Private Collaboration to Implement Evidence-Based Programming

Washington, DC

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PUBLIC CONSULTING GROUP

Family Centered Treatment Foundation

ARKANSAS DEPARTMENT OF HUMAN SERVICES

CWLA

"ANY MODEL NOT BEING IMPLEMENTED UNDER THE SAME CONDITIONS IN WHICH IT WAS STUDIED IS ONLY 'PROMISING'"

The Courage of Leadership to See Models Sustain

This session will demonstrate how the Arkansas Division of Children & Family Services (DCFS), Public Consulting Group(PCG) and the Family Centered Treatment Foundation (FCTF) communicate and share information to improve programming, assist local providers to improve their service delivery, caseworkers to adhere to prevention policy requirements (FFPSA), and measure the extent to which families achieve positive results. Arkansas DCFS is implementing Family Centered Treatment (FCT) across the state as one of its in-home parent-skill-building FFPSA programs. DCFS' contracted evaluator, PCG works closely with DCFS, FCT providers and the FCT Foundation to ensure the program is implemented to fidelity, from both the agency and Foundation's perspective. The parties actively collaborate to demonstrate how the trauma-focused program supports family resiliency to improve family well-being.

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Origins of FCT in AR: 2018

"Arkansas identified a gap in its service array, for families that needed intensive services for longer than four to six weeks to help them achieve stability and maintain gains.

Arkansas wanted a program that was similar to its Intensive Family Services , but in addition to crisis intervention, provided longer-term support to help families achieve the necessary skills and social support network to maintain long-term stabilization."

- Arkansas implemented **Intensive In-Home Services** in February 2019 as part of IV-E Prevention Services Program
- 37 Counties were selected to participate in the Pilot
- Arkansas put out an RFQ with the parameters that needed to be met including length of service and expected outcomes, but requested the providers propose the evidence-based intervention used to deliver the service.
- Arkansas chose three different providers that presented different intervention models.

*For a family to be eligible for Intensive In-Home Services they must have an open in-home case where **at least one child is a candidate for foster care or an open foster care case** where intensive services is needed for **reunification to be successful**.*

While not the target population, any of the Intensive In-Home programs may be appropriate for a parenting foster youth, if their needs cannot be met by IFS once available.

https://familyfirstact.org/sites/default/files/Approved%20Arkansas%20Five%20Year%20Title%20IV-E%20Prevention%20Plan%20Updated%20March%202020.pdf

What is Family Centered Treatment?

- FCT is an **evidence based, intensive trauma treatment** model of home-based family therapy. Practitioner and Family Voice Developed.
- Primary utilization is **stabilization of the family/prevention of removal from home** and **reunification should a youth be placed in foster/kin/congregate care.**
- **Practical, experiential**, and common-sense solutions.
- Designed to **increase family health** and well-being, **promote attachment** and resiliency among members, and develop **functional solutions for maladaptive patterns** (behavior).
- **Builds upon family strengths and addresses individual and family trauma** by addressing underlying causes, not just the symptoms.

4 Phases of FCT

https://www.familycenteredtreatment.org/the-fct-model

www.familycenteredtreatment.org

The Five Pillars of Family Centered Treatment

- Treat Families with Dignity and Respect
- Honor the Function of Behavior
- Treatment that is Relevant and Useful
- Internalization over Compliance
- Power of Giving & Restoring Self-Worth

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Engagement

We must connect before we can correct

>94%

- *Historical joining rate average for families receiving FCT.*
- *Engaging beyond 5 contacts within 30 days.*
- *Nearly 8 of 10 families receive >20 sessions*

The How Philosophy/Guarantees:

- ***Privilege; not a right to be in their home***
- ***Treatment and change is their choice***
- ***Respect and dignity integral to the process***
- ***This process is done "with" them; not "to" or "for" them***

Current Implementation:

- 42 Licensed Organizations
- >80 'Sites'
- Urban, Rural, Mixed, Frontier
- Pilot sites: FCT-R, PRTF reduction, lived experience

Program Funding Includes

- Medicaid (MCO [commercial and state])
- Title IV-E, Prevention Services
- State and local grant/ awards
- Hybrid
- Federal grant funding (SAMHSA)
- Shared Risk/Incentivized

