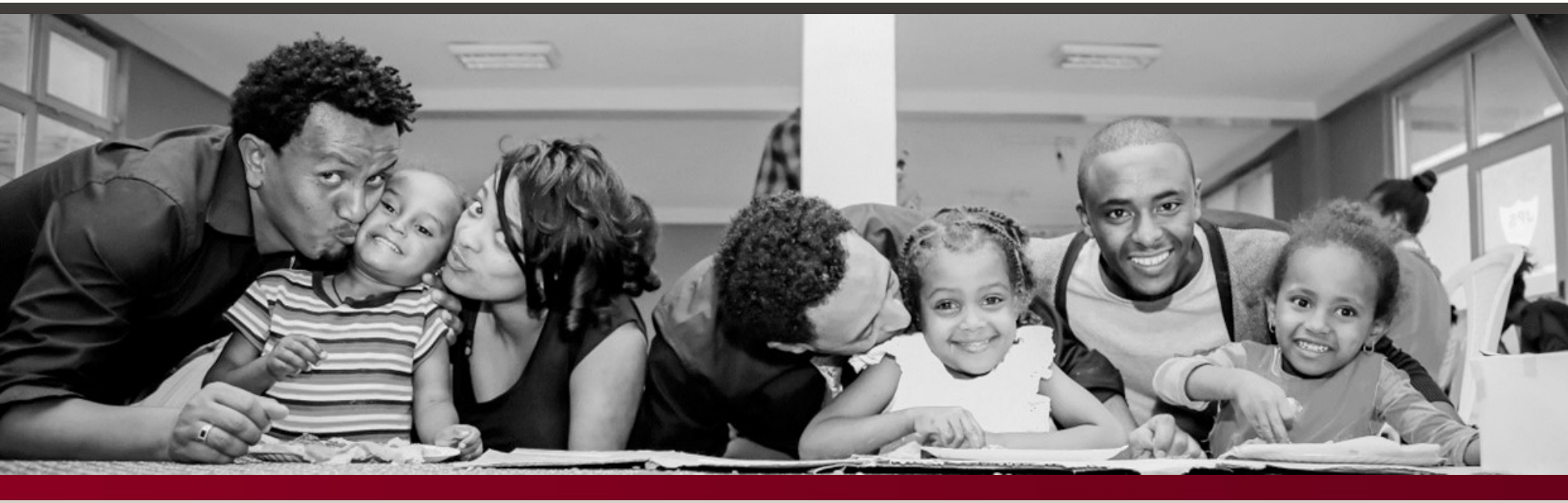
THE ROLE OF CONTINOUS QUALITY IMPROVEMENT

Yolanda Green-Rogers

CHAPIN HALL
AT THE UNIVERSITY OF CHICAGO

SEPTEMBER 21, 2022

Yolanda Green-Rogers, Senior Policy Analyst



THE ROLE OF CONTINUOUS QUALITY IMPROVEMENT IN PREVENTION PLAN IMPLEMENTATION

BEFORE WE BEGIN…

WHAT DO WE MEAN BY CONTINUOUS QUALITY IMPROVEMENT (CQI)?

CQI is a complete process for identifying, describing, and analyzing strengths and problems and then testing, implementing, learning from, and revising solutions.[1]

It relies on an organizational culture that is proactive, that supports **continuous learning**, and that is firmly grounded in the overall **mission, vision, and values** of the agency. Perhaps most importantly, it is dependent upon the **active inclusion and participation** of people with a diverse set of experiences throughout the process, including staff at all levels of the agency as well as children, youth, families, and other stakeholders.

[1]Administration on Children, Youth and Families. (August 27, 2012). Establishing and Maintaining Continuous Quality Improvement (CQI) Systems in State Child Welfare Agencies [ACYF-CB-IM-12-07].

WHY CQI?

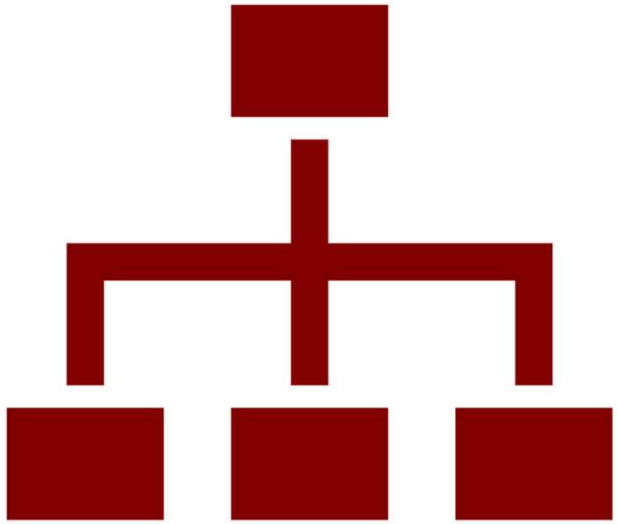
- Child welfare systems tend to be reactive.
- Child welfare systems struggle with turning data into evidence to understand the strengths and barriers impacting the achievement of child and family well-being goals and outcomes.

1. CQI provides a systematic and proactive approach for ongoing problem solving and decision making.
2. State required:
   - Comprehensive Prevention Plan
3. Federally required:
   - Family First Prevention Services Act
   - Guidelines for establishing and maintaining CQI systems in state child welfare agencies (IM 12-07)
   - Child and Family Services Review and Program Improvement Plans
   - 5-year Child and Family Services Plan (CFSP) and Annual Progress and Services Reports (APSR)
4. Accreditation and funders

FOUNDATIONAL ACTIVITIES OF CQI

EQUITY

INCLUSION

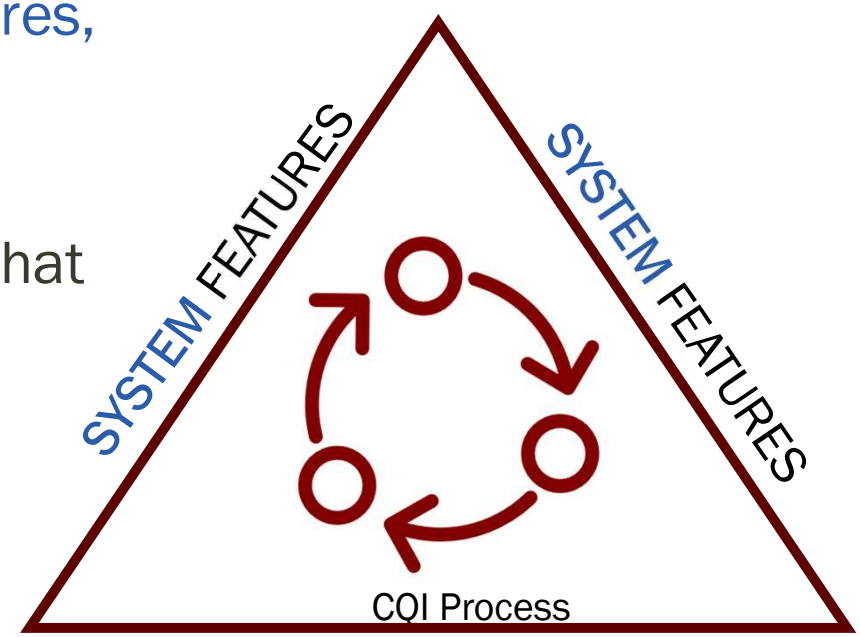


ASSESSING ADMINISTRATIVE STRUCTURES

SETTING THE STAGE FOR GOOD CQI

A sound **CQI system** supports the **CQI process**

- The CQI system is a coherent set of structures, policies, and procedures that support and facilitate the CQI process
- The CQI process is the improvement cycle that functions within the CQI system



CQI SYSTEM FEATURES

Wulczyn, F., Alpert, L., Orlebeke, B., & Haight, J. (2014). 'Principles, language, and shared meaning: Toward a common understanding of CQI in child welfare." Chapin Hall at the University of Chicago.

KEY CQI SYSTEM FEATURES

Organizational Commitment to CQI

Environment and culture

- Leadership promotes the use of evidence to make decisions
- Agency culture promotes continuous learning, analysis, and program improvement
- Adequate resources (personnel, time, training, skill-building) are devoted to CQI activities and available for all levels of staff

Data Processes

Data collection, analyses, and reporting

- Data are collected on the goals and outcomes the County cares about
- Data are routinely analyzed and converted into evidence to tell a story at the systems and case levels
- Meaningful reports are produced and shared with all levels of staff & key constituents

CQI Plan

Policy and procedures

- The county's goals and outcomes are closely aligned with CQI processes and drive them forward
- Specific data collection and reporting methods are clearly outlined for generating the information needed to support decision-making
- Improvement planning processes are clearly outlined and consistently followed

CQI SYSTEM FEATURES REFLECTION EXERCISE

Indicate whether the
CQI system feature
represents a
Strength or Area Needing Development
at your agency or in your program.