Implementation Funding Includes

- Rate governed
- Grant funding (various)
- State sponsored

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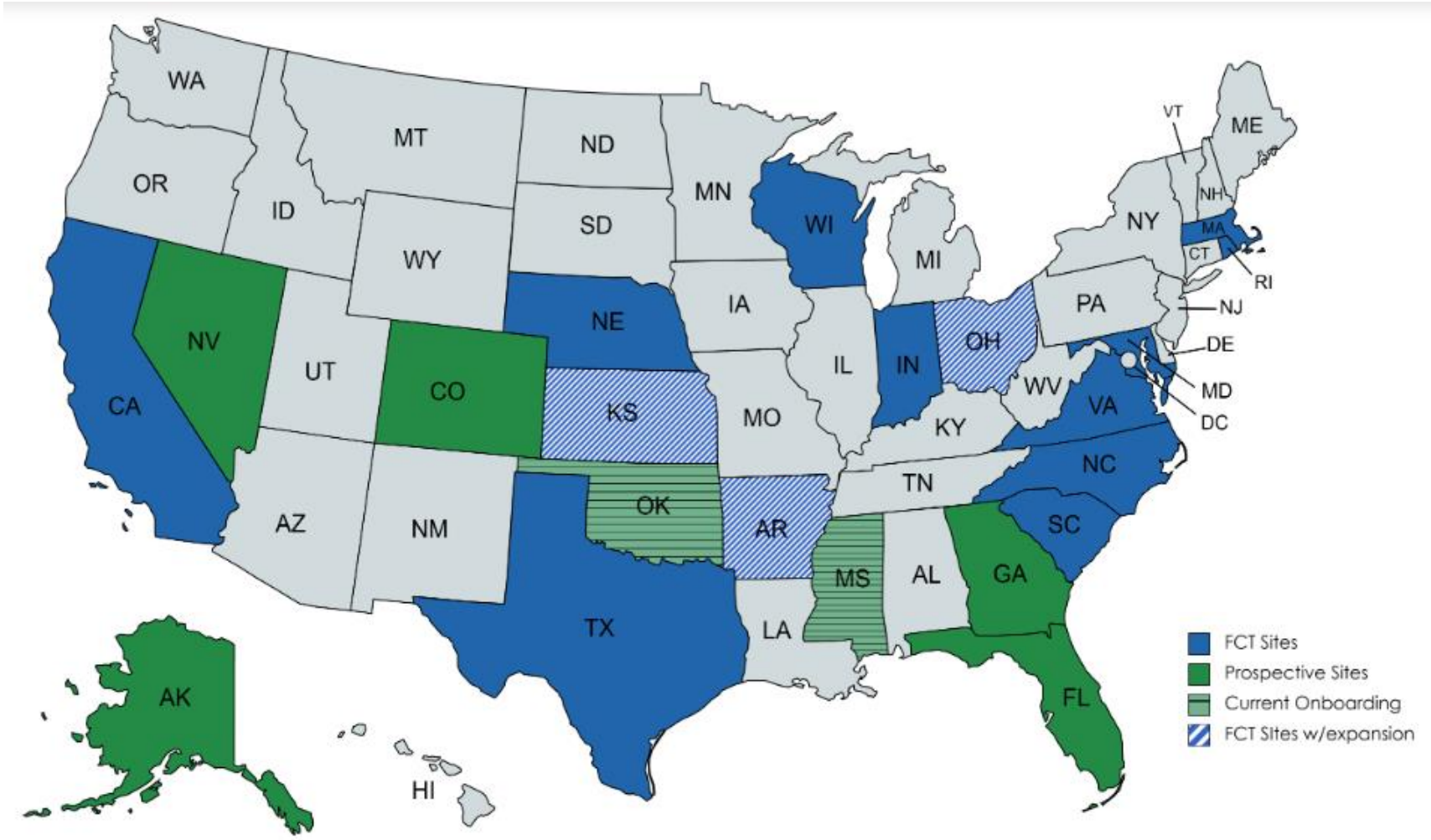

Because even the best ideas need a well-thought-out way to achieve it!

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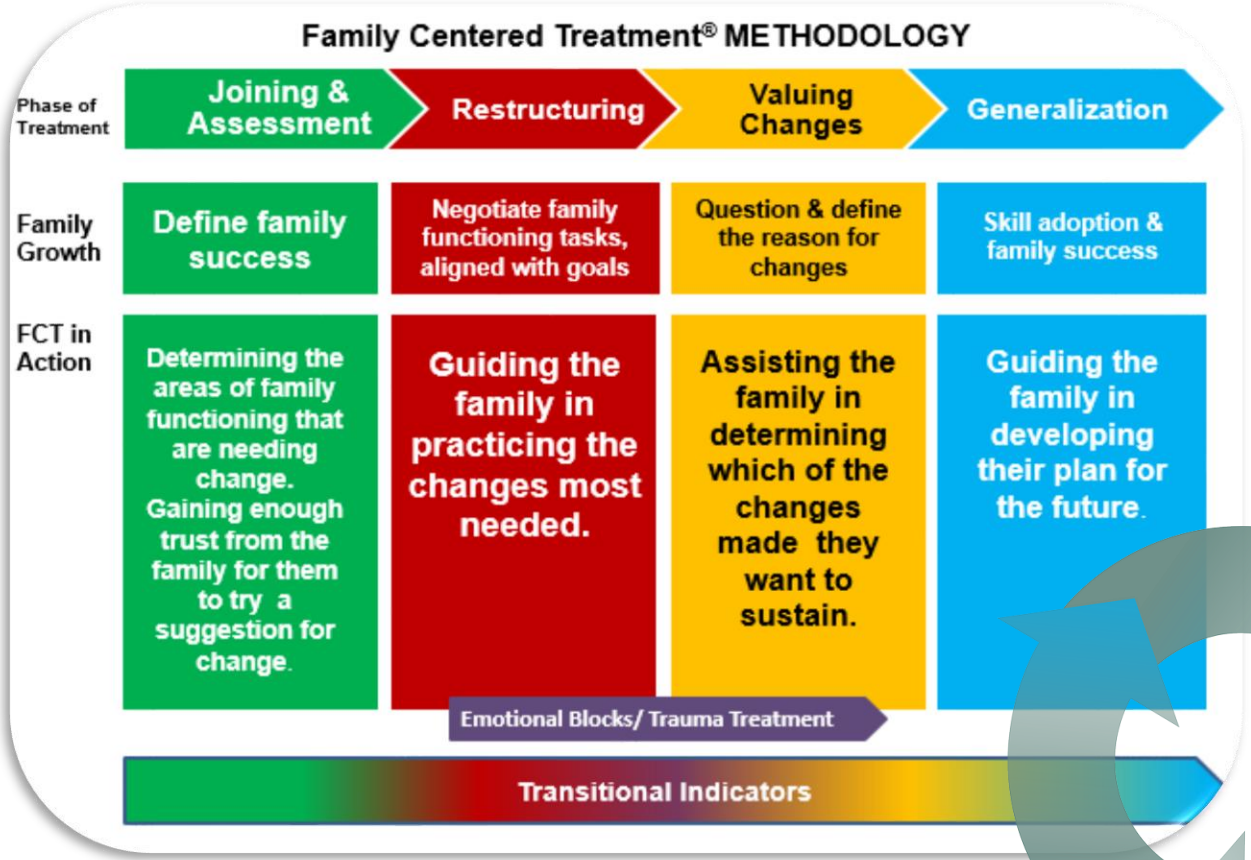