IDENTIFYING STRATEGIC PRIORITIES AND OUTCOMES

THEORY OF CHANGE EXAMPLES

Kentucky-Approved

Appendix A: DCBS' Overarching Theory of Change for its Title IV-E Prevention Plan

	Inputs	Outputs	Impact

RESOURCES	• TWIST enhancements
	• Title IV-E funding
	• CQI/Evaluation team
	  • Evaluation plan
	  • CQI plan
	• Provider agency and child welfare and workforce
	• Provider Readiness findings
		• Intentional services
		• Monitoring for effectiveness and appropriateness
		• Access to accurate and comprehensive data
			Parent Capabilities Built
			• Improved problem-solving skills
			• Improved family relationships
			• Changes are maintained
			• An empowered ability to access resources
			• An ability to independently address issues as they arise
			• The confidence to parent and manage behaviors
			
			Child and Family Outcomes
			• Entries into Out of Home care
			  • Re-entries
			  • Maltreatment
			  • Repeat maltreatment
			  • Caseloads
			• Child and family well-being
			
			Child Welfare Agency Outcomes
			• Increased investments in preventative services
			• Decreased foster care expenditures
			• Decreased child welfare caseloads

PROACTIVE INTERVENTIONS	• Child and Adolescent Needs and Strengths • Structured Decision-Making • Training and Coaching • Family First Prevention Services Act liaisons • Prevention Plan	• Quality assessments of risk, safety, and protective factors • Quality strengths and needs assessments • Appropriate evidence-based practice identification • Greater evidence-based practice linkage and family participation in service	
CULTURE CLIMATE	• Culture of Safety • Public/private partnerships • Legislative commitment • Stakeholder engagement	• A workforce that feels safe and supported with the right tools • Greater workforce retention	

SERVICES	• Expanded business model
	• Well-supported evidence-based practices
	  • Multisystemic Therapy
	  • Functional Family Therapy
	  • Parent-Child Interaction Therapy
	• Promising evidence-based practices
	  • Trauma Focused-Cognitive Behavioral Therapy
	  • 1-2-3 Magic
	  • Cognitive Behavioral Therapy
	  • Sobriety Treatment and Recovery Teams
		• Greater service capacity
		• Aligned service array
		• Fidelity monitoring	

Washington, DC-Approved

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

Target Population

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

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

Interventions

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

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

+

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

- Individualized case management
- Motivational interviewing

Proximal Outcomes

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

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

Child maltreatment declines

- Reduced initial occurrence of maltreatment
- Reduced repeat maltreatment

Distal Outcomes

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

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

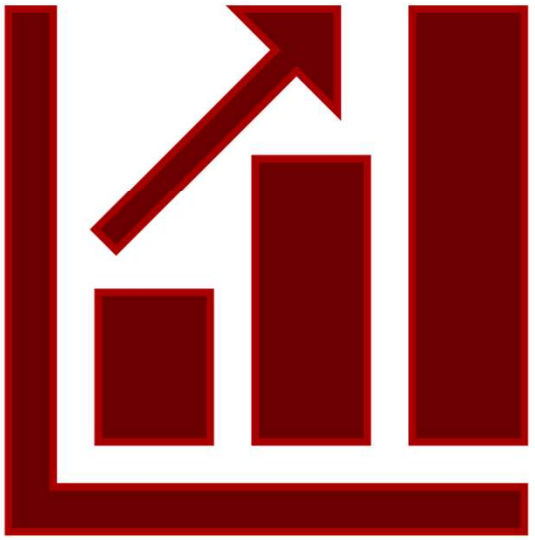
***The child welfare system rebalances** as a primarily preventive and family-strengthening system.*

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

Infrastructure & Implementation Supports

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

- Information technology tools
- Interagency collaboration
- Training & workforce supports



Measuring Performance

PREVENTION PLAN IMPLEMENTATION AND CQI

- Measure and monitor initial and ongoing implementation of the Prevention Plan
- Use a measurement framework to produce the information needed to fuel improvement efforts
- Establish routine forums with a diverse array of partners to engage in improvement planning
- Ensure race equity is centered and constituent engagement is intentional
- Ensure local prevention CQI efforts are connected and aligned with statewide CQI efforts and other systems transformation work

A MEASUREMENT FRAMEWORK

CAPACITY

REACH

FIDELITY

OUTCOMES

AGENCY CAPACITY MEASURES*

Assess the degree to which the agency devoted the necessary resources to support its implementation of prevention services

Reflect key implementation drivers

- Staffing^
- Training
- Coaching
- Technology supports & infrastructure
- Facilitative administration
- Systems interventions

*This framework groups capacity measures into six domains that correspond closely to seven "implementation drivers" identified by the National Implementation Research Network (NIRN). (NIRN's seventh implementation driver – Fidelity – is captured later in its own section.) For more information on NIRN and these implementation drivers, see https://nirn.fpg.unc.edu/module-1/implementation-drivers.

^NIRN calls this driver "Selection"
^^NIRN calls this driver "Decision Support Data System"

REACH

Measures related to children and families referred to services, outcomes of those referrals, and service uptake and completion

REACH MEASURES - REFERRALS

1. Among children **who come to the attention of the agency or screening entity and could be eligible for prevention services, # and %:**
   a) Identified as a candidate (i.e., meet the agency's criteria)
   b) Identified as a pregnant or parenting youth in case (PPY)
   c) Not identified as a candidate nor PPY

   Show data by time (e.g., month or quarter), region, jurisdiction, age, race & ethnicity
2. Among children **identified as a candidate or PPY,** # and %:
   a) Referred to an EBP
   b) Not referred to an EBP

      2.b. Among those not referred to an EBP, # and % reason:

         a) No service(s) available that meets needs or eligibility of child and family
         b) Services in place but at capacity
         c) other

   Show data by time (e.g., month or quarter), region, jurisdiction, age, race & ethnicity

REACH MEASURES – SERVICE UPTAKE

3. Among children identified as a candidate or PPY, and **referred to an EBP,** # and %:
   a) Who started the EBP (i.e., completed at least one session)
   b) Who did not start the EBP (i.e., have not completed at least one session)
      3.b. Among those who did not start the EBP, # and % by reason:
         a) No action taken; referral still in process
         b) Placed on waitlist (i.e., due to provider capacity)
         c) Provider rejected referral (e.g., client not eligible)
         d) Provider unable to contact or engage with family, family did not consent, etc.
         e) Other
      3.c. Among children **referred and placed on waitlist,** median days (and range) on waitlist

Show data by time (e.g., month or quarter), region, jurisdiction, age, race & ethnicity

REACH MEASURES – SERVICE COMPLETION

4. Among children identified as a candidate or PPY, **referred to an EBP and who no longer receive the service,**# and %:
   a) who completed the full EBP (i.e., completed all required sessions)
   b) Who did not complete the EBP

      4.b. Among those who did <u>not</u> complete the full EBP, # and % by reason:

      a) Provider unable to contact or engage with the family, family withdrew, etc.

      b) Family no longer eligible (e.g., moved out of service area, developed condition that impacted eligibility)

      c) Provider capacity issues

      e) Other

      Show data by time (e.g., month or quarter), region, jurisdiction, age, race & ethnicity

IDENTIFYING REACH MEASURES

- The template in the Tool Kit can be used to facilitate conversations between program staff, IT/data analysts, providers and key constituents to identify metrics
- You will need to assess, and more than likely adjust, current data collection and IT systems and processes to get the data you need

MEASURES: REACH

Many of the measures described in this framework use "children" as the unit of analysis for tracking referrals, service uptake, and outcomes. However, some agencies may want to measure such events at different or additional levels, such as those for the child or youth, his or her parents or kin caregivers, the entire family (e.g., case), or all three. For example, is the agency interested in knowing how many *children* were referred to and received a service, how many *parents* of those children were referred to and received a service, or *both*? These decisions will dictate the best approach to building IT systems designed to capture these data – both for the front end which workers see and use and the back end which IT developers create to store the data and allow for analysis and reporting.

Reach

What is Reach?

Reach refers to the degree to which the service is reaching the target population through eligibility determinations, referrals, and service uptake. Some services, particularly well-supported EBPs, will have their own recommended reach measures and should be included; others may have none.

Suggested Measures	Agency's Measures (if different)	Agency's Data Elements
1. Among children **who come to the attention of the agency or screening entity and could be eligible for Family First**, # and %: a. identified as a Family First candidate (i.e., meet the agency's criteria) b. identified as a Family First pregnant or parenting youth in care (PPY) c. not identified as a candidate nor PPY *Show data by time (e.g., month or quarter), region, jurisdiction, age, race & ethnicity*		

FIDELITY MEASURES

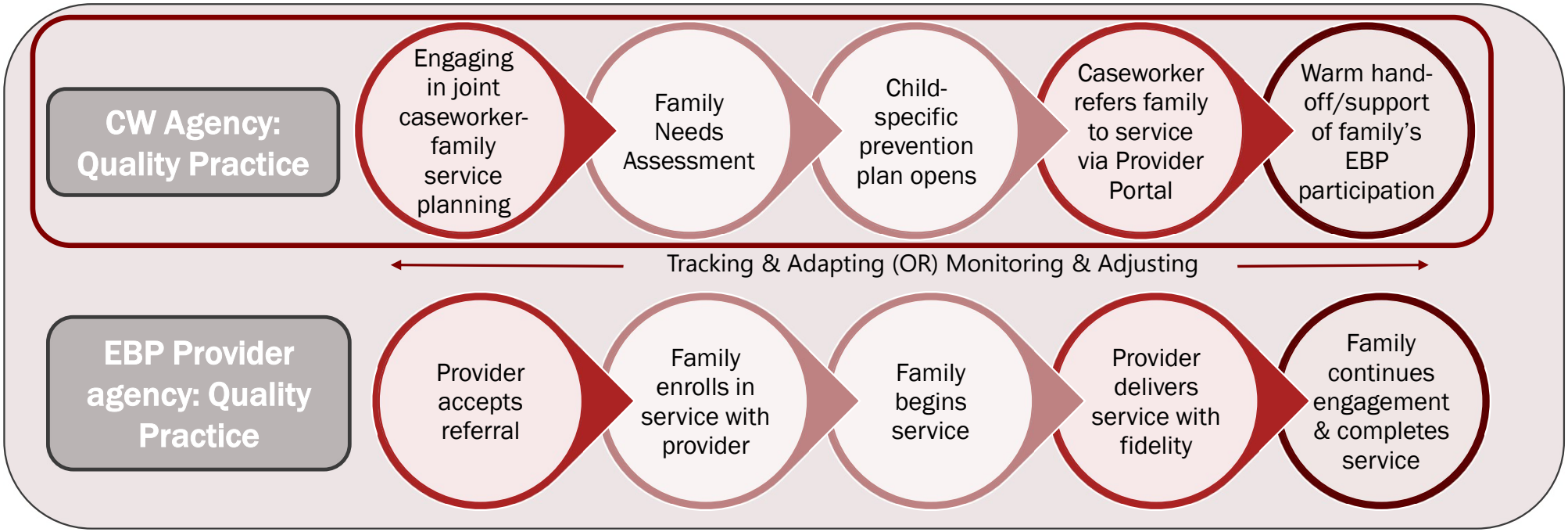
- Fidelity is the extent to which the service is carried out with **adherence to the intended approach** and can be assessed by measuring the degree to which capacity, process, and quality requirements are met.
  - **Process** - How services are delivered and what is done (e.g., type, frequency, intensity, duration, timeliness)
  - **Quality** - How well services are delivered. Quality can be measured with observations, interviews, focus groups, and surveys.
  - **Capacity** - The resources the agency devotes to the work to implement the EBP with fidelity to implementation guidelines and process and quality standard
- The Family First Prevention Services Act requires states to:
  - Clearly outline how EBPs will be continuously monitored to ensure fidelity to the program model and to determine outcomes achieved, as well as how information learned from monitoring will be used to refine and improve practices – the CQI approach
- Selecting the right fidelity monitoring approach will depend on the EBP and available resources

OUTCOMES

The extent to which the services are achieving the desired results for children and families, outcomes may be:

- **Prescribed by the EBP**
- **Agency specific**, for example:
  - CPS report while still receiving the EBP
  - CPS report within 12 mos. of competing an EBP
  - Entered foster care while receiving the EBP
  - Entered foster care after EBP closure by timing
- **Federally required** outcomes for Family First candidates (long term outcomes related to foster care entry)

Quality Practice Leads to EBP Participation and Outcomes Pathway: The Whole Picture



CHAPIN HALL
AT THE UNIVERSITY OF CHICAGO

EBP Outcomes
- Improved parenting skills
- Improved mental health
- Reduced substance use

Child Welfare Outcomes
- Reduce foster care entries
- Reduce repeat maltreatment
- Strengthen family well-being

Heaton, L., Creavey, K., Green-Rogers, Y., Reardanz, J., Obrien, J., Small, L., Harison, A., & Thomas, K., (in preparation). Family First CQI Implementation Framework to Support Practice, Service Delivery, and Improve Outcomes.

COMMUNICATION, COLLABORATION & ENGAGEMENT

- Building the measurement framework should be a collaborative effort, e.g., program staff, IT & data analyst, providers, lived experts, EBP developers/purveyors/trainers
- Building in a race equity focus will be important for monitoring disparities in referrals, service uptake and outcomes for children and families

INTERSECTION OF CQI WITH EBPs

Dan Edwards

GROUP CHALLENGE

A Whopper of a Challenge for the Group

- Watch the YouTube video on making a Whopper at home (1:08)
- Brainstorm: what are all the possible ways that IT COULD GO WRONG…?
- Write your ideas* in the chat

**Ginormous cash prize for the most creative idea…*

GROUP CHALLENGE: TAKE-AWAYS

- A Whopper of a Challenge
  - Would you let someone make a Whopper™ at your home – and serve it to your family?
  - What do you want to know about *how it was made* to be confident that it will 'taste right?'
    - To what extent does it depend on the skills, experience, and 'interest' of the maker?
    - The pickles have decided not to participate – now what?

- Personal Applications – the My Child test

WHAT IS TREATMENT (OR "MODEL") FIDELITY?

- Model Fidelity: "a **measure of the reliability of the administration of an intervention"**
  - an important aspect of the validity of a research setting
- In implementation settings: model fidelity (i.e., 'faithfulness') means
  - following the guidelines, principles, and strategies of the evidence-based program that were used in the original research (RTC) and deemed important by the model developer(s) as 'key ingredients' in the intervention
- **RECENT TREND: EBPS track both program and clinical fidelity**

Question: States can waive certain evaluation requirements with Well-Supported EBPs – WHY?

WHAT IS TREATMENT (OR "MODEL") FIDELITY?

- *Answer: ACF believes that, with Well-Supported EBPs, high-fidelity implementation → positive results can be expected*

- Model fidelity requires that the EBP is implemented:
  - correctly;
  - consistently across all clients (children, youth, parents, or families);
  - consistently across the entire time the treatment is needed, in all phases of treatment

DEFINING OTHER KEY TERMS

- Accommodation: tailoring the EBP to local conditions (e.g., language) *without modifying the key/integral components of the model*
- Adaptation: goes beyond Accommodation – modifies a key characteristic (e.g., target population)
- Adherence, aka fidelity = faithfulness to the original program as tested in RTCs
- Developers = those who created, developed, and tested a treatment intervention or program
- EBP Models = another way of saying evidence-based treatment program
- Outputs (markers related to implementation; e.g., number of staff trained, or average length of treatment) vs. Outcomes (short-term, e.g., status at termination of treatment; and long-term, e.g., how child, youth, or family is doing 6 months or a year later)
- Purveyors = organizations that provide training, licensing, and technical assistance w/r/t an EBP

CAN 'HIGH-FIDELITY' BE MAINTAINED?

Implementation Puzzles for EBP Developers and Purveyors:

- How do you make sure a therapist delivered the EBP 'as intended?'
- If the EBP on-site supervisors are the key to high-quality implementation, what is their role in this process – and who is going to train and support them?
- How would you build the 'internal system' to be able to do this frequently, consistently, and globally?
- How are costs for all these 'person-hours' invested in fidelity monitoring to be covered under Family First?

SELECTED EBPs IN CA (FAMILY FIRST)

1. Brief Strategic Family Therapy (BSFT)
2. Family Check-Up (FCU)
3. Functional Family Therapy (FFT)
4. Health Families America (HFA)
5. Homebuilders
6. Motivational Interviewing (MI)
7. Multi-Systemic Therapy (MST)
8. Nurse Family Partnership (NFP)
9. Parent-Child Interactive Therapy (PCIT)
10. Parents as Teachers (PAT)

**EACH EBP APPROACHES 'TREATMENT FIDELITY' IN THEIR OWN WAY*

EBP EXAMPLE #1: MST

MST QA: The Basic Idea

MST
Multisystemic Therapy

Better outcomes are achieved by the **youth and family** when the MST **Therapist** delivers MST with high-fidelity, and MST **Supervisors** are key to making that happen.