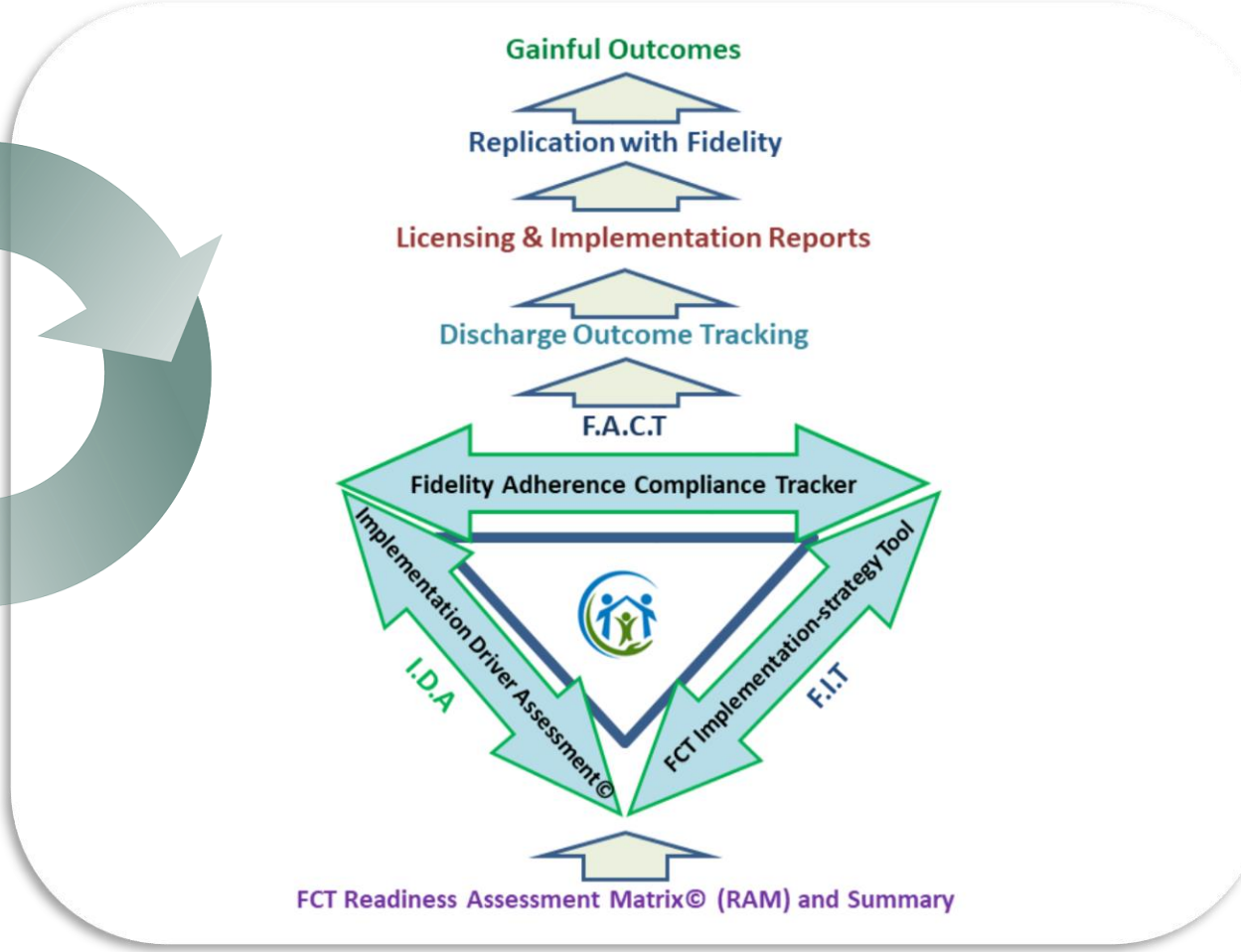
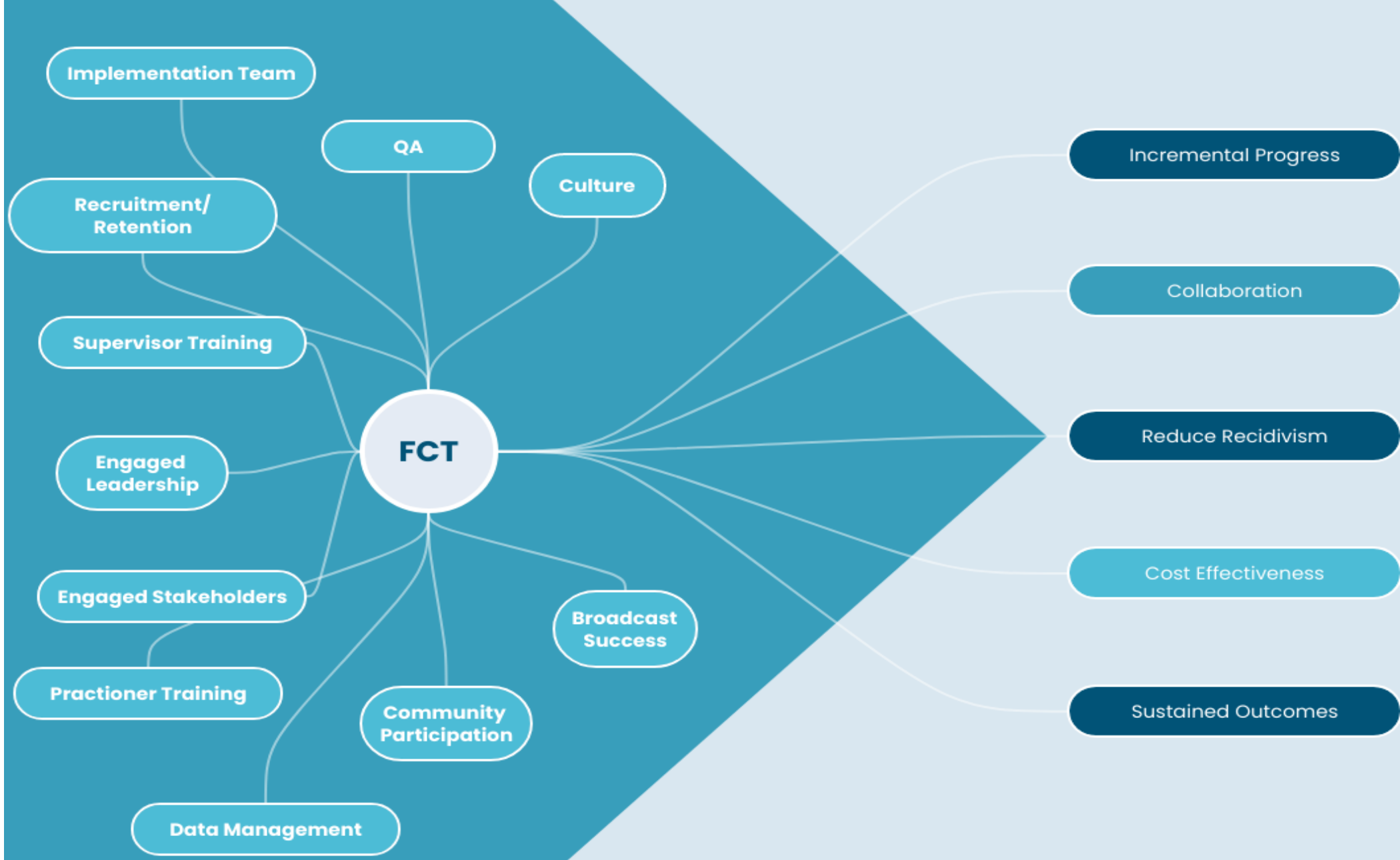




Co-Occurring Processes

Evidence Based Practice: Inputs & Outputs



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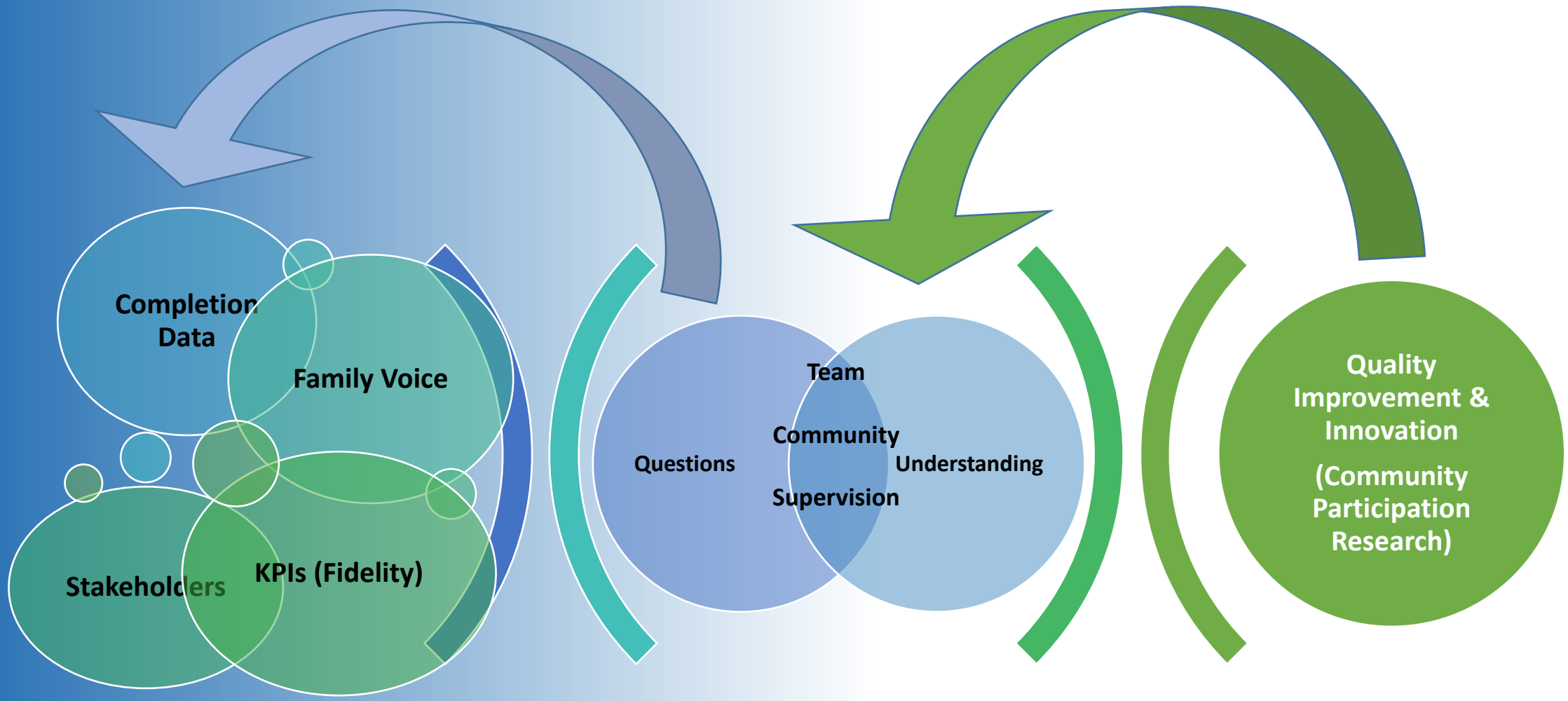