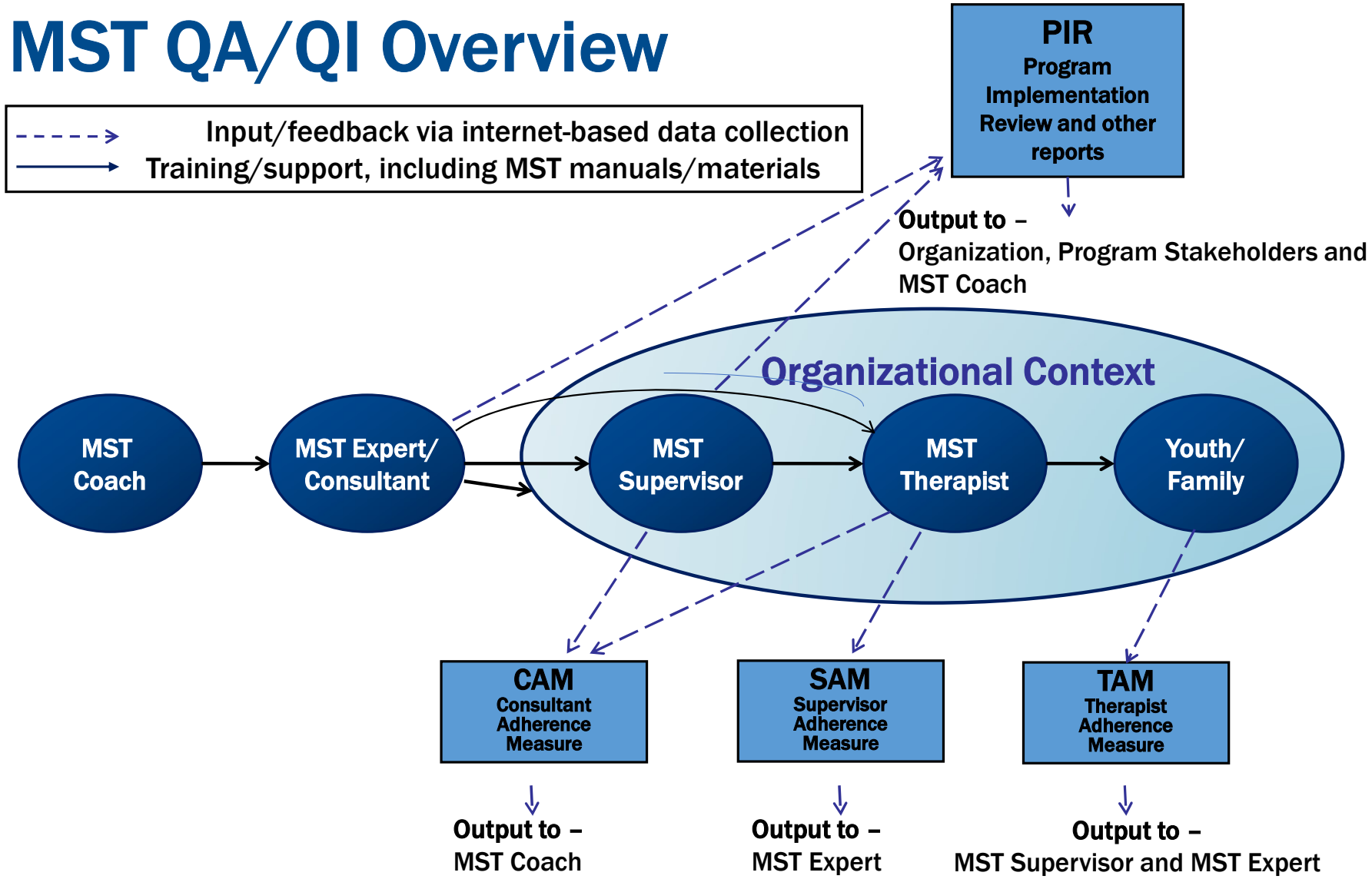
EBP EXAMPLE #1: MST

Building a CQI Framework (2000-2010)

MST Multisystemic Therapy

- Introduce training for Program Directors (Organizational Support)
- Introduce the role of the MST "Coach" and build training resources for MST Experts (training-the-trainers)
- Provide comprehensive program implementation reviews → creation of the MST Program Implementation Review (PIR) report
  - At the inception of the program and every six months thereafter
    - Program adherence (staffing, caseloads, length of treatment etc.)
    - Clinical adherence (fidelity measured on the TAM, SAM and CAM)
    - Outputs and outcomes reviewed (as were established at the beginning by the key stakeholder group or community development team)

MST QA/QI Overview



MST (SAMPLE TAM ITEMS)

Please answer the following two questions:

How many times has the therapist met with your family within the last week? _____

If zero, then when did the therapist last see anyone in the family (mm/dd/yyyy)? _____

Then, regarding your last 2-3 sessions:

	Did Not Respond	Not at All	A Little	Some	Pretty Much	Very Much
1. The therapist tried to understand how my family's problems all fit together.						
2. My family and the therapist worked together effectively.						
3. My family knew exactly which problems we were working on.						
4.The therapist recommended that family members do specific things to solve our problems.						
5. The therapist's recommendations required family members to work on our problems almost every day.						
6. The therapist understood what is good about our family.						
7. My family and the therapist had similar ideas about ways to solve problems.						

EBP EXAMPLE #2: NFP

Nurse-Family Partnership (NFP) fidelity monitoring methodology includes:

1. Quarterly Outcomes Reports:
   - To help supervisors monitor extent to which team is achieving outcomes related to family functioning
2. Agency Implementation Reviews (AIRs)
   - A comprehensive review across several implementation goals (e.g., fidelity; staffing; caseloads)
3. Fidelity Indexes
   - Data collected and submitted to the NSO re: 19 NFP Model Elements
4. Collaborative Success Planning
   - Enables the establishment of "SMART" goals using a CQI process to improve program implementation
5. Site Visits
   - At least annually, NSO staff meet with the team locally and observe, assess, and reflect on progress
6. Ongoing Consultation
   - Training and ongoing consultation – both virtual and in-person – to support the translation and integration of knowledge and skills to ensure that nurses implement NFP with fidelity.

**Nurse consultants guide agencies and nurses in the application of new research findings and innovations as well as adjusting NFP practice to the changing context and demographics of our clientele.*

EBP EXAMPLE #3: FFT*

I. Clinical Adherence (ratings range from 0 to 3)

- represent the degree to which the therapist applies the model as intended (manualized, trained, supervised, etc) – based on what therapists *actually do* in the session (*'how often'*)

II. Clinical Competence (ratings range from 0 to 3)

- represents the creativity, flexibility, breadth of alternative "avenues" the therapist takes to *match to the uniqueness of each family's language and ways of experiencing their world* – based on the quality with which therapist implemented FFT model-specific behaviors *('how well')*

Clinical Adherence + Clinical Competence
= Overall FFT Clinical Fidelity Rating

**this fidelity rating method is utilized by FFT LLC. Note that FFT Partners is also able to provide training and licensing in the FFT model. FFT Partners uses a different method for assessing and rating clinical fidelity to the FFT model – see https://functionalfamilytherapy.com/ for more information about FFT Partners.*

EBP EXAMPLE #3: FFT

III. Dissemination Adherence

- the degree to which the therapist is doing FFT *program activities* (i.e., following the assessment protocol; attending supervision; completing documentation using the web-based system (CSS))

- 'the degree to which the therapist is complying with the basic, procedural elements of the model'
  - attending supervision sessions regularly
  - completing their progress notes for all cases and sessions in a timely manner
  - administering assessments and questionnaires to clients

"…difficulties in monitoring and supervising therapists FFT in community agencies from remote locations has highlighted how critical these components are related to successful implementation. When therapists are not adhering or complying with these (basic procedural) aspects of dissemination, we are not able to effectively assess their adherence and competence in delivering the model to families"

– FFT Supervision Manual (from FFT LLC), Chapter 5, page 4

EBP EXAMPLE #3: FFT

Summary of QA / CQI tasks for FFT Supervisors related to fidelity monitoring (monthly and 'tri-yearly')

Summary of Supervisor Quality Assurance and Improvement Tasks

Monthly Supervisor Tasks

- Aggregate report review
  - Review Active, Referred, and Closed cases for each therapist
    - Focus on length of treatment duration for currently active cases (e.g., is a case taking more than a few weeks to move out of EM?)
    - Review closed cases in CSS for each therapist – Make sure that each case is closed using correct CSS definition
  - Review Case Tracking Report (found under Group Reports)
    - Focus on group data and individual therapist data to determine any possible quality improvement targets for group or specific therapists
      - Completed
      - Non-completed
      - Treatment pacing and duration
      - School enrollment, violations, at home, etc
  - Review Case Review and Progress notes to determine any therapist who is behind in progress notes or other documentation. Develop informal or formal plan to address
  - Based on review, develop informal or formal plans to address compliance issues; monitor therapist progress with any quality improvement plan targets; and use this data to support therapists in supervision.
- Review your compliance with fidelity rating frequency by reviewing Supervision Summary Report

Supervisor Tasks (Every Four Months)