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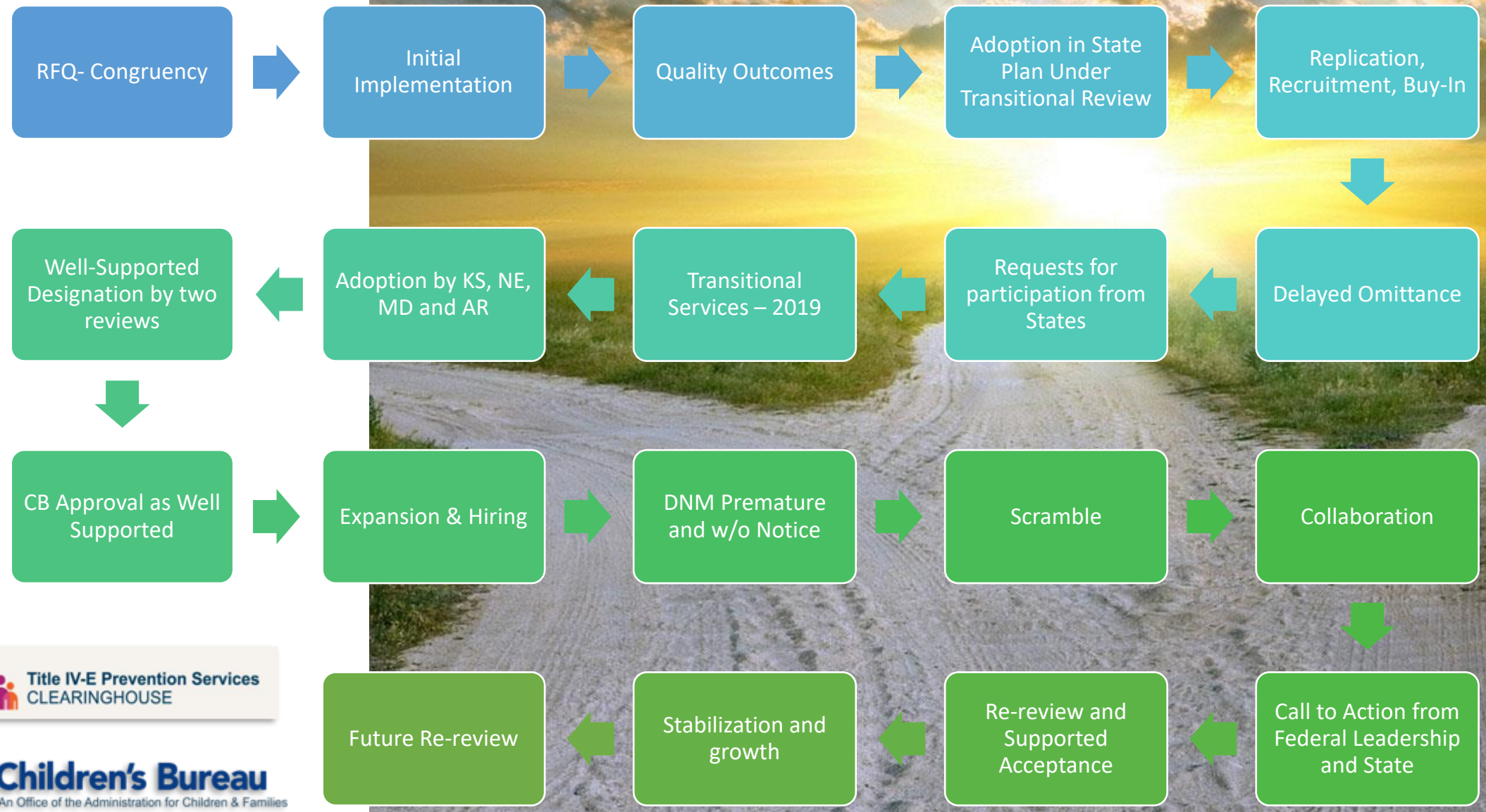
Family Centered Treatment and FFPSA in AR



Title IV-E Prevention Services CLEARINGHOUSE

Children's Bureau
An Office of the Administration for Children & Families

Continuous Quality Improvement (CQI)

Two-fold Approach

- Is the child welfare agency carrying out its role and responsibilities with fidelity?
- Are contracted programs adhering to the program requirements of the model?