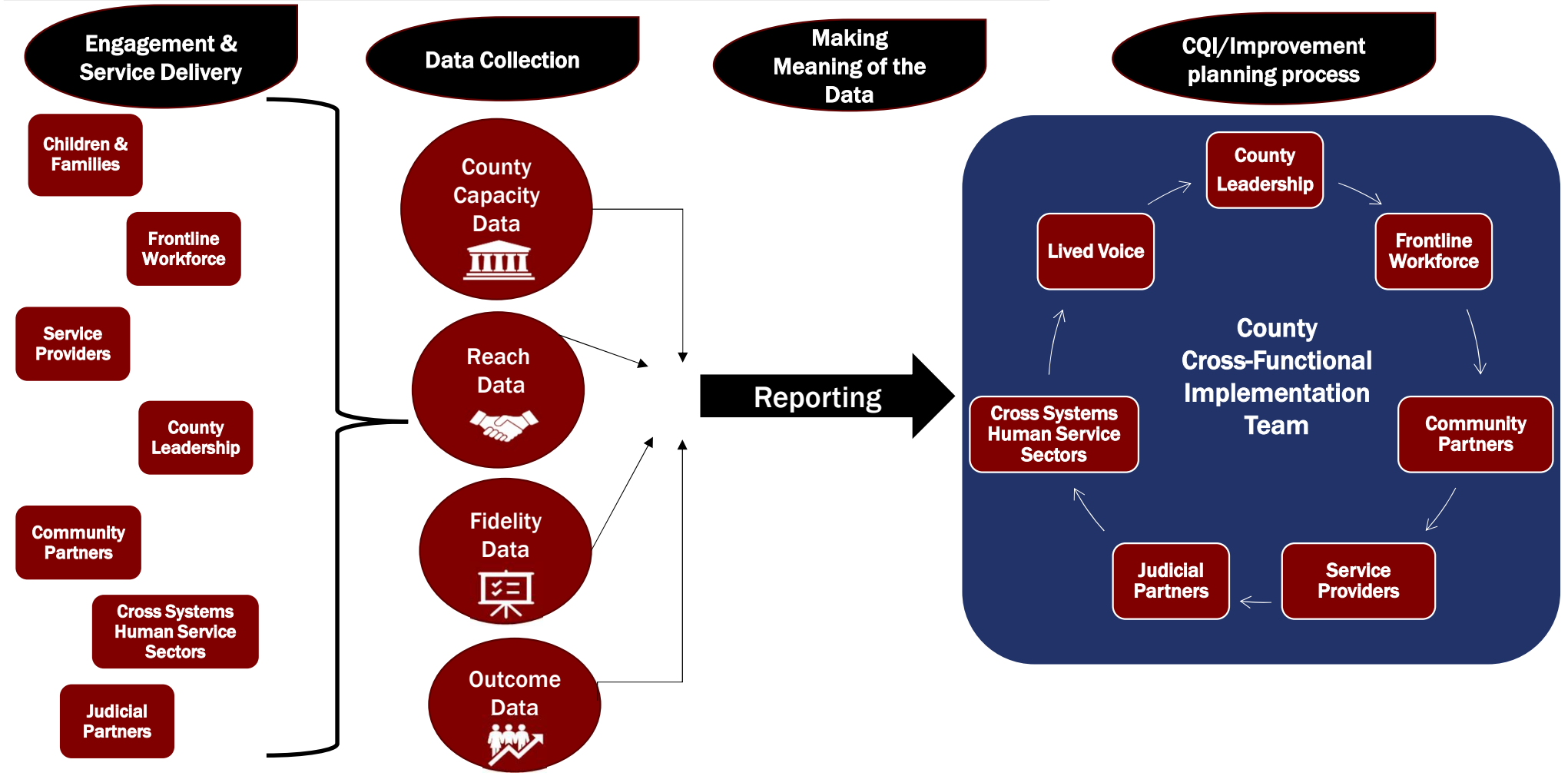
- Complete Global Therapist Report for each therapist
  - Prepare report by reviewing:
    - Case Tracking Report
    - Case Review Report
    - Progress Notes Report
    - Supervision Summary Report (review fidelity ratings and dissemination adherence ratings for each therapist for past 4 months)
  - Based on data from reports, complete the GTR
    - Identify concrete, specific and measurable targets and goals for Learning and Growth Plan in GTR.
  - Meet with each therapist to review GTR and discuss Learning and Growth Plan.

- Complete TYPE Report for team, review data from TYPE Report, and create necessary quality improvement plans.

ACTIVATING THE IMPROVEMENT PLANNING PROCESS

Yolanda Green-Rogers

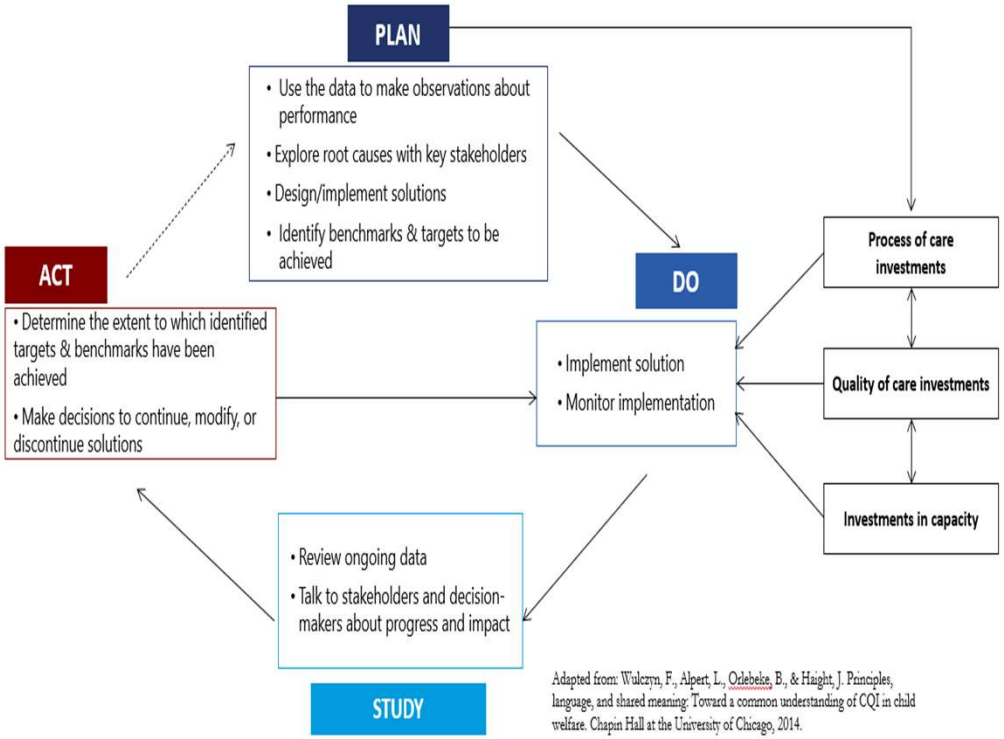
Activation


Engagement & Service Delivery
Data Collection
Making Meaning of the Data
CQI/Improvement planning process
Children & Families
Frontline Workforce
Service Providers
County Leadership
Community Partners
Cross Systems Human Service Sectors
Judicial Partners
County Capacity Data
Reach Data
Fidelity Data
Outcome Data
Reporting
County Leadership
Frontline Workforce
Community Partners
Service Providers
Judicial Partners
Cross Systems Human Service Sectors
Lived Voice
County Cross-Functional Implementation Team

THE BASIC DEMANDS OF A CQI PROCESS

- Identify strengths and gaps in performance
- Understand underlying conditions/root causes
- Identify solutions and plan for implementation
- Implement the solution
- Test the solution and revise the approach
- Use evidence or information (qualitative or quantitative) at each step in the process to support an observation, claim, hypothesis, or decision

PERFORMANCE REVIEW & IMPROVEMENT PLANNING



Adapted from: Wulczyn, F., Alpert, L., Orlebeke, B., & Haight, J. Principles, language, and shared meaning: Toward a common understanding of CQI in child welfare. Chapin Hall at the University of Chicago, 2014.

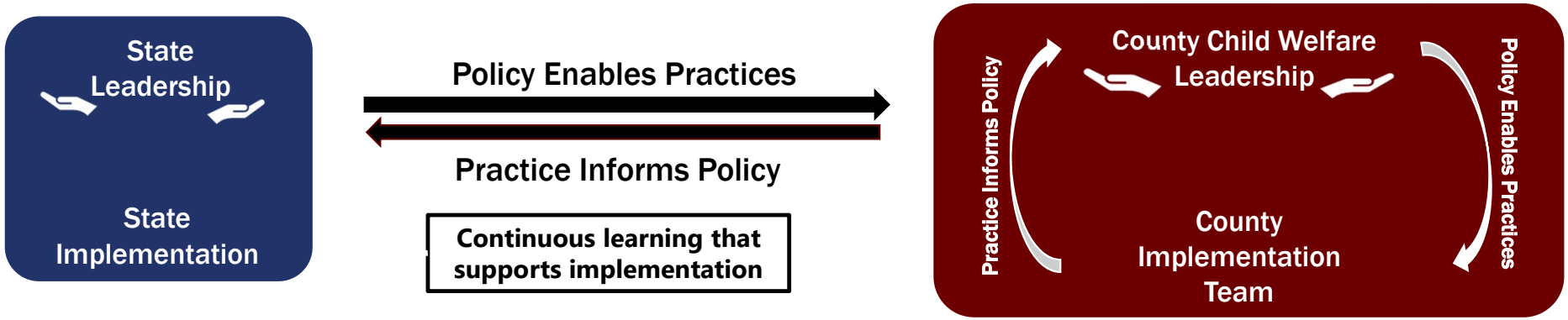
What structured CQI process will be used?

- Plan-Do-Study-Act (PDSA) cycles
- Define, Measure, Analyze, Improve, Control (DMAIC)
- Results-Based Accountability (RBA)
- Data Driven Decision-Making
- LEAN/Six Sigma
- 4 Disciplines of Execution (4DX)

PERFORMANCE REVIEW & IMPROVEMENT PLANNING

- In what forums will performance data and evidence be discussed, root causes identified and improvement strategies co-developed?
  - Front-line staff and supervisor team meetings
  - Meetings with providers
  - Comprehensive CQI meetings that bring everyone together
- How often will meetings take place?
- Who are the key participants in those discussions?

STATE AND COUNTY PRACTICE-POLICY FEEDBACK LOOPS* (WITHIN THE COUNTY AND BETWEEN THE STATE & COUNTY)



- Communicate progress and celebrate success throughout the system
- Report systemic barriers that are preventing or hindering implementation and
  - Should be resolved by one of the groups
  - Need to be moved 'up the line' to the group that can best address the barrier
- Report on actions taken related to resolve or address past issues
- Revisit past decisions and agreements periodically to ensure that solutions are still functional

*Adapted from the National Implementation Research Network (NIRN): http://nirn.fpg.unc.edu/learn-implementation

WHAT THIS LOOKS LIKE

- **Engagement & Service Delivery:** Phased state-wide implementation of 5 EBPs
- **Data Collection:**
  - Reach Data Dashboard produces monthly focused on 4 key indicators
  - Fidelity data aggregated quarterly from:
    - Quarterly case reviews conducted for 3 EBPs; debriefings with providers include purveyor and/or trainer participation & feedback
    - Direct receipt of quarterly reports from the purveyor of one EBP
  - Agency capacity monitored via a Priority Matrix developed based on findings from a survey of state agency staff and focus groups with providers on key agency capacity measures
  - Outcome monitoring will occur through implementation of the evaluation plan by an outside evaluator
- **Data Analyzed and Reported** by CQI data analysts and prevention program specialists; prevention branch leadership oversees this work
- **CQI/Improvement Planning Process:**
  - Quarterly CQI meeting convened virtually with a wide-array of internal and external constituents
    - Performance data and evidence shared
    - Root causes discussed
    - Potential solutions identified
    - Implementation updates provided
  - Learning collaboratives conducted with EBP providers by purveyors and trainings
  - CQI Specialists review and discuss data at regional CQI meetings with providers and case management supervisors
  - CQI Specialists and internal CFSR leads also discuss the data & evidence to better understand performance on OSRI items

THANK YOU

for your interest in using CQI as a lever in your efforts to enhance child and family well-being by keeping children with their families and in their communities!