Mixed-methods Approach

- Case record reviews
- Purveyor data, including family satisfaction surveys
- Interviews with caseworkers, clinicians and families

CQI Structure

Fidelity Monitoring

Item	Research Question
Capacity	Does the provider and its clinicians/therapists satisfy the educational, experience and/or training requirements?
Referral	How quickly are families being engaged?
Program Adherence	Are key program practices being completed as intended?
Enrollment	Is the program benefiting the needs of those for whom it was intended?

Outcome Monitoring

Measure	Research Question
Well-being	Are behaviors and/or parenting skills improving?
Safety / Permanency	Do children have increased safety and permanency?

CQI Benefits and Challenges

Benefits

- Frequent fidelity monitoring provides opportunities to make mid-course corrections quickly.
- Important to receive input from those the program is intended to support and are involved.
- Critical to understand why outcomes are or are not being achieved.

Challenges

- It is difficult to obtain high rates of response from family participants.
- It can be difficult to measure well-being outcomes post-discharge.

Prevention Clearinghouse Review & Approval

Overcoming the Challenge of Obtaining a Clearinghouse Rating

How do I get pass the “does not meet criteria” rating?

- Update studies to satisfy the rigor defined by the Clearinghouse
  - Propensity-score matching
  - Define outcomes that satisfy those defined by the Clearinghouse

How do we obtain a “well-supported” rating?

- Develop structured, streamlined outcome analysis strategies
  - Cross-site (state) evaluation approach
  - Quasi-experimental design

Progress and Celebration in 2023

Celebrating 5 years since passage

As of January 2023, only 6 states have not submitted an FFPSA plan.

Facing the Obstacles

- As of January 2023, The original intent of Congress in FFPSA to provide flexibility to states to identify and select EBP models best fitting their unique needs and populations to be served. However, as of January 2023, the Clearinghouse has reviewed 129 programs, deeming only 17 as “well-supported” and 49 combined as “supported” and/or “promising”. As a result, this guiding principle has been thwarted.
- Workforce retention and attrition rates are plaguing child welfare systems across the country, resulting in lack of foster placements for youth, “hoteling” of youth, lack of cultural understanding, and lack of trained personnel to implement many of the few “well-supported” models.
- While states may apply for a waiver for transitional funding for non-Clearinghouse approved models, states cannot afford the administrative time, the calendar time, nor the additional research costs to complete a separate independent research evaluation to obtain approval of models they prefer that are not rated well-supported.
- Well-supported programs and models continue to struggle with adequately trained personnel for implementation of several of these 17 models. Combined with the few numbers of well-supported programs, children and families are denied access to proven in-home, culturally informed, DEI, trauma-specific models for prevention of removal and stabilization of the family.
- Models need ACF instruction in monitoring fidelity measures, including evaluation of trauma-specific interventions.
- As a result of limited options, States are becoming avoidant of pursuing IV-E prevention funding and transitional waivers in lieu of more achievable sources for services, such as Medicaid.

Recommendations: Private and Public Collaboration to Implementing EB Programs of Choice

Include Clearinghouse programs designated supported and promising to qualify for IV-E reimbursement, given that those programs already have one clinical study meeting the research requirements of Clearinghouse and allow states to invest in those programs of choice, and

Allow designations from other clearinghouses, such as CEBC, to meet the criteria for IV-E reimbursement of programs.

Support “in real time” and fiscally key, cross-agency partnerships supported by independent research and consultation among state IV-E and juvenile justice entities, EBP models chosen by states for the unique needs of their populations, and community and judicial representatives.

Assuming ACF has the authority to issue guidance allowing reimbursement of IV-E Prevention Services for programs designated by the Clearinghouse as well-supported and supported, ACF make that modification to implementation guidelines.

(HHS should) fund models submitted under transitional waivers from one state or from a multi-state submissions.

OPRE and CB work together to ensure evidence-based models achieve implementation and outcome fidelity.