Yolanda Green-Rogers
yrogers@chapinhall.org

CDSS Framework for Improving Practice & Model Fidelity: Monitoring EBPs

Kelly Winston

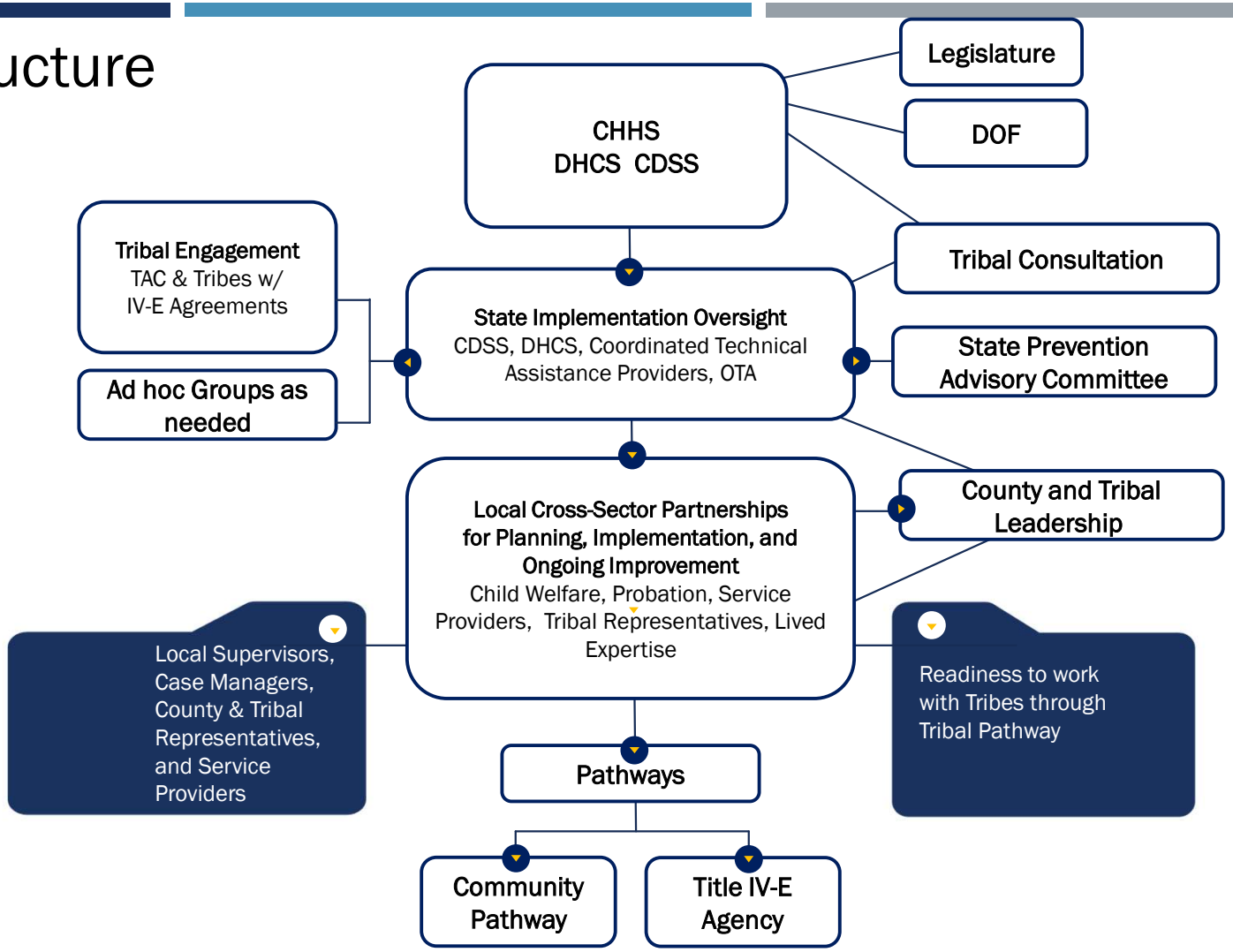
FAMILY FIRST PREVENTION SERVICES

Framework for Improving Practice

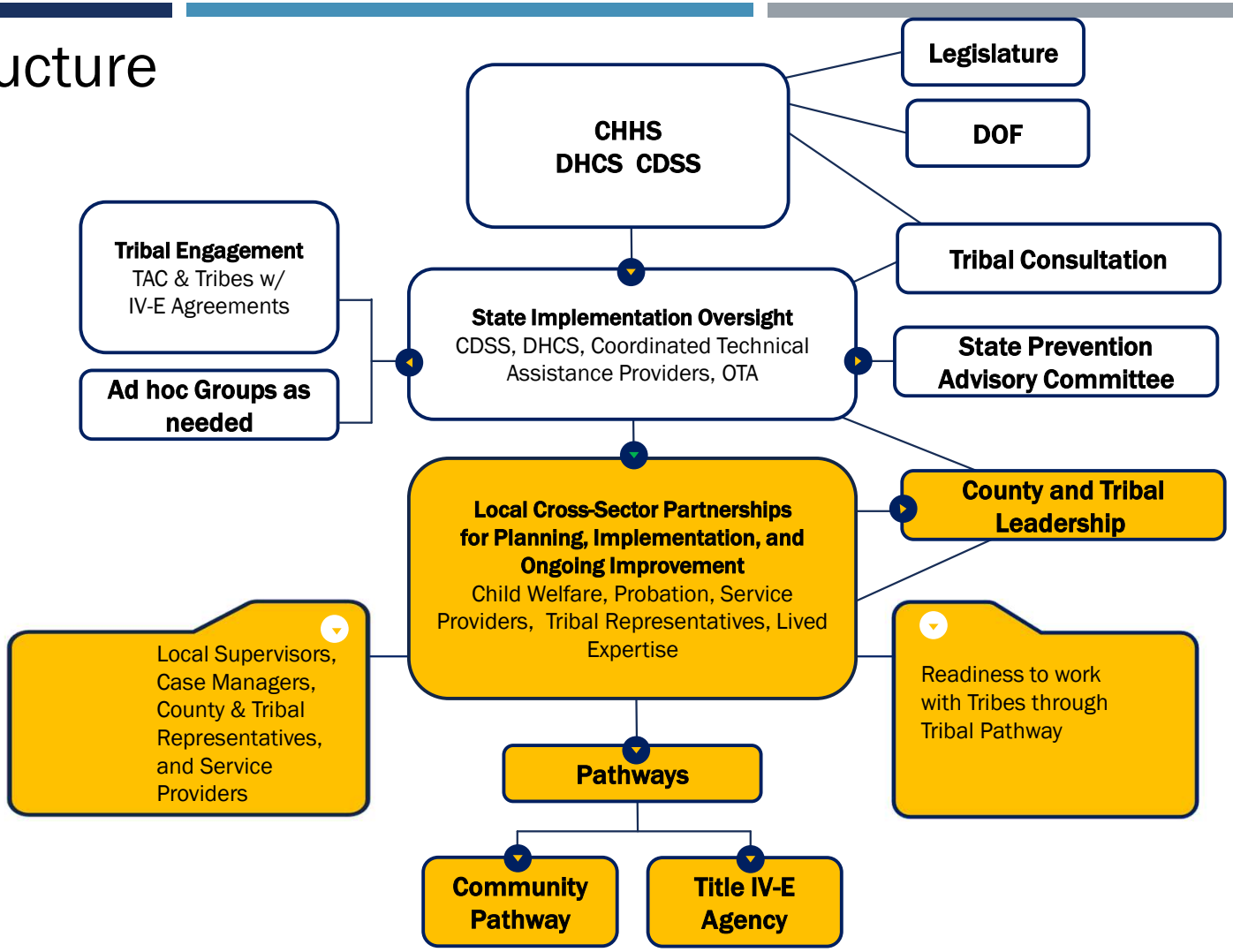
&

Model Fidelity Monitoring of EBPs

Governance Structure



Governance Structure



Feedback Loops for Continuous Monitoring

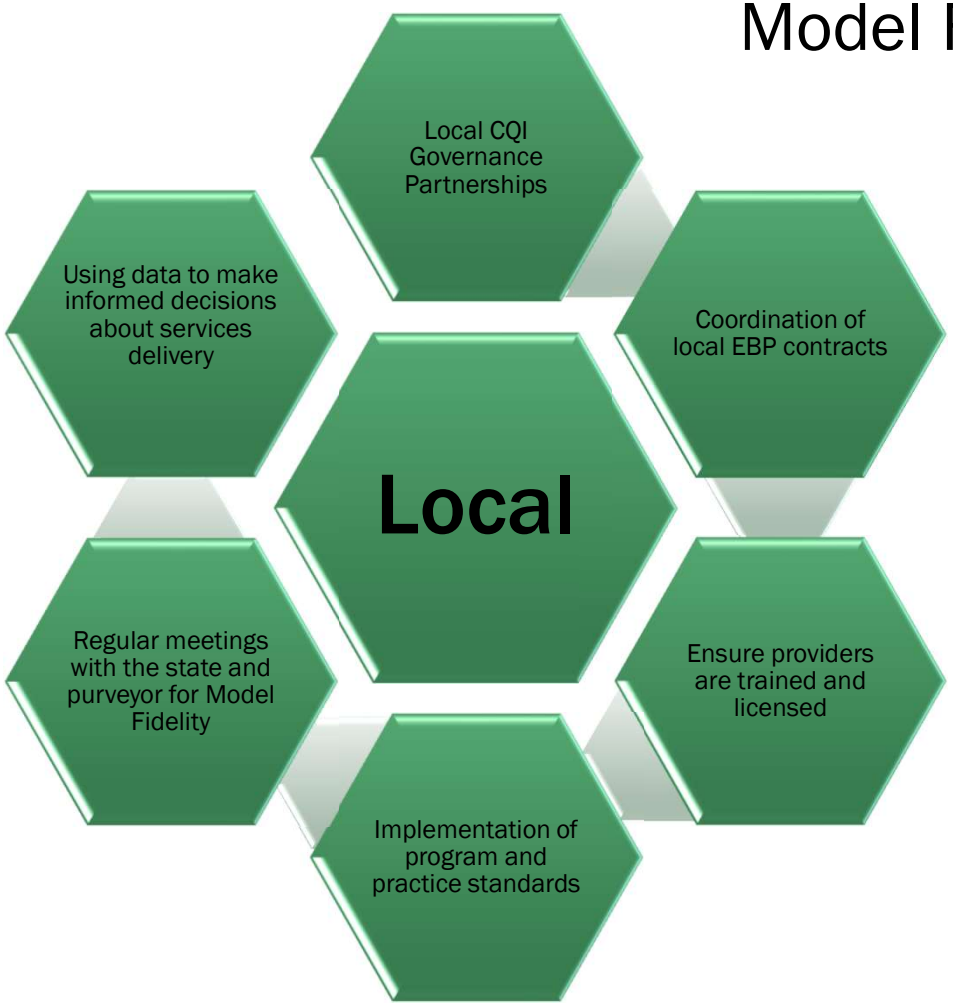
Make the necessary changes identified as needed from the evaluation and restart the cycle of implementation

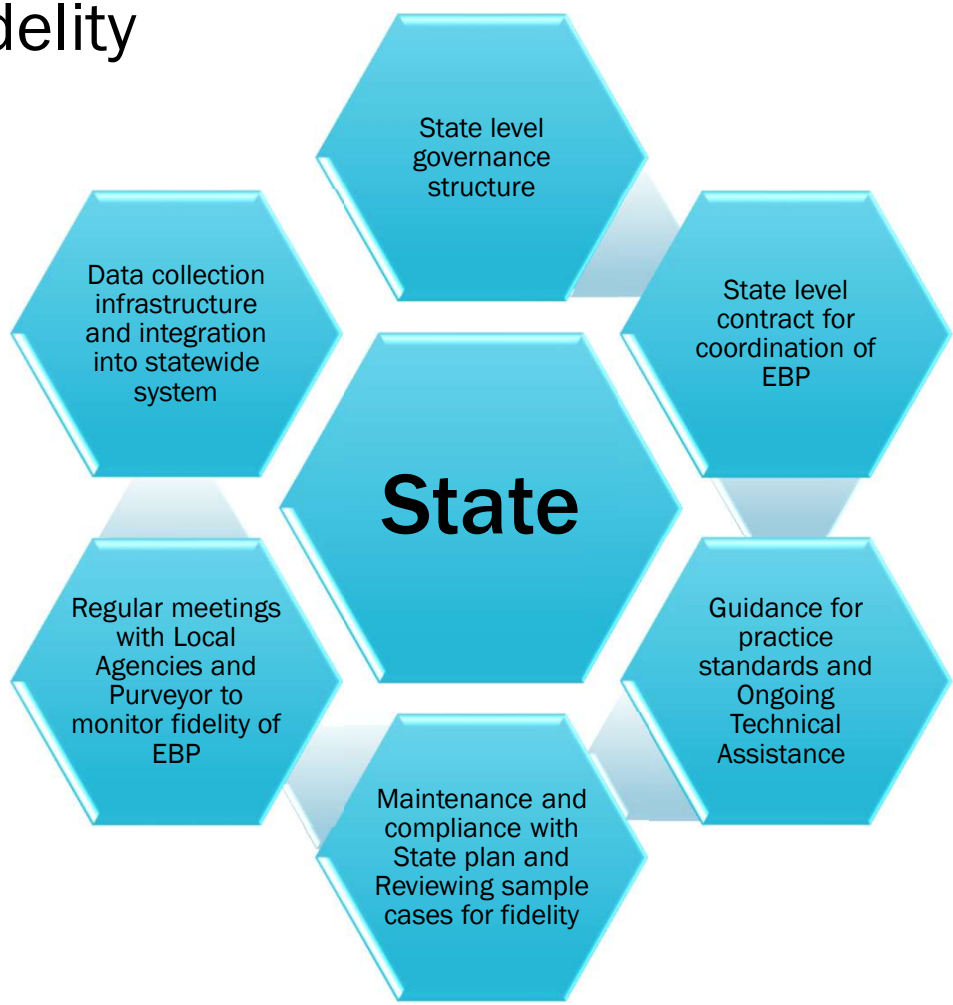
Focus on the who and the what for understanding the problem and complete a deep investigation to uncover the issues

Evaluate the implemented solution and test its effectiveness

Develop actionable strategies grounded in evidence to address the problem and implement those identified strategies

Model Fidelity





STATE & COUNTY PARTNERSHIPS FOR CQI

- State Level Investments
  - Model Fidelity Oversight for each EBP
  - Further development of the state/county CQI structure, feedback loops etc.
  - Common state outcomes for the FFPS program
- Stakeholder Input Processes
- County Assurances

CONCLUDING THOUGHTS

Khush Cooper

WHAT MAKES GREAT OUTCOMES

Implementation Science

INTERVENTION	IMPLEMENTATION: Effective	IMPLEMENTATION: NOT Effective
Effective	**Actual Benefits**	Inconsistent; Not Sustainable; Poor outcomes
NOT Effective	Poor outcomes	Poor outcomes; Sometimes harmful

(Institute of Medicine, 2000; 2001; 2009; New Freedom Commission on Mental Health, 2003; National Commission on Excellence in Education,1983; Department of Health and Human Services, 1999)

Karen A. Blase, PhD & Dean L. Fixsen, PhD

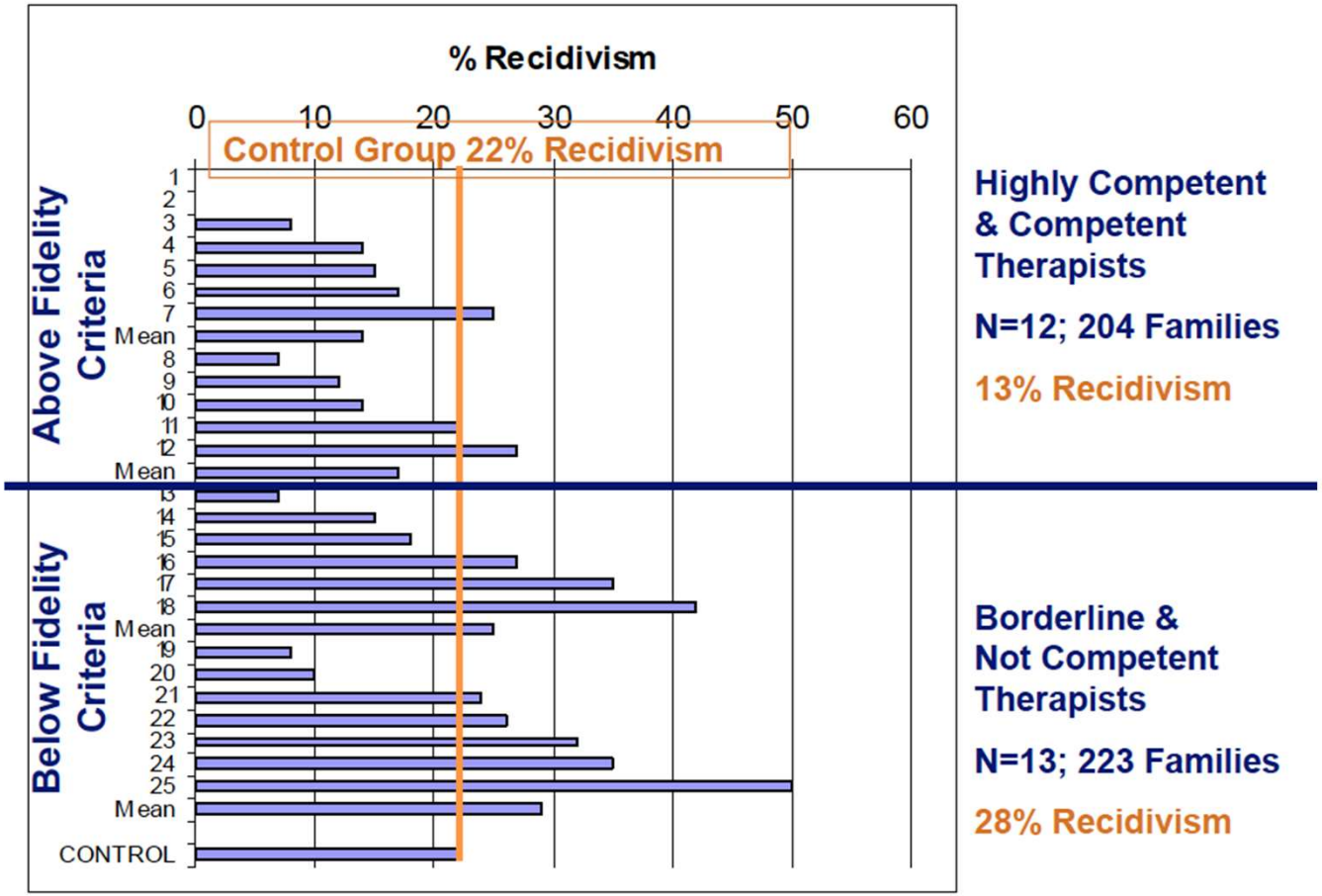
Co-Directors, National Implementation Research Network

Senior Scientists at the Frank Porter Graham Child Development Institute,

UNC, Chapel Hill, North Carolina

BETTER TO DO NOTHING

Functional Family Therapists (WSIPP)



Highly Competent & Competent Therapists

N=12; 204 Families

13% Recidivism

Borderline & Not Competent Therapists

N=13; 223 Families

28% Recidivism

Karen A. Blase, PhD & Dean L. Fixsen, PhD

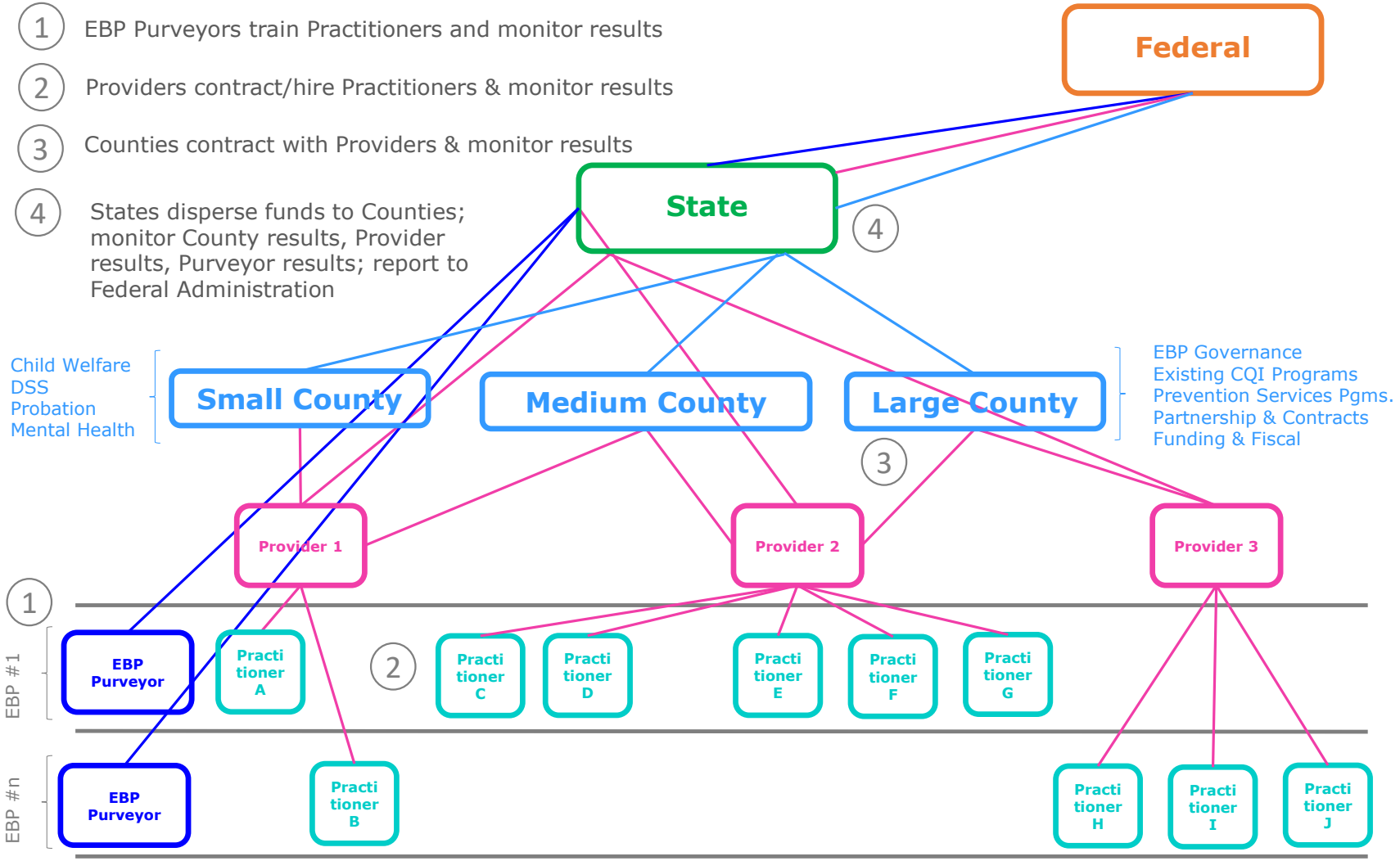
Co-Directors, National Implementation Research Network

Senior Scientists at the Frank Porter Graham Child Development Institute,

UNC, Chapel Hill, North Carolina

THE SYSTEM WE HAVE TO BUILD

1. EBP Purveyors train Practitioners and monitor results
2. Providers contract/hire Practitioners & monitor results
3. Counties contract with Providers & monitor results
4. States disperse funds to Counties; monitor County results, Provider results, Purveyor results; report to Federal Administration



ACKNOWLEDGEMENTS

This Learning Forum would not have been possible without the contribution of our esteemed colleagues.

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Chief, Family Centered Safety
and Support Bureau
CALIFORNIA DEPARTMENT OF
SOCIAL SERVICES

SERIES SCHEDULE

	Learning Forum	Q&A Session
Getting Ready to Deliver Family First Prevention Services - Special Emphasis on Fiscal and Funding		
Building the Team – Prevention System Governance and Collaboration	**Recording and Resources Available at caltrin.org**	
Designing a Comprehensive County Prevention System		
Ensuring Quality and Fidelity to Achieve Outcomes		**10/5/22**
Preparing the Workforce to Deliver Family First Prevention Services	**10/19/22**	**11/2/22**
Putting It All Together	**11/16/22**	**11/30/22**

UPCOMING TRAININGS

mark your calendars!

Visit caltrin.org to view the full training calendar and the self-paced online training options

- 09/28 | Addressing Implicit Bias
- 10/20 | Utilizing Logic Models to Demonstrate Outcome Accountability
- 10/26 | Deepening Constituent Engagement
- 11/03 | Logic Model Development Support Workshop
- 11/09 | Historical & Racial Trauma
- 11/10 | The Data Playbook for Prevention Action Planning

Thanks for joining us!

WHAT'S NEXT?

- Survey and certificate in the chat now
- Register for the Q&A!
- Recording and resources available within two days
- Watch your inbox for the next issue of *CalTrin Connect*

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