Barriers and Lessons Learned in Collaboration and Implementation

- Leadership Changes
- Stakeholder Continuing Education
- Regional Necessity/Buy-in
- Change in Culture of Services
- Workforce (recruitment and retention)
- Pandemic and Implementation

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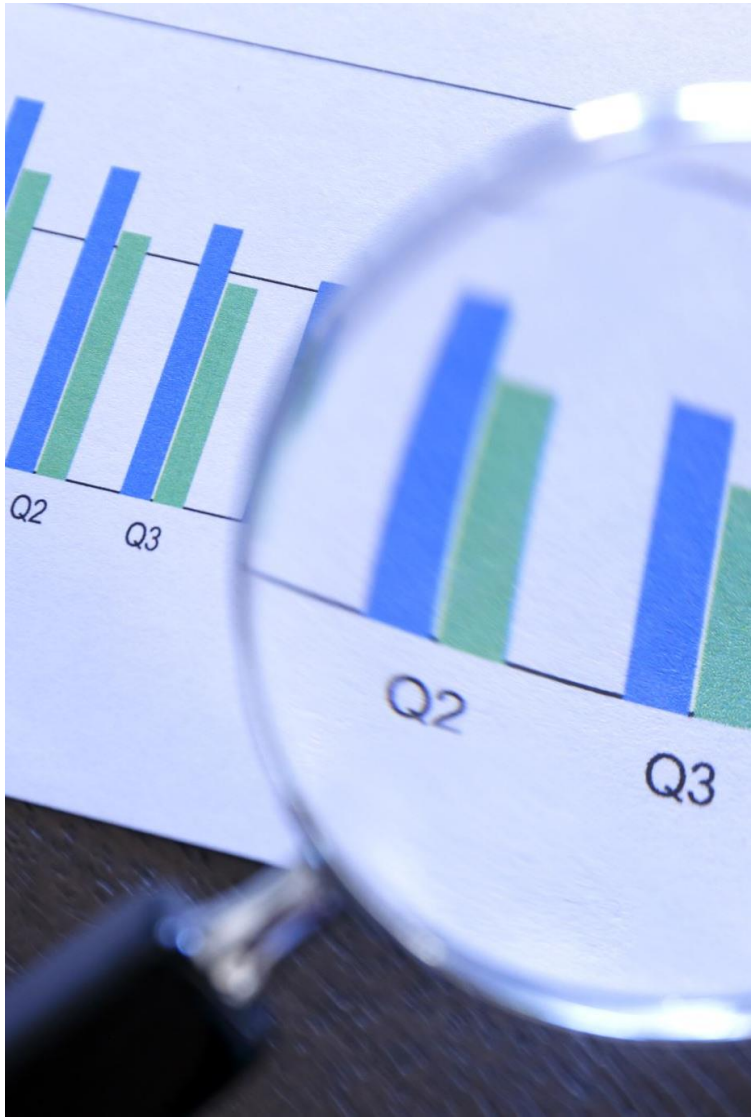
Arkansas Outcome Highlights for Family Centered Treatment Services

N = 222 Case Referral
N= > 500 ARCW Member Referrals
AR Child Welfare 2021-2022



Successful Outcome

85%

Of all FCT referrals had a positive placement at closure

Historical: 89%

Completion Outcomes

98%

FCT families completing the 4 phases of treatment had a positive placement at closure

Historical: 98%

Engagement

92%

Of FCT referrals were successfully engaged into services

Historical: 94%

Family Voice

94%

Families agreed that FCT has improved their family life

Historical: 89%

Preliminary FFPSA Findings
Prevention Services

- Collectively, the counties where IIHS services are available have seen a **9% decrease** in their foster child population in the last two years.
- Also, there has been an **8% increase** in the foster child population in counties where IIHS has not been available.

- Specifically, counties where FCT has been in place has seen a collective **decrease of 16.6%** in the foster child population.
- Also, there has been a **44% decrease** in the number of entries into care in the last two years!

"I do think this is telling. 😊 This is great news."

-Arkansas Department of Human Services
Division of Children and Family Services
November 2020

What's Ahead for Arkansas and FCT

As a result of successful implementation, communication, and QA; 2 IIH models including FCT will be introduced as a Medicaid billable option for youth/families in AR in 2023.

This capacity would not be possible without validation of replicable outcome data and buy-in from State leaders

FCT is also partnering with Juvenile Division of Courts to serve families involved in juvenile welfare system.

These expansions afford the opportunity to be able to greatly expand quality trauma treatment services to families across the State

Family Centered Treatment Foundation®

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